

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

IN RE: 245 Orange Avenue Operating Company II, LLC of Hackensack, NJ d/b/a
Milford North Health Care Center
245 Orange Avenue
Milford, CT 06460

CONSENT ORDER

WHEREAS, 245 Orange Avenue Operating Company II, LLC of Hackensack, NJ (hereinafter the "Licensee") has been issued License No. 2278 to operate a Chronic and Convalescent Nursing Home known as Milford North Health Care Center (hereinafter the "Facility") by the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulation of the Department ("DHSR") conducted unannounced inspections on various dates commencing on September 3, 2003 up to and including September 16, 2003 for the purpose of conducting licensure and certification inspections; 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 the violation letter dated October 8, 2003 (Exhibit A- copy attached); and

WHEREAS, an informal conference with respect to the violation letter dated October 8, 2003 was conducted on October 27, 2003 at the office of 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 Marianne Horn, its Director, and the Licensee, acting herein by Warren D. Cole, its Managing Partner, hereby stipulate and agree as follows:

1. The Licensee represents, stipulates and agrees that at all times it will employ sufficient personnel to meet the needs of the resident population. The Licensee shall appoint a free floating Nurse Supervisor on each shift 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 to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period of time.
2. The Licensee shall, within fourteen (14) days after the execution of this Consent Order, provide an inservice training program to Nurse Supervisors, which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations and staff remediation. Nurse Supervisors shall be supervised and monitored by a representative of the Administrative Staff, (e.g., Director of Nursing, Assistant Director of Nursing). Supervision by Administrative Staff shall be random, inclusive of evenings, nights, weekends and holidays. Said administrative monitoring and supervision shall be documented and retained for the Department's review. Nurse Supervisors shall be responsible for ensuring that care provided to patients is in accordance with the resident's individual comprehensive care plan. Nurse Supervisors shall not have administrative office duties.
3. The Licensee shall, within fourteen (14) days after execution of this Consent Order, review and revise, as necessary, policies and procedures relative to physician notification upon the need to alter treatment and/or the identification of a significant change in condition, provision of care and equipment to prevent the development and/or healing of pressure sores including incontinent care, nutritional support, and the implementation of comprehensive care plans that include identification of individual resident problems, goals and approaches, medication administration, medications procurement, patient hydration, prevention of dehydration, assessment for dehydration, intravenous therapy and documentation of therapy and infection control practices.
4. The Licensee shall, within twenty-one (21) days of the execution of this Consent Order, provide all nursing and ancillary personnel, as appropriate, with inservice training on the

policies and procedures referenced in paragraph #3.

5. Current residents shall be assessed for the risk of dehydration within seven (7) days of the execution of this Consent Order. Subsequent admissions shall be assessed upon admission and in accordance with minimum data set (MDS) requirements.
6. All residents at risk for dehydration shall have a care plan developed inclusive of goals and approaches to address the individual residents issues. Interventions shall be listed on the care plan.
7. Nurse Supervisors shall review intake and output monitoring each shift to determine compliance and evaluate said information relative to each resident's identified needs.
8. Within fourteen (14) days of the execution of this Consent Order, the Licensee shall engage the services of a professionally qualified Wound Consultant. The Wound Consultant shall review Facility policies/procedures, assist administrative staff with development and/or revisions of said policies, as applicable. The Wound Consultant shall inservice all nursing staff. The Wound Consultant shall visit the Facility every two (2) weeks to assess individuals at risk, patients with pressure sores and evaluate the quality of services being provided. Said reports shall be provided to the Facility Administrative Staff and to the Department. This requirement shall be in effect for six (6) months provided the Department does not identify substantial Facility non-compliance regarding the care and services rendered to patients at risk or those with pressure sores.
9. The Facility shall establish a quality assurance program to review patient care issues inclusive of those identified in the October 8, 2003, violation letter issued by the Department. The members of the quality assurance program shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation protocols. Membership shall at a minimum, include the administrator, director of nurses, infection control nurse, nurse supervisors and the medical director. Minutes of said meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
10. Within seven (7) days of the execution of this Consent Order, the Licensee shall identify the Facility's Administrative Staff responsible for monitoring the implementation of this document.
11. The Licensee shall pay a monetary fine to the Department in the amount of twelve

thousand five hundred dollars (\$12,500.00), 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. Said check and any reports required by this document shall be directed to:

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

12. 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 Department upon request.
13. 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 Department may petition any court with proper jurisdiction for enforcement of this Consent Agreement in the event the Licensee fails to comply with its terms. The Licensee retains all of its rights under applicable law.
14. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
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.

245 ORANGE AVENUE OPERATING COMPANY
II, LLC OF HACKENSACK, NJ.

Jan 23, 2004
Date

By: [Signature]
Warren D. Cole, its Managing Partner

STATE OF New Jersey

County of Bergen) ss Jan 23, 2004 2004

Personally appeared the above named WARREN D. COLE and made oath to the truth of the statements contained herein.

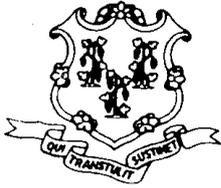
My Commission Expires: May 8, 2005
(If Notary Public) [Signature]
Notary Public
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

Nancy E. Trimpin
Notary Public, State of New Jersey
My Commission Expires May 8, 2005

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

February 3, 2004
Date

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



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

October 8, 2003

Albert Saunders, Administrator
Haven Health Center of Milford North
245 Orange Avenue
Milford, CT 06460

Dear Administrator:

Unannounced visits were made to Haven Health Center of Milford North on September 3, 4, 5 and 8, 2003 by representatives of the Division of Health Systems Regulation for the purpose of conducting a licensure and certification inspection with additional information obtained on September 10, 11 and 16, 2003.

