

**State of Connecticut
Department of Public Health
Division of Health Systems Regulation**

In Re: Hillcrest Healthcare, Inc. of Uncasville, CT, d/b/a
Hillcrest Health Care Center
5 Richard Brown Drive
Uncasville, Connecticut 06382

INTERIM AMENDED CONSENT ORDER

WHEREAS, Hillcrest Healthcare, Inc. of Uncasville, Connecticut (hereinafter the "Licensee"), has been issued License No. 2106-C to operate a Chronic and Convalescent Nursing Home known as Hillcrest Healthcare Center (hereinafter the "Facility") be the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on July 30, 2002 up to and including January 13, 2003 for the purpose of conducting multiple investigations, a certification inspection and a licensure inspection; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of the Connecticut State Agencies in a violation letter dated February 7, 2003; and

WHEREAS, the Licensee entered into a Consent Order with the Department effective June 11, 2003 (Exhibit A - copy attached); and

WHEREAS, subsequent inspections of the Facility during the period of June 27, 2003 to March 3, 2004 identified continued non-compliance with the Regulations of Connecticut State Agencies, Connecticut General Statutes and Federal laws and regulations and the original Consent Order effected with the Department on June 11, 2003 as evidenced by the March 8, 2004 (Exhibit B- copy attached); and

MAR 15 '04 11:26 FR HILLCREST HEALTH CARE860 848 7456 TO 918605097539 P.03/05 003

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.

Page 2

WHEREAS, the Licensee is willing effect an Interim Amended Consent Order inclusive of the June 11, 2003 Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein by and through Marianne Horn its Director, and the Licensee, acting herein and through John Antonino, its President, hereby stipulate and agree as follows:

1. The Consent Order between the Licensee and the Department effected June 11, 2003 is incorporated into this Interim Amended Consent Order.
2. The Licensee shall immediately cease admissions to the Facility except for patients returning from an acute care hospital stay. Admissions shall not resume unless and until the Department and the temporary manager agree that the Facility is in substantial compliance and is likely to maintain such compliance with all applicable state and federal statutes and regulations and the provisions of the Consent Orders.
3. The Licensee shall immediately increase registered nurse (RN) supervision within the Facility from one (1) free-floating supervisor per shift to two (2) RN Supervisors per shift, except that no additional RN supervision is required between the hours of 12 a.m. and 5 a.m. Such additional RN supervision shall continue until the Department and the temporary manager agree that the Facility is in substantial compliance with all applicable state and federal regulations and the provisions of the Consent Orders and is likely to maintain such compliance if the additional RN supervision is reduced. RN supervisors shall have the sole function of over-sight of the delivery of care and services to the patients of the Facility and immediately remediation of staff that fail to perform duties in accordance with standards of care and/or the Consent Orders effected with the Department.
4. The terms of this Interim Amended Consent Order and the Consent Order effected June 11, 2003 shall remain in effect until such time that the Department identifies that the

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.
Page 3

Licensee is able to provide care and services that meet federal and state laws and regulations and the provisions of the Consent Orders.

5. Execution of this Interim Amended Consent Order does not preclude the Department from initiating additional remedial actions.

*

*

*

*

*

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.
Page 4

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

HILLCREST HEALTHCARE, INC OF
UNCASVILLE, CONNECTICUT

3-17-04
Date

By: 
John Antonino, its President

State of Connecticut)
County of Hartford)

ss _____ 2004

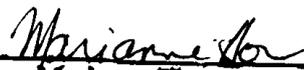
Personally appeared the above named _____ and made oath to the truth of the statements contained herein.

My Commission Expires: _____

Notary Public []
Justice of the Peace []
Town Clerk []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

3/24/04
Date

By: 
Marianne Horn, J.D., R.N., Director
Division of Health Systems Regulation

MAR 15 '04 14:46

MAR 16 '04 12:37

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

IN RE: Hillcrest Healthcare, Inc. of Uncasville, CT, d/b/a, Licensee
Hillcrest Health Care Center
5 Richard Brown Drive
Uncasville, CT 06382

CONSENT ORDER

WHEREAS, Hillcrest Healthcare, Inc. of Uncasville, CT (hereinafter the "Licensee") has been issued License No. 2106-C to operate a Chronic and Convalescent Nursing Home known as Hillcrest Healthcare Center (hereinafter the "Facility") by the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on July 30, 2002 up to and including January 13, 2003 for the purpose of conducting multiple investigations, a certification inspection and a licensure inspection; and

Whereas, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of the Connecticut State Agencies in a violation letter dated February 7, 2003 (Exhibit A- copy attached); and

WHEREAS, an informal conference with respect to the violation letter dated February 7, 2003 was conducted on February 21, 2003 at the Department; and

Whereas, the Licensee is willing to enter this Consent Order and agrees to the conditions set forth herein.

Now therefore, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein and through Wendy Furniss, its Director, and the Licensee, acting herein by John Antonino, its President, hereby stipulate and agree as follows:

1. The Licensee shall contract with a registered nurse acceptable to the Department to perform independent assessments of the Facility said Registered Nurse Assessment Consultant (RNAC) shall initiate services within two (2) weeks of the effective date of this Consent Order. The Department shall meet with the Licensee, RNAC and the Licensee's Regional Coordinator on a monthly basis for the first (3) months of the Consent Order.
2. The RNAC shall conduct and submit to the Department an initial assessment of the Facility. The RNAC shall visit the facility at least weekly and assess the care/services provided to patients. Documentation of said assessments shall be provided to the Licensee, Administrator, Corporate Regional Nurse Coordinator and the Department. The RNAC shall arrange his/her schedule in order to observe care and services at various times on all three (3) shifts, said Consultant shall confer with, and shall make recommendations to the Administrator, Director of Nurses and Regional Coordinator concerning the assessment of nursing services and the Licensee's compliance with the Regulations of Connecticut State Agencies, applicable Connecticut General Statutes and federal laws and regulations.
3. The RNAC shall visit the Facility at least weekly and shall devote sufficient time to adequately perform his/her duties. For the first month the RNAC shall devote at least twenty-four (24) hours onsite per week for two (2) weeks and twenty (20) hours per week for the remaining two (2) weeks, thereafter the RNAC hours shall be determined through consultation with the Licensee, Department and RNAC. Said determination of hours shall be based upon the recommendation of RNAC and Department onsite inspections. The RNAC services shall be discontinued after six (6) months or earlier as determined by the Department and RNAC in consultation with the Licensee.
4. The Licensee represents, stipulates and agrees that at all times it will employ sufficient personnel to meet the needs of the resident population.

5. The Licensee shall within fourteen (14) days after execution of this Consent Order review and revise, as necessary policies and procedures relative to notification of physicians upon the need to alter treatment and/or the identification of a significant change in resident condition, provision of care to prevent the formation and/or treatment of pressure sores, incontinent care, assessment for and the application of pressure relieving devices, development and implementation of comprehensive care plans that include identification of individual resident problems, goals and approaches, supervision and safety of residents, administration of medications, notification of physician when medications not available and compliance with applicable, state and federal laws and regulations. All treatment modalities and professional disciplines involved with the resident shall specify the specific problems and the approaches they will utilize to attain stated goals.
6. Within thirty (30) days after the effective date of this Consent Order the Quality Assurance Committee shall institute a skin assessment team which shall evaluate and monitor all residents identified as having the potential for and/or residents with impaired skin integrity. The team shall be under the direction of the Infection Control Nurse with consultation from a professional with credentials in wound management, as applicable. The Infection Control Nurse with consultation from the Wound Care Consultant shall have the following responsibilities:
 - a. Weekly assessment of residents with impaired skin integrity and documentation of said assessments.
 - b. Review of and implementation of facility policies/procedures pursuant to treatment and/or preventative measures for the maintenance of skin integrity.
 - c. Evaluation of the provision of care/treatments to pressure and/or stasis ulcers by staff.
 - d. Inservicing of staff pursuant to maintenance of skin integrity and/or treatment for those residents with impaired skin.

- e. Interfacing with the primary physician and/or the Medical Director, the Dietitian and Rehabilitation Professionals regarding wound management.
 - f. Attendance at Quality Assurance meetings and medical staff meetings.
 - g. Participation in the care planning process for residents identified at risk and/or those individuals with impaired skin integrity.
 - h. Observation of staff providing wound treatments for compliance with physician orders and professional standards of practice.
7. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nurses, shall each ensure compliance with the following:
- a. Sufficient nursing personnel are available to meet the needs of the patients.
 - b. Appointment of a free floating Nurse Supervisor on the day, evening and night shifts whose primary responsibility is the assessment of patients and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken or resolution of the problem(s). Said records shall be made available to the RNAC and the Department upon their request and shall be retained for a three (3) year period of time.
 - c. Nurse Supervisors shall be provided with the following:
 - i. A job description which clearly identifies the supervisors day-to-day duties and responsibilities;
 - ii. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;

- iii. Nurse Supervisors shall be supervised (includes reasonable on-site supervision as described below) and monitored by a representative of the Facility Administrative Staff, (e.g., Director of Nurses Services, Assistant Director of Nurses Services) to ensure the Nurse Supervisors are functioning in accordance with this Consent Agreement and state and federal requirements. Said administrative supervision and oversight shall be provided on all three (3) shifts on an irregular scheduled of visits. Records of such administrative visits and supervision shall be retained for the Department's review;
 - iv. Nurse supervisors shall be responsible for ensuring that all care is provided to patient by all care givers in accordance with individual comprehensive care plans.
8. The Licensee shall retain the services of the Corporate Regional Nurse Coordinator onsite a minimum of thirty-two (32) hours per week for the initial six (6) month period this Consent Order is in effect.
9. Within forty-five (45) days of the effective date of this Consent Order, the Medical Director, with advice from the Facility's Administrator and Corporate Regional Nurse Coordinator and Director of Nurses, shall issue each physician that is a member of the Facility's medical staff a document which delineates the physician's obligations and responsibilities to their individual patients and the facility's nursing staff.
10. In accordance with Connecticut General Statutes Section 19a-494.(3), the Department hereby censures the Licensee for failure to comply with the stated requirements of the Regulation of Connecticut State Agencies.
11. The Licensee, agrees to pay a monetary fine to the Department in the amount of twelve (\$12,000.00) thousand dollars, which shall be payable by certified check to the Treasurer of the State of Connecticut and shall be posted to the Department within (2) weeks of the effective date of this Consent Order.

12. Any documents and/or meetings required by this document shall be sent to:

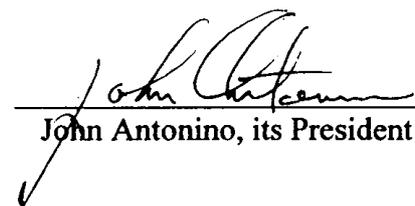
Cher Michaud, SNC
Division of Health Systems Regulation
Department of Public Health
410 Capitol Avenue, P.O. Box 340308
MS #12HSR
Hartford, CT. 06134-0308

13. Any records maintained in accordance with any state or federal laws or regulations or as required by this Consent Order shall at all times be made available to the Independent Nurse Consultant, and the Department upon request.
14. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
15. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

HILLCREST HEALTHCARE, INC. OF
UNCASVILLE, CT

6-2-03
Date

By: 
John Antonino, its President

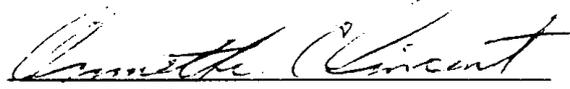
STATE OF CT

County of New London) ss June 2nd 2003

Personally appeared the above named John Antonino and made oath to the truth of the statements contained herein.

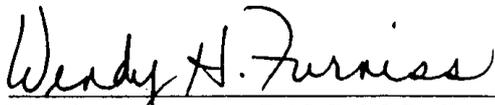
My Commission Expires: 2-28-06
(If Notary Public)

ANNETTE C. VINCENT
Notary Public, State of Connecticut
No. 0047648
Filed in New London County
Commission Expires Feb. 28, 2006


Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

6/11/03
Date

By: 
Wendy H. Furniss, R.N.C, M.S., Director
Division of Health Systems Regulation



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 7, 2003

Deborah Putnam, Administrator
Hillcrest Health Care Center
5 Richard Brown Drive
Uncasville, CT 06382

Dear Administrator:

Unannounced visits were made to Hillcrest Health Care Center on July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 by representatives of the Division of Health Systems Regulation for the purpose of conducting a licensure and certification inspection and complaint investigations with additional information obtained on December 2 and 11, 2002.

Attached are violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

An office conference has been scheduled for February 21, 2003 at 1 PM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut.

The purpose of this meeting is to provide you with an opportunity to show why further action by this Department should not be instituted.

You may wish to be accompanied by your attorney. It is not mandatory that you attend this meeting, however, if you do not attend we will have no recourse but to institute further proceedings.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS #.12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Deborah Putnam, Administrator
Hillcrest Health Care Center
Page 2

If there are any questions, please do not hesitate to contact this office.

Respectfully,



Marsha Balet, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

MLB/DML/jf

c: Director of Nurses
Medical Director
President

CI2002-1225, 2002-0992, 2002-0667, 2002-1025,
2002-1091, 2002-0360, 2002-0501, 2002-0550
RE2002-0975, 2002-1088, 2002-489

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

1. For two of two residents in the sample survey the facility failed to notify the physician of a change in condition, and failed to notify a physician of a medication omission (Resident #22, 23). The findings are based on review of the clinical record and staff interviews and includes the following:
 - a. Resident #22 was admitted to the facility on 10/14/98 with diagnoses of bilateral stroke with aphasia, a mitral valve replacement, and seizure disorder. Review of the clinical record identified a podiatry consult dated 5/9/02 which noted slow healing nail matrixectomies on the first and second toes of both feet with a recommendation to continue the oral antibiotic. A physician's order dated 5/11/02 prescribed Clindamycin 250 milligrams through the G-tube four times a day for ten days. Review of the Medication Administration Record {MAR} from 5/15/02, 12:00AM through 5/18/02, 6:00AM revealed that Clindamycin was not available {14 doses} and consequently was not administered. In an interview with the DNS on 7/31/02 at 12:45PM, he stated that apparently there had been a problem with the delivery of the Clindamycin and was not made aware of the issue until after the medication had been delivered. In an interview with MD #1 on 12/2/02 at 8:30AM, he stated that he was not notified of the medication omission and because of Resident #22's apparent difficulty with healing he would have expected to be. He further stated that he often had difficulty with the facility executing orders and then not being notified of the issues until he saw the resident in follow up.
 - b. Resident #23 was admitted to the facility on 11/21/02 with diagnoses of femoral popliteal bypass, ischemic ulcer right foot, peripheral vascular disease, and non insulin dependent diabetes mellitus. Review of the clinical record identified pre-admission documentation which identified that Resident #23 was having pain control issues which noted that Resident #23 yells when she has unrelieved pain. A pain assessment dated 11/21/02 identified leg and spine pain, as sharp, relieved by medication, and increases with movement. The nurse's note identified that on 11/23/02 at 1:00AM that the Dilaudid administered at 9:15 AM and relief at midnight was ineffective of the left upper leg pain and the resident was then given Tylenol. The nurse's note further identified that Resident #23 rang the call bell at least 20-30 times each time screaming in pain and a call was made to the physician and the facility was awaiting a return call. Further review identified a nurse's note dated 11/23/02 at 2:00 PM which noted the residents' continued complaints of pain. Although a call was placed to the physician on 11/23/02 at 1:00AM the physician

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

was not notified of the uncontrolled pain until 11/23/02 at 2:00PM when changes to the pain medications were initiated.

2. Based on observation, record review, and staff interview for two of two sampled residents, (Resident #'s 27, 28) the facility failed to assess the residents for the ability to self administer nebulizer treatments. The findings include:
 - a. Resident # 27 was admitted on 1/6/03 with diagnoses that included metastatic disease, and right pleural effusion. The self medication administration assessment dated 1/7/03 identified the resident as choosing not to self administer medications, and not wanting to be assessed by the interdisciplinary team. Observation on 1/7/03 during tour identified Resident # 27 lying in bed holding the nebulizer treatment while it was being administered. Further observation identified a nurse-aide enter the residents room to answer the call bell and assist the resident in holding the nebulizer treatment up to the residents mouth. The nurse-aide was then observed to leave the room and get the nurse who entered the residents room and stayed with the resident while the nebulizer treatment was being administered. Interview on 1/7/03 at 9:40am the charge nurse stated that she was unaware if the resident had been assessed to self administer her nebulizer treatment. Interview with the Director of Nursing on 1/9/03 at 2:30pm stated that no resident should self administer their own medications until they have been assessed.
 - b. Resident #28 was admitted on 1/7/03 with a terminal diagnosis. The self medication administration assessment dated 1/7/03 identified the resident as choosing not to self administer medications, and not wanting to be assessed by the interdisciplinary team. Observation on 1/7/03 at 10:45am identified Resident # 28 lying in bed holding a nebulizer treatment in her hand. The nebulizer was not observed in her mouth. The resident was then observed with shaky hands to bring it to her mouth and then remove it. At 10:50am while the resident continued to hold the nebulizer in her hand, the charge nurse walked by. Interview with the charge nurse at that time stated she was unaware if the resident had been assessed to self administer her own nebulizer treatment. Interview with the Director of Nurses on 1/9/03 at 2:30pm stated that no resident is to be left alone administering their own treatments unless they were assessed to do so.
3. The facility failed to ensure that a social service assessment had been completed in accordance with the policy and procedure. The findings are based on review of the

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

clinical record, review of policy and procedure, and staff interview and includes the following:

- a. Resident #35 was admitted to the facility on 9/21/02 with diagnoses inclusive of metastatic adenocarcinoma. Review of the clinical record identified a discharge summary dated 9/21/02 which noted that the resident was abusive, combative, delusional, and had hallucinations. Review of the RCP identified a risk for falls related to confusion and agitation with interventions that included a calm environment and medicate when necessary. Review of the nurse's notes from 9/21/2002 through 10/6/02 (16 days) identified occasional episodes of lethargy, increased confusion, aggressive behaviors, paranoia with attempts at elopement. Although behaviors were identified, review of the clinical record failed to identify that a social service assessment had been completed. Review of the policy and procedure for social work documentation identified that an initial social service summary will be compiled on each resident and completed within fourteen days of the resident's admission or if the resident is a subacute patient within 48 hours of admission. The initial summary shall include identification and assessment of biopsychosocial factors significant to the resident's care and psychosocial wellbeing. In an interview with the Social Worker on 12/5/02, she stated that she was the only social worker at that time trying to complete all the assessments and discharge planning. She stated that because of time constraints she was unable to complete Resident #35's social service assessment. She further stated that Resident #35 was admitted as a subacute patient and should have had the assessment completed in forty-eight hours.
4. Based on clinical record review and staff interview for one of nine residents, (Resident # 25) who was identified as a high risk for a pressure ulcer, the facility failed to ensure that a plan of care was in place to address the resident's skin. The findings include:
 - a. Resident # 25 was admitted to the facility with diagnoses that include insulin dependent diabetes and a fractured right hip. Nurse's admission assessment dated 10/25/02 identified that the resident's right heel was reddened. Although the observation was documented, the resident lacked a plan of care that addressed the resident's skin integrity. Further clinical review identified that on 10/27/02 the resident was identified with a stage 2 pressure ulcer of the heel. Interview and review of R#25's clinical record with the MDS coordinator on 10/10/03 failed to

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

identify that a care plan had been developed on admission to address the residents risk for breakdown/reddened heels.

5. The facility failed to ensure that services provided by the facility met professional standards of care for three of three residents in the sample survey. The findings are based on review of the clinical record and staff interview and includes the following:
 - a. Resident #32 was admitted to the facility on 3/1/02 with diagnoses of Alzheimers's disease, dementia, and polymyalgia rheumatica. A nurse's note dated 3/20/02, 5:00AM identified that Resident #1 was found on the floor. Review of a reportable event dated 3/20/02, approximately 4:30AM identified that Resident #32 was found on the floor at the bedside. Vital signs obtained subsequent to the fall revealed a blood pressure of 140/90, pulse of 88, and respirations of 20. Review of the nurse's notes from 3/20/02 through 3/21/02 failed to identify any assessment subsequent to the fall with any documentation lacking on 3/20/02, 7-3. The Director of Nurses {DNS} during interview on 7/31/02 at 12:45PM, stated that he would have expected the nurse upon discovery of the fall to assess the resident for any muscular skeletal injury and/or neurological injury and to include if the resident had any head trauma on the reportable event. The DNS identified that he would have expected an assessment to be done every shift for 72 hours subsequent to the fall.
 - b. Resident #36 had diagnoses inclusive of cerebral vascular accident, dysarthria, and muscle spasms. An assessment dated 6/3/02 identified a short and long-term memory deficit and modified independence in decision making abilities. It further identified partial loss of movement and range of motion on the left side that included the arm, hand, leg, and foot. The resident care plan dated 6/19/02 identified that transfer would be accomplished with the assistance of two staff members. Review of the nurse's notes dated 7/13/02 at 1:30 PM transfer. The nurse's note further identified that Tylox 5/500 one capsule was administered to treat the pain. The nurse's note failed to contain documentation that an assessment of the left shoulder or axilla was conducted. On 7/13/02 at 5:00PM a subsequent nurse's note identified that the resident was crying out in pain related to movement of the left axilla and shoulder. The pain was identified to be intense enough that an assessment of the area could not be performed. The physician was notified and a x-ray of the left shoulder was ordered. The initial x-ray report identified no gross fracture. Review of the nurse's note from 7/14/02 through 7/16/02 identified that pain continued to be present in the left shoulder during movement and that the

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

physician was aware. On 7/16/02 per a physician order, Resident #36 was sent to the Emergency Department (ED) for further evaluation of the left shoulder. Review of the left shoulder x-ray performed at the hospital identified a left proximal humerus fracture. In an interview with the Director of Nurses (DNS) on 12/4/02, she stated that an assessment of the left shoulder and/or the axilla was not conducted when the complaint of pain was first reported.

6. Based on observation, record review, and staff interview for five of twenty four residents who required positioning devices and/or nasal sprays, and/or administration of insulin, and/or following physicians orders, the facility failed to implement physicians orders according to the resident care plans. R#'s 19, 20, 24, 34, 35 and 36. The findings include:
 - a. R# 19 was admitted to the facility on 10/13/98 with diagnoses that included Parkinson disease. The Minimum Data Set dated 11/16/02 identified a history of falls. Review of fall screen done on 11/16/02 identified a recommendation for a Dycem that would prevent the resident from sliding from the chair was initiated. Clinical record review identified that R#19 had slid out of the wheelchair on 12/1/02 and was found lying on the floor on 12/26/02. Observations on 1/9/03 and 1/10/03 identified that the Dycem was not available to the resident. Interview with the Physical Therapist on 1/10/03 identified that Resident #19 should be utilizing a dycem to prevent her from sliding out of the wheelchair. Subsequent to inquiry the resident was issued a Dycem.
 - b. Resident # 20 was admitted to the facility on 3/26/02 with diagnoses that included COPD and asthma. Physician's orders dated 12/12/02 directed that Saline Nasal Spray maybe left at the bedside to be used by the resident whenever necessary. The physician's order was noted by licensed staff on 12/17/02. Observation of R# 20's room with the resident and the Director of Nursing on 1/9/03 at 12:50pm failed to identify nasal spray at the residents bedside. Interview with licensed staff on 1/10/03 noted that the nasal spray was not available.
 - c. Resident #34 was admitted to the facility on 6/28/02 with diagnoses inclusive of breast cancer with metastasis to the bone and brain. An assessment dated 8/26/02 identified short-term and long-term memory deficits, sadness, and tearfulness. A RCP dated 9/17/02 identified a problem with depression with interventions that included every shift behavior monitoring and to explain procedures in a calm approach. Review of a reportable event dated 10/26/02 identified that Resident #34

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- was found in her room with oxygen tubing doubled around her neck and pulling stating I don't want to live anymore. Review of the RCP dated 10/26/02 subsequent to the event identified a risk of injury to self with interventions that included a psychiatric evaluation, monitor for changes in behavior, and one to one staff monitoring. Although a psychiatric evaluation dated 10/28/02 identified that the resident was being monitored one to one and that the resident denied being suicidal with medication recommendations made, review of the clinical record with the DNS #2 failed to identify any documentation that the one to one monitoring had been initiated until 11/9/02.
- d. Resident #35 was admitted to the facility on 9/21/02 with diagnoses inclusive of metastatic adenocarcinoma of L4, L5, and a left parietal brain lesion. Review of the clinical record identified a discharge summary dated 9/21/02 which noted that the resident was abusive, combative, delusional, and had hallucinations. Review of the clinical record identified a nurse's note dated 9/22/02 which noted oppositional behaviors including agitation with an attempt to elope from the facility which resulted in a fall to the ground. Review of the RCP dated 9/22/02 identified a risk for elopement secondary to the resident expressing that he does not want to be in the facility with interventions that included fifteen minute checks for twenty four hours. Although the RCP dated 9/22/02 identified every fifteen minute monitoring, review of the clinical record failed to identify that the monitoring was implemented until 9/23/02 at 3:00PM.
- e. Resident #24 was admitted to the facility on 8/27/02 with diagnoses inclusive of recent left hip fracture with a bipolar hemiarthroplasty and insulin dependent diabetes mellitus. Review of the Minimum Data Set (MDS) dated 9/9/02 identified that short and long-term memory was intact and that decisions were consistent and reasonable. Review of the nursing admission assessment dated 8/27/02, identified that the last bowel movement recorded was on 8/24/02. Review of the physician's order dated 8/27/02 identified that Milk of Magnesia (MOM) 30 milliliters (ml) by mouth at hours of sleep was to be given if no bowel movement was recorded for three consecutive days. A glycerin suppository per rectum was to be administered at 6:30 AM if the MOM was ineffective and a fleet enema was to be administered at 9:00AM if the glycerin suppository was ineffective. Review of the resident care flow record from 8/27/02 through 9/2/02 identified documentation that no bowel activity occurred until after the administration of a fleet enema on 9/2/02. The flow record further identified that no subsequent bowel activity was documented from

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- 9/2/02 until 9/12/02. Review of the Medication Administration Record (MAR) from 8/27/02 through 9/12/02 identified that MOM 30 ml was administered on 9/1/02 and 9/5/02 without results. The MAR failed to identify documentation that subsequent to the administration of the MOM, a glycerin suppository was administered prior to the administration of the fleet enema per the physician's order. In an interview with LPN #4 on 12/5/02 she stated that the evening nurse, who would initiate the MOM, the first step of the bowel regime, compiles the laxative list. LPN #4 could not explain why from 8/24/02 to 9/1/02 (8 days) and from 9/2/02 to 9/12/02 (9 days) Resident #24 went without a documented bowel movement and the bowel regime was not instituted. LPN #4 also was unable to explain why the physician's orders regarding the sequence of laxatives was not followed.
- f. Resident #24 was admitted to the facility on 8/27/02 with diagnoses inclusive of recent left hip fracture with a bipolar hemiarthroplasty and insulin dependent diabetes mellitus. Review of the Minimum Data Set (MDS) dated 9/9/02 identified that short and long-term physician's order dated 8/27/02, identified that NPH insulin 20 units was to be administered sub-cutaneously everyday at 6:30 AM and 4:30 PM. Review of the MAR dated 8/28/02 lacked documentation that the scheduled dose of NPH insulin was administered at 6:30 AM. Review of the nurse's notes dated 8/28/02 identified that at 10:15 AM the licensed nurse became aware that the scheduled dose of insulin was not signed as being administered at 6:30 AM on the MAR. An accucheck of Resident #24's blood sugar level was completed and a level of 249 was obtained. The MAR identified that the usual glucose readings at 6:30 AM. were identified to range from between 82 to 191. The nurse's note further identified that no other signs or symptoms of a glycemic reaction were noted. The physician was notified and an order to administer Novulin regular insulin 3 units for one dose only to treat the accucheck of 249 was obtained. Review of the facility documentation dated 8/28/02 identified that the licensed staff failed to administer the NPH insulin on 8/28/02 at 6:30 AM. In an interview with the DNS on 12/5/02 she stated that the insulin was not administered per the physician's order.
- g. Resident #36 had diagnoses inclusive of cerebral vascular accident dysarthria, and muscle spasms. An assessment dated 6/3/02 identified short and long-term memory deficits and modified independence in decision-making abilities. It further identified partial loss of movement and range of motion present in the left side that included the arm, hand, leg, and the foot. The Resident Care Plan dated 6/19/02 identified that transfer would be accomplished with the assistance of two staff

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

members. Review of the nurse's notes dated 7/13/02 at 1:30 PM identified that the resident stated that nurse aide #5 injured her left axilla during a transfer. On 7/13/02 at 5:00 PM a subsequent nurse's note identified that the resident was crying out in pain related to movement of the left axilla and shoulder. The physician was notified and a X-ray of the left shoulder was ordered. The initial X-ray report identified no gross fracture. Review of the nurse's notes from 7/14/02 through 7/16/02 identified that pain continued to be present in the left shoulder during movement and that the physician was aware. On 7/16/02 per a physician order, Resident #36 was sent to the emergency room for further evaluation of the left shoulder. Review of the left shoulder X-ray performed at the emergency room identified a left proximal humerus fracture. An orthopedic consultation was conducted on 7/16/02. The consultation noted orders for an occupational therapy evaluation, gentle range of motion to the left should and the utilization of a sling to the left arm. The consultation orders were verified by the attending physician. The occupational therapist note dated 7/17/02, identified the resident was evaluated and found to be inappropriate for treatment. The nurse's notes and the treatment kardex from 7/16/02 through 8/1/02 did not provide documentation that the sling had been provided to the left arm. In an interview with the Director of Nurses on 12/4/02 she stated that if the sling was utilized it would have been documented in either the treatment kardex and/or the nurse notes.

7. Based on observations, clinical record review and staff interview, the facility failed to provide incontinent care per the residents care plan for one of eleven sampled residents who required incontinent care. Resident #17, The findings include
 - a. R#17's minimum data set dated 10/10/02 identified the residents cognition as severely impaired, requiring extensive assistance for toileting and personal hygiene and incontinent of bowel and bladder. The resident care plan dated 10/15/02 directed to provide pericare after each incontinence. Observation on 1/9/03 at 6:45am noted the resident to be incontinent of a moderate amount of urine. The nurse aide was observed to remove the wet incontinent pads from under the resident but failed to provide pericare. An interview on 1/9/03 at 7:10am with the nurse-aide identified that the nurse-aide had washed the resident at 4:00am, after the last incontinent episode, and that pericare is not routinely provided at that time in the morning. An interview on 1/10/03 at 11:30am with the Director of Nursing

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

identified that residents are to be provided incontinent care after each incontinent episode.

8. Based on clinical record review, observation, and staff interview, for six of nine residents who either entered the facility with or without pressure sores the facility failed to implement preventive measures and/or regularly assess the residents. The findings include:
 - a. Resident #1's Minimum Data Set dated 12/25/02 identified the resident's cognition as severely impaired requiring total assistance with activities of daily living including bed mobility and a history of a stage two pressure ulcer. The resident care plan dated 12/27/02 identified a potential for impaired skin integrity with interventions that included to turn and reposition the resident every two hours. A constant observation of Resident #1 on 1/9/03 from 5:30 AM to 8:30 AM, (three hours), the resident was noted to be positioned on her back. Although at 7:55 AM two nurses aides provided incontinent care, and pulled the resident up in the bed, they did not reposition the resident off her back. An interview on 1/10/03 at 12:30 PM with the Director of Nurses identified that due to the residents high risk for pressure sores, she should be repositioned every two hours.
 - b. R# 2 was readmitted to the facility on 11/25/02 after sustaining a fractured left hip from a fall. The clinical record reflected an admission nursing assessment dated 11/25/02 that identified the residents heels with intact skin. A weekly pressure sore report dated 12/17/02 and 12/24/02 identified a 5 centimeter by 4 centimeter stage 1 pressure sore on the residents left heel. No further updates were documented. An observation of the left heel with the infection control nurse on 1/8/03 noted a quarter sized dark purple necrotic area. A review of physician's orders dated 12/17/02 indicated a multipodus boot was ordered to the left lower extremity due to pressure area. No other orders to treat the area was noted. An undated pressure sore report identified by the infection control nurse as current on 1/8/03 noted a 3cm 3.5cm closed blister on the residents left heel. Interview and review of the residents clinical record with the Director of Nurses on 1/9/03 at 2:30pm identified that the residents heel had not been monitored on a weekly basis per facility policy. On 1/10/03 observation of the residents left heel with the Director of Nursing noted the area was necrotic.
 - c. R# 6's minimum data set dated 5/30/02 identified the residents cognition as moderately impaired requiring staff assistance for bed mobility and limitations in

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- range of motion in one leg. The clinical record identified the resident was admitted to the facility with a fractured right hip. An admission nursing assessment dated 5/24/02 identified the residents feet to be without open areas. Although a pressure sore assessment dated 5/28/02 identified the resident as a high risk for pressure sore development, the residents care plan lacked interventions to prevent skin impairment. The nurses notes dated 6/6/02 noted a 2.4cmx 1.7cm blister like area on the right heel. The facility pressure sore report dated 6/02 identified the right heel as a stage 4 pressure ulcer. An interview on 1/9/03 at 10AM with the infection control nurse identified that a pressure relieving mattress and heel protectors were not implemented until after the onset of the heel ulcer, and that preventive measures should have been implemented prior to the development of the ulcer. Subsequent to the implementation of a treatment order the pressure sore was resolved on 10/2/02.
- d. R# 15's diagnosis included diabetes and terminal disease. The initial assessment dated 11/14/02 identified no pressure ulcers or a history of pressure ulcers. The nursing admission assessment dated 11/1/02 identified the resident had a pressure area on the coccyx/ buttocks with no description or staging. An interview on 1/9/03 at 3pm with the Licensed Practical Nurse who performed the assessment on 11/1/02 noted that the pressure area was reddened and the facility policy for redness was the use of barrier cream. A review of the clinical record with the LPN identified there was no evidence of monitoring of the area until a stage 3 ulcer with drainage was identified on 12/30/02. Observation of the coccyx with the Director of Nursing on 1/10/03 at 10:40am noted a stage 4 ulcer with purulent drainage.
- e. R#17's diagnosis included a cerebral vascular accident. A minimum data set dated 10/10/02 identified the resident as severely cognitively impaired requiring extensive assistance with activities of daily living including bed mobility. A pressure sore risk assessment dated 12/27/02 identified the resident at high risk for pressure sore development. A weekly pressure sore report dated 1/6/03 identified a stage two pressure ulcer on the right and left buttocks and a pressure blister on the right heel. The current resident care plan dated 10/15/02 identified interventions that included repositioning every two hours. During a constant observation on 1/9/03 from 5:30am to 8:30am, (three hours), the resident was noted to be positioned on her back. Although the resident was checked for incontinence at 6:45am and at 8:00am, she was not repositioned off her back during that time. Further observation noted a heel protector lying on the end of the bed from 5:30 am until placed on the residents foot at 8:10am. An interview on 1/9/03 at 8:30 am with

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- the charge nurse identified that the resident requires repositioning while in bed and the heel protector are to be on her right foot at all times.
- f. R# 25 was admitted to the facility on 10/25/02 with diagnoses that included insulin dependent diabetes and a fracture of the right hip. Although the nursing admission assessment dated 10/25/02 identified the resident's right heel as reddened there was no evidence that preventive measures were implemented to prevent further breakdown. A pressure sore report dated 10/27/02 identified that R #25 had a 3.2 cm x 3.8 cm Stage 2 pressure ulcer on the right heel. Nurse's note dated 10/28/02 identified a fluid filled blister on the right heel. Observation on 1/9/03 identified a nickle sized pressure ulcer with blackened inner area and crusty yellow edges.
9. Based on record review and staff interview for one of six residents who sustained a fall, the facility failed to maintain preventive maintenance for wheelchairs; The findings include;
- a. Resident #19 was admitted to the facility on 10/13/98 with diagnoses that included Parkinson's disease. The Minimum Data Set dated 11/16/02 identified a history of falls. Facility documentation dated 12/1/02 and 12/26/02 identified that the resident had fallen three times. Nurse's note dated 12/26/02 identified that R #19 was found on the floor with a 1 1/2 inches laceration to the right eye. The resident was transferred to the emergency room where she received six sutures and diagnosed with a contusion to the head. The resident stated during interview on 1/9/03 at 2:15pm that because her brake handles are different lengths she is not always sure that they are locked. The emergency room discharge plan included repairing /and or replacing the wheelchair. Review of facility documentation with the Director of Nursing and Maintenance Director on 1/9/03 identified that the probable cause of the fall was due to faulty brakes on the residents wheelchair. Subsequent to surveyor inquiry the wheelchairs brakes were adjusted on 1/9/03.
10. Based on clinical record review and staff interview, the facility failed to provide supervision and/or were transferred in accordance with the plan of care to protect from injury and/or falls for 3 of 8 sampled residents with falls. R#'s 4, 29, and 36. The findings include:
- a. Resident #4's diagnoses included Alzheimer's disease. An assessment dated 12/4/02 identified the resident had moderately impaired cognitive abilities, was non-ambulatory and was dependent on staff for activities of daily living. Quarterly fall

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

assessments identified the resident was at high risk for falls. The resident care plan identified approaches of Lap Buddy in the wheelchair, alarms in bed and chair, side rails elevated when in bed and keeping the bed in its low position. Clinical record review identified the resident fell several times. On 7/31/02 the nurses notes indicated the resident was found on the floor. On 8/6/02 the resident was found on the floor and on 8/8/02 the resident was found sitting on the floor beside the toilet after having been left unattended in the bathroom. The resident care plan identified the resident required assistance of 2 staff members for transferring. The investigation of the 8/8/02 fall did not identify measures to prevent a recurrence. Interview with the Director or Nurses on 1/9/03 at 1:45 p.m. indicated there were no changes made to the resident care plan following the falls.

- b. Resident #29 was admitted to the facility on 7/22/98 with diagnoses of Alzheimer's disease, and upper and lower extremity contractures. An assessment dated 2/19/02 identified total assistance with transfers and a limitation in range of motion in Resident #29's arms, hands, legs, and feet with full loss of voluntary movement. The RCP dated 3/27/02 identified an impaired physical mobility due to contractures with an intervention that included transferring with mechanical lift with two person assistance. Review of a nurse's note dated 4/10/02, 9:30PM identified that at 4:00PM Resident #29 was moaning with apparent discomfort. Upon assessment an ecchymosis was noted on the right shoulder with painful range of motion. The physician was notified and an x-ray was ordered. An x-ray report dated 4/10/02 identified a displaced fracture of the right humeral neck. Review of a reportable event dated 4/10/02 identified that when the nurse aides entered Resident #29's room to render care, it was noted that Resident #29 was in pain with a bruise to her right shoulder and painful ROM. Facility documentation concluded that contrary to the RCP which directed that the resident be transferred via the hooyer lift the resident had been bodily lifted into the shower and back.
- c. Resident #36 had diagnoses inclusive of cerebral vascular accident, dysarthria, and muscle spasms. An assessment dated 6/3/02 identified a short and long-term memory deficit and modified independence in decision making abilities. It further identified that partial loss of movement and range of motion was present on the left side that included the arm, hand, leg, and foot. The resident care plan dated 6/19/02 identified that transfer would be accomplished with the assistance of two staff members. Review of the nurse's notes dated 7/13/02 at 1:30 PM identified that the resident stated that nurse aide #5 (NA#5) injured her left axilla during a transfer.

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The nurse's note further identified that Tylox 5/500 one capsule was administered to treat the pain. On 7/13/02 at 5:00PM a subsequent nurse's note identified that the resident was crying out in pain related to movement of the left axilla and shoulder. The pain was identified to be intense enough that an assessment of the area could not be performed. The physician was notified and a x-ray of the left shoulder was ordered. The initial x-ray report identified no gross fracture. Review of the nurse's note from 7/14/02 through 7/16/02 identified that pain continued to be present in the left shoulder during movement and that the physician was aware. On 7/16/02 per a physician order, Resident #8 was sent to the Emergency Department (ED) for further evaluation of the left shoulder. Review of the left shoulder x-ray performed at the ED identified a left proximal humerus fracture. A consultation with an Orthopedist was conducted on 7/17/02 with an order to apply a sling to the left arm, provide gentle range of motion to the left shoulder and a follow up appointment in four weeks. Review of the facility documentation dated 7/14/02 identified that on 7/13/02 at 1:30 PM, NA #5 transferred Resident #36 back to bed without assistance and without utilizing a gait belt. In an interview with NA #5 on 12/6/02 at 9:30 AM she stated that on 7/13/02 Resident #36 requested to be put into bed. NA #5 proceeded to stand the resident up from the wheelchair and placed her arms around the chest and underneath the axillas to perform the pivot transfer. During the transfer full weight bearing of the resident was not accomplished and NA # 5 was required to lift up underneath the axillas to place Resident #36 onto the bed. NA #5 stated that the transfer was done alone and that although a gait belt should have been used during the transfer it was not utilized. Review of the facility policy and procedure for transfer of residents identified that in the interest of safety and the welfare of residents and staff the facility requires that all employees use transfer/gait belts when transferring or ambulating residents.

11. The facility failed to provide pharmaceutical services to include the acquisition of medication as prescribed by the physician for one of one resident's in the sample survey and includes the following:
 - a. Resident #22 was admitted to the facility on 10/14/98 with diagnoses of bilateral stroke with aphasia, Star Edwards mitral valve replacement, and seizure disorder. Review of the clinical record identified a podiatry consult dated 5/9/02 which noted slow healing nail matrixectomies on the first and second toes of both feet with a recommendation to continue the oral antibiotic. A physician's order dated 5/11/02

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

which prescribed Clindamycin 250 milligrams through the G-tube four times a day for ten days. Review of the Medication Administration Record {MAR} from 5/15/02, 12:00AM through 5/18/02, 6:00AM revealed that Clindamycin was not available {14 doses} and consequently was not administered. Policy and procedure for medication ordering identified that all daily orders called or faxed to the pharmacy will be delivered within 12 hours of receipt of that order. In an interview with the DNS on 7/31/02 at 12:45PM, he stated that apparently there had been a problem with the delivery of the Clindamycin and was not made aware of the issue until after the medication had been delivered.

12. Based on review of the medical record, interview with facility personnel and review of the facility policy and procedure for one of eleven residents (Resident #37) the facility failed to ensure infection control practices were maintained in accordance with facility policy. The findings include.
 - a. Resident #37 who had diagnoses inclusive of Alzheimer's disease and status post right hip fracture with a history of Methicillin Resistant Staphylococcus Aureus (MRSA) in the right hip surgical site. A Minimum Data Set (MDS) dated 8/20/02 identified that repetitive physical movement that included pacing, restlessness, hand wringing and/or fidgeting were present on a daily basis. Review of the nurse's notes dated 10/9 through 10/13/02 identified that an increase in agitation, confusion and inappropriate physical mobility with the wheelchair was observed. On 10/13/02 the nurse's note identified that a culture report of the right hip wound and both nares was positive for MRSA. and that droplet precautions were instituted. The nurse's note dated 10/14/02 indicated that respiratory symptoms; i.e. coughing and sneezing were identified. The note further identified that Resident #37 refused to stay in her room and when self-mobile out of the room, refused to wear a mask over the nose and mouth. Review of the psychiatrist consultation dated 10/14/02, identified that an increase in agitation and irritability was present especially in the evening when mobility in the wheelchair was often intrusive to other residents. In addition the note identified behavior that became more aggressive as the evening progressed and was not easily redirected. Review of the RCP dated 10/15/02 identified that to prevent the spread of infection related to the diagnosis of MRSA, interventions that included isolating the resident in her room and reminders to wear a mask at all times would be instituted. Review of the nurses' notes dated 10/14/02 through 10/16/02 identified that the staff had difficulty maintaining the droplet

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

precautions, specifically keeping the resident in her room and compliance with wearing a mask when out of the room. Review of the record failed to provide documentation that after knowledge of noncompliance was documented; surveillance was conducted by the staff to ensure that precaution interventions were followed. In an interview with the infection control nurse on 12/5/02 she stated that there were times when the staff were unable to maintain the droplet precautions. Although she stated every fifteen minute monitoring checks were instituted she could not locate documentation in the medical record that they were completed. Review of the facility policy and procedure for droplet precaution identified that placement in a private room or with a roommate with an active infection with the same organism is preferred. If this is not possible, the resident will be placed at a distance greater than three feet away from other residents. In addition if the resident is transported out of the room a mask will be worn.

13. Based on clinical record review, observations and staff interviews, for one of one resident requiring oxygen treatment (Resident#30), the facility failed to provide the resident oxygen while the facility was providing emergency power. The findings include:
 - a. Resident# 30 diagnoses included chronic obstructive heart disease. Physician's orders identified the use of oxygen at two liters per minute via cannula as needed to keep oxygen saturation at greater than 93%. A review of the clinical record identified the resident utilizes oxygen at two liters per minute continuously and maintains 95% to 97%. During the building and fire safety's generator testing on 1/8/02 at 1:35p.m., observations of Resident# 30 identified the resident in her room with the door closed, an oxygen nasal cannula in position and attached to an electric-powered oxygen concentrator at 1:35p.m.. Further observations identified that, although the concentrator was in the on position, the machine was not on. The concentrator was found to be plugged into a socket not powered by the generator. Subsequent to surveyor intervention the Supervisor and Assistant Director of Nursing (ADNS) identified at 1:40p.m. that the concentrator was not plugged into an emergency powered outlet.
14. The facility failed to ensure that an elopement assessment was completed for Resident #35 in accordance with policy and procedure. The findings are based on review of the

DATE(S) OF VISIT: July 30, 31, December 4, 5, 2002 and January 7, 8, 9, 10 and 13, 2003 with additional information obtained on December 2 and 11, 2002

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

clinical record, staff interview, review of policy and procedures, and includes the following:

- a. Resident #35 was admitted to the facility on 9/21/02 with diagnoses inclusive of metastatic adenocarcinoma. Review of the clinical record identified a nurse's note dated 9/22/02 which noted oppositional behaviors including agitation with an attempt to elope from the facility which resulted in a fall to the ground. Review of the RCP dated 9/22/02 identified a risk for elopement secondary to the resident expressing that he does not want to be in the facility with interventions that included fifteen minute checks for twenty four hours. Review of the elopement policy and procedure identified that on admission all residents will be assessed for wandering/elopement potential and when identified for being at risk, appropriate interventions will be implemented. Review of the clinical record and interview with DNS #2 on 12/5/02 failed to identify that an elopement assessment had been completed.

15. Resident #27 was admitted to the facility on 1/6/03 following a hospitalization for a terminal illness. Review of Resident #27's clinical record with the Director of Nurses on 1/9/03 and 1/10/03 indicated that a completed medical history and/or physical was not completed within 48 hours from admission, and that the attending physician in the nursing facility was not the same physician as the hospital.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (n) Medical and Professional Services (1) and/or (o) Medical Records (2)(H)(I) and/or (s) Social Work (2)(5) and/or (t) Infection Control (2)(A) and/or Section 19-13-D8v (b) Pharmaceutical Service (1).



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 8, 2004

Deborah Putman, Administrator
Hillcrest Health Care Center
5 Richard Brown Drive
Uncasville, CT 06382

Dear Ms. Putman:

Unannounced visits were made to Hillcrest Health Care Center on June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003, January 9, 12, 22, 23, 24, 26, 27, 28, 29, 30; February 25 and March 2, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a survey and multiple investigations with additional information received through March 3, 2004.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference will be scheduled within ten business days of receipt of this letter.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,


Janet M. Williams, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JMW:zbj

cc: Director of Nurses
Medical Director
President
vlhillhctr.doc



Phone:

Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # _____

P.O. Box 340308 Hartford, CT 06134

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. The Governing Body failed to adequately oversee the management and operation of the facility in that it failed to review the facility's compliance with established policy as evidenced by the violations of the Regulations of Connecticut State Agencies as identified in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B).

2. The Administrator failed to adequately manage the facility in that the Administrator failed to ensure compliance with applicable state regulations as evidenced by the violations as identified in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

3. The Director of Nursing Services failed to oversee the supervision, provision and quality of nursing care in the facility as evidenced by the violations of the Public Health Code of the State of Connecticut as identified in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2).

4. The Medical Director failed to oversee the quality medical care provided in the facility and failed to enforce the facility's by-laws governing medical care as evidenced by the violations identified in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(A)(B).

During the course of an investigation which was initiated on 6/26/03 and concluded on January 22, 2004 the following violations of the Regulations of Connecticut State Agencies were identified:

5. Review of the consent order effected with the Department of Public Health on 6/23/03 identified that the facility failed to ensure compliance as set forth in the consent order and/or Regulations of the Connecticut State Agencies as evidenced by the violations of Regulations of Connecticut State Agencies as identified in this document.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3).

6. Based on one medical record reviewed the facility failed to report a change in condition to the physician and/or resident's family. The findings are based on review of clinical records, review of the policy and procedure, and staff interviews and include the following:
 - a. Resident #1A was re-admitted on 2/10/03 with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus.
 - b. An MDS assessment dated 3/28/03 identified an indwelling catheter, one stage four pressure ulcer, no problems with fever or stability of condition, and no change in the overall care needs. Nurse's notes from 6/4/03 through 6/16/03 identified a change in condition as evidenced by intermittent elevations in temperature (range from 100.1-100.9), respirations (range from 40-68), pulse (range from 98-100), and copious amounts of drainage with a foul odor from the G-Tube and sacral ulcer. Review of the policy and procedure for a change in condition identified that when a change in condition occurs the licensed nurse will notify the physician or his coverage of the change in condition. Although the documentation indicates that the change in condition started on 6/4/03 with a foul odor noted from the pressure ulcer on the coccyx and elevated temperatures from 6/8/03 through 6/16/03, review of the clinical record with MD #1 on 7/25/03 identified that he had not been notified until 6/17/03.
 - c. Further review of nurses notes from 6/18/03 through 6/25/03 identified intermittent fevers (100.1-101.6) elevations in the pulse (96-134) and respiratory rate (30-56), copious amounts of drainage noted from the G-tube site, a decline in energy level, and a white blood cell count of 19.1 (normal 4.8-10.8) on 6/19/03. A physician's progress note dated 6/19/03 identified a poor prognosis regardless of interventions. Further review identified that the resident was sent to the hospital on 6/25/03 after the resident's spouse had been notified of a change in condition and requested that the resident be sent for an evaluation. The resident was admitted with diagnoses inclusive of septic shock, hypovolemia, hyernatremia, and malnourishment. Hospital documentation identified a white blood cell count of 47.1 (normal 4.8-10.8), a BUN of 37 (normal 8-26), a sodium of 154 (normal 135-153), albumin 1.7 (normal 3.4-4.8), temperature of 101.6, and a very large malodorous gangrenous decubiti. The resident expired at the hospital on 6/26/03. MD #6 stated during interview on 7/23/03 at 1:10PM, that Resident #1A upon admission to the hospital was obviously very ill and in shock. As soon as he was undressed they were aware of a very powerful odor that could be best described as

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

decay with an overwhelming odor of putrefecation. When the dressings were pulled off, there was a flow of murky, black purulent fluid that's indicative of extensive tissue decay and tissue death. MD #6 stated that signs of sepsis were identified on the interagency communication form sent by the facility which included low blood pressure, rapid pulse, increased respiratory rate, and high fever. In addition, she stated that when the resident was examined, additional areas were noted on the left hip, right hip, and sacrum which revealed decaying tissue down to the bone on the right hip with purulent decaying gangrenous tissue from the other areas. MD #6 stated that she believed these three areas were the source of the sepsis. MD #1 (the resident's primary physician at the facility) during interview on 7/25/03, stated that regardless of what was done from a medical intervention point of view, the resident was likely to continue to deteriorate and ultimately die. He further stated that he could not recall why he chose not to treat the resident's change in condition. Review of the clinical record identified that documentation was lacking to identify that the resident's family had been notified of the poor prognosis regardless of interventions and/or MD #1's decision not to treat.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1) and/or (k) Nurse Supervisor (2) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C).

7. Based on review of clinical records, a review of facility policy and procedures, and staff interviews, the facility failed to provide the necessary care and services for each resident to prevent neglect and failed to ensure that each resident received the care and services necessary to achieve or maintain their highest practicable functional status, optimal physical and mental well being, provide care and services to prevent the further development of pressure ulcers and assess changes in condition in accordance with professional standards of care for eight of nineteen sampled residents. The findings include:
 - a. MD #3 stated during an interview 12/4/03 that he was the covering physician when Resident #1A was transferred to the hospital. Upon his assessment of the resident he noted multiple pressure areas all over the resident's body. His impression of the areas he stated was that they were in multiple stages and were "terrible and foul smelling and someone who was not a physician would probably have a hard time staying there." He stated that the hospital staff conveyed concerns about the stage of Resident #1A's pressure wounds, malnutrition, and general hygiene. He stated that Resident #1A came to the hospital in septic shock

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and was dehydrated. MD #3 stated that it takes time to develop septic shock and there are certain subtle signs that sepsis is developing which include changes in the level of awareness, fluctuating vital signs, and not tolerating G-tube feedings. It probably started in the wounds and generally affected his whole body. He stated that the quality of care being provided by the facility for the last six months has been below his standards.

- b. LPN #5 stated during interview on 12/2/03 that she had a conversation with MD #3 subsequent to Resident #1A's passing. She stated that MD #3 indicated that the hospital which Resident #1A was transferred to and ultimately expired at, had expressed concerns regarding the care and services that Resident #1A had received while a resident at the facility which included concerns over "how bad the pressure areas were". She stated that MD #3 indicated to her that "it was atrocious the shape that Resident #1A was in". Additionally, LPN #5 stated that MD #3 indicated to her that "he didn't think that all that could have been done had been". She further stated that because there was so much inconsistency with staffing and frequent agency staff were utilized, "a lot of things were missed." She further stated that a lot of agency staff didn't do treatments and felt in general there was a failure to provide treatments. She stated that typically dressing changes were dated with the date of the change and on multiple occasions she found dressing changes to be several days old. In addition, she stated that it was "horrible coming into work and following people who just didn't do their jobs". LPN #5 stated that although the leadership at the facility level and the corporate level were informed of her concerns with staffing and that she "went out on a limb" to try to change things, nothing did.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

8. For one of two medical records reviewed, the facility failed to ensure that an allegation of verbal abuse was reported in accordance with the policy and procedure. The findings are based on review of the clinical record, a review of facility documentation, and a review of facility policy and procedures and include the following:
 - a. Resident #11A was admitted with diagnoses of dementia and bronchiectasis. Review of facility documentation dated 7/4/03 alleged that on 7/1/03 Nursing Assistant (NA) #1A was overheard to yell at Resident #11A. The facility investigation identified that NA #2A and NA #3A who witnessed the interaction

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

were interviewed, both concurred that NA #1A threatened to strike Resident #11A if the resident struck her. The facility investigation concluded that NA #1A was inappropriate in her communication to Resident #11A. Review of the policy and procedure for resident abuse identified in part that verbal abuse includes oral, written or any gestural language that is disrespectful to any resident. In addition, although review of the policy and procedure for abuse indicates that any staff member who witnesses or has knowledge of any abusive actions toward any resident is obligated to report the situation immediately to the Administrator or their immediate supervisor, NA #2A and NA #3A failed to report the 7/1/03 incident until 7/4/03.

The above is a violation of the Connecticut General Statutes Section 19a-550(b)(8) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Events (6).

9. Based on review of the clinical record and staff interview, the facility failed to ensure that one resident (Resident #1A) had the opportunity to exercise self-determination as it related to initiation of antipsychotic therapy. The findings include:
 - a. Resident #1A was admitted with diagnoses inclusive of syncope, cellulitis, and spinocerebellar disease. MDS assessments dated 10/8/02, 10/17/02, and 11/1/02 identified modified independence to moderately impaired decision making and no problems with memory, mood, and/or behavior. Review of the resident care records 10/4/02 through 12/18/02 identified that the resident was generally cooperative with care. Intermittent nurse's notes dated 12/3/02, 12/4/02, 12/11/02, 12/12/02, and 12/16/02 identified anxiety with agitation at times with a RCP dated 12/02 which in addition identified that the resident was refusing care from "females" at times. A behavioral health consult dated 12/18/02 identified delusional thinking, paranoia, that the resident was alert and oriented with Seroquel 25 milligrams ordered. On 12/23/02 a psychiatric diagnostic consultation was conducted with a diagnosis of dementia with delusions assigned and Seroquel increased to 25mg at 1:00PM and 50mg at 5:00PM. Although review of the behavioral health consults indicated delusional and paranoid behavior, review of the nurse notes, MDS assessments, and physician progress notes from 10/15/02 through 1/31/03 failed to identify any such behaviors. Additionally, documentation was lacking which identified any target behaviors to support the administration of Seroquel. During an interview with MD #1 on 7/25/03, he stated that the resident got a little frustrated and combative at times. Additionally, he stated that Seroquel helps with sleep and that's why it was ordered. During an interview with MD #2 on 10/16/03 he stated that although he

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

indicated that Resident #1A had delusional thinking and paranoia, he had not observed those behaviors but had been apprised of those behaviors from the nursing staff. In his assessment he concluded that Resident #1A was not incompetent and although he discussed his findings with Resident #1A's spouse and the initiation of antipsychotic therapy he never reviewed the plan of care with Resident #1A.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

10. Based on review of the clinical record, a review of the social service director's job description, and staff interview, the facility failed to provide the necessary medically related social service needs for one of nineteen residents. The findings include:
 - a. Resident #1A was admitted on 10/4/02 with diagnoses inclusive of multiple falls, cellulitis, and syncope with subsequent re-admissions on 2/10/03 and 3/8/03. A social service summary dated 2/11/03 identified a potential for impaired family and resident coping related to changes in health status with interventions that included one to one social service visits to establish trusting relationships and to assist with goal setting. MDS assessments dated 2/23/03 and 3/21/03 identified calling out for help, persistent anger, unpleasant mood in the morning, and insomnia. Review of the clinical record from 10/4/02 through 6/15/03 identified behaviors that included resistive and/or refusing treatments and/or food, combativeness, foul mood, agitation, and periods of paranoia and delusional behavior as identified in behavioral health consults dated 12/18/02, 12/23/02, and 1/15/03.
 - b. Social Worker #1 stated during an interview on 11/13/03 that when she visited Resident #1A the purpose of her visits were to ensure that he was adjusting, to help him to realistically look at his health, and to offer realistic assurance. She additionally stated that although Resident #1A had an order for do not resuscitate, the family and resident expressed a desire to do for Resident #1A whatever they could to make the resident better. Consequently when something went wrong they wanted the resident sent to the hospital and their intent on treating never changed.
 - c. Although the resident was evaluated by the psychiatric consultant on 12/18/02, 12/23/02, 1/15/03, 3/17/03, 6/9/03, and 6/19/03, review of the clinical record failed to identify any social service visits outside of the quarterly assessments to assist the patient with any impaired coping in accordance with the plan of care

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and/or failed to identify the resident and families strong desire for treatment if the resident condition changed.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

11. For two of two medical records reviewed the facility failed to ensure that significant change MDS and care plans had been completed when a significant change in condition and/or function occurred. The findings are based on review of the clinical records and a review of the policy and procedure and include:
 - a. Resident #1A was admitted with diagnoses inclusive of spinocerebellar disease and syncope.
 - b. An admission MDS assessment dated 10/15/02 identified no problems with memory, independent with daily decision making, no problems with mood and behavior patterns, limited assistance of one with activities of daily living, one, stage one pressure area, and one, stage two pressure area. A subsequent MDS assessment dated 11/8/02 identified moderately impaired decision making ability, extensive assist of one with activities of daily living, weight loss of 5% or more in thirty days, and a stage 3 pressure ulcer.
 - c. An admission assessment dated 3/28/03 identified limited assistance with bathing and dressing activities, extensive assistance with transfers, a feeding tube, a weight of 151 pounds, and a stage four pressure ulcer. Review of the progress notes, wound care consults, and resident care records from 4/15/03 through 6/24/03 identified multiple stage two and stage three pressure ulcers, a weight range of 138.4-151.8 pounds, hoyer lift for transfers, and dependency for bathing and dressing activities.
 - d. Review of the clinical record identified that although significant changes in function and condition occurred between 10/15/02 and 11/8/02 and 3/28/03 and 6/24/03 the facility failed to complete a significant change MDS assessment with revisions to the care plan made as appropriate. Resident #3A was admitted with diagnoses of diabetes mellitus, hip fracture, and hypertension. An MDS assessment dated 1/18/03 identified extensive to dependent assistance with activities of daily living, bladder and bowel incontinence, no pressure ulcers, and no turning and repositioning programs. An MDS assessment dated 4/14/03 identified dependent assistance with all activities of daily living and six pressure ulcers ranging from stage one to stage four. Further review identified that although a significant change in function occurred from 1/18/03 through 4/14/03 the facility failed to complete a significant change assessment with revisions to the care plan made as appropriate.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

12. Based on review of clinical records, a review of facility policy and procedures, and staff interviews, the facility failed to ensure that the Minimum Data Set (MDS) was conducted and/or coordinated by a Registered Nurse (RN). The findings include:
 - a. During interview on 7/25/03, RN #1 stated that sometime around November 2002 she no longer assumed the responsibilities of MDS coordinator. She stated that although she was directed by the administrative leadership to sign the MDS assessments as the RN Assessment Coordinator, the position of MDS coordinator had been assigned to a Licensed Practical Nurse (LPN). During an interview with Licensed Practical Nurse #5 on 12/2/03 she stated that the RN signed off the MDS assessment, however prior to signing the RN did not review and/or read the completed MDS assessment. Review of the MDS coordinator's job description identified that the MDS coordinator must possess accurate and comprehensive assessment skills to ensure standards of practice. In addition the MDS coordinator must be able to coordinate MDS systems, comprehensive resident assessment and appropriate care plans for each resident timely. The Administrator and the Director of Nurses (DNS) during interview on 7/29/03, stated that the MDS coordinator is an LPN who has the responsibility of coordinating the care planning process and MDS process. RN #1 stated during an interview on 7/25/03 that when she signed the MDS "she was told to sign it by her bosses because there has to be an RN signature on the MDS". LPN #5 stated during an interview on 12/2/03 that RN #1 who was the nursing supervisor signed the MDS as completed however she did not read and/or review the MDS prior to signing.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

13. For six of nineteen medical records reviewed the facility failed to revise resident care plans to reflect changes in the resident's skin integrity, and/or behaviors and/or failed to include the resident's family and/or physician in the development of such care plan, and/or failed to demonstrate that the care plan had been prepared by an interdisciplinary team. The findings are based on review of clinical records, staff interviews, and a review of facility policy and procedure and include the following:

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- a. Resident #1A was re-admitted with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. An MDS assessment dated 3/28/03 identified an indwelling catheter, a feeding tube, one stage four pressure ulcer, no problems with fever or stability of condition, and no change in the overall care needs. The Resident Care Plans (RCP) dated 5/3/03 and 5/15/03 identified impaired skin integrity of the sacrum, right hip, and left hip with interventions that included monitor healing and skin care as ordered. Review of the treatment administration record from 6/1/03 through 6/24/03 identified treatment interventions to the coccyx, the right hip, left hip, right calf, and the left knee. A wound consult report dated 6/24/03 identified wounds to the coccyx, right hip, left hip, and right posterior calf. On 6/25/03 the resident was transferred to the hospital where he subsequently expired on 6/26/03. A post mortem report dated 6/26/03 identified decubitus ulcers on the left knee, left tibia, right tibia posteriorly, the right buttock, the left buttock, and the sacrum. Review of the RCP failed to identify any interventions to address the area to the left tibia. Although review of the nurses' notes from 6/4/03 through 6/25/03 identified a change in condition, a physician's progress note dated 6/19/03 identified a poor prognosis regardless of interventions. During an interview with MD #1 on 7/25/03, he stated that regardless of what was done from a medical intervention point of view, the resident was likely to continue to deteriorate and ultimately die. He further stated that he could not recall why he chose not to treat the change in condition. Review of the clinical record failed to identify that the care plan had been revised to reflect the poor prognosis and/or that the resident's family had been involved in the plan of care. On 6/25/03 a nurse's note identified that the resident's spouse was notified of the change in condition and made the decision to send the resident to the hospital for an evaluation where Resident #1A subsequently expired. Physician's orders dated 11/29/02, 12/19/02, 1/23/02, 2/11/03, 3/13/03, and 6/20/03 identified that the care plan was reviewed and approved as outlined. MD #1 (resident's primary physician) during interview on 7/25/03, stated that he did not read Resident #1's care plan and doesn't usually read the care plans as a rule. Review of the resident care conference attendance sheets dated 3/4/03 and 4/1/03 identified that the care plan had been developed and/or prepared by an interdisciplinary team which included social work, dietary, recreation and an LPN, however failed to include the resident's physician and/or a registered nurse.
- b. Review of the resident care conference attendance sheets for Residents #3A, #9, #10A and #38 identified that the care plans had been developed and/or prepared by an interdisciplinary team which included social work, dietary, recreation and

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- an LPN, however failed to include the resident's physician and/or a registered nurse.
- c. Resident #38's diagnoses included dementia and hypertension with a history of cerebrovascular accident. An MDS assessment dated 4/11/03 identified a short-term and long-term memory problem, periods of restlessness, assistance with activities of daily living, and no problems with skin integrity. Resident Care Plans (RCP) dated 6/16/03 and 6/24/03 identified blisters to the right and left heel and an open area on the coccyx with interventions that included heel float boots on at all times. A nurse's note dated 6/20/03 identified that the resident had been noted to kick off the boots with the staff to be "on watch that boots are in place." The resident care card identified heel floats to the right and left foot at all times. Constant observation on 7/1/03 from 12:00PM through 1:30PM identified that the resident was without the benefit of the heel float boots. During an interview with LPN #1 on 7/1/03 at 1:30PM, she stated that the resident's spouse always takes the heel float boots off when visiting. Review of the RCP failed to identify any revisions to the care plan and/or resident care card which identified that the resident had a history of kicking off the boots and/or that the resident's spouse removed them when visiting.
 - d. Resident #10A's diagnoses included congestive heart failure, anemia, and severe chronic obstructive pulmonary disease. Review of a hospital discharge summary dated 5/7/03 identified that the patient required weights every other day and was on a no added salt diet with a 1500 cc fluid restriction. A nutritional assessment dated 5/18/03 identified a 1500 cc fluid restriction and was waiting to hear from nursing on what they required for fluids to maintain the fluid restriction. Review of the clinical record and requests to the Director of Nurses failed to identify that the fluid restriction had been identified in the resident's plan of care with interventions to address the problem.
 - e. Resident #12A's diagnoses included brain tumor, left hemiparesis, seizure disorder and strabismus. A bladder and bowel assessment dated 5/13/03 identified bladder and bowel continence. Review of the resident care records from 5/18/03 through 5/22/03 and 6/8/03 through 6/15/03 indicated that the resident was intermittently incontinent of bladder and bowel functioning. Review of the clinical record failed to identify that the resident's bladder and bowel status had been re-assessed.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (f) Administrator (3)(D) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

14. For four of thirteen medical records reviewed the facility failed to ensure that services provided by the facility met professional standards of care. The findings are based on review of the clinical records and a review of policy and procedures and include the following:
- a. Resident #1A was re-admitted to the facility with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus.
 - i. Review of a wound pressure sore reports from 10/8/02 through 6/17/03 identified assessment of the pressure sore stages and in addition identified that the pressure sore assessments were frequently conducted by a Licensed Practical Nurse (LPN) and/or lacked initials of the assessor. According to the Declaratory Ruling, issued by the Board of Examiners for Nursing in January 1989, The LPN is allowed to contribute to the nursing assessment by collecting, reporting, and recording objective data in an accurate and timely manner. Data collection includes observation about the condition or change in the condition of the client and signs and symptoms of deviation from the normal health status. Although the LPN made observations and collected data relative to the measurement and observation of the pressure ulcers, the LPN also assessed the wounds in that she determined the stage of these areas. Documentation was lacking to reflect that said pressure sore data was reviewed by a registered nurse.
 - ii. A pain assessment dated 2/10/02 identified that Resident #1A denied pain. A physician's order dated 3/8/03 prescribed Tylenol 650mg every four hours for pain. Review of the clinical record identified nurses notes and pressure sore reports from 3/18/03 through 6/24/03 which identified multiple pressure ulcers ranging from stage two to stage four with exposed tendon or muscle noted at times with copious amounts of drainage at times. Review of a nurse's note dated 4/20/03 at 19:00 identified that Resident #1A was complaining of "much pain" during a dressing change and refused further dressing changes. Review of the Medication Administration Record (MAR) and nurse's note failed to identify that Tylenol had been administered and/or that pain had been assessed. Further review of the nurse's notes from 4/20/03 through 6/25/03 identified intermittent refusals and/or

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

agitation with very infrequent inquiry and/or assessments of pain. NA #7A during an interview on 10/27/03 stated that when she cared for the resident he complained of pain with position changes and that the nurses were aware of his pain. Social Worker #1 stated during an interview on 11/13/03 that Resident #1A reported to her discomfort in the buttocks and/or back and further stated that she reported the resident's discomfort to the staff. According to Fundamentals of Nursing, Fourth Edition, 2001, in an effort to improve patients' quality of life and make pain management a priority, the American Pain Society is encouraging care givers to include assessment of pain as a fifth vital sign. Routine measurement of vital signs accompanied by a pain assessment raises awareness of the existence of pain, places additional emphasis on optimizing pain relief, and moves patients more quickly towards comfort and recovery. Review of the clinical record failed to identify any consistent assessment for pain.