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 visit.

An office conference has been scheduled for October 27, 2003 at 10 AM 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.

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

Respectfully,

Rosella Crowley, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

RAC/CM/jf

c: Director of Nurses
Medical Director
President



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

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

1. Based on clinical record review, observation and interview for four of eight sampled residents with a change in condition (R#3, 7, 10, 14), the facility failed to notify the resident's attending physician when the residents developed pressure sores and/or repeatedly refused medications. The findings include:
 - a. Resident #14's diagnoses included multiple sclerosis, septicemia, gastrointestinal bleed, and seizure disorder. The assessment dated 7/17/03 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living and did not have any pressure sores. A nurse's note dated 8/22/03 noted a right heel blister measuring 3.2 cm x 2.4 cm. On 9/05/03 at 5:00 PM and 9/08/03 at 9:00 AM the physician orders, the attending's communication book, twenty-four hour supervisor's report and/or nurse's notes were reviewed with the DNS and failed to provide evidence that the physician had been notified of the right heel blister from 8/22/03 until 9/04/03 when a treatment order was obtained. On 9/08/03 at 2:10 PM, observation of the area noted a circular area of blistered tissue with a darker center. The dimension was measured by the wound nurse and was noted to have increased in size to 4.2 cm x 3.4 cm.
 - b. Resident #3 was admitted to the facility on 7/25/03 with diagnoses that included cancer of the kidney, diabetes and osteoarthritis. The assessment dated 7/31/03 identified short term memory problems and required assistance with activities of daily living. A physician order dated 7/28/03 directed that the resident receive Lexapro (an anti-depressant medication) 10 mg at bedtime nightly for a depressed mood. Review of the medication kardexes for August and September identified that the resident did not receive the medication as ordered on August 23, 24, 25, 26, 28, 29 and September 1, 2, 3, 4, 2003. Documentation identified that the medication was not available. Interview with the unit manager on 9/10/03 noted that the medication had been ordered from the pharmacy, but had not come in. Review of the clinical record failed to provide evidence that the physician had been notified of the medication omissions. The assistant director of nursing noted on 9/5/03 that there had been a problem with transition to a new pharmacy. On 9/5/03 at 12:15 PM the psychiatrist stated that he was not informed that the medication was not given and stated that he should have been.
 - c. Resident # 7's diagnoses included congestive heart failure, hypertension, atrial fibrillation and bipolar disorder. A minimum data set dated 7/1/03 identified the resident was moderately cognitively impaired, and required assistance with activities of daily living. Review of the advanced practice registered nurse's progress note dated 7/2/03 identified that at times the resident refused medication. Review of the medication administration record from 8/20/03 to 9/5/03 identified that the resident refused all medication from

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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- 8/29/03 to 9/4/03. An interview on 9/5/03 at 1:30 PM with the nurse manager identified that facility policy directed that the physician would be notified when the resident refused medication for three consecutive shifts. Review of the clinical record failed to provide evidence that the physician had been notified of the resident's refusal from 8/29/03 until 9/4/03.
- d. Resident #10 was admitted to the facility on 8/23/03 with diagnoses that included a right hip fracture that was surgically repaired. Review of the clinical record failed to provide evidence that an admission assessment had been completed on the day of admission. The care plan dated 8/28/03 identified altered skin integrity related to open areas of both buttocks. Observation of the resident on 9/5/03 noted that the right heel had a 3.5 cm round blood blister present. Interview with the unit manager on 9/5/03 at 12:30 PM noted that the physician had not been notified of the presence of the heel blister. Interview with the wing nurse on 9/4/03 noted that she was aware of the pressure sore on the heel the previous day, but failed to document the area or report it until 9/5/03.

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

2. Based on clinical record review, observation and interview for two of twenty five sampled residents (R#9, 10), the facility failed to ensure the resident's privacy during personal care. The findings include:
- a. Resident #10's diagnoses included right hip fracture with surgical repair. The care plan dated 8/28/03 identified a self care deficit with interventions that included providing maximum assistance with bathing. Observations on 9/3/03 at 11:50 AM noted that the nurse aide was cleaning the resident and providing personal care without the benefit of the privacy curtain being closed. The care was being provided in full view of a family member present in the room at the time.
- b. Resident #9's minimum data set dated 8/5/03 identified the resident was severely cognitively impaired and totally dependent on staff for activities of daily living. Review of facility documentation on 9/8/03 at 2:00 PM with the director of nurses identified that on 8/26/03 the facility received a complaint from the resident's family regarding an incident that occurred on 8/22/03. It was reported that while providing care in the resident's bathroom, a nurse aide left the bathroom door open while the resident was sitting on the toilet without clothes. Further review of facility documentation identified that the nurse aide had left the bathroom to retrieve a clean johnny for the resident. Interview with the director of nurses identified that the resident had not been afforded

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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privacy and that this was an issue of dignity and respect. The nurse aide was inserviced on resident rights and dignity.

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).