- iii. A Resident Care Plan (RCP) dated 3/26/03 identified an alteration in skin integrity related to tube feedings with interventions inclusive of monitoring for placement and patency per policy. Review of the clinical record from 3/27/03 through 6/24/03 identified that the resident was receiving gastrostomy feedings with multiple changes made by the physician. Nurse's notes from 3/27/03 through 6/24/03 identified copious amounts of fluid and/or drainage leaking from the gastrostomy tube ranging from brownish in color to foul smelling drainage. According to Taber's Cyclopedic Medical Dictionary, Edition 19, 2001, page 823, before the patient is fed, tube patency and position are assessed and the volume of the remaining stomach contents is measured by aspirating the stomach. If the volume is greater than the amount permitted by protocol or the physician's direction, feeding is withheld. Review of the policy and procedure for gastroenterostomy feedings identified that prior to infusion of the enteral feeding, the feeding tube is checked for patency by aspirating. Tube feeding placement may be checked by injecting 5-10cc of air into the tube while listening for the characteristic gurgling sound with the stethoscope placed over the gastric area. Review of the clinical record failed to identify

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

consistent documentation to verify that placement and residuals were assessed.

- iv. An MDS for Resident #1A dated 3/28/03 identified an indwelling catheter, one stage four pressure ulcer, no problems with fever or stability of condition, and no change in the overall care needs. Nurse's notes from 6/4/03 through 6/25/03 identified a change in condition as evidenced by intermittent elevations in temperature (range from 100.1-102.6), respirations (range from 40-68), pulse (range from 106-136), copious amounts of drainage with a foul odor from the G-Tube and sacral ulcer, a decline in energy level, and a white blood cell count of 19.1 (normal 4.8-10.8) on 6/19/03. Further review identified that the resident was sent to the hospital on 6/25/03 and admitted with diagnoses inclusive of septic shock, hypovolemia, hypernatremia, and malnourishment. Hospital documentation identified a white blood cell count of 47.1 (normal 4.8-10.8) and a very large malodorous gangrenous decubiti. The resident expired at the hospital on 6/26/03. A post mortem report dated 7/17/03 identified the cause of death as sepsis. MD #6 (hospital physician) stated during interview on 7/23/03 at 1:10PM, that Resident #1A was obviously very ill and was in shock when admitted to the hospital. As soon as he was undressed they were aware of a very powerful odor that could be best described as decay with an overwhelming odor of putrefaction. When the dressings were removed, there was a flow of murky, black purulent fluid that's indicative of extensive tissue decay and tissue death. Additionally, she stated that there were signs of sepsis prior to leaving the nursing home as identified on the interagency communication form sent by the facility which included low blood pressure, rapid pulse, an increase in the respiratory rate, and high fever. According to Clinical Nursing Skills, Fifth Edition, 2000, if any unusual findings are assessed, complete a more in-depth assessment of the particular system affected. Ongoing nursing assessment alerts the nurse to changes in the patient's response to health and illness and suggests necessary changes in the plan of nursing care or care offered by other healthcare professionals. Review of the clinical record identified intermittent elevations in temperature, pulse, and respiratory rate from 6/4/03 through 6/24/03 however further

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- assessments were lacking which would have included a respiratory assessment and/or cardiac assessment, and/or assessment for infection subsequent to identifying changes in the resident's status.
- v. Review of the Treatment Administration Record from 5/1/03 through 6/25/03 identified a directive to pack the G-tube site with gauze twice a day and when necessary. Review of the physician's orders failed to identify any order directing this treatment.
 - vi. Nurses' notes dated 6/25/03, 1:00AM and 6/25/03, 11:30AM identified the utilization of oxygen ranging from two to four liters. Further review failed to identify a physician order prescribing the implementation of oxygen. According to Brunner and Sudarth's Textbook Medical and Surgical Nursing, Seventh Edition 1992, page 524, As with other medications, oxygen is administered with care, and it's effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician. Review of the policy and procedure for oxygen therapy identified that oxygen therapy may be started without a physician's order in an emergency, however an order will be obtained as soon as possible. During an interview with Registered Nurse (RN) #3 on 7/24/03, she stated that as a nursing judgment, oxygen can be administered within twenty four hours of obtaining a physician's order and it is within the nursing scope of practice to provide two liters of oxygen without a physician's order.
- b. Resident #2A was admitted with diagnoses inclusive of respiratory failure, lung cancer, and diabetes mellitus.
- i. A nursing admission assessment dated 5/19/03 identified an old or recent surgical incision on the right scapular area and dark purple discoloration on the coccyx. A care plan dated 5/20/03 identified an alteration in skin integrity with interventions that included monitor for redness and open areas in the morning and the evening. Narrative nurses notes dated 5/30/03 and 5/31/03 identified redness and tenderness to the right scapular area. The physician was notified with no new orders noted. Although redness and tenderness to the right scapular area were identified on 5/30/03 and 5/31/03, review of the clinical record failed to identify any further documentation and/or assessment until

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- 6/4/03. A nurse's note dated 6/4/03 identified that the resident was complaining of increased tenderness of the incision line of the right scapula with the area warm to touch and redness at the area where a drain had been previously located. The physician was notified and the resident was transferred to the hospital on 6/4/03. Review of hospital documentation identified a skin assessment dated 6/4/03 which identified a ten centimeter round red, warm, raised, area on the right scapula. Further review of hospital documentation identified that the resident had a surgical debridement of the right shoulder wound. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, page 904-905, Wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain. Included in the assessment are sutures, any drains or tubes, and manifestations of complications. Assess for the approximation of wound edges, color of the wound and surrounding area, and signs of dehiscence or evisceration.
- ii. A physician's order dated 5/22/03 prescribed Tylox one tab, every four hours as needed for pain. A Minimum Data Set (MDS) dated 5/31/03 identified complaints of moderate pain daily in the last seven days. Review of the nurses' notes and medication administration record from 5/31/03 through 6/4/03 identified multiple complaints of pain with Tylox administered. Further review failed to identify any assessment of pain subsequent to the complaint of pain and/or consistent assessment of the analgesic relief subsequent to administration. According to Fundamentals of Nursing, Fourth Edition, 2001, In an effort to improve patients' quality of life and make pain management a priority, the American Pain Society is encouraging care givers to include assessment of pain as a fifth vital sign. Routine measurement of vital signs accompanied by a pain assessment raises awareness of the existence of pain, places additional emphasis on optimizing pain relief, and moves patients more quickly towards comfort and recovery.
- c. Resident #3A's diagnoses included diabetes mellitus, hypertension, hip fracture, and osteoporosis. A skin assessment dated 1/7/03 revealed a score of 17 identifying the resident as a high risk for pressure sore development. An MDS assessment dated 1/18/03 identified extensive assistance with bed mobility, bladder and bowel incontinence, and no pressure ulcers. Review of the wound

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

pressure sore reports from 3/17/03 through 6/17/03 including assessing the pressure sore stage, identified that the pressure sore assessments were frequently conducted by a Licensed Practical Nurse (LPN) and/or lacked initials of the assessor. According to the Declaratory Ruling issued by the State Board of Nursing Examiners in January 1989, The LPN is allowed to contribute to the nursing assessment by collecting, reporting, and recording objective data in an accurate and timely manner. Data collection includes observation about the condition or change in the condition of the client and signs and symptoms of deviation from the normal health status. Although the LPN made observations and collected data relative to the measurement and observation of the pressure ulcers, the LPN also assessed the wounds in that she determined the stage of these areas. Documentation was lacking to reflect that said pressure sore assessments were reviewed by a registered nurse.

- d. Resident #12A's diagnoses included brain tumor, left hemiparesis, and a seizure disorder.
 - i. Nurse's notes from 6/8/03 through 6/16/03 identified frequent loose stools. Physician orders dated 6/8/03 and 6/9/03 prescribed Immodium 2 milligrams after each loose stool. A subsequent nurse's note dated 6/13/03 identified an excoriated peri-rectal area with Provon cream ordered. According to Taber's Cyclopedic Medical Dictionary, 2001, Nineteenth Edition, in the presence of diarrhea, the patient is assessed for signs and symptoms of dehydration. The frequency, consistency, color, and volume of stools are monitored and bowel sounds auscultated for changes from normal patterns. Review of the policy and procedure for observation and recording of intake and output identified that to ensure accountability and adequate hydration, intake and output records will be maintained under the following inclusive conditions: diarrhea (3 or more liquid stools within twenty four hours). Review of the clinical record identified that although the resident reported loose stools daily between 6/8/03 through 6/16/03, intake and output were not monitored.
 - ii. A nurse' note dated 7/10/03 identified Resident #12A had a small amount of yellowish drainage from the right eye with no pain or redness. A physician's order dated 7/10/03 prescribed Erythromycin Ophthalmic Ointment three times a day for ten days. The medication administration record identified that the ointment should be administered to the left eye. A subsequent nurse's note dated 7/17/03 indicated that the antibiotic ointment was administered to both eyes. According to Fundamentals of Nursing, Fourth Edition, 2001, The

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

medication order consists of seven parts: patient's name, date and time the order is written, name of the drug to be administered, dosage of the drug, route by which the drug is to be administered, frequency of the drug, and signature of the person writing the order. Although the physician's order dated 7/10/03 prescribed an antibiotic eye ointment, the order failed to designate which eye the ointment was prescribed for.

- e. Resident #3's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and Diabetes Mellitus. A nurse's note dated 9/11/03, 12:30AM identified a congested cough, oxygen saturation of 87% on 3 liters of oxygen, and bilateral expiratory wheezing with the resident complaining of "smothering". Review identified that the resident complained of shortness of breath with an oxygen saturation of 84% on 9/11/03 at 11:00PM. Although the resident presented with a change in respiratory condition on 9/11/03, 12:30AM review of the clinical record failed to identify any further assessment of the resident's respiratory status until 9/12/03 at 7:20AM when the resident was experiencing respiratory distress and transferred to the hospital. According to Clinical Nursing Skills, Fifth Edition, 2000, if any unusual findings are assessed, complete a more in depth assessment of the particular system affected. Throughout the day, continue to assess changes in the client's condition by paying particular attention to the alterations from normal that you identified in the original assessment.
- f. Resident #15A was re-admitted to the facility with a diagnosis inclusive of a right above the knee amputation on 7/24/03 at 11:43AM. A nursing admission assessment dated 7/24/03 at 6:00PM identified a surgical incision at the right Amputation (AKA) site.
 - i. Physician orders dated 7/24/03 directed that the stump dressing should be changed every day. Review of the nurses notes from 7/24/03 through 7/25/03, 9:45PM identified frequent complaints of severe pain and that the right stump was draining copious amounts of serosanguineous drainage. A nurse's note dated 7/26/03, 3:00AM identified that upon assessment of the right AKA, the wound did not appear approximated with staples noted. In addition, the left inner area of the right AKA dehisced. The physician was notified and the resident was transferred to the hospital. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, page 904-905, Wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain. Included in the assessment are sutures, any drains or tubes, and manifestations of

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

complications. Assess for the approximation of wound edges, color of the wound and surrounding area, and signs of dehiscence or evisceration. Review of the clinical record failed to identify any assessment of the right AKA incision until 7/26/03, 3:00 AM.

The above is a violation of the Connecticut General Statutes Section 20-87a and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(F) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (n) Medical and Professional Services (6) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical records (2)(K).

15. For two of seven medical records reviewed the facility failed to administer a medication and/or treatments as ordered. The findings are based on review of clinical records and include the following:
- a. Resident #1A was re-admitted to the facility on 2/10/03 with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. An MDS assessment dated 3/28/03 identified one, stage four pressure ulcer with skin treatments that included ulcer care and application of ointments and dressings.
 - i. A physician's progress note dated 4/3/03 identified that the G-tube site had cultured positive for Methicillin Resistant Staphylococcus Aureus with antibiotics ordered. Review of the nurse's notes from 5/3/03 through 6/19/03 identified that the G-tube was draining copious amounts of foul smelling drainage with skin excoriation noted. A physician's order dated 6/19/03 prescribed Bactroban Ointment topically to the G-tube twice a day. Review of the treatment administration record from 6/19/03 through 6/24/03 identified that documentation was lacking on six of the six entries that the treatment had been provided. On 6/25/03 Resident #1A was transferred to the hospital after a change in condition. Hospital documentation dated 6/25/03 indicated that the skin surrounding the G-tube was very excoriated with drainage noted from the G-tube site.
 - ii. A nurse's note dated 6/18/03 identified that Resident #1A sustained a 3 centimeter by 3 centimeter skin tear to the left knee with Bacitracin and a dry clean dressing ordered to be applied every day and when necessary. Review of the treatment

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

administration record from 6/18/03 through 6/24/03 identified that documentation was lacking that the treatment had been provided.

- b. Resident #12A's diagnoses included brain tumor, left hemiparesis, and a seizure disorder. A nurse's note dated 6/8/03 identified that upon return from a Leave Of Absence (LOA), the resident reported five episodes of loose stools while on LOA. Physician orders dated 6/8/03 and 6/9/03 prescribed Immodium 2milligrams after each loose stool. Review of a subsequent nurse's note dated 6/14/03 identified that the resident had three episodes of loose stools. A review of the MAR identified Immodium was administered only once.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

16. For one medical record reviewed the facility failed to develop a plan of care to ensure that Resident #1's ability to perform activities of daily living which included ambulation and/or communication do not decline. The findings are based on review of the clinical record and a review of the facility policy and procedure and include the following:
 - a. Resident #1A was admitted with diagnoses inclusive of syncope, cellulitis, and spinocerebellar disease. A physician's progress note dated 10/10/02 identified that the resident was admitted for physical therapy and general strengthening. Review of the admission MDS assessment dated 10/24/02 identified no problems with short and long term memory, no problems with decision making, and no problems with communication. In addition, the 10/24/02 MDS identified limited assistance of one person with bed mobility, transfers, ambulation, personal hygiene and extensive assistance with dressing. Physical Therapy (PT) and Occupational Therapy (OT) notes from 11/4/02 through 11/14/02 indicated that the resident was ambulating between five feet and forty feet daily with minimal assistance of two with a rolling walker. A PT discharge summary dated 12/19/02, identified that transfers were completed with contact guard to minimal assistance of one, supervision for bed mobility, and ambulation with a rolling walker with assist of two. An MDS assessment dated 11/8/02 and 12/29/02 identified that the resident was no longer ambulating, had short and long term memory problems, and a decline in communication. On 2/11/03 a physician's order prescribed a hooyer lift for all transfers with an assessment dated 3/2/03 identifying extensive assist of two for all transfers. Review of physician progress notes and/or PT and OT notes failed to identify that the decline was unavoidable. Review of

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the clinical record failed to identify that any interventions had been developed to maintain and/or restore the level of function achieved in therapy subsequent to discontinuing therapy on 12/19/02 and/or enhance functional communication skills.

17. Based on observations, clinical record review and staff interviews, the facility failed to ensure that the following residents received the necessary services to maintain adequate hygiene and nutrition.
 - a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses which included CVA, right hemiplegia, aphasia and hypertension. The RCP, which was undated, identified a problem relative to an alteration in nutrition. Interventions included, assist resident with meals as necessary, however the MDS of 12/3/03 identified that the resident required extensive assistance with eating. A dysphagia screen dated 9/12/03 identified that the resident was affected with severe dysphagia and required 1:1 feeding. It was also recommended that the resident be given small amounts of food at a slow rate. The resident also presented with apraxia and had poor motor planning with decreased awareness of his food on the tray which made self-feeding more challenging. A nutrition risk assessment dated 9/18/03 identified the resident to be a high nutritional risk, below his ideal body weight and identified a potential for further weight loss relative to his intake of less than 75%. The resident was further described as having sustained a significant weight loss of 14 pounds. The plan included to feed the patient as needed. Observation of the resident on 1/23/04 during the noon meal identified that the resident was seated at a table alone, with his back to the nurse aide who was assigned to the dining room. His right arm was in an immobilizer. His lunch tray was served to him at 12:10 p.m. Adaptive utensils were observed on the tray. The resident was observed picking up his spoon but not placing it into any of his food, however he would then bring the spoon up to his mouth. The resident also was not wearing his eyeglasses at this time, as identified on his current MDS. As of 12:45 p.m., the resident had consumed 0% of his meal. Interview with the NA in the dining room identified that she would assist R # 9 with his meal upon completion of feeding the other resident. She also reported that his eyeglasses were not able to be located. Further observation of the resident revealed that at 12:45, the NA began feeding the resident however the resident only consumed approximately 40% of his meal. No provision had been made to heat the resident's meal prior to feeding. On 1/26/04, the resident was again observed sitting in the dining room. His lunch was again served at approximately 12:15 p.m. The resident did not begin eating. Approximately ten minutes later a staff person yelled to the resident that he needed to eat. The resident then picked up his fork

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and placed it in his soup and then brought the fork to his mouth. He continued to "eat" his soup by utilizing his fork. At approximately 12:35 a NA began feeding the resident his meal, at which time he ate. Other staff members present in the Dining Room during the lunch meal included the Director of Financial Services, the Social Services Designee and the Administrator's Administrative Assistant. They were observed delivering lunch trays and assisted the residents with their meal by opening up milk cartons, buttering bread and other such tasks. Interviews conducted with the Administrator identified that the aforementioned staff members were performing these meal related tasks as part of "other related duties" which were identified in their individual job descriptions. Interviews with these staff members identified that they did not recollect being oriented to these duties. Documentation was also lacking to reflect that any orientation had been provided.

- b. A tour of the facility on 1/27/04 between 5:30 a.m. and 7:30 a.m. was conducted to observe care and services provided to residents on the first level. NA #4 was accompanied on rounds from approximately 6:15 a.m. during which residents were systematically checked for incontinence and care provided as necessary. At approximately 7:15 a.m., Resident #39, the last resident to be checked on that wing, was observed supine in bed. Resident #39's MDS of 11/5/03 identified the resident as incontinent of bowel and bladder and dependent on staff for personal hygiene. Although NA #4 entered Resident #39's room at approximately 7:15 a.m., no check of Resident #39 was performed despite the odor of urine in the room. Upon surveyor query, NA #4 stated that she thought another nurse aide had already checked Resident #39. However, upon further questioning, NA #4 checked the resident who was found to be incontinent of urine and stool.
- c. Resident #36's quarterly assessment dated 12/22/04 identified the resident to be cognitively impaired, incontinent of bowel and bladder and requiring extensive care for toileting, and hygiene. The resident care plan dated 12/28/03 identified that the resident was at risk for altered skin integrity with an intervention to provide toileting and incontinent care every two hours. Observation during a tour of the unit on 1/23/04 at 11:20AM identified Resident #36 lying in bed. During an interview Resident #36 was requesting care reporting that she "smelled". Although interview with NA #1 identified that the resident was last changed and repositioned at 9:41AM, observation identified a large ring of urine on the incontinent pads with dried urine noted at the perimeter of the ring. Observation of the resident on 1/27/04 identified that NA #8 washed the resident's perineal area from back to front and stool was observed in the rectal area. The resident was incontinent of urine and stool and although the perianal area was washed, the aide failed to wash the buttocks.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- d. Resident #12 was admitted with diagnoses inclusive of hypertension, dementia, and arthritis. A nurse's note dated 1/21/04 identified that the resident was transferred to a physician's office for eye surgery. The resident care record dated 1/21/04 identified that personal and oral care had been provided with total assistance however a signature was lacking for the nurse aide and/or nurse indicating who had completed the care. The Clinical Director of the Eye Surgery Center during interview on 2/3/04, stated that upon receiving the resident for the procedure it was very apparent that mouth care had not been provided. She stated that there was a moderate amount of food debris in the mouth, a lesion in the resident's right buccal mucosa, and dried skin on the lips. The Clinical Director of the Eye Surgery Center also stated that the resident had a body odor that was suggestive of a lack of hygiene and a weepy lesion on her left clavicle. The resident's fingernails as reported by the Clinical Director were long and very dirty and the resident was picking at facial lesions. Oral care was provided prior to the procedure with the resident fully cooperative. She further stated that she reported her concerns to the nursing facility and they indicated to her no knowledge of the oral lesion. Although the resident care record identified that total assistance had been provided to the resident, interview with the Clinical Director of the Eye Surgery Center, identified that necessary services including personal and oral hygiene had not been provided.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (j) Director of Nurses (2)(B) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

18. For four of twelve medical records reviewed the facility failed to ensure that Residents #1A, 2A, 3A, and 38 received the necessary treatment to avoid the development and/or further development of pressure ulcers. The findings are based on review of the clinical records, review of facility policy and procedures, and staff interviews and include the following:
 - a. Resident #1A was re-admitted to the facility on 2/10/03 with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. An MDS assessment dated 3/02/03 identified a feeding tube, a weight of 155 pounds, and one, stage three pressure ulcer with skin treatments that included ulcer care and application of ointments and dressings.
 - i. A nutritional assessment dated 3/8/03 identified an albumin of 1.6 (normal 3.5-5.5), severely depleted visceral protein stores, and opens areas on the coccyx with a plan that included to monitor nutritional

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- status, Isosource HN at 65cc an hour through the G-tube, and weigh weekly. A nurse's note dated 3/22/03 identified that any fluids consumed were leaking out of the gastrostomy site. Nurses notes from 3/22/03 through 4/18/03 identified that the G-tube continued to leak copious amounts of fluids. Nutritional assessments dated 4/22/03 and 5/27/03 indicated that the resident experienced a weight loss of seventeen pounds with the tube feeding increased to 80cc an hour from 10:00PM to 8:00PM on 5/27/03. A wound consult dated 5/27/03 identified pressure ulcers to the coccyx, right hip, left hip, and right posterior calf. Review of the weight record from April 2003 through June 2003 identified that documentation was lacking on six of the twelve entries that the resident had been weighed weekly. Although adjustments were made to the tube feeding, review of the clinical record failed to identify that adjustments were based on the copious amounts of fluid documented to be draining from the G-tube and/or that the nutritional status had been adequately monitored.
- ii. Nurse's notes from 6/4/03 through 6/24/03 identified intermittent elevations in temperature (range from 100.1-102.6), respirations (range from 40-68), pulse (range from 106-136), copious amounts of drainage with a foul odor from the G-Tube and sacral ulcer, a decline in energy level, and a white blood cell count of 19.1 (normal 4.8-10.8) on 6/19/03. Review of a wound consult report dated 6/24/03 identified that all wounds were larger and deeper with no acute signs of infection. Further review identified that the resident was sent to the hospital on 6/25/03 and admitted with diagnoses inclusive of septic shock, hypovolemia, hypernatremia, and malnourishment. Hospital documentation identified a white blood cell count of 47.1 (normal 4.8-10.8) and a very large malodorous gangrenous decubiti. The resident expired at the hospital on 6/26/03 due to sepsis. The Advanced Practice Registered Nurse (APRN) #1 who was the wound care consultant for the nursing home, stated during interview on 7/25/03, that she had not been apprised of the elevated temperatures, pulse, respiration, and white blood cell count nor had she reviewed the resident's medical record. She further stated had she been notified, she would have initiated discussion with the primary physician and recommended antibiotic therapy. In addition, APRN #1 stated that she relied on the Infection Control Nurse to keep her apprised of the resident's current condition.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- iii. A wound consult dated 5/27/03 identified a stage two pressure area to the right posterior calf which measured two centimeters (cm) by one cm and a stage two pressure area to the right hip that measured five cm by six cm. Physician orders dated 6/11/03 identified Silvadene and a dry clean dressing to the right calf twice a day and Accuzyme to the right hip wound base and cover with Alginate and Hydrocolloid every day. Review of the treatment administration record from 6/11/03 through 6/24/03 identified that documentation was lacking for the right calf treatment six of the twenty-eight entries and for the right hip, one of the fourteen entries that treatment had been provided.
- iv. Review of a policy and procedure for weekly body audits identified that all residents will have a body audit by a licensed nurse at least weekly and the audit will be documented. Review of Resident #1A's clinical record from 10/8/02 through 6/25/03 failed to identify that weekly body audits had been completed on any occasion during this time period.
- b. Resident #3A was admitted with diagnoses of diabetes mellitus, hip fracture, and hypertension. A skin assessment dated 1/7/03 identified a score of seventeen indicating a risk for pressure sore development. An MDS assessment dated 1/18/03 identified extensive to dependent assistance with activities of daily living, bladder and bowel incontinence, no pressure ulcers, and no turning and repositioning program.
 - i. The treatment administration kardex dated 1/03 identified an order for Granulex spray topically to both heels every shift and spanco boots bilaterally in bed to keep pressure off the heels. Review of the treatment administration kardex from 1/1/03 through 1/31/03 identified that documentation was lacking on 71 of the 93 entries to indicate that Granulex had been provided and 13 of the 93 entries that the spanco boots had been applied. Further review of the treatment administration kardex from 2/1/03 through 2/27/03 identified that documentation was lacking on 9 of the 84 entries that spanco boots had been applied and that the Granulex had been discontinued on 2/3/04. Review of the pressure sore report dated 2/27/03 identified a closed blister to the right heel which measured 2.5 centimeters (cm) by 3.3 cm with an onset date of 1/22/03 and a closed blister to the left

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- heel which measured 4.3cm by 2.4cm with an onset date of 1/22/03.
- ii. An MDS assessment dated 4/14/03 identified dependent assistance with all activities of daily living and six pressure ulcers ranging from stage one to stage four. Review of the treatment administration records dated 4/14/03 through 6/10/03 identified treatments to multiple pressure areas which included the right and left heel, right buttock, left hip, coccyx, with multiple treatment changes noted. Further review of the treatment administration kardex identified that documentation was lacking on multiple occasions to indicate that the treatments had been provided. Review of a wound consult dated 6/10/03 identified a pressure ulcer to the left heel which measured 7cm by 5cm, pressure ulcer to the right buttock which measured 5cm by 6cm, pressure ulcer to the left hip which measured 3cm by 1cm, pressure ulcer to the left shin which measured 4cm by 2cm, pressure area to the right hip which measured 5cm by 3cm, and a pressure area to the right ear which measured 1cm by 1cm. Review of the clinical record identified that the resident was admitted to the hospital on 7/5/03 with a diagnosis inclusive of sepsis syndrome subsequent to an episode of excessive bleeding from a sacral decubitus.
 - iii. LPN #5 stated during interview on 12/2/03 that because there was so much inconsistency with staffing and frequent agency staff were utilized, "a lot of things were missed." She further stated that a lot of agency staff didn't do treatments and felt in general there was a failure to provide treatments. She stated that typically dressing changes were dated with the date of the change and on multiple occasions she found dressing changes to be several days old. In addition, she stated that it was "horrible coming into work and following people who just didn't do their jobs."

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- c. Resident #38 was admitted with diagnoses inclusive of dementia and hypertension with a history of a cerebrovascular accident. Resident Care Plans (RCP) dated 6/16/03 and 6/24/03 identified blisters of the right and left heel and an open area on the coccyx. A physician order dated 6/24/03 prescribed heel float boots on at all times. Review of the treatment administration record from 6/23/03 through 6/30/03 identified that documentation was lacking on five of the twenty-three entries to reflect that the float heel boots had been applied.
- d. Resident #3 was re-admitted with diagnoses inclusive of pneumonia, COPD, and diabetes mellitus. An admission nursing assessment dated 9/15/03 identified red spongy heels. A nursing care plan dated 9/15/03 identified an alteration in skin integrity with an intervention that included heel protectors when in bed. Review of the clinical record identified the development of a stage II pressure area on the right heel on 9/29/03. Further review of the clinical record from 9/15/03 through 9/29/03 failed to identify consistent documentation that the heel boots had been applied.
- e. Resident #16A was admitted on 9/29/03 with diagnoses inclusive of end stage Chronic Obstructive Pulmonary Disease (COPD), chronic renal failure, and anemia. An admission nursing assessment dated 9/29/03, identified a stage II pressure area to the left buttocks with redness noted over the entire buttocks. A physician's order dated 10/2/03 directed the implementation of a low air loss mattress. Observation and interview on 10/8/03 at 12:30PM identified Patient #16A lying in an oversized bed without the benefit of the low air loss mattress. Interview with Resident #16A identified that the current mattress system was not comfortable and that she had reported her discomfort to the staff. The Director of Nursing stated during interview on 10/8/03 that the situation was "confusing". The resident was transferred to the private room on 10/6/03 which had an oversized bed which would not accommodate a low air loss mattress. The facility was waiting for permission from the corporation to remove the oversized bed from the room and replace with a standard size bed which could accommodate a low air loss mattress.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K) and/or (t) Infection Control (2)(A).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

19. For one medical record reviewed the facility failed to ensure that adequate hydration and monitoring had been provided for Resident #1A who was receiving gastrostomy feedings. The findings are based on a review of the clinical record and a review of the policy and procedure and include the following:
- a. Resident #1A was admitted with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. Physician's orders dated 2/11/03 prescribed Fibersource 70 cc an hour via the gastrostomy tube and a regular vegetarian diet with a water flush every shift ordered on 3/8/03.
 - i. A nutritional assessment dated 3/8/03 identified a weight of 145.6 pounds, an Albumin of 1.6 (normal 3.5-4.8), and severely depleted protein stores with a recommendation to weigh the resident weekly. A nurse's note dated 3/22/03 identified that any fluids consumed were leaking out of the gastrostomy tube site. Nurse's notes from 3/22/03 through 4/18/03 continued to identify that the G tube continued to leak copious amount of fluids that ranged from thick brown to foul smelling drainage. A nursing care plan dated 5/3/03 identified an alteration in nutrition with interventions that included intake and output each shift, 2.0 Resource, eight ounces with the medication pass, and tube feeding as ordered. Review of nursing notes from 5/3/03 through 6/24/03 identified that the enteral feedings were increased to Fibersource 80cc an hour from 10:00PM -8:00AM and Fibersource 65cc an hour from 8:00AM-10:00PM and continued to identify that the G-tube was draining copious amounts of foul smelling drainage. Although nurses notes identify that the G-tube was draining copious amounts of drainage, nutritional assessments dated 5/27/03 and 6/24/03 failed to reflect the drainage from the G-tube and/or that any further laboratory work had been assessed. Additionally, although the nutritional assessment recommended weekly weights, review of the weight record failed to identify the resident had been consistently weighed weekly.
 - ii. Review of the policy and procedure for intake and output identified that a worksheet is kept daily on any resident on intake and output. All fluids are recorded. Intake measurements and recording will include all fluids ingested, water content of all foods, and tube feedings. Output measurement includes the amount of urine output, vomitus, gastric solutions, and diarrhea. The 3-11 Licensed Nurse is responsible to enter the 24 hour total on the intake and output sheet. Review of the intake and output records from March through June 2003 failed to identify any measurement of the G-tube drainage and lacked twenty four hour totals.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of the March through May 2003 intake and output records identified that multiple omissions were noted regarding intake of oral fluids and enteral feedings and catheter output on all three shifts, all three months. In June 2003, intake of oral fluids was lacking documentation on 39 of the 72 entries, enteral feedings documentation was lacking on 17 of the 72 entries, and catheter output documentation was lacking on 10 of the 72 entries. Additionally, although the prescribed amount of enteral feedings was 2310cc in twenty four hours, the twenty four hours totals for enteral feedings in the month of June was never achieved. Review of the clinical record identified that the resident was transferred to the hospital on 6/25/03 and admitted with a diagnosis inclusive of hypernatremia probably on the basis of dehydration and subsequently expired on 6/26/03. A post mortem report dated 7/17/03 identified the cause of death as sepsis. During an interview with Dietician #1 on 7/25/03, she stated that monitoring accurate intake and output would be extremely important. Additionally, she stated that not receiving the prescribed amount of tube feeding was an issue regarding the weight loss.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

20. For two of three records reviewed the facility failed to monitor weights in accordance with the facility, policy and procedure. The findings are based on review of the clinical record, a review of policy and procedure, and staff interview and include the following:
- a. Resident #2A was admitted with diagnoses inclusive of respiratory failure, lung cancer, and diabetes mellitus. A nursing admission assessment dated 5/19/03 identified a weight of 118 pounds, an old or recent surgical incision on the right scapular area and purple discoloration on the coccyx. A nursing care plan dated 5/21/03 identified a decreased appetite and decreased endurance to eat. A nutritional assessment dated 5/22/03 identified that the resident's ideal body weight was 139-151 pounds and that the resident was a high nutritional risk with Pulmocare 120cc two times a day added to the plan of care. Review of the nursing flow sheets and social service progress notes from 5/22/03 through 6/4/03 identified that Resident #2A consistently consumed between 25-50% of his meals with the resident's family expressing concern over the resident's hydration status. On 6/4/03 Resident #2 was transferred to the hospital. Review of the hospital physiological assessment dated 6/4/03 revealed that the resident weighed 105 pounds (weight loss of 13 pounds over a period of seventeen days) with a

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- diagnosis of malnutrition. Review of the facility policy and procedure for weights identified that all residents will be weighed on admission, weekly times four, and then monthly. Review of the clinical record failed to identify any weights subsequent to the weight of 5/19/03.
- b. Resident #3A was admitted with diagnoses inclusive of Insulin Dependent Diabetes Mellitus (IDDM), cerebrovascular accident, and hypertension. A nutritional assessment dated 1/6/03 identified a weight of 161.5 pounds, with a usual body weight of 166 pounds, and recommended an 1800 calorie diet with graham crackers and milk at bedtime.
- i. A skin assessment dated 1/7/03 identified a score of seventeen indicating a risk for pressure sore development. An MDS assessment dated 1/18/03 identified extensive to dependent assistance with activities of daily living, no pressure ulcers, and no weight loss and/or weight gain. Review of the clinical record from 1/22/03 through 4/7/03 identified multiple pressure ulcers and weights that included a weight in February 2003 of 152 pounds (weight loss of 8.5 pounds), a weight in March 2003 of 150 pounds, and a weight of 153 pounds in April 2003. An MDS assessment dated 4/7/03 identified one, stage one pressure ulcers, two, stage two pressure ulcers, one, stage three pressure ulcer, and two, stage four pressure ulcers, and no weight loss and/or gain. Further review identified that although the 4/7/03 assessment identified the presence of six pressure ulcers and the weight had declined 8.5 pounds, the resident was not re-assessed until 5/8/03 (123 days subsequent to last assessment). Review of the nutritional assessment dated 5/8/03 identified a weight of 142.6 pounds (weight loss of 10.4 pounds from April weight and weight loss of 18.9 pounds from 1/6/03 assessment) and that the resident continues to lose weight in spite of good intake and nutritional supplements and had increased nutritional needs secondary to the decubitus ulcers with changes made to the resident's diet. Laboratory values included an albumin of 2.1 (normal 3.5-4.8). Review of the policy and procedure for resident at high nutritional risk which includes a weight loss of five pounds or more in one month and any resident with a new pressure sore or open area identified progress notes should be written every ninety days in the medical record. Review of the clinical record identified that although the resident exhibited a weight loss and developed pressure ulcers the resident's

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

nutritional status was not re-assessed until 123 days subsequent to the annual assessment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

21. For one medical record reviewed the facility failed to identify adequate indications for the implementation of an antipsychotic medication and consistently monitor one resident's behaviors subsequent to initiation of antipsychotic therapy. The findings are based on review of the clinical record and a review of policy and procedures and include the following:

- a. Resident #1A was admitted with diagnoses inclusive of syncope, hypertension, and cellulitis. MDS assessments dated 10/15/02, 10/24/02, 11/8/02 and 12/8/02 identified no behavioral problems. Behavioral health consults from 12/18/02 through 1/15/03 identified that the resident was referred for anxiety and agitation that was more pronounced on the evening shift. The consults indicated that delusional and paranoid behaviors were present with the diagnosis of dementia with delusions assigned. Seroquel was added with the dose increased to 50 milligrams (mg) at 1:00PM on 1/15/03 and 100mg at 5:00PM on 1/24/03. According to the Physician's Desk Reference 2002, Edition 56, 2002, page 685, Seroquel is indicated for the treatment of schizophrenia with warnings and/or precautions that included orthostatic hypotension, neuroleptic malignant syndrome, tardive dyskinesia, and the development of cataracts. Review of the policy and procedure for antipsychotic drugs indicates that antipsychotic drugs should not be used unless the clinical record documents that the resident's organic mental syndrome with associated psychotic behaviors have been quantitatively and objectively documented. Although review of the behavioral health consults indicated delusional and paranoid behavior, review of the nurse notes, MDS assessments, and physician progress notes from 10/15/02 through 1/31/03 failed to identify any such behaviors. Additionally, documentation was lacking which identified any target behaviors to support the administration of Seroquel. During an interview with the Medical Director on 7/25/03, he stated that the resident got a little frustrated and combative at times. Additionally, he stated that Seroquel helps with sleep and that's why it was ordered.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1)

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

22. For one of twelve medical records reviewed the facility failed to ensure that Resident #5A was free from a significant medication error. The findings are based on review of the clinical record, staff interviews, and facility documentation and include the following:
- a. Resident #5A was admitted with a diagnosis inclusive of diabetes. A physician's order dated 6/26/03 prescribed accuchecks before meals and at bedtime with regular insulin coverage as follows: for an accucheck result of 150-250: administer 3 units of regular insulin, 251-300: 6 units, 301-350: 9 units, and 351-400: 12 units. Review of the Medication Administration Record dated 7/1/03, 6:30AM identified an accucheck result of 230. A nurse's note dated 7/1/03, 10:25AM identified that 30 units of regular insulin had been administered to the resident instead of 3 units. Further review identified that the physician was notified and accuchecks every 2 hours times 6 times were ordered. During an interview with LPN #6 on 7/2/03 at 5:30AM, she stated that the morning medication pass is too large for one nurse and "stresses her out". When she read the MAR the 3 appeared to be a 30 and consequently she administered 30 units of Regular Insulin.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(C).

23. Based on review of the clinical records and interviews with staff, the facility failed to provide adequate staff to maintain the highest practicable, mental, physical, and psychosocial needs of thirteen residents in the sample survey. The findings include:
- a. Interviews conducted on 7/24/03 with multiple nurse aides identified that they had verbalized concerns to the administrative leadership identifying that there was not enough staff on duty to meet the needs of the residents. LPN #5 stated during an interview on 12/2/03 that frequent agency staff were utilized to provide care and services. She stated that because there was so much inconsistency in staffing patterns " a lot of things were missed." She further stated that a lot of agency staff didn't do treatments and felt in general there was a failure to provide treatments. She stated that typically dressing changes were dated with the date of the change and on multiple occasions she found dressing changes to be several days old. In addition, she stated that it was "horrible coming into work and following people who just didn't do their jobs. LPN #5 stated that although the leadership at the facility level and the corporate level were informed of her concerns with staffing

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and that she "went out on a limb" to try to change things nothing did. She stated that although the leadership at the facility level and the corporate level were informed of her concerns with staffing and that she "went out on a limb" to try to change things, nothing did.

- b. Interviews with the DNS and the Administrator on 7/29/03 identified that although they indicated that they met on a monthly basis to discuss staffing as it related to patient acuity they were unable to provide minutes of such.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3)(F) and/or (j) Director of Nurses (2)(E) and/or (m) Nursing Staff (1) and/or (m) Nursing Staff (3).

24. For one of thirteen medical records reviewed the facility failed to ensure that physician orders and visits were obtained timely in accordance with the policy and procedure. The findings are based on review of the clinical record and a review of policy and procedure and include the following:

- a. Resident #1A was re-admitted on 3/8/03 with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. Review of the physician's orders dated 4/24/03 identified that they were in effect for thirty days. Review of the clinical record identified that the physician had not examined the resident and/or orders were not reviewed and renewed until 6/20/03 (fifty seven days later).

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

25. For one of two medical records reviewed the facility failed to ensure that pharmacy consultations had been provided every thirty days. The findings are based on review of the medical record and a review of policy and procedures and include the following:

- a. Resident #1A was admitted with diagnoses inclusive of cerebellar ataxia, syncope, and a sacral decubitus. Review of the pharmacist consultation report identified a consult visit dated 1/20/03 with no further consultations thereafter. Review of the policy and procedure for consultant pharmacist responsibilities identified that the pharmacist will visit at least monthly for the purposes of conducting a drug regimen review for all residents in the facility.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

26. For two of two medical records reviewed the facility failed to ensure that pharmacy consultation recommendations were acted upon. The findings are based on review of the clinical record and a review of policy and procedures and include the following:
- a. Resident #1A was admitted with diagnoses inclusive of cerebellar ataxia, syncope, and a sacral decubitus. Review of the pharmacist consultation report dated 1/20/03 recommended to discontinue the Paxil related to the problem of weight loss and poor nutrition and suggested a trial of Remeron. Further review of the physician progress notes and pharmacy consult failed to identify that the report had been acknowledged by the primary physician.
 - b. Resident #12A was admitted with diagnoses inclusive of a brain tumor, left hemiparesis, and a seizure disorder. Review of the pharmacist consultation dated 5/26/03 recommended updating the diagnosis as the resident was receiving Risperdal and to complete the baseline Abnormal Involuntary Movement (AIMS) assessment. Further review of the physician progress notes, physician order sheets, and AIMS assessment form, and pharmacy consult failed to identify that the report had been acknowledged by the primary physician.
 - c. Review of the policy and procedure for timely response to the pharmacist comment identified that physician's shall respond timely to the pharmacist's comments directed to the physicians on the pharmacist/physician progress note, sign, and date. The pharmacist shall review this response on their next timely visit for resolution.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (h) Medical Director (2)(B).

27. For one medical record reviewed, the facility failed to maintain an accepted professional standard of hand-washing between glove changes during a dressing change in accordance with the facility policy and procedure. The findings are based on observation, review of the clinical record, staff interview, and a review of facility policy and procedure and include:
- a. Resident #3A was admitted with diagnoses inclusive of diabetes mellitus, hip fracture, osteoporosis, and hypertension. A physician's order dated 6/10/03 prescribed cleansing the wound with normal saline, pack with accuzyme, and followed by alginate twice a day when necessary. Observation of wound care on 7/2/03 at 7:00AM identified that RN #4 applied clean gloves after washing her hands to remove a moderately saturated dressing. Subsequent to removing the soiled gloves and re-applying clean gloves observation failed to identify that RN #4 washed and/or applied a cleansing gel to the hands. Review of the policy and

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

procedure for a clean dressing procedure identified that subsequent to removing a soiled dressing and applying a clean dressing, hands are washed.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

28. Regional Corporate Nurse #1 (Regional Coordinator) stated on 9/18/03 that a regional coordinator had been assigned to the facility subsequent to the annual survey that was completed in January 2003. She stated that on the last survey, deficiencies were cited relative to pressure ulcers. As the regional coordinator she was responsible for clinical and operational oversight of the facility and her duties included development of the plan of correction subsequent to the January 2003 survey and implementation and monitoring of the same. The Regional Corporate Nurse indicated that although she had been informed that Resident #1A had multiple stage III and stage IV pressure ulcers she never felt the need to visit the resident to ensure that the facility was in compliance and/or implemented the plan of correction as it related to his pressure ulcers. Although the managing corporation assigned regional coordinators subsequent to the January 2003 licensing survey to assist with the development of a plan of correction and implementation and monitoring of same, the facility failed to ensure that Residents #1A, 2A, 3, 3A, 10A, 12A, 15A, 16A and #38 attained and/or maintained their highest practicable physical, mental, and psychosocial well-being.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (1).

29. MD #1 (Resident #1A's primary physician and Medical Director) stated during an interview on 7/25/03 that he never read Resident #1A's care plan and does not read resident care plans as a rule. He further stated that he visited Resident #1A on 6/19/03 and although his assessment was that the resident's prognosis was poor and would not benefit from any interventions, he did not discuss this with the resident's family. MD #2 stated during an interview on 12/4/03 that he admitted Resident #1A to the hospital on 6/25/03 as he was covering for MD #1. He stated that when he saw him in the hospital he had concerns with his care received while at the facility. He stated that he did not believe Resident #1A was getting proper comfort care in the time frame before he assessed him in the hospital. MD #2 indicated that if Resident #1A had been his patient, he would have documented exactly what the family wanted done for treatment. Because nutrition was falling behind he would have insisted on a tentative means for nutrition and provided the family with the option for antibiotics. He further stated that the quality of care being

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

provided by the facility for the last six months has been below his standards. Review of the facility medical by-laws identified that the duties of the medical director included assuring that quality medical care is provided in the facility.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (h) Medical Director (2)(B).

30. Based on review of the clinical record and staff interview, the facility failed to notify the covering physician of an abnormal laboratory value in a timely manner. The findings include:

- a. Resident #1A was re-admitted on 2/10/03 with diagnoses inclusive of cerebellar ataxia, sepsis syndrome, poor oral intake requiring Gastrostomy Tube (G-tube) insertion, and a sacral decubitus. Nurse's notes from 6/4/03 through 6/16/03 identified a change in condition as evidenced by intermittent elevations in temperature (range from 100.1-100.9), respirations (range from 40-68), pulse (range from 98-100), and copious amounts of drainage with a foul odor from the G-Tube and sacral ulcer. A physician's order dated 6/18/03, 9:00PM ordered a complete blood count. A laboratory report dated 6/19/03 identified a white blood cell count of 19.1 (normal 4.0-10.0). Further review of nurses notes from 6/19/03 through 6/25/03 identified intermittent fevers (100.1-101.6) elevations in the pulse (96-134) and respiratory rate (30-56), copious amounts of drainage noted from the G-tube site, a decline in energy level, and a white blood cell count of 19.1 (normal 4.8-10.8) on 6/19/03. . Further review identified that the resident was sent to the hospital on 6/25/03 after the resident's spouse had been notified of a change in condition and requested that the resident be sent for an evaluation. The resident was admitted with diagnoses inclusive of septic shock, hypovolemia, hyernatremia, and malnourishment and subsequently expired on 6/26/03. Although the laboratory report is dated 6/19/03, review of the clinical record and facility documentation failed to identify that the physician was notified until 6/22/03 (period of three days).

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1)(2).

31. For one medical record reviewed, the facility failed to ensure that a complete medical record was retained to reflect the actual needs and care provided to Resident #1A. The findings are based on review of the clinical record and include the following:

- a. Review of Resident #1A's clinical record identified a social service progress note dated 10/29/02 and 1/7/03 which indicated that a resident care conference had

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- been conducted with the plan of care reviewed and discussed. Further review failed to identify the resident care plans relative to such dates.
- b. Review of the clinical record failed to identify a "care card" which included direction to the care givers to address Resident #1A's care needs. During an interview with the Administrator on 7/29/03, she stated that the "care card" is retained with the medical record when the record is closed, however Resident #1A's care card could not be located.
 - c. Review of the facility supervisor's report from 6/4/03 through 6/25/03 identified very frequent in at least one element of Resident #1A's vital signs to include temperature, pulse, and/or respiration. Review failed to identify that the elevated vital signs had been reflected in Resident #1A's clinical record.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1) and/or (o) Medical Records (2)(K).

32. The facility failed to ensure that for two of two agency staff employees interviewed, that they were aware of evacuation routes and/or policy and procedures related to fire. The findings are based on interview and include the following:
- a. During an interview with NA #4A and #5A on 7/24/03, they stated that in the event of a fire they were unaware of what the evacuation policy was and/or policy and procedures related to such.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (u) Emergency Preparedness Plan (5).

33. The facility failed to ensure that quality assessment and assurance activities were conducted quarterly. The findings are based on review of facility documentation and include the following:
- a. During an interview with the Administrator on 7/29/03, she stated that prior to the current Continuous Quality Improvement program that was initiated in July 2003, the facility conducted Quality Assurance (QA) meetings in collaboration with the quarterly medical staff meetings. A review of the medical staff meeting minutes dated 1/10/03 identified that although a review of the QA committees appeared on the agenda, review of the minutes failed to identify any discussion relative to the QA program and/or such committees.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

34. For one medical record reviewed the facility failed to ensure that annual testing was completed in accordance with policy and procedure. The findings are based on review of the clinical record and a review of policy and procedure and include the following:
- a. Resident #1A was admitted with diagnoses inclusive of spondylitis, cellulitis, and syncope. Review of the physical examination and required test form dated 10/4/02 identified the only testing completed was a physical examination and tuberculosis testing. Review of the clinical record failed to identify any recent laboratory testing relative to stool for occult blood and/or a dental examination. Further review failed to identify any documentation and/or contraindication that the attending physician determined that the testing was not medically necessary.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5) and/or (8)(b)(v)(vi).

35. For one medical record reviewed the facility failed to ensure that physician orders were renewed timely and that medications and treatments had been administered with a physician order. The findings are based on review of the clinical record and include the following:
- a. Resident #3A was admitted with diagnoses inclusive of diabetes mellitus, hip fracture, and hypertension. Physician orders dated 5/1/03 indicated that the orders were reviewed and renewed for thirty days. Review of the clinical record on 7/1/03 (62 days) failed to identify that the orders had not been renewed. Although the physician orders had not been renewed, review of the medication and treatment administration record identified that medications and treatments continued to be administered.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(B) and/or (n) Medical and Professional Services (6).

36. Observation on 7/14/03 identified that four nurse aides were providing care to residents without the benefit of nurse aide assignments. During an interview with NA #4A on 7/14/03 at 11:00AM, she stated that there had been "call outs" that day and the nurse aides were providing care for residents as they went along. She further stated that she did not receive any report from the licensed nurse prior to providing care and seldom does. Review of the policy and procedure for the 7-3 certified nursing assistant routine identified that between the hours of 7:00AM through 7:15AM, the nursing assistant should listen to report and obtain the assignment for the day.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (f) Administrator (3) and/or (j) Director of Nurses (2)(I).

37. Review of the consent order effected with the Department of Public Health on 6/23/03 identified that the facility will ensure compliance with the appointment of a free floating Nurse Supervisor on the day, evening, and night shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. Review of nursing schedules, weekly time logs, and facility documentation from 6/23/03 through 6/26/03 identified that the facility was non-compliant with providing a free floating Nurse Supervisor on 6/23/03: day shift, 6/23/03: night shift, 6/24/03: day shift, 6/24/03: night shift, 6/25/03: night shift, and 6/26/03: day shift.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (e) Governing Body (1)(B) and/or (f) Administrator (3)(A).

38. Although the Administrator and the Director of Nurses stated during an interview on 7/29/03, that the facility conducted monthly staffing acuity meetings, they were unable to provide minutes of the meetings which reportedly had occurred during the period of April, 2003 through July 29, 2003.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (f) Administrator (3) (F) and/or (m) Nursing Staff (3).

39. Resident #24 was admitted with diagnoses inclusive of a fractured right humerus, hypertension, and a seizure disorder. A laboratory report dated 9/8/03 identified a Dilantin level of 14.5 (normal 10-20). A RCP dated 10/5/03 identified a potential for trauma related to seizure disorder with interventions that included administering Dilantin as ordered. A physician's order dated 12/27/03 prescribed Phenytoin 100 milligrams (mg) three times a day. Review of the Medication Administration Record (MAR) on 1/24/04 revealed that the 1:00 PM dose of Phenytoin was omitted. A nurses' note dated 1/28/03, 8:20 AM identified that the nurse was summoned to assess the resident for seizure activity. Assessment included a slight eye twitch and general tremors. The physician was notified and ordered a Dilantin level. A laboratory report dated 1/28/04 identified a Dilantin level of 7.6. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #24's 1:00 PM dose of Phenytoin was omitted as the 9:00 AM dose was administered at 12:35 PM (three hours and thirty five minute delay). Review of the policy and procedure for accidents and incidents identified that all accidents and incidents are recorded on the reportable event form. Reportable events are defined as any happening, occurrence, or situation or circumstance which was unusual or

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

inconsistent with the policies and practices of the facility. Review of facility documentation failed to identify that a reportable event had been completed relative to the omission. During an interview with the ADNS identified that reportable events were completed regarding the medication omissions that occurred on 1/24/04 and could not recall if she had been aware of Resident #24's medication omission.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13 D8t (g) Reportable Events (1) (3).

During the course of an inspection initiated on January 9, 2004 and concluded on January 13, 2004 the following violations of the Regulations of Connecticut State Agencies were identified:

40. Resident #12 was admitted with diagnoses inclusive of hypertension, dementia, and arthritis. A physician's order dated 12/24/03 directed cleansing a skin tear on the sternal area with normal saline followed by bacitracin and a dry clean dressing and to change every three days. Review of nurses' notes dated 12/27/03 and 12/28/03 identified that the dressing to the sternal skin tear was intact. Observations of Resident #12 during a tour of the unit on 1/9/04 identified Resident #12 sitting in a wheel chair in the corridor with a dressing apparent on the sternal area and a cluster of "scab like" areas on both cheeks. The resident was also noted to have long fingernails. Nursing Supervisor #1 stated during an interview on 1/15/04 that the area that was previously described as a skin tear was an open area that resulted from a "scab like" area that had separated from the resident's chest. She stated the area was a 2 centimeter (cm) by 2 cm open area that was draining serous drainage. In addition Nursing Supervisor #1 stated that the area that was on her chest was similar to the lesions that she had on her lower extremities. The Infection Control Coordinator stated during an interview on 1/13/04 at 2:00PM that the areas on Resident #12's cheeks are a result of her "picking at the dry skin on her face". She stated the resident has a history of "picking" at her face and if redirected the "picking" will generally cease. When she last observed her "picking her face" she did not inform the unit staff as they were busy working, however she redirected the resident. She further stated that skin tears and alterations in skin integrity monitoring are not an element of the wound care program and consequently she does not assess and/or monitor them. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, pages 904-905, Wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain. Included in the assessment are sutures, any drains or tubes, and manifestations of complications. Assess for the approximation of wound edges, color of the wound and surrounding area, and signs of dehiscence or evisceration. Review of the clinical record with the ADNS on 1/9/04 failed

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

to identify that the "skin tear" and/or the cluster of scab like areas on both cheeks had been assessed. Furthermore, staff were not able to provide any information relative to the etiology of the facial lesions and/or date of occurrence. Review of the nursing care plan and the resident care card failed to identify any interventions to address the issue of the resident's "picking" behavior.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nursing Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (o) Medical Records (2)(I).

41. Resident #12 was admitted with diagnoses inclusive of hypertension, dementia, and arthritis. A behavioral health follow up dated 10/31/03 identified a notation that the resident is constantly agitated as the reason for the referral. The assessment identified the resident as quiet and calm. In addition, the behavioral health follow up identified that no agitation was documented in the nurse's notes. Recommendations included if the resident was agitated on evenings or nights it needs to be documented. A psychiatric consult dated 11/10/03 identified in part that the resident was evaluated because although agitated intermittently, the resident was most recently overly sedated. The assessment identified that the resident was awake but lethargic and recommendations included reducing Zyprexa to 7.5 milligrams every day. MDS assessment's dated 9/25/03 and 12/12/03 identified no behavior problems. The corresponding Resident Care Plan identified that the resident receives Zyprexa for behaviors with interventions that included behavior monitoring every shift. Review of nurses' notes from 9/19/03 through 12/28/03 failed to identify any episodes of agitation. According to the Nursing 2004 Drug Handbook, 2004, pages 492-493, Zyprexa is indicated for the treatment of schizophrenia and short term treatment of acute manic episodes from Bipolar I Disorder with alerts that included monitoring for evidence of neuroleptic malignant syndrome, tardive dyskinesia, and an altered mental status. Review of the policy and procedure for antipsychotic drugs indicates that antipsychotic drugs should not be used unless the clinical record documents that the resident's organic mental syndrome with associated psychotic behaviors have been quantitatively (number of episodes) and objectively (biting, kicking, scratching) documented. Although review of the December 2003 and January 2004 medication administration record on 1/9/04 directed that targeted behavior be monitored with the behavior identified as agitation, it failed to identify specific targeted behaviors in accordance with the policy and procedure. Additionally, documentation was lacking which identified any target behaviors to support the administration of Zyprexa.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nursing Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

42. Resident #25A was re-admitted on 1/8/04 with diagnoses inclusive of acute renal failure, congestive heart failure, and Parkinson's disease. The admission nursing assessment dated 1/8/04, 2:15 PM identified redness to the coccyx, red and spongy bilateral heels, and a rash underneath the right breast absent of a full description of the redness. A skin assessment dated 1/8/04 identified a high risk for pressure sore development. Observation by surveyor on 1/12/04 with facility staff noted redness to the coccyx with an approximately 1 centimeter "slit like" area to the coccyx with dry flaky skin surrounding the area. NA # 18 reported that she informed the nurse of the observation on 1/12/04. Review of the policy and procedure for pressure sore prediction and prevention identified that all pressure sores will be documented on the pressure sore report sheet as soon as the charge nurse initially observes a pressure sore. The Infection Control Coordinator during an interview on 1/13/04 stated that she had not completed an assessment of Resident #25A's skin as of yet but had plans to do so. In addition, she stated upon identifying redness, the area should be assessed for blanching or non-blanching to ascertain if the area is caused from pressure. Further interview with the Infection Control Coordinator on 1/15/04 identified that upon assessing Resident #25A's coccyx on 1/13/03, she identified a stage two open area that is probably from pressure with dry peeling skin surrounding the wound. Although redness to the coccyx was identified on the admission assessment on 1/8/04, review of the clinical record failed to identify any description of the area until assessed by the Infection Control Coordinator on 1/13/04 and not until the area had progressed to a Stage II area.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nursing Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

43. Resident #25A was re-admitted with diagnoses inclusive of acute renal failure, cardiomyopathy, and Parkinson's. A physician order dated 1/8/04 directed do not resuscitate and that the nurse may pronounce. Review of the policy and procedure for do not resuscitate identified in part that upon completion of all necessary documentation a "DNR" will be typed or written in red ink on a revised name bracelet. Observation on 1/12/04 identified that the resident was wearing an identification bracelet, however failed to identify a "DNR" in red ink on the resident's name bracelet in accordance with the policy and procedure.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nursing Supervisor (1).

44. Review of personnel records for RN #1, NA #18, NA #19, and NA #20 failed to identify that an annual performance evaluation had been conducted. Review of the policy and procedure for performance appraisals identified in part that department heads and supervisors will complete performance appraisals upon the following occasions: by the end of the first six months of employment and prior to the anniversary date of employment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(K).

45. Documentation was lacking to reflect that administration completed an annual review of the facility policy and procedure manual. The Administrator reported on 1/13/04 that although she has reviewed the policy and procedure manual she was unable to locate the documentation indicating that such was completed.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

46. Observation during a tour of the upper level nursing unit on 1/9/04 at 3:55PM identified that although five nurse aides had been scheduled for the three to eleven shift only four had reported to the unit. In addition the nursing supervisor and/or the unit nurses were unaware that the fifth nurse aide had not reported for duty. During an interview with Nurse Aides (NA) #11A and #12A on 1/9/04 at 4:00PM, they stated that they had not received assignments as of yet and although they did receive report from the previous shift nurse aides they had not received report from the nurse. Observation on 1/12/04 at 9:45 AM and review of the staffing schedules identified that five nurse aides had been assigned to the lower level unit however observation and interviews identified that assignments had not been disseminated. Review of the policy and procedure for the 3-11 nursing assistant routine identified that between the hours of 3:00PM-3:15 PM the nursing assistant is to listen to report on each resident and obtain their assignment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nursing Supervisor (1).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

47. Based on observations, clinical record review and staff interviews, the facility failed to provide Resident #20 with care and services in accordance with the resident's plan of care. The findings include:
- a. Resident #20 was readmitted to the facility on 12/11/03 with diagnoses of pneumonia, hypertension, status post cerebral vascular accident (CVA), hemiparesis and seizure disorder. On 1/12/04, facility staff called a "Code Blue" in response to the resident being found unresponsive in his bed. Staff (LPN #2 and the ADNS) were observed providing CPR to the resident, absent a firm flat surface and the resident's knees were noted flexed due to the "knee gatch" being engaged. Upon surveyor query regarding the absence of a firm flat surface, a staff member was directed by a nurse to obtain a back board from the "med room." The staff member was unable to locate the board in the room. The staff continued to provide CPR to the resident without the benefit of a firm flat surface. Upon additional surveyor query, regarding the absence of the firm flat surface, staff again stated that the back board could not be located. After several additional minutes, the staff removed the resident from the bed and placed him on the floor. At this point, a staff member was directed to obtain the key to an oxygen canister and the staff member again went to the oxygen storage room. The staff member could not locate the key in that it was not found in its "usual" location. A staff member then went to another floor and located an oxygen key as well as a backboard. During the provision of CPR to the resident, staff were observed to intermittently stop chest compressions as well as mechanical ventilation by removing the mask from the resident's face. Observation revealed that the nurse (LPN #2) performing the chest compressions ceased doing so, in order to suction the resident. At other times, chest compressions ceased and the nurse was observed repositioning the resident's head. Mechanical ventilation had also been interrupted and the nurse aerating the resident was observed adjusting the resident's head. Although the resident's abdomen became extremely distended, observation revealed that there was no consideration of aeration issues and/or that periodic assessments had been performed to establish whether or not adequate aeration had been established. Observation also revealed that there was a lack of coordination efforts between the nurse performing chest compressions and the nurse aerating the resident (e.g. ratio of ventilations to compressions). Approximately fifteen minutes after the code had been called, the ambulance team arrived and the resident was identified as asystole. Although the code continued for at least another ten to fifteen minutes, the code was terminated after the nursing staff discovered that the resident had advance directives as well as a physician order for do not

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

resuscitate (DNR). This information had been incorporated onto the RCP which was dated 12//29/03. The resident was pronounced dead at this time. Interviews with the ADNS and with a regional corporate nurse identified that the "crash" cart was to be checked nightly by the 11:00 PM to 7:00 AM nursing supervisor and the "crash cart check" form was to be signed off, attesting to the verification that the cart was appropriately stocked. Documentation was lacking as to when the cart had been checked last. The ADNS thought that it might have been checked about 2 1/2 weeks ago, when their last code had been performed but wasn't sure. She added that it was the facility's desire to immediately provide oxygen to the resident through the ambu bag, however, there was at least a four minute delay in doing so because the key to the oxygen cylinder could not be located. She also reported that an adequate seal around the resident's nose and mouth had not been established because the resident began vomiting and she didn't have a towel readily available to wipe the resident's face. She also reported that the resident was not wearing a DNR bracelet at the time of his arrest, as per facility policy. Facility policy states that "DNR" will be typed or written in red ink on a revised name bracelet. The charge nurse is responsible to check each resident with a "DNR" order each shift to assure it is on the resident and can be clearly read. A review of the facility's Emergency Preparedness Plan relative to Code Blue, identified that the supervisor was responsible to assign on a daily basis, staff who would be responsible for responding to a Code Blue. This assignment would be identified by placing an asterisk on the time schedule. Should a Code Blue, be called, the team would respond and receive their direction from the supervisor. The "Code Blue" team was also to respond with necessary equipment, to include CPR board, ambu bag, suction machine, oxygen, and recording sheet. A Code Blue team member would also be designated to call 911, the physician and the family. Observation of the facility's response to the code revealed that there was no team response and did not include a staff member procuring the necessary equipment. Additionally, a recorder for the code was not identified nor was a recording sheet initiated. Interview with the Administrator regarding the code response revealed that she was not familiar with the facility policy and deferred all questions to the ADNS. The ADNS did not ever recall the designation of a Code Blue Response Team and the facility did not have a document (e.g. recording sheet) in the facility.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (f) Administrator (3)(D) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C) and/or (u) Emergency Preparedness Plan (5).

During the course of an investigation initiated on January 22, 2004 and concluded on February 2, 2004 the following violations of the Regulations of Connecticut State Agencies were identified:

48. Based on the findings of the inspection which concluded on February 2, 2004, the facility failed to have sufficient staffing to meet the needs of the residents in the facility as evidenced by the violations of the Regulations of Connecticut State Agencies as identified in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(F) and/or (m) Nursing Staff (1).

49. Based on clinical record reviews, staff interviews and a review of facility policies and procedures, the facility failed to notify the physician when there was a significant change in status and/or a need to alter treatment significantly for the following ten (10) residents. The findings include:
- a. Resident #6 was admitted to the facility with diagnoses of Charcot-Marie-Tooth Syndrome, IDDM, paraplegia and neurogenic bladder. A nutritional assessment identified that the resident was a moderate nutritional risk and required 2000cc's of fluid daily to meet his fluid needs. A review of the facility's intake and output documents identified that during the months of October and November of 2003, the resident's average daily fluid intake was 1400 cc's. Documentation was lacking to reflect that the physician was notified of the resident's inability to achieve his daily fluid requirement. On 11/25/03, the resident was admitted to the hospital with diagnoses of clinical sepsis, dehydration and UTI.
 - b. Resident #6 was admitted to the facility with diagnoses which included Charcot-Marie-Tooth Syndrome, IDDM and neurogenic bladder. A physician order dated 8/6/03 directed that the resident receive 500 mg of Levaquin daily times ten days. On 8/8/03, a physician notation identified that the resident was allergic to the Levaquin, in response to the resident's development of a "splotchy" rash. On 11/25/03, the resident was transferred to the hospital and was admitted with clinical sepsis, dehydration and UTI. Upon return to the nursing home the resident was started on Levaquin 500 mg for seven days, despite the documented allergy to the medication. Documentation was lacking to reflect that the physician was

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

notified of the discrepancy and/or that the resident was monitored for any side affects to the medication.

- c. Resident #30 was admitted to the facility on 1/8/04 following surgery for a fractured hip. Although the admission skin assessment dated 1/8/04 identified areas of impaired skin integrity on the buttocks and/or coccyx and/or bilateral heels, there was no physician order for treatments to the right buttocks and/or left heel until 1/11/04. The pressure ulcer report dated 1/11/04 identified that the left heel was a stage one pressure ulcer measuring 0.6 cm by 3.5 cm in size and identified that a treatment of Granulex had been obtained. The pressure sore report of 1/22/04 identified that the left heel was now a stage two pressure ulcer measuring 5 cm by 2.2 cm in size and that the treatment was now Xenaderm. In addition, the pressure ulcer report dated 1/23/04 identified that the resident had two stage two open areas on the buttocks, one measuring 0.2 by 0.2 cm. in size and the other measuring 1 cm. by 1.5 cm. in size. Although the resident's skin was impaired on 1/8/04, there was no record of physician notification until 1/11/04. Interview with RN #2 identified that she obtained a treatment for Granulex to the left heel on 1/9/04 but forgot to write it on the physician's orders and forgot to write it on the treatment kardex.
- d. Resident #14 had diagnoses of congestive heart failure, gastric ulcer and esophagitis. A review of the physician's orders dated 9/25/03 identified that the resident's diuretic, Bumex was discontinued. Observation of the resident on the evening of 1/26/04 revealed the resident to be sitting in a chair with his legs and feet in a dependant position. The resident's lower legs were very edematous. Observation of the resident at 5:35 AM on 1/27/04 revealed the resident was congested and his legs were noted to be edematous. Interview with the charge LPN (LPN #3) identified that the Supervisor was contacted and upon the Supervisor assessing the resident identified that the resident had pitting edema of the legs. The supervisor stated the resident had edema but that it usually goes down when the resident is in bed. Interview with the night LPN (LPN #3) identified that Resident #14 always has dependant edema. that "his legs are two to three plus edema." Review of the weight record reflected that the resident gained eighteen pound from September 03 through January 04. Interview with the physician/medical director on 1/28/04 identified that he did not recall being informed of the resident's weight gain and that the diuretics were discontinued because of an elevated BUN (blood, urea and nitrogen) and creatinine. The resident was admitted to the hospital on the evening of 1/27/04. A review of the hospital record identified that the resident was in respiratory distress, required suctioning and remained in moderate to severe respiratory distress with labored breathing and hypoxia. On route to the hospital the resident was given Lasix and

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Nitro paste with some improvement in O2 sats. The physician history and physical questioned aspiration versus sudden onset congestive heart failure. A chest X-ray done on 1/27/04 at 7:23 PM identified possible congestive heart failure, left lower lobe atelectasis/infiltrate and was noted to be worse than the previous study. The resident's diagnosis was identified as pneumonia and hypoxia.