3. Based on clinical record reviews observation and interviews for one sampled resident (R#25) who utilized a call bell and for all facility residents who had the facility wash their laundry, the facility failed to ensure that the resident had a working call light/bell and/or failed to ensure that resident's personal clothing was labelled and returned to the residents. The findings include:
 - a. Resident #25's diagnoses included acute pancreatitis. An assessment dated 8/5/03 identified that the resident with without cognitive impairment . Interview with the resident on 9/4/03 at 11 AM noted that the resident had not had a call bell for 4-5 days. Observation of the room at the time noted that the resident's call bell was attached to the roommate's bed with no alternative provided for the resident. Interview with the unit manager on 9/4/03 at 12 noon noted that she was not sure why the resident had not been provided with a hand bell. Interview with the Plan Manager on 9/4/03 at 12:15 PM noted that the call bell had been broken since 8/29/03 and he was waiting for a part to come in.
 - b. During the group meeting on 9/4/03, the residents identified a concern related to missing clothing. A tour of the laundry on 9/5/03 at 10:45 AM noted several large stacks of unidentified clothing. During an interview with the laundry staff on 9/5/03 at 10:50 AM, she stated that although clothing should be labeled by families or given to the facility to label, there was no formal process to ensure that it was being routinely done therefore there were stacks of unidentified clothing that were not returned to the owners.

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

4. Based on clinical record reviews and interviews for three of four sampled residents with changes in condition (R# 8, 13, 17), the facility failed to conduct a significant change in condition assessment when the resident's abilities declined in two or more areas. The findings include:
 - a. Resident #17's diagnoses included dementia and a history of pneumonia and urinary tract infections. The significant change assessment dated 10/24/02 identified that the resident required limited assistance for transfer and ambulation and extensive assistance for

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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- dressing. A quarterly assessment dated 1/6/03 identified that the resident had declined in transfer, ambulation, and dressing ability from the 10/02 assessment. Review of the assessments and clinical record with the director of nursing on 9/4/03 at 7:45 PM failed to provide evidence that a significant change assessment had been completed when the resident was noted to have declined in functioning.
- b. Resident #8's diagnoses included Parkinson's disease and dementia. A quarterly assessment dated 5/1/03 identified the resident's cognition was moderately impaired, required supervision while ambulating in his room and limited assistance for ambulating in the corridor with no limitation in range of motion. The assessment also identified that the resident had had no change in his weight. Review of the clinical record identified that on 6/2/03 the resident was readmitted to the facility following treatment for a subcapital femoral neck fracture of the right femur. Further review of the clinical record noted that a quarterly assessment was done on 7/23/03 that identified the resident had not ambulated in his room or the corridor, had had a significant weight loss of 5% and a limited range of motion in one leg and foot. Review of the clinical record and interview on 9/4/03 with the MDS coordinator identified that although a quarterly assessment had been done, the resident had a decline in three areas and therefore a significant change assessment should have been done.
- c. Resident #13's significant change assessment dated 11/26/02 identified that the resident was moderately cognitively impaired, required limited assistance with locomotion, extensive assistance with dressing and eating and was frequently incontinent of bowel and bladder. The quarterly assessment dated 2/2/03 identified that the resident was severely cognitively impaired and totally dependent on staff for locomotion, dressing, eating and was totally incontinent of bowel and bladder. Review of the assessments and clinical record with the registered nurse coordinator on 9/8/03 at 4:50 PM failed to provide evidence that a new significant change in condition assessment was completed when the resident was noted to decline in multiple areas.
5. Based on clinical record review and interview for one of twenty five sampled residents (R#17), the facility failed to ensure that the assessment was accurate. The findings include.
- a. Resident #17's quarterly assessment dated 1/16/03 identified that the resident had fallen in the previous 31-180 days, but had not experienced any fractures. Review of the clinical record identified that the resident had fallen on 12/10/02 and was sent to the emergency department where she was diagnosed with a nose fracture. Review of the clinical record/assessment with the director of nursing on 9/4/03 at 7:45 PM noted that the

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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1/16/03 assessment was inaccurate due to the failure to document the resident's fractured nose.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

6. Based on clinical record reviews, observations and interview for three of nine sampled residents (R#7, 8, 9) who needed assistance for personal hygiene, had behaviors of refusing food, medications and/or measures to promote healing, the facility failed to identify interventions to meet the residents needs. The findings include:
 - a. Resident # 8's diagnoses included Parkinson's disease, congestive heart failure, hypertension, recent fracture of the femur and a history of significant weight loss and dehydration. A minimum data set dated 7/23/03 identified the resident's cognition was moderately impaired, that the resident required assistance with activities of daily living and was occasionally incontinent of urine. Review of the medication administration record from 8/1/03 to 9/4/03 identified the resident frequently refused all medication. Review of dietary progress notes dated 7/28/03 identified the resident often refused to eat or drink resulting in an 11 pound weight loss. Review of the clinical record with the nurse manager on 9/4/03 at 6:30 PM identified that although the resident care plan identified that the resident often refused medications and food, it lacked interventions. The resident care plan dated 7/21/03 noted a goal that the resident will toilet self with minimal assist. Review of the nurse aide flow sheets from 8/1/03 to 9/7/03 identified the resident was frequently incontinent of urine. Review of the clinical record and interview on 9/4/03 at 6:30 PM with the nurse manager identified that the resident care plan lacked interventions for incontinence.
 - b. Resident #19's diagnosis included necrotizing fasciitis, with wound debridement, wound infections, parasitic disease, diabetes mellitus, stage II and stage IV pressure ulcers. The initial assessment dated 5/27/03 noted that the resident had no short term or long term memory problems, required assistance for transfer out of bed and movement on and off the unit, was independent for eating, was incontinent of bowel and utilized a Foley catheter. Physician orders dated 8/04/03 directed for the resident to be out of bed with the assistance of a Hoyer lift. The quarterly assessment dated 8/18/03 noted that transfer out of bed and movement on and off the unit did not occur. The care plans dated 7/21/03 and 8/25/03 noted that the resident was to be out of bed via the Hoyer lift with the assistance of two staff. On 9/08/03 at 1:30 PM during interview with the MDS coordinator, she stated she was aware that the resident did not always want to move and/or get out of bed,