- e. Resident #31 was admitted to the facility on 1/23/04 following right total hip arthroplasty surgery. On 1/23/04 nurses' notes identified the resident had a fever of 101.2 degrees F. The physician's order dated 1/24/04 directed a dry, clean dressing to the right hip incision to be done every day on the 7-3 shift. On 1/26/04 and 1/27/04 two nurse surveyors identified that the right hip incision line was clean, dry, staples were in place and there was no redness or signs of infection. On 1/26/04, an aide was observed to take the resident for a shower without the benefit of a protective dressing on the right hip incision line. There was no documentation to reflect that the physician was contacted regarding the resident's ability to shower. Upon inquiry of the physician, he identified that staff should have called him regarding whether the resident could be showered. A review of a nursing note written as a late entry for 1/28/04 identified that the physician was informed that the resident refused the dressing to the hip and stated to the nurse, "It's fine, leave it alone." This note further identified that the physician was informed on 1/28/04 that there was swelling, increased warmth and redness of the incision line and a small amount of sero-sanguinous drainage. On 1/29/04, in the morning, nurse surveyors observed that the resident's incision line had changed and the incision line was reddened and had an extended area of swelling over approximately five inches of the incision line. The nursing note on 1/29/04 identified that there was continued swelling and increased warmth and redness at the incision line and that the supervisor was notified and will notify MD #3. Interview with the resident's physician (MD #1) identified that he was informed by the surveyor on 1/29/04 of the condition of the incision line and later that day (1/29/04) the physician received a fax from the facility identifying the same description and an antibiotic (Augmentin) was initiated for a wound infection.
- f. Resident #32's quarterly assessment dated 11/13/03 identified the resident as having a memory impairment, having some difficulty make decisions and with no weight loss. Diagnoses included depression, hypertension and diabetes mellitus. The care plan dated 11/20/03 identified that the resident had varied weights due to diuretic use with interventions to monitor the monthly weights. The resident was on Lasix 40 mg daily since 5/2/03 and no additional diuretics were noted as prescribed. A review of the resident's weight record reflected that the resident's

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

December weight was 176.5 pounds and the January weight was 154 pounds. On 1/27/04 the dietitian was questioned regarding the resident's weight loss and lack of re-weights. A second interview with the Dietitian #2 and the ADNS on 1/29/04 identified that a re-weight was done and the resident weighed 148.5 pounds. Although the resident lost 27.5 pounds, there was no documentation in the dietitian's notes or in nurses' notes to reflect interventions were implemented based on the weight loss or that the physician was informed of this weight loss. Upon inquiry as to lack of follow-up, the ADNS replied that they questioned the weight and were going to get another weight. Interview with the physician on 1/29/04 identified that he was sure he was not informed of the 27.5 pound weight loss.

- g. Resident #21 diagnoses included a history of cerebral vascular accident, macrocytosis and arthritis. The resident's MDS of 12/11/03 indicated that the resident required supervision with most activities of daily living and on 11/25/03 received physical therapy. Nursing progress notes indicated that on 12/18/03 the resident exhibited increased tracheal congestion, bilateral rhonchi in all lung fields and clear nasal drainage. Although progress notes indicated that the physician had been notified on 12/18/03, the clinical record lacked documentation of any physician response to the resident's change in condition. The progress notes indicated that the resident continued to experience respiratory congestion for the next two days including scattered rhonchi in all lobes on 12/20/03 at 5:30 a.m. The clinical record lacked documentation that the patient's physician was notified of the resident's change in respiratory status until the resident was found in acute respiratory distress at 12:00 noon on 12/20/03.
- h. Resident #27 was admitted with diagnoses inclusive of sepsis, aspiration pneumonia, and congestive heart failure. A nurse's note dated 1/14/04 identified bilateral crackles and that the resident was examined by the physician. A physician's progress note dated 1/14/04 indicated that the resident presented with a change in status with increased respiratory secretions and some shortness of breath. The physician ordered an antibiotic and a chest x-ray for 1/15/04. Subsequent nurse's notes from 1/15/04 through 1/28/04 identified a moist productive cough with a temperature of 102.9 degrees on 1/28/04. Review of the clinical record identified that although a chest x-ray was ordered for 1/15/04, the results of the chest x-ray were not in the clinical record and/or could not be located in the facility. Subsequent to surveyor inquiry the results were transmitted to the facility via a facsimile and revealed a left bibasilar infiltrate. Further review failed to identify that the physician had been notified.
- i. Resident #3 was admitted with diagnoses inclusive of Chronic Obstructive Pulmonary Disease (COPD) and Diabetes Mellitus. A nurse's note dated 9/11/03,

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- 12:30AM identified a congested cough, oxygen saturation of 87% on 3 liters of oxygen, and bilateral expiratory wheezing with the resident complaining of "smothering". Further review identified that the resident complained of shortness of breath with an oxygen saturation of 84% on 9/11/03 at 11:00PM. Clinical record review identified that although the resident presented with a change in condition on 9/11/03, the physician was not notified until 9/12/03, 7:20AM when the resident experienced respiratory distress. The physician was notified and the resident was transferred to the hospital and admitted with a diagnosis of pneumonia. Review of the policy and procedure for a change in condition identified that when a change in condition occurs the licensed nurse will notify the physician or his coverage of the change in condition.
- j. Resident #13 was admitted with diagnoses inclusive of toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension. An MDS assessment dated 12/23/03 identified weight loss with a weight of 217 pounds, and leaves 25% or more of food uneaten at most meals. Nutritional notes dated 1/15/04 and 1/20/04 identified a weight of 176.8 pounds (weight loss of 40.2 pounds), reduced lower extremity edema, and potential weight loss is due to an intake of less than 75% of meals. Review of the clinical record with Registered Dietician #2 and the Assistant Director of Nurses on 1/29/04 at 4:15PM failed to identify that the physician was notified of the significant and rapid weight loss of 40.2 pounds.
- k. Resident #12 was admitted with diagnoses inclusive of hypertension, dementia, and arthritis. A nutritional consult dated 12/18/03 revealed a weight of 132.5 pounds which identified a significant weight loss of 19.1 pounds from the November 2003 weight of 151 pounds. Review of the facility weight records identified that upon reweighing (re-weight lacking a date) the resident weighed 141 pounds indicating a 10 pound weight loss versus a 19.1 pound weight loss. Review of the policy and procedure for observation and recording of weights identified that the charge nurse will notify the physician whenever the resident experiences a three pound or more weight loss. Although the resident's weight record revealed a weight loss of 10 pounds from November 2003 to December 2003, review of the clinical record failed to identify that the physician was notified.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1) and/or (k) Nurse Supervisor (2).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

50. Based on clinical record reviews and staff interviews, the facility failed to conduct thorough investigations of allegations of abuse for the following two (2) residents. The findings include:
- a. Resident #25 diagnoses included Depression and Dementia. A quarterly assessment dated 7/4/03 identified that the resident had a short-term memory deficit, independence in cognitive skills for daily decision-making, repetitive anxious complaints and the ability to make self understood. The assessment further recorded that the resident required extensive assistance with hygiene and bathing. A resident care plan dated 8/7/03 documented problems that included a bathing/hygiene deficit and forgetfulness and identified interventions for staff to allow ample time for tasks, to assume an unhurried manner and to orient the resident to the surroundings. Review of the nurses' narrative notes dated 9/4/03 identified that the resident had informed the nurse that two tall men had molested her. The resident stated she thought she was "bruised all over." Although the facility initiated an investigation, there was no evidence that the facility attempted to conduct a physical examination of the resident until 9/5/03 when an examination revealed no signs or symptoms of trauma although two faded bruises were observed on the resident's right inner thigh. Although numerous staff members recorded written statements, the facility failed to conduct further interviews to obtain specific information regarding the care and services that had been provided to the resident during the period from 9/3/03 through 9/4/03. The facility further failed to document any conclusion or an analysis of the information that was obtained during the course of the investigation. During an interview on 1/30/04 the Assistant Director of Nursing (ADNS) stated the facility had determined that no incident had occurred based on a psychiatric consultation conducted on 9/8/03. The psychiatrist's report documented that although the resident had been very consistent in describing the event, there was no evidence of any truth.
 - b. Resident #3 diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, and a history of congestive heart failure. An MDS assessment dated 12/9/03 identified problems with long-term and short-term memory. Review of facility documentation dated 1/25/04 revealed that the resident stated that "a girl put her hand on the resident's left shoulder and pressed hard". Review of the facility investigation identified that the facility initiated an investigation and conducted some interviews however the investigation failed to identify the nurse aide that had been assigned to care for the resident and/or other staff who may have participated in direct care.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Events (6).

51. Based on record reviews, the facility failed to ensure MDS assessments were accurately completed to include all required signatures and/or care planning decisions for the following residents. The findings include:
- a. Resident #26's 14-day Assessment dated 1/12/04 did not have signatures at Section AA9, indicating staff who assisted in completing portions of the MDS. In addition, this MDS did not have the required RN signature at Sections R2, VB1 and VB3. An MDS designated as "none of above" at Section AA8a, completed on 1/4/04 for Resident #26 did not have signatures at Sections AA9 or R2.
 - b. Resident #28's 14-day Assessment dated 1/6/04 did not include the required documentation at Section V indicating the location and date of the RAP assessment documentation as well as the care planning decision.
 - c. Resident #8 had an annual assessment dated 12/8/03. Although the Resident Assessment Protocol Summary identified problems that had triggered (e.g. cognitive loss, visual function, rehabilitation potential, nutritional status, psychotropic drug use), the assessment failed to record any care planning decision regarding the specific problem areas.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical records (2)(H).

52. Based on record review, the facility failed to complete a significant change assessment subsequent to a decline in condition for one resident. The findings include the following:
- a. Resident #13 diagnoses included of toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension. An MDS assessment dated 12/23/03 identified limited assistance with activities of daily living, no pressure ulcers, and weight loss with a weight of 217 pounds. A nutritional assessment dated 1/15/04 identified a weight of 176.8 pounds (weight loss of 40.2 pounds), identified that the resident was having trouble feeding self, with the weight loss potentially due to an intake of less than 75% of the meals. A pressure sore report dated 1/13/04 identified a stage two pressure area on the coccyx which measured 3 centimeters (cm) by 0.2 cm, a stage two pressure area on the right buttocks which measured 4.3 cm by 3.0 cm, and a stage two pressure area to the left buttocks which measured 3.3 cm by 2.0 cm. Review of the resident care record flow sheet from 1/11/04 through 1/24/04 identified that the resident required total assistance with activities of daily living.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Although the clinical record identified a significant weight loss, the presence of four stage two pressure ulcers, and a decline in ability to perform activities of daily living, review on 1/30/04 failed to identify that a significant change assessment with revisions to the care plan had been conducted.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

53. Based on clinical record review and staff interview, the medical record failed to accurately reflect the current status of one resident. The findings include the following:
- a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses inclusive of CVA with right hemiplegia, right aphasia and hypertension. The MDS of 9/9/03 identified that the resident had advance directives, was a DNR and had a durable POA. The subsequent MDS of 12/3/03 identified that the resident did not have advance directives, and did not have a legal guardian or any other responsible person. Physician orders in place at the time of the 12/3/03 MDS identified that the resident was a DNR. Facility staff could not account for the discrepancy on the 12/3/03 MDS.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H).

54. Based on clinical record reviews and staff interviews, the facility failed to revise the following care plans to reflect the residents' current needs. The findings include:
- a. Resident #19's MDS assessment dated 11/11/03 identified that the resident was cognitively impaired, experienced shortness of breath and had no weight change recently. The resident's diagnosis included congestive heart failure. Observation of the resident during the period of 1/26/04 through 1/28/04 revealed the resident to be seated in a wheelchair with her legs and feet in a dependent position. Bilateral lower extremity edema was noted. Interview on 1/29/04 with the nurse on duty, LPN #3 she identified that the resident was noncompliant with elevating her legs. Upon review of the resident's care plan with this nurse, noncompliance with elevating the legs or an intervention to elevate the legs was absent. Subsequent to the above interview, an intervention to elevate the resident's legs when out of bed was added to the care plan.
 - b. Resident #22's diagnoses included dementia and renal failure. During the month of December 2003, the resident experienced ongoing respiratory illnesses requiring physician intervention. The resident subsequently expired on 1/1/04.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- Upon inquiry of staff as to why the resident was not hospitalized, they stated that they thought the resident was terminal. A review of the care plan with LPN #1 reflected the care plan did not identify a request not to hospitalize the resident nor that the resident was terminal. Interview with the physician reflected this resident was not sent out to hospital, because he spoke with the family and the family did not want tube feedings or a work up and did not want the resident to go to the hospital and that the resident was only to be kept comfortable. This information was not part of the resident's care plan.
- c. Resident #17 diagnoses included Parkinson's disease and a history of cerebral vascular accident. The resident's Minimum Data Set (MDS) of 7/29/03 indicated that the resident required limited assistance of one to ambulate. On 9/25/03, a significant change in condition was identified indicating that the resident required extensive assistance with ambulation. The resident was assessed by physical therapy (PT) and received skilled services from 10/22/03 through 11/19/03 for decreased functional mobility, decreased balance and decreased gait. The resident was then discharged from PT to a nursing ambulation program. Although the resident's care plan indicated that the resident should ambulate twice per day with the assistance of one, the facility's Ambulation Program Flow Sheet identified that for the month of January, 2004, the resident was ambulated only once per day with six days noted without any documented ambulation and with frequent indications that the resident refused. Although the RCP of 10/2/03 identified that the resident frequently refused to ambulate due to a recent decline, no revisions to the RCP were identified to address this issue during subsequent care plan reviews. Upon interview, the resident stated that she looked forward to walking.
 - d. Resident #35 diagnoses included congestive heart failure, arthritis, chronic obstructive pulmonary disease, and pneumonia. A nurse's note dated 1/21/04 identified intermittent dyspnea with bibasilar crackles noted when lungs were auscultated. The physician was notified and ordered Lasix intramuscularly. Subsequent nurse's notes from 1/22/04 through 1/29/04 identified two to three plus lower extremity edema. Although a resident care plan dated 1/24/04 identified respiratory distress, review of the resident care plan with Registered Nurse #1 on 1/30/04 failed to identify any interventions to address the lower extremity edema.
 - e. Resident #13 diagnoses included toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension.
 - i. A pain assessment dated 10/23/03 identified that the resident experienced intermittent pain with the worst pain rated as a seven on a scale of zero to ten which is relieved by rest and medication. An MDS assessment dated 12/23/03 identified moderate pain daily. The

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

corresponding care plan identified a problem with comfort with interventions that included assessing characteristics of pain including location, duration, quality, aggravating factors, radiation, intensity and to document such information. In addition, interventions included assessing the effectiveness of pain medication and to update the physician if ineffective. A computed axial tomography exam dated 1/6/04 of the lumbar spine revealed moderate to severe spinal stenosis L3-4, L4-5, and L5-S1 and moderate central spinal stenosis L2. Physician orders from 12/4/03 through 1/28/04 identified multiple changes to the analgesia medication regime. Nurse's notes and the medication administration records from 12/4/03 through 1/28/04 identified frequent complaints of leg and/or back pain with frequent pain medication administered. Constant observation on 1/27/04 from 6:40AM through 11:30AM identified that when repositioning and/or position changes were initiated, Resident #26 would moan with even the slightest touch and plead with the staff to expedite their task. Review of the resident care plan failed to identify any interventions to address the level of pain experienced with positioning.

- ii. A nutritional consult dated 1/15/04 for Resident #13 identified a significant weight loss of 40.2 pounds from December 2003 to January 2004 with the resident complaining of trouble feeding self. An occupational therapy evaluation on 1/15/04 identified that the resident was provided a lower lip plate and built up silverware. Observation on 1/27/04 at breakfast identified that the resident was provided with a built up knife and fork, however was without the benefit of a built up spoon. Further observation identified that the resident requested from the nurse aide a spoon for her scrambled eggs. The nurse aide returned and provided the resident with a plastic spoon. Observation identified that the resident had difficulty with manipulating the spoon consequently consumed approximately 50% of the eggs. Review of the resident care card that directs the nurse aides and the RCP failed to identify that the resident required built up silverware for eating.
- iii. The Resident Care Plan (RCP) for Resident #13 dated 11/20/03 identified a potential for an alteration in skin integrity with interventions that included monitoring for redness and open areas. An MDS assessment dated 12/23/03 identified no problems with long-term and/or short-term memory. Observations on 1/27/03, 1/28/03, 1/29/03, and 1/30/03 identified multiple ecchymotic areas on the resident's forearms and forehands. RN #1 stated during an interview on 1/30/04 at

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- 11:00AM that the resident had what she believed were petichiae on her forearms. During an interview on 1/30/04 Resident #13 reported to RN #1 that the ecchymotic areas were a result of her "banging her arms" when repositioned. Review of the RCP failed to identify any revisions to address the ecchymotic areas to her forearms and forehands and/or interventions to reduce the resident's risk of injury during repositioning.
- f. Resident #12 diagnoses included hypertension, dementia, and arthritis. An ophthalmology consult undated identified ectropian of the lower lids with a recommendation for surgery to repair the lower eye lids. A nurse's note dated 1/21/04 identified that the resident was sent to the physician's office for eye surgery with medications given. Additionally, the nurse's notes of 1/21/04 indicated that the resident received nothing by mouth. Discharge instructions from an eye surgery center included Bacitracin Ophthalmic ointment to the suture lines of both eyes, twice a day and to monitor the blood pressure. RN #2 stated during an interview on 1/30/04 that usually when surgery is scheduled the consulting facility and /or practitioner will send pre-operative instructions, however, in this case did not occur. RN #2 stated that she conveyed in report that the resident was to receive nothing by mouth after midnight preceding the surgery and that lotions and/or powders should not be utilized.
- g. Observation of Resident #12's leg identified a darkened area approximately 5cm round in size on the right tibial area which as described by the Infection Control Nurse on 1/22/04 as fluid filled and soft in the center with scattered dry lesions from the bilateral knees to the feet. Further observation identified scattered flaky dried lesions on the bilateral lower extremities extending from the knees to the feet. A dermatology consult dated 1/23/04 identified findings that included a slow healing wound to the left clavicle area, skin lesions on the face, chest, and legs, and darker areas to the lower extremities. The dermatology diagnoses included basal cell cancer to the chest and face and ecchymosis to the shins. Subsequent observation on 1/30/04 continued to identify darkened areas to the right tibial area. During an interview with RN #2 on 1/30/04 she stated that the ecchymosis on the right tibial area have been there as long as she can remember. Review of the clinical record failed to identify interventions to the care plan to address the altered skin integrity.
- h. Resident #14 diagnoses included hypothyroidism, urinary retention, and non insulin dependent diabetes mellitus and had a history of falls. A nurse's note dated 1/20/04 identified that the resident was complaining of an inability to start a urinary stream. A physician's order dated 1/21/04 directed a straight catheterization every eight hours if unable to void. Review of the clinical record with LPN #2 on 1/22/04 failed to identify any care planning interventions to

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

address the problem with voiding and/or any interventions to identify when the resident had last voided.

- i. The facility failed to update the care plan to reflect additional safety measures for Resident #2, a patient identified as having a Seizure Disorder, Dementia – Alzheimer's type, and at risk for aspiration.
 - i. A review of the physician orders for Resident #2 revealed an order dated 12/13 indicating that the resident was to receive a soft-mechanical diet. An order dated 12/26 indicating "bed against wall- mat on floor" and " 1½ siderail up secondary to decreased safety awareness secondary to dementia."
 - ii. Resident #2's current care plan, dated 12/31/03, indicated problems with the resident being a fall risk with approaches to include "bed against the wall with ½ siderail up, mat on floor. A ground diet was documented as an approach to address the resident's problem of altered nutritional status.
 - iii. On 1/27/04, 3:05pm and 1/28/04, 9:00am observations of Resident #2 while lying in bed revealed that the right side of the resident's bed was up against the wall and 2 padded ½ siderails were up.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-3-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

55. Based on clinical record reviews and staff interviews, the facility failed to apply professional standards of quality for the following residents. The findings include:
- a. Resident #7 diagnoses included non-insulin dependent diabetes mellitus, CVA and seizure disorder. Nurses' notes dated 1/15/04 identified that a "stat" alert was called because Resident #7 vomited and was in respiratory distress. The PO2 was 83 percent (therapeutic range 95-100) and the resident's respiratory rate was 28-32 (prior-16-20) and there were crackles throughout the lungs. Documentation further identified that the resident was suctioned, however, it did not help the respiratory distress. There was no documentation to reflect that the resident's blood pressure and pulse were taken prior to sending the resident to the hospital where the resident was admitted with a diagnosis of aspiration pneumonia and urinary tract infection. In addition, during the period of 1/18/04 through 1/23/04, the resident intermittently experienced nausea, "dry heaves" and a slightly distended abdomen. There was no documentation to reflect complete abdominal assessments were performed. During record review with RN #1 on 1/29/04, it was identified that there was no record of a pulse or blood pressure for Resident #7 on 1/15/04 when the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

resident experienced respiratory distress and no abdominal assessments were in the record for the above mentioned time frame.

- b. Resident #14 diagnoses included congestive heart failure, gastric ulcer and esophagitis. A review of the physician's orders dated 9/25/03 identified that the resident's diuretic Bumex was discontinued. Observation of the resident on the evening of 1/26/04 identified the resident to be sitting in a chair with his legs and feet in a dependant position. The resident's lower legs were edematous. Observation of the resident at 5:35 AM on 1/27/04 identified that the resident was congested and his legs were noted to be edematous. Interview with the charge LPN identified that the Supervisor was contacted. The Supervisor, upon assessing the resident identified that the resident had pitting edema of the legs. She further stated the edema identified that the resident had edema but that it usually goes down when the resident is in bed. Interview with the night LPN identified that Resident #14 always has dependant edema, that "his legs are two to three plus edema." A review of nursing notes during the period of 11/22/03 through 1/26/04 lacked documentation that the resident was assessed for edema in spite of staff interviews which reflected that the resident had edema and the fact that the resident's diuretic had been discontinued in September. Review of the weight record reflected that the resident gained eighteen pounds from September 03 through January 04.
- c. Resident #14 diagnoses included congestive heart failure, gastric ulcer and esophagitis. On the morning of 1/27/04 the resident experienced bronchial congestion and was sent out to the emergency department. The resident returned from the hospital at 12 noon on 1/27/04 with a diagnosis of acute bronchitis. Upon return to the facility orders directed that the resident be suctioned as needed and to administer oxygen at two liters. At 1:10 PM on 1/27/04 the resident was observed by two nurse surveyors to be congested and in need of suctioning. The resident's nasal oxygen cannula was observed not in the resident's nostrils. Upon surveyor intervention the Infection Control Nurse responded and said that the resident had been assessed at 12 noon and his oxygen saturation was 95 percent on two liters of oxygen. The nurse listened to the resident's lungs, and went to get the oxygen saturation machine. The resident's oxygen saturation was 89 percent, a drop of six percent. The ICN took the resident's vital signs and then proceeded to obtain a suction machine. The nurse identified that this machine was new, didn't know where the on/off device was and said the machine needed an adapter. The ICN then left to get another suction machine. The nurse returned to the room and started to suction the resident's oral (buccal) cavity at 1:25 PM. Minimal

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

secretions were suctioned from the oral cavity and no attempt was made to suction the nasopharynx area. Several minutes later the resident gagged and expectorated a large amount of yellow-gray mucous. Interview with the staff development nurse and corporate nurse identified that the facility only suctioned the oral cavity and not the nasopharynx. Interview with the DNS on 1/28/04 identified that at 6:30 PM on 1/27/04 the resident started vomiting, had grunting respirations, color was ashen and the oxygen saturation was 56 percent. 911 was called, the resident's oxygen saturation rose to 71 percent once a non-rebreather was utilized. The resident was admitted to the hospital on the evening of 1/27/04. A review of the hospital record identified that the resident was in respiratory distress and suctioned by the physician and remained in moderate to severe respiratory distress with labored breathing and hypoxia. On route to the hospital the resident was given Lasix and Nitro paste with some improvement in O2 sats. The physician history and physical questioned aspiration versus sudden onset congestive heart failure. The 7:23 PM chest x-ray on 1/27/04 identified possible congestive heart failure, left lower lobe atelectasis/infiltrate and the X-ray reading identified it was worse than the previous study. The resident had a diagnosis of pneumonia and hypoxia. Upon identifying the observation of the issues associated with suctioning to the DNS, an action plan was submitted to address emergency equipment checks and the inservicing of staff on assessments of residents with change of conditions and documentation of said assessments. According to Brunner and Suddarth's Textbook of Medical Surgical Nursing, 7th edition, mucous obstructing in the pharynx or the trachea is suctioned with a pharyngeal suction tip or a nasal catheter introduced into the nasopharynx or the oropharynx. The catheter can be passed into the nasopharynx or the oropharynx safely to a distance of 15 to 20 cm (six to eight inches) if secretions are obtained at this level.

- d. Resident #22's diagnoses included dementia and renal failure. The care plan dated 10/17/03 identified that the resident had altered nutrition related to difficulty chewing/swallowing and potential for weight loss related to altered cognition. The resident was placed on aspiration precautions. Interventions included monitoring weights, appetite and percentage of meals eaten. Nurses notes identified that the resident was experiencing ongoing respiratory infections requiring antibiotic therapy during the period of December 2003. Nurse's notes during the period of 12/16/03 through 12/29/03 identified that the resident had temperature of 100-101.6 degrees F. intermittently, as well as fair to poor appetite and required encouragement for fluid intake. A review of

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- the resident's fluid intake during this same time frame reflected the intake to be below 1000 cc's on nine out of fourteen days. The dietitian's recommended daily fluid intake for this resident was 1400 cc's per day. There was no documentation during the period of 12/16/03 through 12/29/03 that the resident was assessed for dehydration. Nurse's notes dated 12/30/03, identified that the resident was very lethargic and not alert enough to take "p.o. well". A dehydration assessment checklist was completed on 12/30/03 however, it failed to indicate that the resident had intakes of less than 1000 cc's per day and/or recent low grade to fevers and/or failed to identify whether the resident had a decline in ADL's, dry skin, dry mucous membranes, dry eyes and or presence of lethargy. The resident subsequently expired on 1/1/04. Upon inquiry of the physician as to why this resident was not sent out to hospital, the physician responded that he spoke with the family and the family did not want tube feedings or a work up and did not want the resident to go to the hospital and that the resident was only to be kept comfortable.
- e. Resident #21 diagnoses included a history of cerebral vascular accident, macrocytosis and arthritis. The resident's MDS of 12/11/03 indicated that the resident required supervision with most activities of daily living. Nursing progress notes indicated that on 12/18/03 the resident exhibited increased tracheal congestion, bilateral rhonchi in all lung fields and clear nasal drainage. Progress notes indicated that the resident continued to experience respiratory congestion for the next two days including scattered rhonchi in all lobes. On 12/20/03 at 12:00 p.m., the resident was found in acute respiratory distress with an irregular apical pulse and non-detectable blood pressure. The clinical record failed to identify measures taken to address the patient's acute condition. However, documentation indicated that the covering physician was notified and advised that if the resident had orders for "do not resuscitate" that nothing was to be done. Upon interview, RN #1 stated that she did not implement emergency interventions when the resident was found in respiratory distress on 12/20/03 because she believed that the resident was actively dying. According to RN #1 the patient's feet were mottled. RN #1 further stated that in her conversation with the covering physician, she indicated her assessment that the resident was dying to which the physician responded that nothing should be done. Subsequent nursing documentation on 12/20/03 at 6:00 p.m. identified that the resident appeared to exhibit "flu-like" symptoms and evaluation at the emergency department (ED) was reconsidered. The resident was transferred to the ED but was ultimately returned to the facility and expired on 12/21/03. Facility policy regarding

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Change of a Resident's Condition directs that in all life threatening situations, 911 is immediately called and the resident transferred.

- f. Resident #11 was admitted to the facility for short-term rehabilitation on 1/13/04 following an acute care admission for a myocardial infarction, renal insufficiency and rectal bleeding. Nursing progress notes dated 1/14/04 indicated that the resident currently had a Foley catheter for which there were no physician orders. The catheter was discontinued on 1/14/04 at 1:00 p.m. with the notation that the resident was "due to void." No further assessment of the resident's ability to void was made until the resident reported to nursing staff on 1/15/04 at 4:00 a.m. that she hadn't been able to void. The resident indicated that she had been trying to drink an increased amount of fluid but was unable to void. An assessment of the resident indicated that the resident's abdomen was tender. The resident was catheterized for approximately 600 ml. of urine.
- g. Resident #23 was readmitted to the facility on 1/11/04 with diagnoses that included congestive heart failure and a recent CVA. The physician's admission orders directed the facility to provide oxygen therapy via nasal cannula at the rate of 2 liters a minute and to monitor the resident's oxygen saturation level each shift. A nurse's narrative note dated 1/11/04 at 3:00 PM identified that the resident's lung sounds were diminished in all fields and noted that the resident's oxygen saturation level was 88% on room air and 90% when the resident was receiving oxygen therapy. Review of the nurses' narrative notes and records of the resident's vital signs identified that the facility failed to consistently monitor the resident's oxygen saturation level each shift during the period from 1/11/04 through 1/14/04. Documentation of the resident's oxygen saturation level was lacking for the 11:00 PM to 7:00 AM shift on 1/12/04, the 7:00 AM to 3:00 PM and the 11:00 PM to 7:00 AM shifts on 1/13/04 and the 3:00 PM to 11:00 PM shift on 1/14/04. The nurse's narrative notes further failed to record documentation of ongoing monitoring of the resident's overall respiratory status during this period. On 1/15/04 at 3:40 AM a nurses' narrative note documented that the resident's respiratory rate was "slightly labored." Although the note identified that the resident's oxygen saturation level was 94% at the time, the facility failed to record any further assessment and/or monitoring of the resident's vital signs or overall respiratory status. On 1/15/04 at 8:35 AM a nurse's narrative note for Resident #23 identified that the resident had been found moaning with a respiration rate of 32, an irregular apical pulse of 100, diminished lung sounds and a blood pressure of 204/100. The physician was notified and the resident was transferred to the hospital and admitted. Review of the clinical record

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

with the nurse who evaluated Resident #23 on 1/15/04 at 8:35 AM identified that there was no further documentation regarding any assessment or monitoring of the resident's respiratory status. The nurse noted that when she arrived on duty she was not provided with any information regarding the resident's labored breathing during the night. According to the Illustrated Manual of Nursing, Second Edition, basic assessment of respiratory function requires determination of the rate, rhythm and quality of the resident's respirations as well as an inspection of chest configuration, chest symmetry, skin condition and accessory muscle use.

- h. Resident #12 diagnoses included hypertension, dementia, and arthritis. A history and physical dated 10/16/03 identified chronic skin changes to the legs and no abnormalities of the mouth. A physician's order dated 12/24/03 directed cleansing a skin tear on the sternal area with normal saline followed by Bacitracin and a dry clean dressing and to change every three days. A nurse's note dated 1/21/04, 4:40PM identified a 1cm by 0.5 cm oral lesion in the right inner cheek. Observations on 1/22/04 identified a lesion on the left upper chest and scattered lesions on the cheeks. Observation subsequent to surveyor inquiry of the resident's skin identified a darkened area approximately 5cm round in size on the right tibial area which as described by the Infection Control Nurse on 1/22/04 on assessment as fluid filled and soft in the center with scattered dry lesions from the bilateral knees to the feet. Further observation identified scattered flaky dried lesions on the bilateral lower extremities extending from the knees to the feet. A dermatology consult dated 1/23/04 identified findings that included a slow healing wound to the left clavicle area, skin lesions on the face, chest, and legs, and darker areas to the lower extremities. The dermatology diagnoses included basal cell cancer to the chest and face and ecchymosis to the shins. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, pages 904-905, Wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain. Included in the assessment are sutures, any drains or tubes, and manifestations of complications. Assess for the approximation of wound edges, color of the wound and surrounding area, and signs of dehiscence or evisceration. According in part to Brunner and Suddarth's Textbook of Medical and Surgical Nursing, Seventh Edition, 1992, page 844, The principle nursing activities in the assessment phase include a health history to determine teaching and learning needs for preventative oral hygiene and to determine symptoms requiring medical evaluation. Physical assessment includes inspection and palpation of both the internal and external structures of the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

mouth. The examination begins with inspection of the lips for moisture, hydration, color, and the presence of ulcers or fissures. A complete assessment of the oral cavity is essential as many disorders such as cancer may be manifested by changes in the oral cavity. During an interview with RN #2 on 1/30/04 she stated that the lesions on the resident's face and legs and the ecchymosis on the right tibial area have been there as long as she can remember. MD #1 stated during an interview on 1/28/04 that his assessment of the oral lesion included the possibility of a nevus but could not rule out the possibility of a malignancy. He further stated that on the resident's next consultation with the dermatologist he would request that an evaluation of the oral lesion be completed, however he was unable to indicate when that would be.

Review of the clinical record with RN #2 failed to identify any assessment and/or ongoing monitoring of the chest and facial lesions and/or darkened area in the right tibial area. Although the nurse's note dated 1/21/04 identified a lesion to the inner right cheek, review of the clinical record failed to identify a complete assessment and/or any ongoing monitoring of the lesion.