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- and that she was aware of the resident's wounds. During review of the care plans she was unable to demonstrate different approaches and/or efforts to educate the resident related to the resident refusing to get out of bed, to change positions while in bed and/or efforts to educate the resident. The initial assessment dated 5/27/03 and quarterly dated 8/18/03 noted that the resident had no short term or long term memory problems, and required assistance for activities of daily living. The care plan dated 7/21/03 identified a self care deficit for bathing and/or personal hygiene due to the need for extensive/total assistance with interventions that included to encourage the resident to participate in bathing and showering. The clinical record identified that the resident refused to get out of bed and refused showers. The care plan did not address approaches for shampooing the resident's hair. On 9/04/03 at 4:00 PM and 9/05/03 at 2:00 PM, the resident's hair was noted to be matted down and unkempt. The resident stated that she had received only two shampoos since the 5/21/03 admission. On 9/05/03 at 5:00 PM the August 2003, and September 2003 flow sheets were reviewed with the DNS and licensed nurse and failed to provide evidence that any showers/shampoos had been given. Review of the care plan 9/08/03 at 10:45 AM with the MDS coordinator failed to provide evidence that a care plan had been developed to address the resident's grooming needs related to shampooing hair.
- c. Resident # 7's diagnoses included congestive heart failure, hypertension, atrial fibrillation and bipolar disorder. A minimum data set dated 7/1/03 identified the resident was moderately cognitively impaired, and required assistance with activities of daily living. Review of the advanced practice registered nurse's progress note dated 7/02/03 identified that at times the resident refused medication. Review of the medication administration record from 8/20/03 to 9/5/03 identified that the resident refused all medication from 8/29/03 to 9/4/03. Review of the clinical record noted that although the resident care plan dated 7/16/03 identified that the resident refused medication at times, it lacked interventions.

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

7. Based on clinical record review, observations and interview for two of twenty-three sampled residents (R#13, 14) who were dependent on staff for transfer and/or assistance with dentures, the facility failed to identify interventions to meet the residents needs. The findings include:
- a. Resident #14's diagnoses included multiple sclerosis, septicemia, gastrointestinal bleed and seizure disorder. The assessment dated 7/17/03 identified that the resident was

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- severely cognitively impaired, totally dependent on staff for activities of daily living and did not have any pressure sores. The care plan dated 7/23/03 identified a problem related to impaired mobility with an approach for the resident to be transferred out of bed with the assistance of two staff via the Hoyer lift. On 9/08/03 at 11:05 AM, two staff members were observed to manually lift the resident from the bed into the wheelchair. During interview and review of the clinical record and nurse aide assignment with the MDS Coordinator, on 9/08/03 at 11:45 AM she stated that she did not get the information regarding the change in the resident's transfer status which initiated 11/15/02. During interview with the Unit Manager at that time, she was unable to explain except to say it didn't get picked up.
- b. Resident #13's diagnoses included Alzheimer's disease. The care plan dated 7/21/03 identified a problem with swallowing with interventions that included to wear properly fitting dentures. Observations 9/5/03- 9/8/03 noted that the resident's dentures were on a shelf in the bathroom. The registered nurse coordinator stated that the resident had been without dentures for 5-6 months due to an ill fit and that the family did not want them fixed. Review of the care plan failed to provide evidence that the care plan had been reviewed/revised to reflect the lack of dentures and measures to ensure continued safe eating.
8. Based on clinical record reviews and interviews for two sampled residents (R#5, 7), the facility failed to provide care in accordance with standards of professional practice related to monitoring a resident with a critical INR for bleeding and/or monitoring of lower extremity edema and/or altering/falsifying a clinical record. The findings include:
- a. Resident #5 was admitted on 8/15/03 with diagnoses that included congestive heart failure, atrial fibrillation, mitral valve insufficiency and diabetes. Physician orders directed that the resident receive Coumadin. Laboratory reports dated 8/31/03 identified that the resident's Prothrombin time was 60 (normal 11-14) and INR was 23.8 (normal 2-3). The physician was notified and ordered Vitamin K intramuscularly and to monitor for signs and symptoms of bleeding. Review of the clinical record with the director of nursing on 9/3/03 failed to provide evidence that the resident was monitored for bleeding when the INR was noted to be at a critical level. According to 23rd Edition of Nursing 2003 Drug Handbook with the administration of coumadin the patient is to be regularly inspected for bleeding gums, bruising on arms/legs, petechiae, nosebleeds, melena, tarry stools and hematemesis.
- b. Review of the medicare daily notes and nurse's progress notes with the director of nursing on 9/3/03 failed to provide evidence that the resident was monitored for bleeding when