The above is violation of Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

56. Based on clinical record reviews, observations and interviews with staff and residents, the facility failed to ensure that residents were provided with care and services in accordance with the resident care plan. The findings include the following:

- a. Resident #9 was identified with severe expressive aphasia. A therapy assessment dated 5/21/03 identified severe communication problems with a goal to be able to communicate basic needs to nursing staff. The focus of treatment was to orient the family and caregivers to the use of a communication device. The resident was also noted to be progressing at this time. A review of the RCP dated 9/16/03 identified impaired verbal communication. Interventions included to encourage self-expression in any manner that provides information to staff and family to ensure needs are being met. The MDS of 12/3/03 identified that the resident was rarely understood. Interviews with the nursing staff identified that no specific mechanism was in place to communicate with the resident and a communication device was not present for the resident. Observations of the resident/staff interactions

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- revealed that there were no communication techniques utilized other than the resident's smiles to staff.
- b. Resident #6 diagnoses included Charcot-Marie-Tooth Syndrome, IDDM, neurogenic bladder and paraplegia. The RCP of 10/2/03 identified a problem of impaired physical mobility related to paraplegia. Interventions included the application of a right knee splint twice daily. The splint schedule directed that the splint was to be applied at 10:00 AM and off at 2:00 PM and on at 7:00 PM and off at 11:00 PM. Physician orders, however, directed that the splint was to be applied at 8:00 AM and off at 4:00 PM and on at 7:00 PM and off at 11:00 PM. On 1/26/04 at 11:00 PM, the resident was observed still in bed despite a customized wheel chair schedule which directed that the resident be out of bed at 10:00 AM with a tilt of 30 degrees. The resident was not wearing his right knee splint at this time. Interview with NA #17 assigned to the resident identified that she "had never seen the resident wearing a knee splint, didn't know what it looked like and wouldn't even know where to look to find it. Upon review of the NA care card, it was identified that the splint was to be applied at 8 a.m. On 1/29/04 at approximately 9:30 AM the resident was again observed without his right knee splint. Interview with NA #16 assigned to the resident identified that the splint had not been applied because he had to pass out breakfast trays.
 - c. Resident #4 was admitted to the facility on 12/01 with diagnoses which included right leg ulcers, mild depression, mild dementia and history of PVD. The MDS of 1/7/04 identified that the resident was severely impaired in the area of cognition and required extensive assistance and/or was completely dependant on staff for ADL's. A nursing narrative note dated 12/17/03 identified that the resident was noted to have pitting edema to her bilateral lower extremities. Documentation reflected that this edema was an on-going problem through January. TEDS hose had been applied. Observation of the resident on 1/27/04 revealed the resident sleeping in the wheelchair, without any support for elevation to her extremities. Interview with the nursing staff revealed that the resident "self-propels" in the wheelchair and therefore the wheelchair did not have footrests. Observation did not identify that an alternative mechanism to provide support for the resident's extremities had been attempted. Documentation was also lacking to reflect that the RCP had been revised to reflect this problem.
 - d. Resident #29 was admitted to the facility on 1/22/04 for short term rehabilitation status post total hip replacement. The discharge summary from the hospital identified that the resident required assist with turning, hygiene and dressing. The medical record at the nursing home lacked documentation

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- to reflect that the resident received any assistance with care until 1/25/04, (e.g. turning and repositioning, hygiene, etc.).
- e. Resident #31 was admitted to the facility on 1/23/04 following right total hip arthroplasty surgery. Physician orders dated 1/24/04 directed a dry, clean dressing to the right hip incision to be done every day on the 7-3 shift. Observation of the resident on 1/26/04, 1/27/04 and 1/29/04 the AM of reflected that no dressing was on the right hip incision line. On 1/26/04 and 1/27/04 two surveyor nurses identified that the right hip incision line was clean, dry, staples were in place and there was no redness or signs of infection. On 1/26/04, an aide was observed to take the resident for a shower without the benefit of a protective dressing on the right hip incision line. Upon inquiry of the physician, he identified that staff should have called him regarding whether the resident could be showered. In addition, although there was a nurses note dated 1/24/04 that identified that the resident refused a dressing secondary to tape burns, multiple interviews were conducted with the resident in the presence of surveyors both state and federal and a corporate nurse in which the resident identified that the dressing was removed on Friday (1/24/04) and no staff had applied a dressing until the afternoon of 1/29/04 and the resident stated that he never refused to have a dressing put on his hip. This resident was identified on 1/26/04 as alert, oriented and interviewable by the Nursing Supervisor. Upon identifying the fact that no dressing was observed on the resident, a nursing note was written as a late entry for 1/28/04 which identified that the physician was informed that the resident refused the dressing to the hip and stated to the nurse, "It's fine, leave it alone". This note further identified that the physician was informed on 1/28/04 that there was swelling, increased warmth and redness on the incision line and a small amount of sero-sanguinous drainage. On 1/29/04, in the morning, nurse surveyors observed that the resident's incision line had changed and the incision line was reddened and had an extended area of swelling over approximately five inches of the incision line and these findings were reported to the physician by the surveyor on 1/29/04. Interview with RN #1 identified that the dressing was not on the resident's hip because the resident refused to have the dressing on his hip. This nurse was told by the surveyor that the resident said he never refused to have a dressing applied to his hip. Of note is the fact that after this interview, the next observation of the resident reflected that there was a dressing on the resident's hip and the resident said that the dressing had been applied by this nurse on the afternoon of 1/29/04. On 2/3/04 the physician was called and stated that after speaking to the surveyor about the resident's incision line on 1/29/04 the facility faxed him a

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

description of the incision line which was similar to information by the surveyor. The physician said that based on this information he felt the resident had a wound infection and started the resident on antibiotics (Augmentin). In addition the resident's care plan dated 1/26/04 identified that the resident was at risk for altered skin integrity with an intervention that included turning and repositioning every two hours. Observation of the resident on 1/26/04 between the hours of 7:07 AM and 10:20 AM identified that the resident was positioned on his back. Upon inquiry as to whether he could move himself in bed, the resident responded that he could not move himself, "It's too hard" and stated that he had just had hip surgery. A review of the nurse aide assignment on 1/26/04, that was in the resident's bedside table, failed to identify that the resident required assistance with turning and repositioning every two hours.

- f. Resident #7 diagnoses included cerebral vascular disease (CVA) and seizure disorder. A physician's order dated 12/29/03 directed that the resident receive Tegretol 300 mg twice a day. The Tegretol dose had been increased from 200 mg to 300 mg because the Tegretol level on 12/29/03 was 3.8 (therapeutic range-8-12). Nurses' notes reflected that the resident experienced seizure activity on 1/1/04 and 1/3/04 and fell on 1/2/04. Review of the medication administration record for January 5, 2004 reflected that the 9 am dose of Tegretol was not administered. A review of the Tegretol level ordered for 1/5/04 reflected a sub-therapeutic level of 5.3. Nurses' notes dated 1/5/04 identified that the morning dose of Tegretol was not documented. Interview with RN #1 reflected that she did not recall the Tegretol being held for any reason.
- g. Resident #16 was admitted to the facility on 12/23/03 with diagnoses including a fractured right humerus and chronic obstructive pulmonary disease. On 1/26/04, the resident was noted to have an oxygen saturation level below 80% with an increased respiratory rate of twenty-six. The resident was started on oxygen 2 l/m via nasal cannula to maintain oxygen saturations above 90%. Although the resident care plan identified interventions including assessment of lung sounds every shift, documentation through 1/29/04 was lacking to indicate that the resident's lung sounds were assessed every shift as directed by the nursing care plan.
- h. Resident #16 diagnoses included chronic obstructive pulmonary disease and on 1/26/04, the resident was noted to have an oxygen saturation level below 80% with an increased respiratory rate of twenty-six. Physician orders included combivent inhaler two puffs four times per day with a spacer. On 1/27/04 at approximately 9:00 a.m., LPN #1 was unable to administer

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- combivent via inhaler because a spacer was unavailable. According to nursing progress notes the 1:00 p.m. dose of combivent was not administered for the same reason. An interview with the staff nurse administering medications on 1/28/04 indicated that the medication had been administered but without a spacer. Upon further inquiry, the nurse was unable to locate a spacer for Resident #16 in the medication cart. Nursing Supervisor #1 stated upon interview on 1/29/04, that it was unclear what happened to the spacer, but that a new one had been ordered and she was unaware that it had not been available as of 1/28/04.
- i. Resident #20 diagnoses included hypertension, anemia and chronic renal insufficiency. On 1/15/04, the resident's care plan identified a problem of alteration in nutrition evidenced by weight loss of 8 pounds in one month, cognitive deficit, decreased appetite and anatomical deficits. Approaches included dietary consult, weekly weights, nutritional supplements, assistance with meals and monitoring of intake and output. Review of the clinical record and other facility documentation indicated that recording of intake and output was lacking. During an observation of NA #3 feeding Resident #20, the nurse aide was unaware, when interviewed, that intake and output should be monitored for the resident. Additionally, LPN #1 was unable to locate intake and output documentation nor was LPN #1 aware that intake and output had been implemented as an intervention for this resident.
 - j. Resident #10 diagnoses included history of cerebral vascular accident and hypertension. The resident's current medication regime included Zyprexa with interventions that included orthostatic blood pressure monitoring on the twenty-second of each month. Although the resident stated, upon interview on 1/26/04, that he had experienced dizziness when transferring approximately one week ago, the resident's clinical record lacked documentation of orthostatic blood pressure monitoring for January, 2004. The Nursing Supervisor #1 indicated upon interview that she was not aware that orthostatic blood pressures had not been monitored. RN #1 was unaware of the resident's complaints of dizziness with position change.
 - k. Resident #11 was admitted to the facility for short-term rehabilitation on 1/13/04 following an acute care admission for a myocardial infarction, renal insufficiency and rectal bleeding. Physician orders upon admission included daily weights with physician notification if greater than three pounds gained from admission and oxygen at 2 l/m to maintain oxygen saturation levels greater than 90%. Review of nursing progress notes, treatment kardex and weight records indicated that although the resident was weighed upon admission (124.2 lbs), no further weights were obtained until 1/29/04 (127.4).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of nursing progress notes and the treatment kardex indicated that documentation of oxygen saturation levels on 1/14/04, 1/16/04 and 1/18/04 were lacking despite documentation on 1/14/04 of wheezes heard in the resident's lungs upon auscultation and documentation on 1/18/04 of fatigue after care was provided. Upon interview on 1/29/04, Resident #11 stated that she was weighed when admitted and again on 1/29/04.

- i. Resident #1 diagnoses included pneumonia, chronic obstructive pulmonary disease, j-tube insertion, depression, insulin dependant diabetes mellitus, asthma and anxiety. The resident's quarterly assessment dated 12/31/03 identified that the resident was alert, oriented and capable of making decisions. Interview with the Resident on 1/26/04 identified that the agency nurse on 1/24/04 gave the resident insufficient medications for a 24 hour leave of absence. The resident identified that the nurse failed to provide the 5 PM and 9:00 PM dose of Ativan on 1/24 and the 9:00 AM and 5:00 PM Ativan for 1/25/04. In addition, the 9 PM dose of Remeron for 1/24/04 failed to be included in the medications. The resident stated the nurse did not provide enough insulin syringes so the resident had to reuse a syringe. Interview with the DNS identified that the pharmacy did prepare medications for the LOA and there is a question of what medications the agency nurse provided to the resident on 1/24/04. The ADNS stated they were conducting an investigation of this incident but as of 2/4/04 the investigation had not been completed.
- m. Resident #18's quarterly assessment dated 12/3/03 identified the resident as cognitively impaired, totally dependent for all care and limited range of motion of the hand and arm. Physician orders dated 5/14/03 directed that the resident have an EZ orthosis to the left wrist, hand, fingers per schedule. The schedule directed that the splint be on at 4:00 PM and off at 8:00 PM. Observation of the resident on 1/26/04 at 6:15 PM identified that the resident failed to have the orthosis device on the left wrist, hand and fingers. Upon informing the DNS of this observation, the DNS got the aide and the orthosis device was put on the resident.
- n. Resident #23 was admitted to the facility on 12/12/03 with diagnoses that included a recent CVA, vascular disease and diabetes. During the 3:00 PM to 11:00 PM shift on 12/12/03 a nurses' narrative note identified that the second and third toes of the resident's left foot were necrotic, black and draining. On 12/13/03, physician orders directed the facility to apply Silvadene cream topically to the affected areas of the left foot each day. On 12/15/03 the physician provided a new order for the Silvadene cream to be applied twice a day to the resident's toes. However, review of treatment records identified that no treatment was provided on 12/13/03 or 12/14/03, and on 12/15/03 only

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

one treatment was provided to the resident's toes. On 12/16/03 the physician again changed the order and directed the facility to apply the Silvadene cream once a day. However, there was no documentation that the treatment was provided on 12/17/03. On 12/18/03 during the 7:00 AM to 3:00 PM shift the nurses' narrative notes recorded that the resident's spouse had expressed concern about the delay and/or lack of a treatment to the resident's foot. Treatment records documented that although a dressing was applied on 12/18/03 and 12/19/03, no treatment was provided on 12/20/03. Review of the resident care plan further revealed that the necrotic areas were not addressed until 12/18/03 when an interim care plan noted that the resident had a necrotic toe. On 12/21/03 prior to the resident's transfer to the hospital the nurses' notes identified that the dressing to the left foot was changed. The notes recorded that the lower left extremity was cold to the touch, and the nurse was unable to palpate a pulse. Review of clinical record documentation with a RN #2 on 1/30/04 failed to provide further information regarding the lack of consistent implementation of the physician's treatment orders or evidence of the facility's assessment and monitoring of the condition of the resident's lower extremities.

- o. Resident #5 had an assessment dated 12/18/03 which identified that the resident's diagnoses included a history of TIA and gastritis. The assessment further recorded that the resident had short and long-term memory loss, required supervision while eating, experienced swallowing and chewing problems and received a mechanically altered diet. Physician orders for December 2003 directed the facility to provide the resident a regular pureed diet. On 12/17/03 an evaluation conducted by speech therapy recorded that the resident had been experiencing signs and symptoms of aspiration and recommended that a Modified Barium Swallow (MBS) be conducted. Subsequent to the speech therapy evaluation, the resident continued to experience swallowing difficulty. Review of the nurses' narrative notes identified that on 12/22/03 the resident had aspirated during supervised treatment with the speech therapist and on 12/24/03 the resident choked while drinking coffee. Although the nurses' notes documented that messages were left with the physician's answering service requesting a swallowing evaluation and informing the physician of the resident's episodes of choking and/or aspiration, there was no evidence of any physician response until 1/2/04 when the nurses' notes recorded that the physician had approved a Modified Barium Swallow (MBS) and the physician's orders directed the facility to schedule the MBS. Subsequently, there was no further documentation regarding the implementation of the physician's order for a swallowing evaluation until

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- 1/16/04 when the facility sent a facsimile message to the hospital requesting that an appointment for the MBS be scheduled as soon as possible. During an interview on 1/28/04 the Director of Nursing stated that the MBS had not yet been scheduled.
- p. Resident #35 was admitted with diagnoses inclusive of congestive heart failure, arthritis, chronic obstructive pulmonary disease, and pneumonia. Review of facility documentation identified a weight of 207 pounds in November 2003, a weight of 218 pounds in December 2003, and a weight of 208.5 pounds in January 2004. Review of the policy and procedure for observation and recording of weights identified that if a resident's weight is three pounds more or less than the previous weight taken, the certified nurse assistant will re-weigh the resident with another staff member and report the weight to the charge nurse. Review of the resident's weight record identified that a re-weight had not been done subsequent to the eleven pound weight gain from November 2003 to December 2003. The Assistant Director of Nurses stated during an interview on 1/29/04 at 4:00PM that residents are weighed monthly on their first shower day of the month and then the weight is reported at the following weight committee meeting. If a weight loss or weight gain is identified then the resident should be re-weighed on the subsequent shower day.
- q. Resident #27 diagnoses included benign prostatic hypertrophy, sepsis, aspiration pneumonia, and congestive heart failure. A nurse's note dated 1/14/04 identified bilateral crackles and that the resident was examined by the physician. A physician's progress note dated 1/14/04 indicated that the resident presented with a change in status with increased respiratory secretions and some shortness of breath with orders for an antibiotic and a chest x-ray for 1/15/04. A resident care plan dated 1/15/04 identified an upper respiratory infection with interventions that included monitoring oxygen saturations and lung sounds every shift. Although nurse's notes from 1/15/04 through 1/27/04 identified a moist productive cough, review failed to identify that oxygen saturation and/or lung sounds were assessed in accordance with the plan of care.
- r. Resident #3 was admitted with diagnoses inclusive of chronic obstructive pulmonary disease, diabetes mellitus, and a history of congestive heart failure. A physician's order dated 9/15/03 prescribed coverage with Novolin Regular Insulin three times a day and at bedtime according to the blood sugar using the following sliding scale: if the blood sugar is 150-250, give 3 units, if the blood sugar is 251-300, give 6 units, if the blood sugar is 301-350, give 9 units, if the blood sugar is 351-400, give 12 units, and if the blood sugar is greater than

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

400 call the physician. An endocrine consult dated 12/10/03 assessed the resident as having uncontrolled Diabetes Mellitus with recommendations that included continuing Accu-Checks as is currently being carried out and also continue on current Regular Insulin schedule. Although the consult recommended continuing the Regular Insulin schedule the Medication Administration Kardex (MAR) from 12/10/03 through 12/17/03 identified that the Regular Insulin coverage had been discontinued absent an order. Blood sugars obtained during that time period ranged from 120-386 with eight entries noted to be greater than 150 requiring Regular Insulin coverage in accordance with the physician's orders. Review of the MAR identified that the sliding scale Regular Insulin schedule was then transcribed onto the MAR on 12/17/03 however lacked direction for a blood sugar of 150-250 until transcribed to the MAR on 12/26/03 with a blood sugar result of 169 on 12/24/03 which was lacking Regular Insulin coverage in accordance with physician's orders.

- s. Resident #13 was admitted with diagnoses inclusive of toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension. A pain assessment dated 10/23/03 identified that the resident experienced intermittent pain with the worst pain rated as a seven on a scale of zero to ten which is relieved by rest and medication. An MDS assessment dated 12/23/03 identified moderate pain daily. The corresponding care plan identified a problem with comfort with interventions that included assessing characteristics of pain including location, duration, quality, aggravating factors, radiation, intensity and to document such. In addition, interventions included assessing the effectiveness of pain medication and to update the physician if ineffective. Physician orders from 12/4/03 through 1/28/04 identified multiple changes to the analgesia medication regime. Nurse's notes and the medication administration record from 12/4/03 through 1/28/04 identified frequent complaints of leg and/or back pain with frequent pain medication administered. A computed axial tomography exam dated 1/6/04 of the lumbar spine revealed moderate to severe spinal stenosis L3-4, L4-5, and L5-S1 and moderate central spinal stenosis L2-3. Observation and interview with Resident #26 on 1/27/04 at 6:40AM identified the resident lying in bed moaning. Upon inquiry, Resident #26 reported severe pain in her back and rib area reporting the pain as a ten on a scale of zero to ten. The nurse was notified and medicated the resident as ordered. Review of the policy and procedure for pain management identified that resident's receiving medication and/or other interventions will have pain management documentation completed each time a medication or other intervention is

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- provided. A pain management flow sheet will be initiated the first time a resident experiences pain. Review of the clinical record and/or medication administration record failed to identify that a pain management flow sheet had been initiated and/or maintained and/or pain had been assessed in accordance with the plan of care, and/or that the effectiveness of the pain medication had been consistently assessed subsequent to administration.
- t. Resident #24 was admitted with diagnoses inclusive of a fractured right humerus, hypertension, and a seizure disorder. A laboratory report dated 9/8/03 identified a Dilantin level of 14.5 (normal 10-20). A RCP dated 10/5/03 identified a potential for trauma related to seizure disorder with interventions that included administering Dilantin as ordered. A physician's order dated 12/27/03 prescribed Phenytoin 100 milligrams (mg) three times a day. Review of the Medication Administration Record (MAR) on 1/24/04 revealed that the 1:00 PM dose of Phenytoin was omitted. A nurses' note dated 1/28/03, 8:20 AM identified that the nurse was summoned to assess the resident for seizure activity. Assessment included a slight eye twitch and general tremors. The physician was notified and ordered a Dilantin level. A laboratory report dated 1/28/04 identified a Dilantin level of 7.6. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #24's 1:00 PM dose of Phenytoin was omitted as the 9:00 AM dose was administered at 12:35 PM (three hours and thirty five minute delay).
 - u. Resident #41 was admitted with diagnoses inclusive of Parkinson's disease, and hypertension. Physician orders dated 12/28/03 prescribed Carbidopa/Levodopa 25/100mg, one capsule three times a day. Review of the MAR on 1/24/03 revealed that the 1:00 PM dose of Carbidopa/Levodopa 25/100 mg was omitted. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #41's 1:00 PM dose of Carbidopa/Levodopa 25/100 mg was omitted as the 9:00 AM dose was administered at 12:15 PM (three hours and fifteen minute delay).
 - v. Resident #42 was admitted with diagnoses inclusive of hypothyroidism and bipolar disorder. Physician's orders dated 12/28/03 prescribed Depakote 250 mg three times a day. Review of the MAR dated 1/24/04 revealed that the 1:00 PM dose of Depakote was omitted. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #42's 1:00 PM dose of Depakote 250 mg was omitted as the 9:00 AM dose was administered at 12:15 PM (three hours and fifteen minute delay).
 - w. Resident #43 was admitted with diagnoses inclusive of polymyalgia. Physician's orders dated 12/27/03 prescribed Cyclobenzaprine 10mg three times a day and Neurontin 600mg three times a day. Review of the MAR

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- dated 1/24/04 revealed that the 9:00AM dose of Cyclobenzapine 10mg and 9:00AM dose of Neurontin 600mg was omitted.
- x. Resident #6 was admitted with diagnoses inclusive of gastroesophageal reflux disease, chronic blepharitis, and paraplegia. Physician's orders dated 12/27/03 prescribed Lorazepam 1mg three times a day, Reglan 10mg four times a day, and Cortisporin, one drop to both eyes four times a day. Review of the MAR revealed that the 1:00 PM doses of Lorazepam, Reglan, and Cortisporin eye drops were omitted. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #44's 1:00 PM dose of Lorazepam, Reglan, and Cortisporin eye drops were omitted as the 9:00 AM dose was administered at 12:15 PM (three hours and fifteen minute delay).
 - y. Resident #9 was admitted with diagnoses inclusive of hypertension, hyperlipedemia, and irritable bowel syndrome. Physician orders dated 12/27/03 prescribed Bentyl 10mg capsule three times a day. Review of the MAR dated 1/24/03 revealed that the 1:00 PM dose of Bentyl was omitted. Nursing Supervisor #2 stated during an interview on 1/24/04 at 1:00 PM that Resident #9's 1:00 PM dose of Bentyl was administered at 12:15 PM (three hours and fifteen minute delay).
 - z. Frequent intermittent observations of the medication pass on 1/24/04 from 8:30 AM through 1:00 PM identified multiple delays in the administration of medications. Observation identified at 11:50 AM Nursing Supervisor #2 assumed administration of the medication. Review of the policy and procedure for medication administration identified that medications will be administered at facility approved times of administration unless otherwise noted. Doses may be given within 60 minutes before or after the time designated.
 - aa. Resident #5 was admitted with diagnoses inclusive of congestive heart failure hypertension, and hypertension. Physician orders dated 12/15/03 directed nectar thick liquids. Observation on 1/27/04 at 10:30AM during medication administration identified that RN #1 administered thin consistency cranberry juice with medications. Observations noted the resident coughing after consuming a small amount of the juice. Subsequent to surveyor inquiry on 1/27/04, RN #1 stated that prior to the resident's recent hospitalization, nectar thick liquids had been ordered. She further stated that the cranberry juice should have been thickened but she hadn't given it any thought until inquiry was made. Review of the clinical record identified a physician order dated 1/27/04 which directed nectar thick fluids.
 - bb. The facility failed to implement the care plan for Resident #2, a patient identified as having a Seizure Disorder; Dementia - Alzheimer's type; history

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

of healed pressure ulcers on the right heel and coccyx; and an aspiration risk. The findings are based on observation and clinical record review. A review of the physician orders for Resident #2 revealed an order dated 12/12, indicating "heel float applied to right foot while in bed." An order dated 12/26 indicating "bed against wall- mat on floor" and " 1 ½ siderail up secondary to decreased safety awareness secondary to dementia." An observation on 1/27/04 at 3:05pm of Resident #2 while lying in bed revealed that the mat was positioned upright on it's side, wedged between the resident's bed and the nightstand. At the surveyor's request, a facility nurse removed the resident's comforter to check for the application of the heel boot to the right foot. The heel boot had not been reapplied when the resident was assisted to bed by staff after a family visit. On 1/28/04 at 9:00 am observation revealed the resident in bed with the floor mat leaning against the wall on the opposite side of the room. The right heel boot was visible in the chair at the foot of the resident's bed.

The above is violation of Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

57. Based on clinical record review, the facility failed to ensure that the activities of daily living of one resident did not decline. The findings include:
- a. Resident #4 was admitted to the facility on 12/01 with diagnoses which included right leg ulcers, cellulites, adjustment depression, mild depression and history of PVD. The MDS of 1/7/04 identified a decline in the areas of bed mobility, ambulation, dressing, eating, toilet use and personal hygiene. According to this MDS, the resident was now totally dependant on staff in most of her ADL. Documentation was lacking in the medical record to reflect a rationale as to reason for the decline. The resident had received OT services in the past she had been discharged in August of 2003. Documentation was lacking to reflect that the resident care plan addressed the resident's issues regarding to her ADL skills and/or developed a plan to prevent further decline in this area following her discharge from OT.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (j) Director of Nurses (2)(B) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(K).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

58. Based on observations, clinical record review and staff interviews, the facility failed to ensure that the following residents received the necessary services to maintain adequate hygiene and nutrition.
- a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses which included CVA, right hemiplegia, aphasia and hypertension. The RCP, which was undated, identified a problem relative to an alteration in nutrition. Interventions included, assist resident with meals as necessary, however the MDS of 12/3/03 identified that the resident required extensive assistance with eating. A dysphagia screen dated 9/12/03 identified that the resident was affected with severe dysphagia and required 1:1 feeding. It was also recommended that the resident be given small amounts of food at a slow rate. The resident also presented with apraxia and poor motor planning with decreased awareness of food on the tray which made self-feeding more challenging. A nutrition risk assessment dated 9/18/03 identified the resident to be a high nutritional risk, below his ideal body weight and identified a potential for further weight loss relative to his intake of less than 75%. The resident was further described as having sustained a significant weight loss of 14 pounds. The plan included to feed the patient as needed. Observation of the resident on 1/23/04 during the noon meal identified that the resident was seated at a table alone, with his back to the nurse aide who was assigned to the dining room. His right arm was in an immobilizer. His lunch tray was served to him at 12:10 p.m. Adaptive utensils were observed on the tray. The resident was observed picking up his spoon but not placing it into any of his food, however he would then bring the spoon up to his mouth. The resident also was not wearing his eyeglasses at this time, as identified on his current MDS. As of 12:45 p.m., the resident had consumed 0% of his meal. Interview with the NA in the dining room identified that she would assist Resident #9 with his meal upon completion of feeding the other resident. She also reported that his eyeglasses were not able to be located. Further observation of the resident revealed that at 12:45, the NA began feeding the resident however the resident only consumed approximately 40% of his meal. No provision had been made to reheat the resident's meal prior to feeding. On 1/26/04, the resident was again observed sitting in the dining room. His lunch was again served at approximately 12:15 p.m. The resident did not begin eating. Approximately ten minutes later a staff person yelled to the resident that he needed to eat. The resident then picked up his fork and placed it in his soup and then brought the fork to his mouth. He continued to "eat" his soup by utilizing his fork. At approximately 12:35 an NA began feeding the resident his meal, at which time he ate. Other staff members present in the Dining Room during the lunch meal included the Director of Financial Services, the Social Services Designee and the Administrator's

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Administrative Assistant. They were observed delivering lunch trays and assisted the residents with their meal by opening up milk cartons, buttering bread and other such tasks. Interviews conducted with the Administrator identified that the aforementioned staff members were performing these meal related tasks as part of "other related duties" which were identified in their individual job descriptions. Interviews with these staff members identified that they did not recollect being oriented to these duties. Documentation was also lacking to reflect that any orientation had been provided.

- b. A tour of the facility on 1/27/04 between 5:30 a.m. and 7:30 a.m. was conducted to observe care and services provided to residents. NA #4 was accompanied on rounds from approximately 6:15 am during which time residents were systematically checked for incontinence and care provided as necessary. At approximately 7:15 a.m., Resident #39, the last resident to be checked on that wing, was observed supine in bed. Resident #39's MDS of 11/5/03 identified the resident as incontinent of bowel and bladder and dependent on staff for personal hygiene. Although NA #4 entered Resident #39's room at approximately 7:15 a.m., no check of Resident #39 was performed despite the odor of urine in the room. Upon surveyor query, NA #4 stated that she thought another nurse aide had already checked Resident #39. However, upon further questioning, NA #4 checked the resident who was found to be incontinent of urine and stool.
- c. Resident #36's quarterly assessment dated 12/22/03 identified the resident to be cognitively impaired, incontinent of bowel and bladder and requiring extensive care for toileting, and hygiene. The resident care plan dated 12/28/03 identified that the resident was at risk for altered skin integrity with an intervention to provide toileting and incontinent care every two hours. Observation during a tour of the unit on 1/23/04 at 11:20AM identified Resident #36 lying in bed. During an interview Resident #36 was requesting care reporting that she "smelled". Although interview with NA #1 identified that the resident was last changed and repositioned at 9:41AM, observation identified a large ring of urine on the incontinent pads with dried urine noted at the perimeter of the ring. Observation of Resident #36 on 1/27/04 identified that NA #8 washed the resident's perineal area from back to front and stool was observed in the rectal area. The resident was incontinent of urine and stool and although the perianal area was washed, the aide failed to wash the buttocks.
- d. Resident #12 diagnoses included hypertension, dementia, and arthritis. A nurse's note dated 1/21/04 identified that the resident was transferred to a physician's office for eye surgery. The resident care record dated 1/21/04 identified that personal and oral care had been provided with total assistance however a signature was lacking for the nurse aide and/or nurse indicating who had

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

completed the care. The Clinical Director of the Eye Surgery Center during interview on 2/3/04, stated that upon receiving the resident for the procedure it was very apparent that mouth care had not been provided. She stated that there was a moderate amount of food debris in the mouth, a lesion in the resident's right buccal mucosa was noted, and the lips were noted with dry skin. The Clinical Director of the Eye Surgery Center also stated that the resident had a body odor that was suggestive of a lack of hygiene and a weepy lesion on her left clavicle. The resident's fingernails as reported by the Clinical Director were long and very dirty and the resident was picking at facial lesions. Oral care was provided prior to the procedure with the resident fully cooperative. She further stated that she reported her concerns to the nursing facility and they indicated to her no knowledge of the oral lesion. Although the resident care record identified that total assistance had been provided to the resident, interview with the Clinical Director of the Eye Surgery Center, identified that necessary services including personal and oral hygiene had not been provided.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (o) Medical Records (2)(K).

59. Based on observation, clinical record reviews, and staff interviews, the facility failed to evaluate, monitor and/or implement treatments for pressure sores for the following residents. The findings include:
- a. Resident #30 was admitted to the facility on 1/8/04 following surgery for a fractured hip. The admission skin assessment dated 1/8/04 identified areas on the body audit on the buttocks and/or coccyx, but failed to stage these areas and/or obtain a treatment for the buttock until 1/11/04, as identified in the physician order of 1/11/04. In addition, although the resident's bilateral heels were identified as spongy and/or red, there was no physician order for treatments to the left heel until 1/11/04 and no identified treatment to the right heel. The pressure ulcer report dated 1/11/04 identified that the left heel was a stage one pressure ulcer measuring 0.6 cm by 3.5 cm in size and identified that a treatment of Granulex had been obtained. The pressure sore report of 1/22/04 identified that the left heel was now a stage two pressure ulcer measuring 5 cm by 2.2 cm in size and that the treatment was now Xenaderm. In addition, the pressure ulcer report dated 1/23/04 identified that the resident had two stage two open areas on the buttocks, one measuring 0.2 by 0.2 cm. in size and the other measuring 1 cm. by 1.5 cm. in size. Interview with the unit RN #2 identified that she obtained a treatment for Granulex to the left heel on 1/9/04 but forgot to write it on the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- physician's orders and forgot to write it on the treatment kardex. The MDS of 1/19/04 identified Resident #30 required limited staff assistance with bed mobility and had three stage II pressure ulcers. The care plan dated 1/22/04 identified areas of actual skin breakdown on the buttocks (2) and left heel with an intervention to encourage repositioning. Observation of the resident on 1/26/04 between the hours of 7:15 AM through 10:30 AM reflected the resident to be positioning on her back. At 11:15 am the resident was observed to be lying on her right side. Upon inquiry, Resident #30 stated that her "bottom is sore."
- b. Resident #19's MDS assessment dated 11/11/03 identified the resident as cognitively impaired, incontinent of urine and stool, requiring extensive staff assistance for toileting and hygiene needs. This assessment further identified no pressure ulcers. The care plan dated 11/18/03 identified a potential for impaired skin integrity related to incontinence and decreased mobility with an intervention to turn and reposition every two hours. An additional problem dated 11/18/03 identified that the resident was incontinent and to toilet or provide incontinent care every two hours. An updated care plan dated 1/24/04 identified a "stage two" on the left thigh and gluteal fold and to not use reusable briefs until areas healed. The facility's pressure sore report dated 1/23/04 identified that Resident #19 had two pressure areas on the left thigh and left gluteal fold. Observation of this resident on 1/26/04 at 6:30 PM identified that the resident was seated in a wheelchair and expressed that she was wet. The resident was observed to have slacks on that were wet with urine covering the front of her slacks and extending down both legs of the slacks. Upon surveyor intervention both aides assigned to the resident's unit were questioned regarding when incontinent care was last provided to Resident #19. NA #10 stated that she was not assigned to care for this resident, but that she had checked on the resident last at 3 PM (on 1/26/04) and had pulled open the resident's diaper and said that the resident was dry at that time. Interview with the other aide (NA #11) identified that he had not provided incontinent care to Resident #19 since 3PM (on 1/26/04) but pointed to the other aide and said she has resident. The resident was subsequently brought to the bathroom and placed on the toilet. The resident had on an incontinent brief which was saturated with urine and stool and the buttocks were very reddened. Resident #19's elastic hose were wet with urine and the aide removed the stockings. Upon inquiry LPN #3 on the early morning of 1/27/04, of what the status of the open areas on Resident #19, this nurse replied that she didn't see the areas because the resident refused to have the nurse do the treatment to the pressure ulcers.
- c. Resident #24's quarterly assessment dated 11/25/03 identified the resident as cognitively impaired, incontinent of urine and stool and requiring total care for all needs. This assessment further identified the presence of a stage two pressure

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- ulcer. The care plan dated 12/4/03 identified that the resident required perineal care after each incontinence. The pressure ulcer report dated 1/23/04 identified that the resident had a stage two pressure ulcer on the left buttocks measuring 2 by 1.4 cm in size. Observation of care at 6:05 AM on 1/27/04 identified NAs #7 and #8 to state to surveyor that the resident was dry and they were just going to reposition the resident. Observation of the pad under the resident's coccyx noted an area of soiling/drainage approximately four by five inches in size. The resident was noted to have an odor of urine. Upon informing the aides of this observation NA #7 washed the resident's perineal area up and down several times without changing the position of the wash cloth and was observed to wash the rectal area the washed over the pressure ulcer areas. The previously identified pressure ulcer on the left buttock was observed and a new open area on the right buttocks approximately ½ inch by ½ inch in size was noted and this was mentioned in the presence of both aides. During an interview with LPN #1 on 1/29/04 the nurse identified that she was never informed by the 11-7 staff on 1/27/04 of the new open area. Subsequently, on 1/29/04, the care plan identified open areas present on the right and left buttocks.
- d. Resident #38 was observed during incontinent care on 1/27/04 at 7:10 AM to have a Foley catheter in place, but the Foley catheter tubing was not attached to leg strap and was pulling on the resident's penis. The NA reattached the catheter tubing to the leg strap. The urinary meatus was reddened and the scrotal area was also reddened. There was a small open area noted on the tip of the penis under the meatus. This opening was identified to the aides caring for the Resident #7 and Resident #8. In addition open areas previously identified by staff were noted on the resident's left and right buttocks. A review of the resident's record reflected that the resident had a culture of his penis which was positive for MRSA (methicillin resistant staph aureus) noted on 12/03 and had been receiving treatment consisting of Xenaderm and Bactroban to the tip of the penis. Interview with LPN #1 on 1/29/04 identified that the 11-7 staff on 1/27/04 had never reported the open area on the penis. Subsequent to this interview and assessment of the resident, the open area on the penis had healed.
- e. Physician orders dated 10/15/03 prescribed normal saline wash followed by Xenaderm to the right heel twice a day for five days and Xeroform gauze, double thickness to the left heel every day for five days. Review of the treatment administration record from 10/15/03 through 10/20/03 identified that documentation was lacking on four of the ten entries that the treatment had been provided to the right heel and on one of the five entries that treatment had been provided to the left heel. Further review of the treatment administration record from 10/21/03 through 10/27/03 identified that although the physician orders

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

dated 10/15/03 directed treatments to the right and left heel for five days concluding on 10/20/03, treatment continued for seven additional days absent a physician order. Physician orders dated 11/6/03 prescribed cleansing the right and left heel with normal saline and to apply nickel thick Panafil to the open areas followed by a dry clean dressing twice a day. Review of pressure sore reports of the left heel from 11/6/03 through 12/2/03 identified that the left heel, healed on 12/2/03. Pressure sore reports of the right heel from 11/6/03 through 1/6/04 identified that the area was improving, however remained with a measurement on 1/6/04 of six centimeters by four centimeters after debridement. Although the left heel pressure area was healed on 12/2/03, review of the physician orders and treatment administration record dated 12/03 identified treatment orders continued to the left heel and failed to identify treatment to the right heel until 1/6/04. The Infection Control Coordinator stated during an interview on 1/13/04 that although treatment orders and the treatment administration record identified treatment to the left heel, treatment was provided to the right heel and not the left heel as it was healed. Review of a pressure sore report dated 12/9/03 identified a stage III pressure sore to the right heel which measured 2 cm by 2 cm with 0.1 cm of depth and no drainage. Further review of the pressure sore reports from 12/16/03 through 1/13/04 identified that although the measurements were improving, it failed to stage the wound and or identify the site. Review of the policy and procedure for weekly pressure sore reports identified that documentation will include the stage and site of the wound.