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- the INR was noted to be at a critical level. Copies were obtained by the surveyor of the clinical record on 9/3/03. Review of the record on 9/4/03 with the director of nursing noted that added to the medicare daily note, was the word "bleeding" for 8/26, 27, 28/03 and a note had been added that was not previously noted for 8/25/03. Interview with the nursing staff on duty on 9/3/03 after the surveyor inquired as to the assessment for bleeding failed to provide evidence as to which staff member falsified the clinical record. According to Christensen and Kockrow, 2nd edition, (1995), accuracy and completeness of documentation are important for communication, continuity of patient care, legal matters, accreditation and quality assurance/assessment/improvement audits, and costs reimbursement purposes. It further explains when making a late entry, note it as a late entry and then proceeds with your notation.
- c. Resident # 7's diagnoses included congestive heart failure, hypertension, atrial fibrillation, pulmonary edema, bilateral leg edema, bipolar disorder and a history of dehydration and weight loss. A minimum data set dated 7/1/03 identified that the resident was cognitively impaired, and required assistance with activities of daily living. Review of the advanced practice registered nurse's (APRN) progress note dated 7/30/03 identified the resident had bilateral 1 to 2 plus pitting edema of the lower extremities, extending up to the knees and shortness of breath/wheezing. It further identified an impression of pulmonary edema with interventions that included Lasix therapy and thigh high TED stockings. A physician progress note dated 8/13/03 identified 2 to 3 plus pitting edema up to the knees. Review of the clinical record identified the resident was admitted to the hospital on 8/17/03 and readmitted to the facility on 8/19/03 with a diagnosis of an exacerbation of congestive heart failure and atrial fibrillation. Observations on all days of the survey identified the resident's legs were edematous with the resident observed sitting in a wheelchair without the benefit of TED stockings or leg rests to elevate the legs. Further observations noted the wheelchair leg rest on the resident's bedside chair. Review of the clinical record and interview on 9/5/03 at 1:30 PM with the nurse manager identified that although the resident care plan dated 8/13/03 identified 3 plus pitting edema it lacked nursing interventions. She further identified that although the thigh high TED stockings were not reordered after the resident's readmission, the resident's legs should be elevated, the edema should be assessed daily and pedal pulses checked. Further review of the clinical record failed to provide evidence that the resident's lower extremities had been monitored. According to American Nurses' Association Standards of Nursing Practice - The collection of data about the health status of the client / patient is systematic and continuous. The data are accessible, communicated and recorded.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D&t
(j) Director of Nurses (2).

9. Based on clinical record reviews, and interviews for three of twenty-four sampled residents (R# 14, 20, 21), the facility failed to monitor intake and output and/or failed to provide shampoos/showers and/or failed to complete a daily weight in accordance with the resident's care plan and/or physician orders. The findings include:
 - a. Resident #14's diagnoses included multiple sclerosis, septicemia, gastrointestinal bleed, and seizure disorder. The assessment dated 7/17/03 identified that the resident was severely cognitively impaired, totally dependent on staff for ADL and did not have any pressure sores. Physician orders dated 8/18/03 prescribed to wash the resident's hair with Selsun shampoo twice weekly with each shower. The care plan dated 7/23/03 identified a self care deficit for bathing with interventions that included showers as scheduled. On 9/03/03 and 9/05/03 the resident was observed on several occasions either in bed or seated in a custom wheelchair. Her hair was noted to be greasy, stringy and matted. The Treatment Kardex and Nurse Aide Flow sheets were reviewed with the DNS and unit licensed nurse on 9/05/03 at 5:00 PM and 9/08/03 at 9:00 AM. Although a "B" was noted indicating a bed bath had been given, there was no evidence that the resident had received a shower and shampoo twice a week on Sunday and Thursday, on the 3-11 shift as indicated by the shower schedule.
 - b. Resident #20's diagnoses included congestive heart failure, dehydration and diabetes. Physician orders dated 8/31/03 directed that the resident be weighed daily. Review of the clinical record with the unit manager on 9/4/03 at 11:15 AM failed to provide evidence that the resident's weight had been obtained daily from 8/31/03 until 9/4/03.
 - c. Resident # 21's diagnoses included chronic renal failure requiring hemodialysis, congestive heart failure, hypertension and depressive psychosis. A minimum data set dated 7/15/03 identified the resident was not cognitively impaired and required limited assistance with activities of daily living. The resident care plan dated 7/15/03 identified the resident's noncompliance with the dialysis recommendations to limit fluid intake. Interventions included monitoring of the resident's intake and output every shift. A hemodialysis quarterly report of July 2003 identified a fluid gain goal of less than 5% of body weight. On 7/29/03 the resident's fluid gain was identified as 11.6% and recommended limiting fluid intake to 32 oz per day. Review of the clinical record on 9/8/03 at 2:00 PM with the director of nurses identified that the resident's intake and output record from 6/28/03 to 7/30/03 lacked 24 hour totals and had 31 blanks in shift

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

documentation. Further review of the clinical record identified ongoing inconsistent documentation of intake and output records from 7/31/03 to present.

10. Based on clinical record reviews, observation and interviews for three sampled residents (R#3, 5, 23), the facility failed to administer medications and/or obtain laboratory reports and/or monitor the resident for signs of bleeding in accordance with physician orders. The findings include:
 - a. Resident #5 was admitted on 8/16/03 with diagnoses that included congestive heart failure, atrial fibrillation, mitral valve insufficiency and diabetes. Physician orders on admission directed the administration of Coumadin daily with specific monitoring prescribed for protime and INR. Review of physician orders noted that a protime/INR was ordered for 8/25/03. Review of the laboratory report dated 8/25/03 noted that the protime was 25.2 (normal 11-14) and the INR was 4.2 (normal 2-3). The facility advanced practice registered nurse (APRN) reviewed the lab results on 8/25/03 and directed that the Coumadin be held for two days and the PT/INR repeated on 8/27/03. Review of the medication administration kardex identified that the resident did not receive the Coumadin for five days (8/25-8/30). On 8/30/03 the resident received one dose of Coumadin with a PT/INR ordered for the next day. Review of lab results identified that the PT/INR was not repeated on 8/27/03 as ordered. The PT/INR obtained on 8/31/03 resulted in a PT of 60 and an INR of 23.5. The physician was notified and the resident received Vitamin K intramuscularly stat. Interview with the physician on 9/4/03 at 1:15 PM noted that the resident's lab results were at a critical level and that she could not understand how they could have been so high if the Coumadin was held for five days. She stated that she even ordered that the lab test be repeated stat and that came back the same. The director of nursing began conducting an investigation subsequent to surveyor inquiry. She was unable to determine if the resident inadvertently received the Coumadin from 8/25-8/30 because the staff were either borrowing the Coumadin from other residents, or taking it from the emergency box without signing it out in accordance with policy. Interview with the physician on 9/4/03 at 1:15 PM noted that the resident's lab results on 8/31/03 were at a critical level and that she ordered that the resident be monitored for bleeding including quiac of stools. Review of the clinical record with the director of nursing on 9/4/03 failed to provide evidence that the resident was assessed/monitored for signs and symptoms of bleeding or that the resident's stools were monitored for the presence of blood.
 - b. Resident #3 was admitted to the facility on 7/25/03 with end stage cancer. An admission assessment dated 7/31/03 identified the resident was not cognitively impaired. The care

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- plan dated 7/23/03 identified an alteration in mood related to depression with interventions that included to have the psychiatrist see the resident as needed. A psychiatric evaluation dated 7/25/03 directed a trial of Lexapro 10 mg nightly for mood. A review of the medication administration record identified that the resident did not receive the medication from 8/22/03 through 8/28/03 because the medication was not available. The assistant director of nursing stated on 9/9/03 that the facility was having problems with a new pharmacy during that time period.
- c. Resident #23 was admitted to the facility on 9/3/03 with diagnoses that included bilateral hip replacements. The intra-agency referral (W-10) dated 9/3/03 identified that the resident was alert and oriented. Physician orders dated 9/3/03 directed that the resident receive Codeine 30-60 mg by mouth every 3 hours for pain. Observation of the resident on 9/4/03 at 5:40 AM noted the resident to complain of pain. The resident stated that the pain medication had not been received because the facility had not received the Codeine from the pharmacy. Licensed staff stated during interview on 9/4/03 at 6 AM that the Codeine had not arrived from the pharmacy and that she gave the resident Tylenol instead.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t
(j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

11. Based on clinical record reviews, observations and interviews for four of eight sampled residents with pressure sores (R#10, 11, 14, 23), the facility failed to initiate interventions to treat pressure sores and/or prevent new one from developing. The findings include:
- a. Resident # 14's diagnoses included multiple sclerosis, seizure disorder, and gastrointestinal bleed. The assessment dated 7/17/03 identified that the resident was severely cognitively impaired, totally dependent on staff for activities of daily living (ADL) and was without pressure ulcers. The care plan dated 7/23/03 identified a potential for impaired skin integrity with approaches which included to protect the skin from bumps, scrapes, restrictive or tight clothing, and to provide padding to the side rails and wheelchair. A nurse's note dated 8/22/03 identified a right heel blister measuring 3.2 cm x 2.4 cm which was to be monitored. There was no evidence of further monitoring, treatment and/or measurement of the wound noted in the nurse's notes or the pressure ulcer record. Physician orders dated 09/04/03 prescribed a Betadine solution treatment and the application of a Multipodus Foot to the right foot. On 9/05/03 at 4:30 PM the resident was observed with the director of nursing. The resident was noted to be lying in bed on the left side with socks on and the right foot resting on top of the left without the

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- benefit of padding between the feet or the multipodus boot. An approximately 2.5 cm circular open area painted with Betadine solution was observed. On 9/05/03 at 5:00 PM and 9/08/03 at 9:00 AM, during interview and review of the physician orders with the DNS, she stated that she was aware of the order for the Multipodus Boot but that she had had to order one. Subsequent to surveyor inquiry, the DNS noted something (protective) could be applied. On 9/08/03 at 2:10 PM, the right heel was observed with the wound nurse. The area appeared larger, with a darker circular spot in the center. The new measurements were 4.2 cm x 3.4 cm.
- b. Resident #10 was admitted to the facility on 8/23/03 with diagnoses that included a right hip fracture. A nursing admission assessment or narrative note could not be located in the clinical record. A physician order dated 8/29/03 directed to apply DuoDerm to the right and left buttock. The care plan dated 8/28/03 identified the open areas of the right and left buttock with interventions that included to use a draw sheet for bed mobility. The pressure ulcer record identified stage two pressure sores of the right and left buttock measuring 3 x 3 cm first noted on 8/26/03. Observation of the resident on 9/5/03 at 12 noon noted an intact blister measuring approximately 3.5 cm round on the right heel. Review of the clinical record with the assistant director of nursing failed to provide evidence that the heel ulcer had been identified by staff or that interventions to prevent heel breakdown had been put in place on admission when the resident was noted to be at risk for skin breakdown.
- c. Resident #11's diagnoses included Alzheimer's disease and a history of pressure sores. An annual assessment dated 7/27/03 identified that the resident was cognitively impaired, and was totally dependent on staff for all activities of daily living. The care plan last updated on 9/4/03 identified that the resident was at risk for impaired skin integrity with interventions that included to reposition the resident every two hours, use pressure reducing devices and to apply a Spenco boot to the boggy right heel. Review of the clinical record identified that on 9/4/03 a stage one pressure sore was identified on the right heel that measured 3 x 2 cm. Physician orders dated 9/4/03 directed the application of a Spenco boot to the right foot. Observation of the resident on 9/8/03 noted the resident without the benefit of the Spenco boot on the right foot. Interview with the director of nursing on 9/8/03 at 11 AM noted that she had ordered the boot but it had not arrived. Review of the clinical record with the unit nurse on 9/8/03 at 11:15 AM failed to provide evidence that any alternative interventions were put in place to aide in healing the pressure sore while the boot was not available from 9/4-9/8/03. The nurse stated that that the size of the pressure sore had increased to 4 x 2.5 cm.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- d. Resident #23 was admitted to the facility on 9/3/03 with diagnoses that included bilateral hip replacements. The intra-agency referral noted that the resident was alert and oriented, able to bear weight as tolerated and had a stage two pressure sore of the coccyx and rash to the groin. Observation of the resident on 9/4/03 at 5:50 AM and 11 AM noted the resident requesting to use a commode and the staff refusing to allow the resident use of the commode. The resident was then placed in a disposable brief to void. The dressing on the coccyx was noted to be saturated with urine at 6 AM. At 11 AM, the resident was noted to be complaining of pain in the tailbone and the dressing was noted to be saturated with urine. Review of the record/treatment kardex with the nurse failed to provide evidence that the dressing had been changed after the incontinence at 6 AM. Subsequent to surveyor inquiry, the resident's dressing was changed.