- f. Resident #13 was admitted with diagnoses inclusive of toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension. The RCP dated 11/20/03 identified a potential for an alteration in skin integrity with an intervention that included assisting with turning and repositioning every two hours. The weekly pressure sore report dated 1/23/04 identified a stage two pressure area on the coccyx which measured 3 centimeters (cm) by 1.4 cm, a stage two pressure area on the right buttocks which measured 3.2 cm by 2 cm, and two, stage two pressure areas to the left buttocks which measured 2.4 cm by 1.6 cm and .3 cm by 1 cm. Constant observation on 1/27/04 from 7:45AM through 11:30AM (two hours and forty five minutes) identified that Resident #13 was without the benefit of a position change from the right side to the left side in accordance with the plan of care.
- g. Resident #5 was admitted with diagnoses inclusive of congestive heart failure and hypertension. A nurse's note dated 1/24/04 identified that the resident was re-admitted. The admission assessment identified reddened heels and a stage two open area to the right buttocks. The current care plan identified a potential for impaired skin integrity with interventions that included turning and repositioning

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

every two hours. Constant observation on 1/27/04 from 6:50AM through 11:05AM (period of four hours and fifteen minutes) noted the resident positioned on the right side without the benefit of turning and repositioning in accordance with the plan of care. Further observation noted a stage two pressure area on the right buttocks which was assessed by RN #1 at 11:05AM. Assessment by RN #1 included a measurement of 6 cm by 2.1 cm.

- h. Review of the pressure sore report dated 1/15/04 identified that Resident #14 had a stage two pressure area on the bilateral buttocks which measured 6 cm by 6 cm with 0.1 cm of depth. Observation of the pressure sore measurement on 1/22/04 completed by LPN #4 identified measurements of 6 cm by 6 cm. Observations on 1/27/04 during measurement identified a 6 cm by 6 cm area of stage one redness extending across the gluteal fold with one, stage two pressure area noted to the right and left of the gluteal fold. The Infection Control Coordinator stated during an interview that that she was trained to measure wounds from the farthest points on non-blanchable redness and to stage at the highest stage and that is how she has trained the staff. Although the measurements are from the furthest point of the non-blanchable redness, assessments of Resident #14's pressure ulcers as currently being completed do not capture an accurate assessment and/or the progress or lack of, of the two, stage two pressure areas on the bilateral buttocks.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

60. Based on observations, clinical record review and staff interview, the facility failed to ensure that for one resident, the necessary care and services were provided to prevent a decline in range of motion. The findings include:
 - a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses which included CVA, hemiplegia right, aphasia and hypertension. The MDS of 9/9/03, identified partial loss of voluntary movement and partial loss of range of motion in the arm, hand, leg and foot. The MDS of 12/3/03, identified full loss of voluntary movement in the arm, hand, leg and foot. A review of the RCP dated 1/3/04, identified a problem relative to physical mobility and right hemiparesis. Interventions included to monitor for evidence of complications of immobility to include contractures. Documentation was lacking to reflect that the RCP had been revised to reflect the increased contractures and/or that specific interventions had been identified to address the problem. Observation of the resident during the course of the inspection identified that although the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

resident was provided with a "carrot" to the right hand by the nurse aides, other individualized clinical interventions were lacking to address the resident's increased deficits related to loss of voluntary movement and range of motion. Although a NA reported that all of the residents receive ROM "with care", the facility was unable to provide documentation at the time of the inspection regarding the resident's range of motion status. The facility policy and procedure reflects that the "nurse will document in the Monthly Progress Note section, a full assessment of the resident's progress or lack of progress with regards to ROM." Interview with the ADNS on 1/26/04, identified that the facility's restorative nursing program consisted only of "walks" with the PT aide and did not encompass any other areas.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

61. Based on clinical record reviews and staff interviews, the facility failed to ensure that the following residents received adequate supervision and/or assistive devices to prevent accidents. The findings include:
- a. Resident #6 was admitted to the facility with diagnoses which included paraplegia and IDDM. The RCP of 7/03 identified redness and swelling of the right great toe due to diabetic neuropathy. The RCP directed that three staff members were to assist with transfer. On 12/13/03, the resident's left great toe sustained a medial laceration as the nurse aide was readying the resident for transfer. Facility investigation identified that the resident's foot had not been positioned on the footrest of the wheelchair and the resident's foot hit the "cupboard."
 - b. Resident #29 was admitted to the facility on 1/22/04 for short term rehabilitation status post total hip replacement. The resident was also admitted with a foley catheter in place. Documentation in the medical record identified that on 1/24/04, the resident's foley catheter tubing was inadvertently pulled by the nurse aide during transfer which resulted in hematuria. The foley catheter continued to drain hematuria through 1/25/04. Further documentation was lacking regarding this issue in that the resident was transferred to another nursing home on 1/26/04. Interview with the ADNS on 12/30/03 identified that the nurse aide who had pulled the foley catheter, had threaded the catheter tubing inappropriately while getting the resident dressed which resulted in the accident.
 - c. Resident #22's clinical record identified that the resident had dementia and renal failure. A review of the facility documentation identified that on 10/24/03 the resident sustained a five by five cm. skin tear when the resident's sweater got

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- caught on the resident's skin. Interview with LPN #1 identified that the resident had geri arms (protective covering) on her arms and had a previous skin tear on her arm earlier that day and there was blood from the earlier skin tear that "stuck" to the geri arm and as staff took the sweater off, the skin stuck to the sweater.
- d. Resident #14 was admitted with diagnoses inclusive of hypothyroidism, urinary retention, and non insulin dependent diabetes mellitus. The resident also had a history of falls. A nurse's note dated 8/18/03 identified that the resident was found sitting on the floor of the bathroom. Interventions to the RCP included keeping the chair alarm out of reach and every fifteen minute checks. Subsequent nurse's notes dated 9/15/03 and 11/17/03 identified additional falls with the resident sustaining an abrasion to the left parietal area on 11/17/03. An RCP dated 11/20/03 identified a risk for falls with interventions that included every fifteen minute checks. On 12/4/03, a nurse's note identified that the resident was found on the floor with the television on his right lower leg and a laceration to the head. The resident was transferred to the hospital and diagnosed with a closed head injury. Review of the clinical record with the DNS on 1/26/04 at 2:50PM failed to identify that the every fifteen minute checks had been completed in accordance with the plan of care. In addition, although revisions to the care plan subsequent to the 9/15/03 fall included a velcro belt the family refused. Review failed to identify any intervention subsequent to the refusal of the velcro belt to reduce the resident's risk to fall. Review of the Reportable Event Report for Resident #7 identified that at 7:30pm on 1/2/04 "Pt [patient] found face down in room on floor in front of w/c (wheelchair). She states 'I lean over to see what my w/c (wheelchair) was dragging on and I feel out of my chair'". Further review of the reportable event indicated that the "previous preventive measures" implemented by the facility were "positioning in chair, verbal reminders." A nurses' note documented at 7:50pm on 1/2/04 documents "7:30pm called to resident's room by another resident. Large hematoma...8x5cm left forehead. "A care plan initiated on 11/17/03 to address the resident's "Alteration in safety secondary to fall on 11/15/03" indicates the use of a bed/chair alarm as an approach to address this problem. Review of the reportable event and the nurses notes does not indicate that the chair alarm was in use when the resident sustained a fall on 1/2/04 resulting in a 8x5cm hematoma on her left forehead. Interview with the DON on 1/28/04 confirmed that the facility documentation does not indicate that a chair alarm was in use when Resident #7 sustained her fall.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

62. Based on observations, clinical record reviews and staff interviews, the facility failed to implement prompt measures to address significant weight losses for the following residents. The findings include:
- a. Resident #16 was admitted to the facility on 12/23/03 with diagnoses including a fractured right humerus, chronic obstructive pulmonary disease and hypoalbuminemia. The resident's weight upon admission was 71 pounds. The Admission Weight Sheet indicated that residents are to be weighed upon admission and weekly for four weeks following admission and if the resident's weight is stable, weights are to be monitored monthly thereafter. Resident #16's clinical record, including the Admission Weight Sheet, lacked documentation of weekly weights following admission. Review of the facility's January Monthly Weight Record indicated that on an unidentified date, the resident had a weight of 65 pounds. Although the ADNS stated upon interview, that the monthly record had not been updated and that another weight was ascertained for Resident #16 during January (71 pounds), the clinical record lacked documentation of weight monitoring for four weeks following admission. Additionally, the clinical record lacked documentation that the dietician and/or physician had been notified of the weight loss or that additional interventions had been implemented since identification of the weight loss. Upon interview, the facility Registered Dietician #2 was unaware of the resident's current weight status and indicated that she is usually informed of weight issues during weekly rounds.
 - b. Resident #13 was admitted with diagnoses inclusive of toxic metabolic encephalopathy, chronic renal failure, and pulmonary hypertension. A RCP dated 11/20/03 identified a potential for an altered nutrition with an intervention that included a 2-4 gram sodium ground diet with no black pepper or chili powder. An MDS assessment dated 12/23/03 identified weight loss with a weight of 217 pounds, and leaves 25% or more of food uneaten at most meals. A dietary review dated 12/23/03 identified a weight loss of 7.5 pounds from the previous months weight with recommendations to continue 2-4 gram sodium diet with regular portions and to monitor weight. The resident care flow records from 1/11/04 through 1/17/04 identified that the resident consumed 50% or less for thirteen of the twenty-one meals consumed. Nutritional notes dated 1/15/04 and 1/20/04 identified a weight of 176.8 pounds (weight loss of 40.2 pounds), reduced lower extremity edema, and potentially weight loss is due to an intake of less than 75% of meals. Review of the policy and procedure for identification of residents at nutritional risk identified weight loss guidelines that included in part a weight

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

loss of five pounds in one month. Should a resident be assessed as at a high nutritional risk, then the calorie count protocol will be followed. Supplements and/or more aggressive nutritional therapy may be warranted after assessment and consulting the health care team. Although it was identified that the resident lost 7.5 pounds from November 2003 to December 2003 and a 40.2 pound weight loss from December 2003 to January 2004, review of the care plan failed to identify any revisions that included a calorie count and/or addition of supplements, and/or assessment of nutritional laboratory values related to weight loss. During an interview with the Registered Dietician on 1/29/04 at 4:00PM, she stated that a calorie count was not completed as she believes they have very little value in the long term care setting as they generally are not completed accurately.

- c. Resident #32 quarterly assessment dated 11/13/03 identified the resident as having a memory impairment, having some difficulty make decisions and with no weight loss. Diagnoses included depression, hypertension and diabetes mellitus. The care plan dated 11/20/03 identified that the resident had varied weights due to diuretic use with interventions to monitor the monthly weights. The resident was on Lasix 40 mg daily since 5/2/03 and no additional diuretics were noted as prescribed. A review of the resident's weight record reflected that the resident's December weight was 176.5 pounds and the January weight was 154 pounds. On 1/27/04 the dietitian was questioned on this weight loss and that no reweight was found. A second interview with Registered Dietitian #2 and ADNS on 1/29/04 identified that a reweight was done and the resident weigh 148.5 pounds. Although the resident loss 27.5 pounds, there was no documentation in Dietitian #2's notes or in nurses' notes to reflect intervention were implemented based on the weight loss. Upon inquiry as to why no interventions, the ADNS replied that they questioned the weight and were going to get another weight. The Registered Dietitian #2 stated she did not complete a nutrition alert on this resident's weight loss.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

63. Based on clinical record review and staff interviews, the facility failed to implement recommendations of the dietitian subsequent to weight loss for one resident. The findings include:

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- a. Resident #12 was admitted with diagnoses inclusive of hypertension, dementia, and arthritis. A nutritional consult dated 12/18/03 revealed a weight of 132.5 pounds which identified a significant weight loss of 19.1 pounds from the November 2003 weight of 151 pounds with a plan to increase the supplement of Med Pass 2.0 from 60cc to 120cc four times a day. Review of the facility weight records identified that upon reweighing (re-weight lacking a date) the resident weighed 141 pounds indicating a 10 pound weight loss versus a 19.1 pound weight loss. Review of the resident care records from 12/18/03 through 1/19/04 identified that the resident consumed fifty percent or less of the meal on 81 of 99 occasions. Weekly weights for January 2004 identified a weight range of 141-143 pounds. Although the nutritional consult recommended increasing the nutritional supplement on 12/18/03, review of the clinical record with the Registered Dietician #2 and the Assistant Director of Nurses on 1/29/04 failed to identify that the increase was ordered and implemented until 1/19/04.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

64. Based on clinical record reviews and staff interviews, the facility failed to provide adequate fluid intake to maintain adequate hydration for four (4) residents. The findings include the following:
 - a. Resident #6 was admitted to the facility with diagnoses which included Charcot-Marie Tooth Syndrome, IDDM, paraplegia and neurogenic bladder. A nutritional assessment identified that the resident was a moderate nutritional risk and required 2000 cc of fluid per day to meet his fluid needs. The RCP of 7/29/03 identified a problem of a foley catheter as related to his neurogenic bladder. Interventions included, encourage fluids. A review of the facility's intake and output documents for Resident #16 identified that during the months of October and November of 2003, the resident's average daily fluid intake was 1400 cc's. A nursing narrative dated 11/21/03, identified that a new foley catheter was inserted on 11/20/03 and subsequently dry blood was noted on the pad and the character of the urine was dark and concentrated. At 7 p.m. the resident reported not feeling well and his temperature was noted to be 102.2 degrees F. Two hundred (200 cc's) of dark blood tinged urine was noted in the foley catheter bag. The resident continued to have an elevated temperatures and concentrated urine until 11/25/03 when he was noted to have a temperature of 102.2 degrees F. and was transferred to the hospital. The resident was admitted to the hospital with clinical sepsis,

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

dehydration and UTI. Documentation was lacking to reflect that the resident reached his required fluid needs prior to his hospitalization and/or that his fluid needs had been reassessed in response to his on-going fevers and concentrated urine.

- b. Resident #7 diagnoses included non-insulin dependant diabetes mellitus, CVA and seizure disorder. In addition, during the period of 1/18/04 through 1/23/04, nurses notes identified that the resident intermittently experienced nausea, "dry heaves", vomiting, impaired fluid and food intake and lethargy. There was no documentation to reflect that the resident was assessed for dehydration. The nutrition risk assessment dated 1/20/04 identified that the resident's recommended fluid intake was 1710 cc's a day. A review of the intake and output record for the period of 1/18/04 through 1/24/04 reflected that the resident's intake on three out of eight days was less than 1000 cc's per day and on eight out of eight days during the same period the resident failed to consume the recommended fluid intake. Nurses notes dated 1/22/04 identified that the resident vomited and was lethargic and on 1/24/04 the resident was noted to have a change in level of consciousness and was sent out to the emergency department at 9:40 pm. The resident was returned to the nursing home on 1/25/04 with diagnoses of mild dehydration and urinary tract infection.
- c. Resident #23 was admitted to the facility on 12/12/03 with diagnoses that included a recent CVA and diabetes. The hospital discharge summary recorded that the resident was receiving nutrition through a G-tube. The physician's admission orders directed the facility to provide the resident with a nutritional formula at the rate of 40cc an hour (960 cc a day). An admission dehydration assessment, which was undated, determined that the resident was at moderate risk for dehydration, and on 12/16/03 the dietitian conducted an assessment of the resident's fluid and nutritional needs which identified that the resident required a total of 1982 cc of fluid each day. However, the facility failed to develop a resident care plan to address the resident's risk for dehydration or to identify interventions for assessing and monitoring the resident for signs/ symptoms of inadequate fluid intake. The facility further failed to maintain records of the resident's intake and output. During the period from 12/16/03 through 12/19/03 the facility contacted the physician regarding specific problems (e.g. the resident's blood sugar levels of >400 on multiple occasions, an elevated temperature of 100 degrees). During an emergency room visit on 12/19/03 the resident was diagnosed with a urinary tract infection, and hospital laboratory tests revealed abnormal values (e.g. high sodium level of 155, high BUN). Although the physician provided orders for changes in medications and on 12/18/03 increased the resident's tube feeding to 55cc an hour with a 300cc water flush each shift, the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

facility failed to assess the resident for dehydration and/or implement measures to promote adequate fluid intake in light of the resident's fever, abnormal laboratory values and elevated blood sugar levels. On 12/21/03 the resident was transferred to the hospital and admitted. A subsequent discharge summary recorded that prior to the hospitalization the resident had developed "worsening dehydration secondary to fever and a urinary tract infection." The discharge summary further identified that the nursing facility was not able to provide IV fluids and had been unable to meet the resident's fluid needs through the G-tube. During an interview on 1/29/04 Dietitian #2 stated that she had identified the resident's risk for dehydration. The dietitian further noted that if the nursing staff had requested that she evaluate the resident's status and/or provide further input, she would have made additional recommendations.

- d. Resident #5 diagnoses included a history of TIA, gastritis and congestive heart failure. A nutritional assessment dated 9/30/03 recorded that the resident required 1890cc of fluid each day. Review of resident care records for the period from 11/16/03 through 1/16/04 identified that the resident consumed 50% or less of the meal 59% of the time. During December 2003 speech therapy documentation and the nurses' narrative notes identified that the resident was experiencing difficulty swallowing liquids. However, the facility failed to assess and/or monitor the resident for dehydration. Although the medication administration record documented that the resident received a nutritional pudding on the lunch and dinner trays, review of records of the daily nourishments that were provided for the period from 1/1/04 through 1/16/04 identified that the resident had not received these fluids 70 % of the time (e.g. 4 ounces of milk at 2:00 PM, 4 ounces of nectar thickened juice at 2:00 PM and HS). Documentation identified on multiple occasions that the resident had been asleep or refused. However there was no evidence that the facility had subsequently attempted to offer the resident the nourishments. On 1/16/04 at 6:00 PM the resident was observed to be lethargic and difficult to arouse with labored irregular breathing. The notes identified that the resident was transferred to the hospital for evaluation. The resident was admitted with a diagnosis of dehydration.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

65. Based on clinical record reviews, observations and staff interviews, the facility failed to ensure for three (3) residents who were receiving antipsychotic drug therapy that monitoring and/or evaluation was implemented. The findings include:

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- a. Resident #6 was admitted to the facility with diagnoses which included Charcot-Marie-Tooth Syndrome, IDDM, paraplegia and neurogenic bladder. The RCP of 7/29/03 identified a problem of psychotropic medication "takes Seroquel for agitation and Ativan for anxiety". Interventions included AIMS testing as needed, every shift behavior monitoring and observe for side effects of psychotropic medications. Documentation was lacking to reflect that the resident had been provided with AIMS testing and/or that target behaviors had been identified for the purpose of psychotropic monitoring. Observation of the resident on all days of the survey identified that the resident was experiencing bilateral upper extremity tremors. Documentation was also lacking in the medical record to reflect that these tremors had been identified by the nursing staff and were being monitored.
- b. Resident #4 was admitted to the facility on 12/01 with diagnoses which included right leg ulcers, mild depression, mild dementia and history of PVD. The resident was receiving Haldol 1 mg twice daily. Observation of the resident on 1/27/04 and 1/28/04 identified the resident to be having tremors of her bilateral upper extremities. Documentation was lacking to reflect that any AIMS testing had been conducted. Interview with the facility staff identified that they were unaware of the resident's tremors.
- c. Resident #10 had diagnoses that included a history of cerebral vascular accident and hypertension. The RCP of 5/5/03 identified a problem of organic mental syndrome with psychosis for which antipsychotic medication was ordered. The RCP identified approaches that included behavior monitoring every shift, however, failed to identify specific targeted behaviors indicative of the need for continued antipsychotic medication. In addition, behavior-monitoring documentation identified only "agitation" and "anxiety" as targeted behaviors, which were documented as not evident for December 2003 or January 2004.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

66. A review of the medical records for Resident #6 and Resident #9 identified that MD #1 reviewed and approved the patient care plan as outlined. This acknowledgement was signed by the physician. Interview with the physician on 1/29/04 identified that he had not reviewed the patient care plan and furthermore was not even aware what the patient care plan encompassed. A subsequent interview with the physician identified that he had not reviewed any patient care plans for any patients at the facility. He added that he

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

might have signed acknowledgement of this review because "maybe at some time the facility might have shown him one". Interview with facility staff on 1/29/04 identified that MD #1 was responsible for 64 residents at the facility. A review of the facility medical director agreement which was signed by the physician and dated 3/16/95 identified that "he/she participates in the development of a system that assures the provision of a plan of care for each resident.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(B) and/or (n) Medical and Professional Services (1)(C).

67. Based on clinical record review and interviews, the facility failed to ensure that irregularities reported by the pharmacist had been acted upon. The findings include:
- a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses which included CVA, right hemiplegia hypertension and GERD. Medications included Ranitidine 150 mg capsule twice daily. A pharmacist recommendation dated 11/26/03 identified that the resident's creatinine level was low and suggested reducing the Zantac dose to once daily. Documentation in the medical record as of 1/30/04, did not reflect that the physician acknowledged the recommendation.
 - b. Resident #6 was admitted to the facility with diagnoses which included Charcotte-Marie-Tooth Syndrome, IDDM, paraplegia and neurogenic bladder. A pharmacist review of the resident's medication regime during the months of April 2003 and October 2003 revealed recommendations which included the need for a diagnosis to support the use of Seroquel, need for a baseline AIMS test, Ativan dose exceeds daily limit and the need to review therapy for GERD. Although the Seroquel had been discontinued, physician response to the other recommendations was lacking as of 1/29/04.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (h) Medical Director (2)(B).

68. Based on clinical record review, observations and staff interview, the facility failed to provide care in a manner to prevent the development and transmission of infection. The findings include:
- a. Observation of Resident #29 on the January 23, 2004 initial tour identified that the resident's Foley catheter drainage bag was in contact with the floor. Upon informing the Day Supervisor #1 of this observation, the Supervisor moved the drainage bag from the floor.
 - b. A review of the facility's Quality Indicators for the period of 7/1/03 through 12/31/03 identified that the facility had a UTI rate of 13.9 % which placed the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

facility in the 93rd percentile in the report of the state's quality indicator statistics. A review of the facility's infection control committee meeting minutes identified that this issue had not been addressed. Interview with the Infection Control Nurse identified that she had raised this issue at the last infection control meeting, which occurred on 1/9/04 however the Medical Director made no recommendations in response to the problem.

- c. Upon tour of the facility on 1/27/04, Resident #37's Foley catheter drainage bag, without case, was observed to be resting on the floor.
- d. A review of the infection control surveillance rounds identified that provisions for staff monitoring had not been incorporated into the monthly rounds. Interview with the infection control nurse identified that her position was for only 16 hours weekly and she did not have enough time to monitor staff performance with regards to infection control.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C) and/or (t) Infection Control (2)(A) and/or (t) Infection Control (2)(B).

69. Based on observations, the facility failed to handle linen in a manner so as to prevent the spread of infection. The findings include:

- a. On 1/27/04, Resident #9 was observed receiving incontinent care by NA #2. The resident was soiled with urine and feces. NA #2 cleaned the resident with washcloths and then placed the soiled washcloths on the bedside table. She also placed the soiled gloves on the bedside table. A short time later the resident was served his breakfast on the bedside table without any prior cleaning of the table.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C) and/or (t) Infection Control (2)(A).

70. Based on a review of facility documentation, observations, interviews and the findings contained in this document, the facility failed to ensure that the active medical staff functioned in accordance with the facility's medical by-laws. The findings include:

- a. A review of the medical staff committee meeting minutes for the past year identified that the facility lacked an active organized medical staff as per the facility medical by-laws. The only physician present at all four meetings was the medical director. Facility by-laws identify that the facility shall have an active organized medical staff. All staff members must attend at least 50% of the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

meetings per year and 50% of the members must be present at each meeting. Staff members will review all deaths, facility acquired infections, and complications to residents. Meetings were to be conducted once every ninety days. Interview with the Administrator on 1/30/04 identified that none of the medical staff members attended the meetings. They just "did not show up". She also added that there were a total of five physicians on staff who were considered to be the facility's organized medical staff. She was aware that the medical staff meetings were held despite the lack of physician attendance but she did not address the problem. She also reported that the medical director was also aware of the problem but did not take any measures to rectify the lack of attendance. Medical by-laws identify that the medical director will suspend or terminate medical staff privileges in accordance with facility by-laws if a physician is unable or unwilling to adhere to applicable policies.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (f) Administrator (3)(C) and/or (h) Medical Director (2)(A)(C) and/or (i) Medical Staff (1)(4)(i)(ii)(iii).

71. Based on clinical record reviews, facility staff interviews, tours of the facility and a review of facility policies and procedures, the facility failed to have an effective and functioning governing body. The findings include:
- a. A review of the governing body responsibilities identified that the governing body was to oversee the management and operation of the facility. The Governing Body has adopted by-laws and is responsible for enforcing the rules and regulations relative to the health care and safety of the residents. The facility failed to have an effective governing body as evidenced by the findings contained in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1) and/or (e) Governing Body (1)(B).

72. The facility failed to ensure that personnel employed through an agency are practicing under current registrations.
- a. CNA # 14 had a CNA registration issued on 5/13/97. The facility's record for this CNA indicates that the registration expired on 10/2/03. A review of the facility's January nursing schedule revealed that CNA #14 worked as recently as 1/18/04.
 - b. CNA # 15 had a CNA registration issued on 7/11/00. The facility's record for this CNA indicates that the registration expired on 10/1/03. A review of the facility's January nursing schedule revealed that CNA # 15 worked on 1/4/04, 1/17/04,

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1/18/04 and 1/25/04. Interview with the ADNS on January 30, 2004 at 11:25am revealed that the facility's updates regarding CNA registrations is a part of the contractual agreement with the agency. The ADNS confirmed that CNA #14 and CNA #15 worked the shifts indicated in #1 and #2 above. Currently there is no system to ensure that registration updates are provided in a timely manner.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(F) and/or (j) Director of Nurses (2)(F).

73. Based on a review of facility documentation, the facility failed to complete a performance review at least every twelve months for two nurse aides (Nurse Aides #3, #5). The findings include:

- a. A review of the personnel records of Nurse Aides #3 and #5 identified that the facility failed to maintain documentation that job performance evaluations had been conducted during the past twelve months. Documentation in the personnel records of the employees indicated that the evaluations were due in October 2003.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(F) and/or (j) Director of Nurses (2)(F).

74. Based on clinical record reviews, a review of facility policies and procedures and interviews with facility staff the facility failed to ensure that the medical director was responsible for the overall quality of care in the facility and/or adequately supervised physician services. The findings include:

- a. A review of the medical director's agreement signed by the medical director and dated 3/16/95 identified that the Medical Director supervises the quality of medical care provided. The Medical Director, through the Administrator, is also responsible for the written by-laws, rules, regulations which are approved by the governing body and include delineating of the responsibilities of staff physicians. He would also become an active member of committees serving resident care and would document monthly in a report to the administrator the overall condition of the facility with regards to nursing services and infection control.
- b. A review of the medical by-laws also identified that the medical director was to serve as a liaison between the medical staff and the administrator, responsible for the agenda of all general meetings of the medical staff, would appoint an assistant medical director who would be approved by

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- the governing body, and would conduct monthly audits of active medical records to assure that physician services are being provided appropriately.
- c. A review of medical staff committee meeting minutes, which also encompassed the pharmacy and infection control committee meetings, for the last year identified that the facility lacked an active organized medical staff. Documentation was lacking that any physicians other than the medical director attended these meetings.
 - d. Interview with the Administrator on 1/30/04 identified that the medical director was aware that physicians did not attend medical staff however the issue had not been addressed. She had not received any monthly reports from the medical director regarding the overall condition of the facility but could not specify why. Although, she was aware that the medical director had made verbal arrangements with another physician for coverage in his absence, a formal arrangement had not been made and to her knowledge an assistant medical director had not been appointed. She also added that she was not aware that the medical director performed random audits of active medical records.
 - e. A review of the medical director's weekly rounds book identified that during the period of 12/4/03 through 1/29/04, the medical director reviewed twelve residents in the facility who were not assigned to him as the primary physician. The additional sixty residents reviewed during this time period were assigned to him as the primary physician.
 - f. During a closed record review of Resident #21 the surveyor noted the name of Physician # 4, a physician not previously identified by the facility as providing services to residents. Interview on 1/29/04 with the Administrative Assistant and the Regional Administrator, it was revealed that the facility was not aware that Physician #4 was providing on-call/covering services for at least one facility physician, Physician #5. The facility could not provide the surveyor with credentialing paperwork for Physician #4. Follow-up surveyor interview on 1/30/04 at 8:30am with the Administrative Assistant indicated that Physician #5 was contacted by the facility and he was unable to provide credentialing paperwork for Physician #4. The medical director has the ultimate responsibility in the coordination of medical care in the facility to include insurances that all physicians providing care to residents are credentialed.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Connecticut General Statutes Section 19a-555 and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (h) Medical Director (2)(A) and/or (h) Medical Director (2)(B) and/or (h) Medical Director (2)(C) and/or (h) Medical Director (2)(K).

75. Based on clinical record reviews and staff interviews, the facility failed to ensure that the following clinical records were complete, accurately documented and/or readily accessible. The findings include:
- a. Review of Resident #7's nurses' notes dated 1/15/04 identified that the resident experienced an episode of respiratory distress and was transferred to the hospital. A review of the clinical record identified that no copy of the inter-agency patient referral report (W-10) was part of the record.
 - b. Resident #7 had diagnoses of non-insulin dependent diabetes mellitus, CVA and seizure disorder. A review of the dental evaluation identified that the resident had an altered ability to retain the dentures. There was no documentation to reflect follow of this problem on the care plan and or with the physician or dietitian. The resident's weight record indicated that the resident had a seven pound weight loss from December 2003 through January 2004. The 12/03 weight was 132 and the January 2004 weight was 125.5 pounds. There was no documentation to reflect that a reweigh was done. Upon interview with the Dietitian she stated she was not aware of a problem with retaining the resident's dentures but that the resident was on a pureed diet. Upon inquiry about the seven pound weight loss, the Dietitian stated there may have been a mix up in the weights of this resident and the resident's roommate because the resident's roommate weighed 132 pounds and the roommate's December weight was 125 pounds.
 - c. Review of the clinical record of Resident #14 reflected that the resident was experiencing respiratory congestion and was sent to the hospital on 1/27/04. A review of the clinical record lacked a copy of the inter-agency interview with the 7-3 pm Nurse Supervisor identified that she sent out the complete W-10 and didn't realize a copy stayed at the facility.
 - d. Resident #33 was sent to the hospital on 1/15/04. The hospital discharge summary identified that the resident presented to the hospital with complaints related to constipation. The resident

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

underwent a workup and was diagnosed with a parathyroid tumor. A review of the clinical record lacked documentation of the resident's bowel movements during the period of 1/1/04 through 1/10/04. Upon several requests of facility staff for this record, this information could not be provided.