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

12. Based on clinical record review, observation and interview for one of seven sampled residents who were incontinent (R#23), the facility failed to provide incontinent care in a manner that prevents infection. The findings include:
 - a. Resident #23 was admitted to the facility on 9/3/03 with diagnoses that included bilateral hip replacements. The intra-agency referral noted that the resident was able to bear weight as tolerated and get out of bed to a recliner chair. Observation of personal care at 5:50 PM on 9/4/03 noted the resident had been utilizing a disposable brief and had been incontinent. The nurse aide was observed to neglect cleansing the resident thoroughly. On 9/4/03 at 11 AM, the resident complained of burning while urinating and physician orders directed that the resident received antibiotics for a urinary tract infection.

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

13. Based on clinical record reviews, observations and interviews, the facility failed to maintain an environment that was safe for the residents related to keeping medications locked and/or assessing the resident's ability to smoke independently (R#22, 6). The findings include:
 - a. Resident #22 was admitted to the facility on 8/12/03 with diagnoses of multiple fractures of the upper extremities which were casted. Review of the clinical record failed to identify that the resident smoked. The resident was observed on 9/5/03 in possession of smoking materials and smoking outside. Review of the clinical record with licensed staff

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- on 9/8/03 failed to provide evidence that the resident had been assessed for the ability to smoke independently or that a care plan had been developed to address smoking. During tour of the facility on 9/4/03 at 5:45 AM a medication cart was observed to be unlocked with no licensed staff in sight. A resident was noted ambulating in close proximity to the cart and another resident was observed in a wheelchair self-propelling in the hallway. The licensed nurse stated during interview at 5:55 AM that she had been busy and was working out of two medication carts. The nurse then again left the cart without locking it.
- b. Resident #6's diagnosis included a surgical repair of a fractured hip, Diabetes Mellitus, and peripheral vascular disease. The assessment dated 6/11/03 identified that the Resident had short term memory problems, required limited to extensive assistance with most activities of daily living (ADL), and self propelled in a wheelchair. Review of the clinical record on 9/03/03 at 11:30 AM with the director of nursing service (DNS) and unit manager (UM), failed to provide evidence that a smoking assessment had been completed or that a care plan had been developed until 7/25/03 when cigarettes and a lighter were found in the resident's room. Facility smoking policy directs that a resident who smokes will be assessed to determine safety and a care plan will be developed.

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).

14. Based on clinical record reviews and interviews for twelve of sixteen sampled residents who were at risk for dehydration (R# 1, 2, 5, 7, 8, 11, 15, 16, 17, 19, 20, 27), the facility failed to monitor the resident's intake and output and/or failed to assess the residents for signs/symptoms of dehydration and/or failed to initiate interventions to prevent dehydration in those residents with poor food/fluid intake. The findings include:
- a. Resident #1's diagnoses included acute renal failure, volume depletion, atrial-fibrillation (Afib), hypertension (Htn) and congestive heart failure (CHF). A quarterly assessment dated 3/13/03, identified the resident as having modified independence, required supervision and oversight including encouragement and/or cueing with eating and/or drinking. The resident care plan dated 3/10/03 that identified impaired swallowing and diuretic therapy as problems with interventions that included encourage fluid intake, record intake of food/fluids and to monitor for signs and symptoms of dehydration, decreased urinary out put, poor skin turgor and thirst. Review of the nursing notes from 2/19/03 through 3/29/03, failed to provide evidence of monitoring and/or assessment and/or documentation of the resident's hydration status. Further review of the resident's percentage of meal intake for the month of 4/03 noted that the resident normally