- e. Resident #35 was admitted with diagnoses inclusive of congestive heart failure, arthritis, chronic obstructive pulmonary disease, and pneumonia. Review of the clinical record identified that three history and physical forms were lacking dates and in addition failed to identify an assessment of general and/or mental status.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1) and/or (o) Medical Records (2)(C)(E) and/or (o) Medical Records (2)(K).

- 76. The facility failed to ensure that personnel were knowledgeable concerning the facility's emergency fire plan.
 - a. During a tour of the facility on 1/24/04, NA #18 was interviewed regarding the facility's fire plan. NA #18 stated that she was employed through an agency and had previously worked at the facility. Although NA #18 indicated that she had been oriented to the facility's fire plan, she was unable to state what she would do if a fire was discovered in the facility.
 - b. NA #1 and NA #2 during interview on 1/23/04 were unable to state emergency procedures as it related to fire safety.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2)(K) and/or (u) Emergency Preparedness Plan (2)(5).

During the course of an inspection which was initiated on 2/24/04 and concluded on 2/25/04, the following violations of the Regulations of Connecticut State Agencies were identified:

- 77. *The facility failed to provide C/S*
~~Based on F309, F310, F312, F314, F318 and F327 a situation of neglect was identified as evidenced by the following.~~

- a* For Residents #2, 4, 5, 7, 9, 13, 14, 16, 19, 24, 44, 45, 46, 47, 48 and 50, the facility failed to provide care/services in accordance with the residents' individual assessments and plans of care.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- b. The facility failed to assess, monitor and/or implement interventions/treatments for Residents #5, 24 and 38 who were identified with pressure sores.
- c. For Residents #12 and 35 the facility failed to monitor the implementation of systems to ensure that care and services were provided in accordance with standards of care.
- d. For Residents #5, 7, 9, 47 and 48 infection control practices were not maintained during care and/or wound treatments.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (f) Administrator (3)(F) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (t) Infection Control (2)(A).

78. Based on clinical record review and observations, the facility failed to apply professional standards of quality for the following residents:
- a. Resident #35 was identified on 2/20/04 with papules in the pubic area. A review of the clinical record failed to identify that the facility had conducted a complete assessment of the papules and/or monitored this change in the resident's skin integrity.
 - b. Resident # 12 was admitted with diagnoses inclusive of hypertension, dementia and arthritis. A history and physical dated 10/16/03 identified chronic skin changes to the legs. A dermatology consultation dated 2/2/04 identified electro-dissection and curettage of basil cell carcinoma of the left chest, right nose, right neck and right upper lip. A body audit dated 2/17/04 identified senile keratosis of the face and neck, shingles on the trunk and 3 cm by 3 cm ecchymotic areas on both pre-tibial areas. Review of the 2/24/04 body audit failed to reflect that the areas had been observed and/or monitored according to the facility's policy and procedures for a body audit.
 - c. Resident #18 had a physician's progress note dated 2/2/04 which identified that a skin lesion on the left forehead appeared to be enlarging and ordered a dermatology consultation. Review of the clinical record identified that although the skin lesion had initially been identified on 4/23/03, the facility had failed to assess or monitor the alterations in the resident's skin integrity. Observation on 2/24/04 at 2:00 PM identified a round scaly lesion approximately 3 cm. on the left temporal area. According to Skin Disorders, Mosby, 1994, an assessment of skin lesions should include a description of the

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

characteristics of the lesion, presence of exudates, pattern of arrangement as well as the location and distribution.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(K).

79. Based on clinical record review, observations and interviews, the facility failed to ensure that the following residents were provided with care and services in accordance with their individual resident care plans. The findings include:

- a. Resident #4 was admitted to the facility on 12/01/03 with diagnoses that included right leg ulcers, mild depression, mild dementia and a history of peripheral vascular disease (PVD). Documentation in the clinical record reflected that bilateral leg edema was a recurrent problem through January 2004. The resident care plans of 2/13/04 and 2/20/04 identified a problem relative to the lower extremity edema. Interventions included for staff to assess the lower extremity edema, to encourage rest periods with the legs elevated in order to decrease the edema and to consult the physician regarding the use of TED (anti-embolism) stockings. Observation of the resident on 2/24/04 from 7:00 AM through 9:35 AM reflected the resident seated in a wheelchair across from the nurse's station. The resident's left extremity was markedly edematous, and both lower extremities were resting on the floor. Interventions had not been implemented for the elevation of the resident's lower extremities. Observations further identified that the resident was wearing elastic knee-high hosiery instead of the TED stockings, and the edema was prevalent around the upper rim of the elastic hosiery. Documentation was lacking in the clinical record that the physician had been consulted regarding the TED stockings and/or that an assessment had been conducted regarding the edema during the period from 2/20/04 through 2/24/04. Interview with LPN #1 identified that the nurse aide who transferred the resident out of bed had provided the resident with the elastic stockings in lieu of the TED hosiery.
- b. Resident #14 had a recent hospitalization with diagnoses that included aspiration pneumonia. Subsequent to the resident's readmission to the facility, the resident was identified to require aspiration precautions, honey thickened liquids and supervision during meals. Observations made during breakfast on 2/24/04 identified that the resident was left unattended while eating the meal.
- c. Resident # 19's RCP of 1/23/04 identified an alteration in the plan of care, secondary to the resident's refusal to have the lower extremities elevated to

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- decrease edema. Interventions included to provide TED stockings when out of bed, to assess for increased edema and to explain and reinforce the need to elevate the legs when edema was present (i.e. elevate in wheelchair and return to bed for rest periods and document any refusal or behavior in relation to compliance with the plan). Observation of Resident # 19 on 2/24/04 identified that the resident was out of bed seated in a wheelchair without any foot elevation. Both lower extremities were edematous. Although TED stockings were in place, marked edema was also present above and around the upper perimeter of the stockings. Review of the clinical record identified that documentation was lacking during the period of 2/20/04 through 2/25/04 to identify that an assessment of the edema had been performed and/or that the TED stocking were evaluated for the appropriateness of size. Documentation was also lacking to reflect that the resident was encouraged to elevate the legs and/or that the resident had refused.
- d. Resident # 7's significant change in status MDS dated 11/6/03 identified the resident as having allergies. Review of the clinical record including the physician's orders dated 2/5/04 recorded that the resident was allergic to Zyprexa, sulfa and pollen. However, on 2/20/04 the facility obtained an order for the resident to receive Zyprexa, which was administered to the resident during the period from 2/20/04 through 2/24/04 when the error was identified and the medication was discontinued. During an interview on 2/25/04 at 9 AM the Regional Corporate Nurse # 2 stated that nurses were expected to check the resident's allergies before medications were transcribed and/or administered.
- e. Resident # 46 had diagnoses of cerebral vascular accident with left spastic hemi paresis and dementia. The quarterly assessment of 1/12/04 identified that the resident was cognitively impaired and dependent on staff for activities of daily living.
- i. The current care plan directed staff to reposition the resident every two hours. On 2/24/04 the resident was observed constantly from 8:55 AM to 11:55 AM (a total of three hours). Throughout that period the resident was seated upright in the bed without a change of position.
 - ii. The current care plan and the nurse aide assignment further recorded that the resident was at risk for aspiration, directed staff to be in attendance when the resident was eating and included an intervention for the resident to drink from an adaptive cup. On 2/24/04 from 9:04 AM to 9:16 AM the resident was observed to be in bed with the breakfast tray in front of her. There was no staff in attendance for about fifteen minutes until the DNS directed an aide to provide supervision. During the noon meal on 2/24/04

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- the adaptive cup was on the resident's tray. However, the aide did not use the cup and gave the beverage to the resident in a regular cup.
- f. Resident # 48's diagnoses included dementia. A quarterly assessment dated 12/2/03 identified that the resident was cognitively impaired and required extensive assistance with activities of daily living. The care card identified that the resident was at risk for aspiration, required supervision during meals, needed to wear spenco boots and required anti-tipping devices on the front of the wheelchair. The resident was observed on 2/24/04 during the breakfast meal to be eating unattended. On 2/24/04 and 2/25/04 the resident was observed seated in the wheelchair without the anti-tipping devices in place. On 2/25/04 at 6:50 AM the resident's left heel was noted to be reddened, and the spenco boots were not in place. A nurse aide indicated that the resident refused to wear the spenco boots and stated that she would inform the nurse of the reddened area. Interview with the charge nurse on duty during the 7:00 AM to 3:00 PM shift indicated that she was unaware of the reddened area.
 - g. Resident #7's quarterly assessment dated 2/3/04 identified the resident as requiring limited to extensive assistance with activities of daily living (ADL), having an indwelling foley catheter and a current urinary tract infection and MRSA. The RCP dated 2/11/04 included an intervention for staff to provide foley catheter care every shift. During observation of a hooyer lift transfer on 2/24/04 the foley catheter was placed in the resident's lap for twenty minutes. Interview with one of the two nurse aides who participated in the transfer identified that the facility had not provided her with any instruction regarding the procedure for hooyer lift transfers of residents with foley catheters. When the nurse aide subsequently asked a nurse about the proper procedure, the nurse identified that an appropriate procedure had been implemented during the transfer.
 - h. Resident #16 had diagnoses that included chronic obstructive pulmonary disease (COPD). The MDS dated 1/4/04 identified that the resident was alert and oriented. The RCP dated 1/26/04 documented that the resident experienced respiratory distress and an increased respiratory rate secondary to COPD. Interventions included to assess the resident's lung sounds every shift and to monitor for respiratory distress. Review of the clinical record on 2/25/04 with the Regional Corporate Nurse #2 for the period from 2/20/04 through 2/24/04 failed to identify that assessments and/or monitoring of the resident's respiratory status and/or lung sounds were completed.
 - i. Resident #7's quarterly assessment dated 2/3/04 identified that the resident required limited to extensive assistance with Activities of Daily Living (ADL) and had a history of falls. The care plan dated 2/21/04 noted the resident was

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- at risk for falls and included an intervention for a chair alarm. During intermittent observations on 2/26/04 the resident was observed to be out of bed in a recliner chair without the benefit of a chair alarm. Interview with the Regional Corporate Nurse #2 identified that the resident was to have a chair alarm on at all times.
- j. Resident #47 had diagnoses which included dementia with agitation. A quarterly assessment dated 10/15/03 indicated that the resident was cognitively impaired and required extensive assistance with eating. The nurse aide's care card identified that the resident was at risk for aspiration, required staff to be in attendance while eating and identified that the resident was to remain upright for 30 to 60 minutes after eating. The speech therapist on 11/13/03 recommended that the resident clear the oral cavity before liquids were provided from an adaptive cup. On 2/24/04 the resident was observed during the breakfast meal to be feeding herself while an aide was seated with her back to the resident feeding Resident #44. Resident #47 was eating and drinking liquids from a regular cup without any supervision to ensure that the resident had cleared the oral cavity of food before drinking. The resident was returned to bed with the head of the bed at 30 degrees. Following surveyor inquiry, the head of the bed was elevated.
- k. Resident #44's diagnoses included dementia. The Minimum Data Set of 11/25/03 indicated that the resident was cognitively impaired and required extensive assistance to eat. The resident was observed on 2/25/04 at breakfast to be fed by a nurse aide. The nurse aide's care card identified that the resident was at risk for aspiration and included an intervention for staff to have the resident sit up at 90 degrees for forty- five minutes after eating. On 2/25/04 the resident was observed to finish breakfast about 9:00 AM. The resident was returned to bed at 9:25 AM with the head of the bed at 45 degrees. Following surveyor inquiry, the charge nurse elevated the head of the bed to an upright position.
- l. Resident #13 was admitted to the facility with diagnoses that included a history of stenosis, dermatitis, toxic metabolic encephalopathy, chronic renal disease, right heart failure and pulmonary hypertension. The RCP of 1/20/04 identified problems of an open area on the coccyx and the potential for further alteration in skin integrity related to the resident's decreased mobility. Approaches included every 2-hour checks, monitoring for red/open areas, assisting the resident to turn and position every 2 hours. On 2/24/04 the resident was observed lying in bed on her back from 7:10 AM to 10:15 AM (a total of 3 hours and 5 minutes) without the benefit of turning and positioning.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- m. Resident # 5 was admitted to the facility with diagnoses, which included urosepsis, paroxysmal atrial fibrillation, hypertension, degenerative joint disease, gastritis, and duodenitis. The RCP of 1/26/04 identified that the resident had experienced an alteration in skin integrity and included interventions for staff to reposition the resident approximately every 2 hours and to provide care for incontinence every 2 hours. On 2/24/04 the resident was in bed from 7:10 AM to 10:15 AM on her back without the benefit of turning and positioning.
- n. Resident # 9's diagnoses included CVA with right hemiplegia, aphasia and hypertension. An RCP dated 9/12/03 identified that the resident had a swallowing deficit and recorded that subsequent to a Modified Barium Swallow (MBS), it was recommended that the resident receive no food or liquid by mouth. However, documentation identified that the resident's family wanted the resident to receive some food by mouth, and the care plan recorded an intervention for staff to implement aspiration precautions. A dysphasia screen dated 9/12/03 further identified that the resident had severe dysphasia and required one-to-one feeding. The screen further recommended that the resident be given small amounts of food at a slow rate. On 2/25/04 after hearing the resident coughing, a surveyor observed a nurse aide feeding Resident #9 who was lying in bed with the head of the bed at 60-75 degrees. Subsequent to the arrival of the surveyor, the DNS entered the room, directed the surveyor to obtain the suction machine and instructed NA #1 to raise the head of the bed. The surveyor informed facility staff that the DNS had requested suctioning for Resident # 9. Continued observation identified that although the DNS requested the suction machine, Resident #9 did not need suctioning but continued to cough for approximately 7 minutes. The physician was notified and ordered a chest x-ray. Although the nurse aide's care card identified that aspiration precautions were to be implemented, it failed to identify that the resident was to be given small amounts of food at a slow rate.
- o. Resident #48's diagnoses included a history of a cerebral vascular accident with left spastic hemiparesis, dementia and hypertension. The quarterly assessment of 1/12/04 identified that the resident was cognitively impaired and dependent on staff for activities of daily living. On 2/24/04 during morning care the resident was provided with care for incontinence. The aide did not change the gloves and after providing incontinent care proceeded to obtain the resident's toothbrush and mouth care equipment, wiped the resident's mouth, took clothing out of the closet and left the room while continuing to wear the gloves. The nurse aide then went to the room of

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Resident #9, took off the gloves she had been wearing and without washing the hands gathered linen from two carts. The nurse aide proceeded to assist another resident to get out of bed, provided assistance with the resident's dentures and combed the resident's hair before again returning to assist R # 9 out of bed without any hand washing.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K) and/or (t) Infection Control (2)(A).

80. Based on observations, clinical record review and staff interview for the following residents who were dependent on staff for transfers, hygiene, grooming and/or eating, the facility failed to provide the necessary services to maintain the residents' abilities in activities of daily living. The findings include:
- a. Resident #4 was admitted to the facility on 12/01/03 with diagnoses, which included right leg ulcers, cellulitis, adjustment depression and a history of peripheral vascular disease. An MDS assessment dated 1/7/04 identified that the resident had experienced a decline in the areas of bed mobility, ambulation, dressing, eating, toilet use and personal hygiene. The resident care plan of 2/16/04 identified a problem in the area of ADL and a decline in the resident's ability to eat independently. Interventions included to provide skilled occupational therapy, ADL training and for the resident to feed meals to self. An observation on 2/24/04 at 8:35 AM identified the resident seated in a wheelchair across from the nursing station with the bedside table and the breakfast meal. The resident was observed to be sleeping. The resident continued sleeping until approximately 8:50 AM at which time the resident consumed approximately 10% of the cereal and 5% of the tea. At 9:00 AM a nurse aide began to feed the resident, and the resident ate some of the meal. However, the nurse aide discontinued feeding at 9:05 AM, and the resident again began sleeping. At 9:15 AM LPN #1 fed the resident a few spoonfuls of cereal and then left. Upon surveyor intervention at 9:35 AM, LPN #1 again began feeding the resident. Although the RCP included an intervention for occupational therapy to address the resident's activities of daily living and in particular the resident's decline in the ability to eat independently, observation on 2/24/04 failed to identify that interventions had been implemented to prevent further decline.

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- b. Resident #46 had diagnoses of cerebral vascular accident with left spastic hemi paresis, dementia and hypertension. A quarterly assessment of 1/12/04 identified that the resident was cognitively impaired and dependent on staff for activities of daily living. The current care plan included an intervention for the resident to participate in dressing and grooming (i.e. brushing teeth, washing face and brushing hair). During morning care the aides did not offer the resident an opportunity to participate in dressing and grooming in order to prevent further decline in the resident's ADL abilities.
- c. Resident #47's diagnoses included dementia with agitation. A quarterly assessment dated 10/15/03 recorded that the resident was totally dependent on staff for transfers. The current care plan included an intervention for staff to transfer the resident with the assistance of two. During transfers observed on 2/24/04 at 9:50 AM and 11:21 AM and on 2/25/04 at 9:17 AM the resident was lifted under the arms and did not bear weight while being transferred. During the transfer observed at 9:50 AM on 2/24/04 the resident was further observed to be transferred while the legs were crossed. During the transfers observed on 2/24/04 and 2/25/04 the facility failed to implement the necessary interventions to prevent further decline in the resident's ability to transfer.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

81. Based on observations and record review, the facility failed to ensure that the following residents received the necessary services to maintain adequate hygiene and/or nutrition.

The findings included:

- a. Resident #50 had an identified problem of impaired skin integrity. Interventions included to assist with turning and positioning every 2 hours and to toilet and/or provide care for incontinence every two hours. On 2/24/04 the resident was observed in bed from 7:10 AM to 8:30 AM. At 8:30 AM the resident was transferred to a wheelchair. The resident had been incontinent of a large amount of urine, and the incontinent pad was saturated with urine. The resident's nightwear was changed, and a dry incontinent pad was placed on the seat of the wheelchair. The resident was not provided with any incontinent care and continued to sit in the wheelchair until 11:00 AM.
- b. Resident #45's diagnoses included dementia - Alzheimer's Type. An assessment dated 1/9/04 identified that the resident had short and long-term memory deficits and required extensive assistance with eating. A nutrition

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

- assessment dated 1/6/04 identified a potential for weight loss. On 1/14/04 a resident care plan documented that the resident had ADL deficits and included an intervention for staff to feed the resident. On 2/24/04 the resident was observed with the breakfast meal uneaten. After thirty-five minutes a nurse aide began to assist the resident with the meal. During the noon meal on 2/24/04 the resident's tray was delivered by an administrative staff member who handed the resident a spoon before leaving the tray. The meal remained uneaten for twenty-five minutes until a nurse aide arrived and fed the resident.
- c. Resident #46 had diagnoses that included cerebral vascular accident with left spastic hemi paresis, dementia and hypertension. The quarterly assessment of 1/12/04 identified that the resident was cognitively impaired and dependent on staff for activities of daily living. The current care plan included an intervention for staff to provide mouth care. During observations of morning care on 2/24/04 mouth care was not provided to the resident.
- d. Resident #2's diagnoses included Alzheimer's disease. A Minimum Data Set (MDS) assessment dated 1/17/04 identified that the resident had severely impaired decision-making abilities and total dependence on staff for eating. A nutritional assessment dated 1/15/04 identified the resident's potential for weight loss and documented an average intake of 50-70% at mealtime. Observation on 2/24/04 identified a non-heated food cart was delivered to the unit at 8:15 AM. Although the food cart arrived on the unit at 8:15 AM, Resident # 2 did not receive assistance with breakfast until 9:35 AM (1 hour and 20 minutes). Upon interview the nurse aide stated she was feeding other residents and could not provide the resident with assistance with the meal earlier.
- e. Resident #47's diagnoses included dementia. A quarterly assessment dated 10/15/03 identified that the resident was incontinent of bowel and bladder and totally dependent on staff for personal hygiene and bathing. On 2/25/04 at 11:10 AM the resident was observed to have been incontinent of urine and was lying in bed uncovered. The resident's hand was touching the perineal area. A nurse aide moved the hand from the perineum, provided care for incontinence, placed the resident in a customized wheelchair and transported the resident to the nursing station. The aide did not wash the resident's hands until the surveyor noted the observations that had been made.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(l) and/or (t) Infection Control (2)(A).

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

82. Based on observations, clinical record review and staff interviews the facility failed to evaluate, monitor and/or implement treatments for pressure sores. The findings include:
- a. Resident #24's diagnoses included Alzheimer's disease and contractures of the lower and upper extremities. An MDS assessment dated 11/25/03 identified that the resident was totally dependent on staff for activities of daily living, incontinent of bladder and had a stage II pressure area. The RCP dated 1/15/04 identified that the resident was at risk for impaired skin integrity and included interventions for staff to reposition the resident and provide incontinent care every two hours. Observation on 2/25/04 identified Resident #24 in bed lying on the left side. The resident's arms were flexed upward against the chest and both legs were drawn upward under the buttocks. Further observation identified that from 6:00 AM to 8:45 AM (2 hours and 45 minutes) no repositioning and/or incontinent care was provided. The facility further failed to provide protection to the pressure point areas on the resident's upper and lower extremities.
 - b. Resident #5 was admitted to the facility with diagnoses that included urosepsis, paroxysmal atrial fibrillation, hypertension, degenerative joint disease, gastritis and duodenitis. The resident care plans of 1/26/04 and 2/12/04 identified a stage II area on the coccyx and the right buttock and included interventions for staff to provide care for incontinence and to turn and reposition the resident every two hours. The care plan further identified that the facility was to provide treatment as ordered by the physician. The physician's order of 1/28/04 identified a treatment of Xenaderm ointment to the open area on the right buttocks. The order directed staff to use a sufficient quantity as needed. On 2/24/04 at 10:15 AM, a licensed nurse provided wound care to the resident's right buttock. The resident had been incontinent of urine and feces. Although the nurse removed the feces from the buttocks with a moist washcloth, the anal area was still soiled with feces. Xenaderm ointment was applied to the open wound on the right buttock without the benefit of cleansing the wound.
 - c. Resident #38 had a quarterly assessment dated 12/18/03 which identified that the resident had short and long-term memory deficits, total dependence on staff for bed mobility, transfers, toileting and hygiene. Observation on 2/24/04 at 6:30 AM identified a 1 cm stage II open area to the coccyx. Interview with the nurse aide identified that the resident's open area had been present for approximately a week. During an interview the charge nurse stated that when she arrived on the unit at 11:00 PM on 2/23/04 the previous shift reported that the resident had a pressure area on the coccyx. Review of

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the clinical record and weekly pressure sore reports failed to identify any assessment of the recurrent wound.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (t) Infection Control (2)(A).

83. Based on observations, clinical record review and interviews the facility failed to ensure that the necessary care and services were provided to prevent a decline in range of motion for the following residents. The findings included:
- a. Resident #9 was admitted to the facility on 12/16/02 with diagnoses, which included CVA, right hemiplegia, aphasia and hypertension. The MDS assessment of 9/9/03 identified partial loss of voluntary movement and partial loss of range of motion (ROM) in the arm, hand legs and foot. The MDS of 12/3/03 identified full loss of voluntary movement in the arm, hand, legs and foot. The care plan identified a problem relative to contractures in the right hand, wrist and elbow. On 2/13/04 the care plan was revised to include a nursing intervention of daily range of motion and the use of a cane. Although a revision to the care plan dated 2/16/04 directed that passive ROM be provided, the NA care card identified active ROM. However, documentation was lacking in the medical record for the period of 2/20/04 through 2/24/04 to reflect that any type of ROM had been provided. Interview with a licensed nurse on 2/24/04 identified that she was not familiar with the resident's plan of care relative to range of motion. Documentation was lacking to reflect that in-services had been provided to nursing staff regarding the range of motion that was to be provided to the resident according to the plan of care. Facility policy and procedure regarding ROM identified that the goal of ROM was to prevent contractures and maintain optimum flexibility of the joints.
 - b. Resident # 24 was admitted to the facility with diagnoses, which included Alzheimer's Disease, seizure disorder and contractures of the upper and lower extremities. The MDS of 11/25/03 identified the resident's full loss of voluntary movement in both the upper and lower extremities. A care plan dated 9/4/03 identified that the resident had a problem in the area of physical mobility due to contractures and included an intervention for staff to provide splints to prevent further contractures. A physician order dated 1/29/04 directed the use of a knee splint with a schedule for it to be on at 1 PM, off at 4 PM, on at 6 PM and off at 9 AM. Documentation was lacking to reflect that the RCP included individualized interventions to address the resident's

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

increased deficits related to the loss of voluntary movement and range of motion. Observation of the resident during morning care identified that the nurse aide did not provide range of motion.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

84. Based on clinical record review and staff interview the facility failed to provide adequate fluid intake to maintain hydration for one resident (Resident #41). The findings include:
- a. Resident #41 was admitted to the facility with diagnoses inclusive of Parkinson's disease and hypertension. Review of the nurses' narrative notes dated 2/2/04, 2/16/04, 2/17/04, 2/18/04, 2/19/04, 2/22/04 and 2/24/04 identified that the resident's twenty-four hour intake was less than the resident's fluid requirement of 1639 cc for 24 hours. Although the resident's dehydration assessments had identified that the resident was a low risk for dehydration, the care plan failed to identify any interventions to address the resident's failure to ingest the minimum daily fluid requirements. Review of the clinical record identified that after the resident's blood pressure was found to be 70/40, Resident #41 was transferred to the hospital on 2/25/04 at 4:00 AM and diagnosed with dehydration. Review of hospital documentation identified a BUN of 72 (normal range 8-26) and Creatinine of 2.6 (normal range 0.5-1.5).

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

During the course of an investigation which was initiated on 3/2/04 and concluded on 3/3/04, the following violations of the Regulations of Connecticut State Agencies were identified:

85. Based on clinical record reviews, observations and staff interviews, for three (3) of four (4) residents, Resident #51, #52 and #53, the facility failed to provide care and services in accordance with the resident's care plan. The findings include:
- a. Resident #51 was admitted to the facility on 1/27/04 with diagnoses of COPD, hypertension, PAF, Hyperthyroidism, depression and questionable early dementia. The Discharge Summary from the hospital and dated 1/27/04 identified that the resident had experienced increasing shortness of breath fatigue, low oxygen saturation levels and had a right lower lobe pneumonia. The resident was

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

admitted to the nursing home to improve his general status and for short term rehabilitation. The RCP of 2/11/04 identified a problem with a history of COPD, pneumonia and interstitial lung disease. The goal was that no exacerbation of COPD would occur over the next ninety days. Interventions included to monitor for increase severity of respiratory distress and to monitor pulse oximetry every shift.

Observation of the resident on 3/2/04 identified him lying in bed with the head of the bed elevated at approximately a 10 degree angle. A Regional Nurse elevated the bed and identified that it was too low.

A review of the resident's care card did not include directions for the appropriate positioning of the bed to minimize respiratory distress.

A review of the treatment kardex for the month of February identified that there were seven omissions relative to his oxygen saturation levels being monitored on each shift. A physician's order dated 2/12/04 directed that oxygen should be titrated to 2L via n/c and oxygen sats should be maintained between 90-92%. Documentation was also lacking on the treatment kardex during the period of 2/13/04 through 2/29/04 to reflect that oxygen was provided on fifteen shifts.

- b. Resident #52 was observed on 3/2/04 at approximately 5:00 PM sitting in her wheelchair in the corridor and in close proximity to the nursing station. The resident was visibly upset and was crying. Staff were observed walking by the resident, however, no one stopped to address the resident's distress. Upon surveyor intervention, the ICN spoke with the resident briefly, however, the resident continued to cry and she then left the resident and reported that she cries frequently. The resident continued to cry and again staff continued to walk by the resident and again ignoring the resident's distress. This writer then spoke with the resident for several minutes and the resident stopped crying and asked to go to the dining room. The current RCP identified a problem of anxiety with interventions to encourage discussions of fear and anxiety, allow to cry and report.
- c. Resident #53 was admitted to the facility with diagnoses which included left cerebellar hematoma A-fib, CVA, hypertension, CAD, seizures, depression and anxiety. The MDS of 2/1/04 identified the resident to be totally dependent on staff for transfer and that the resident had not walked in the room or corridor during the last seven days. The current RCP identified a problem relative to a DX of CVA. An intervention included to ambulate with assist of two and follow with wheelchair to include PT aide and nursing. A physical therapy discharge summary which included service dates from 12/10/03 through 1/5/04 identified that the resident had met maximum benefit from skilled patient services. Recommendations included daily ambulation with nursing. Documentation in the medical record during the period of 2/23/04 through 3/2/04 did not identify that

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the resident had been ambulated on any occasion by the nursing staff. A review of the facility care card did not provide information for the NA to include direction for ambulation.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

86. Based on a clinical record review and staff interviews for one resident, Resident #7, the facility failed to ensure that the resident received necessary fluids as prescribed by the RCP. The findings include:

- a. Resident #7's diagnoses included urinary frequency, C Difficile Colitis, pseudomonas pneumonia, anemia, NIDDM, bronchospasm and urinary retention. A dietary assessment dated 2/17/04 identified the resident's fluid needs as 1450 cc's daily. A physician's order dated 2/17/04 directed that fluids be encouraged and also that she should receive 480 cc's per shift. On 1/22/04 and 2/23/04 the resident was diagnosed with a UTI. The RCP of 2/25/04 identified problems of risk for dehydration, risk of UTI and a LLL infiltrate. A goal identified that the resident would receive 1423-1708 cc/day. Interventions included offer to provide fluids with each meal and in between meals, maintain hydration and encourage po fluids. A review of the intake and output monitoring record identified that during the period of 2/17/04 through 2/29/04 the resident received an average of 1076 cc's daily. Although the physician was made aware of the resident diminished fluid intake, documentation was lacking to reflect that the resident was provided with fluids on the 11PM-7AM shift as per the physician's order and the RCP. Documentation was also lacking to reflect a rationale to why fluids were not offered on this shift. A review of the dehydration assessments conducted in February identified the resident at low risk for dehydration, however, factors were not considered such as a BUN of 37 and the receipt of Lopressor 25 mg po twice daily. On 2/28/04 at 6:30 PM the resident was identified as responding to painful stimuli, o2 sats at 89% and a temperature of 101. At 6:45 PM the resident was transferred to the hospital, at which time she was described as "responsive to painful stimuli only." The resident was admitted to the hospital with diagnoses of pneumonia, dehydration, perennial azotemia and was thought to have a possible sepsis, BUN was noted to be 84.

FACILITY: Hillcrest Health Care Center

Page 111 of 111

DATES OF VISIT: June 27, 29, July 1, 2, 3, 14, 16 and October 8, 2003; January 9, 12, 22, 23, 24, 26, 27, 28, 29 and 30; February 25 and March 2, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (o) Medical Records (2)(K).

**State of Connecticut
Department of Public Health
Division of Health Systems Regulation**

In Re: Hillcrest Healthcare, Inc. of Uncasville, CT, d/b/a
Hillcrest Health Care Center
5 Richard Brown Drive
Uncasville, Connecticut 06382

INTERIM AMENDED CONSENT ORDER

WHEREAS, Hillcrest Healthcare, Inc. of Uncasville, Connecticut (hereinafter the "Licensee"), has been issued License No. 2106-C to operate a Chronic and Convalescent Nursing Home known as Hillcrest Healthcare Center (hereinafter the "Facility") be the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on July 30, 2002 up to and including January 13, 2003 for the purpose of conducting multiple investigations, a certification inspection and a licensure inspection; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of the Connecticut State Agencies in a violation letter dated February 7, 2003; and

WHEREAS, the Licensee entered into a Consent Order with the Department effective June 11, 2003 (Exhibit A - copy attached); and

WHEREAS, subsequent inspections of the Facility during the period of June 27, 2003 to March 3, 2004 identified continued non-compliance with the Regulations of Connecticut State Agencies, Connecticut General Statutes and Federal laws and regulations and the original Consent Order effected with the Department on June 11, 2003 as evidenced by the March 8, 2004 (Exhibit B- copy attached); and

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.
Page 2

WHEREAS, the Licensee is willing effect an Interim Amended Consent Order inclusive of the June 11, 2003 Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein by and through Marianne Horn its Director, and the Licensee, acting herein and through John Antonino, its President, hereby stipulate and agree as follows:

1. The Consent Order between the Licensee and the Department effected June 11, 2003 is incorporated into this Interim Amended Consent Order.
2. The Licensee shall immediately cease admissions to the Facility except for patients returning from an acute care hospital stay. Admissions shall not resume unless and until the Department and the temporary manager agree that the Facility is in substantial compliance and is likely to maintain such compliance with all applicable state and federal statutes and regulations and the provisions of the Consent Orders.
3. The Licensee shall immediately increase registered nurse (RN) supervision within the Facility from one (1) free-floating supervisor per shift to two (2) RN Supervisors per shift, except that no additional RN supervision is required between the hours of 12 a.m. and 5 a.m. Such additional RN supervision shall continue until the Department and the temporary manager agree that the Facility is in substantial compliance with all applicable state and federal regulations and the provisions of the Consent Orders and is likely to maintain such compliance if the additional RN supervision is reduced. RN supervisors shall have the sole function of over-sight of the delivery of care and services to the patients of the Facility and immediately remediation of staff that fail to perform duties in accordance with standards of care and/or the Consent Orders effected with the Department.
4. The terms of this Interim Amended Consent Order and the Consent Order effected June 11, 2003 shall remain in effect until such time that the Department identifies that the

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.
Page 3

Licensee is able to provide care and services that meet federal and state laws and regulations and the provisions of the Consent Orders.

5. Execution of this Interim Amended Consent Order does not preclude the Department from initiating additional remedial actions.

*

*

*

*

*

Licensee: Hillcrest Healthcare, Inc. of Uncasville, CT.
Page 4

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

HILLCREST HEALTHCARE, INC OF
UNCASVILLE, CONNECTICUT

3-17-04
Date

By: *John Antonino*
John Antonino, its President

State of Connecticut)
County of Hartford)

ss _____ 2004

Personally appeared the above named _____ and made oath to the truth of the statements contained herein.

My Commission Expires: _____

Notary Public []
Justice of the Peace []
Town Clerk []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

3/24/04
Date

By: *Marianne Horn*
Marianne Horn, J.D., R.N., Director
Division of Health Systems Regulation

MAR 15 '04 14:46

MAR 16 '04 12:37