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- consumed 75% to 100% of her meals and/or liquids. On 4/26/03, 4/27/03, 4/28/03 , 4/29/03 and 4/30/03 noted a decline in consumption, with less than 50% intake recorded on 4/28, 4/29 and 4/30/03. Review of the hospital admission history and physical assessment dated 5/02/03, identified the resident as having had dry oral mucosa. It further identified the resident's initial impression as Acute renal failure secondary to volume depletion. Review of laboratory findings noted that the resident's BUN was 137 (normal 7.0 - 18.0) and creatinine was 4.6 (normal 0.7 - 1.5). During interview and clinical record review with licensed nurse on 9/8/03 at 3:30 PM she was unable to provide evidence of monitoring for sign and symptoms of dehydration.
- b. Resident #2 was admitted to the facility on 5/28/03 with diagnoses that included diabetes, congestive heart failure, and an ulcer of the left foot infected with methicillin resistant staphylococcus aureus (MRSA) and osteomyelitis. An assessment dated 6/3/03 identified that the resident required assistance with activities of daily living and had experienced a significant weight loss. The care plan dated 6/04/03 identified the potential for dehydration with interventions that included to monitor intake and output and to assess for signs and symptoms of dehydration. The resident had been receiving intravenous antibiotic therapy intermittently since admission for treatment of the left foot wound infection. Review of physician progress notes identified multiple entries noting that the resident experienced nausea and/or vomiting questionably related to narcotics for pain. Laboratory reports identified that the resident's BUN was within normal limits on 6/2/03 and 6/23/03. Laboratory reports dated 8/29/03 identified that the BUN had risen to 47 (normal 7-18), on 8/31/03 the BUN was 36 and on 9/5/03 the BUN was 47. Review of dietary notes identified that the resident's fluid needs goal was 1, 500 cc per day. A dietitian's note dated 7/21/03 identified that the resident had an 11% weight loss since admission and had poor oral intake the previous 2 months. Review of intake and output records from 8/22/03 to 9/8/03 (18 days), noted that the resident's intake met the fluid goal on only two days. The intakes and output records were incomplete and/or not totaled on 5 out of 18 days. Review of the clinical record with the corporate nurse on 9/10/03 at 2 PM failed to provide evidence that the resident was monitored for signs and symptoms of dehydration or that interventions were initiated to resolve the dehydration when the resident's BUN was noted to be elevated on 8/29/03. The resident was transferred to the hospital for a procedure on 9/08/03. Hospital laboratory reports dated 9/11/03 subsequent to having received IV therapy after a procedure on 9/09/03, noted that the resident's BUN had lowered to 21.
- c. Resident #5's diagnoses included acute and chronic renal failure and congestive heart failure. The initial assessment dated 8/21/03 identified that the resident required

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

extensive assistance with all activities of daily living and had an indwelling catheter. The physician orders on admission directed that the resident maintain a 1,000 cc per day fluid restriction and to monitor intake and output. Physician orders dated 8/29/03 directed that the resident receive Flagyl for ten days for clostridium difficile colitis. An APRN progress note dated 9/2/03 identified that the resident had increased lethargy and mental status changes. The resident was noted to have poor skin turgor and dry mucous membranes. The note identified that the resident's BUN was 158 (normal 7.0-18.0) with a creatinine of 2.4 (normal 0.7-1.5) and that the resident was dehydrated. Review of prior lab work noted a BUN of 84 and creatinine of 1.8 on 8/20/03. The resident was placed on IV hydration that day (9/02/03). Review of the clinical record and intake and output records for 8/17/03 through 9/3/03 with the assistant director of nursing on 9/4/03 at 2:30 PM, and director of nursing service on 9/04/03 at 7:45 PM, failed to provide evidence that intake and output were monitored and documented on 10 of the 14 days and included the IV parental infusion as of 9/02/03 and 9/03/03, or that the resident was assessed for signs and symptoms of dehydration. In addition; review of the IV Therapy flow sheets for 9/02/03 failed to include all pertinent information related to initiating the IV (date, time, site, device, lacked amount infused for 7-3 PM and 3-11 PM shift, complete monitoring vital signs per policy, in part). The IV therapy flow sheet for 9/03/023 was incomplete as above.

- d. Resident # 7's diagnosis included congestive heart failure, stroke, atrial fibrillation, bipolar disorder and dementia. An admission MDS dated 5/12/03 identified the resident had moderately impaired cognition and required assistance with activities of daily living including eating. An interagency referral (W-10) dated 4/28/03 identified that the resident had a history of refusing food and fluids and had required IV hydration in the past due to an increase in BUN and creatinine levels. A Dietary Progress note dated 5/1/03 identified a history of weight loss and a daily fluid requirement of 1477 cc. The care plan dated 5/12/03 identified an intervention to monitor the resident's intake and output (I & O). Review of the intake and output record identified that I & O monitoring was initiated on 4/29/03 and continued for three days in accordance with the facility admission policy. Although the resident did not meet her recommended daily fluid needs during the three days of monitoring, I & O was discontinued on 5/2/03. I & O monitoring was resumed on 5/9/03 and continued until 5/24/03. The I&O records lacked 24 hour totals and contained twelve blank shifts. Review of the clinical record on 9/5/03 at 1:30 PM with the nurse manager failed to provide evidence that the resident had been assessed for dehydration. Laboratory results dated 5/8/03 noted a BUN of 51, (7.0-18.0) and on 5/9/03 a BUN of 62. Physician's progress notes dated 5/9/03 identified a diagnosis of dehydration and

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- recommended forcing fluids. Physician progress notes dated 5/14/03 continued to identify dehydration with an order to start IV hydration. In addition;
- e. The resident care plan dated 7/16/03 identified a potential for fluid volume deficit with interventions that included monitoring I & O and assessing for signs and symptoms of dehydration. Review of the intake and output record from 8/1/03 to 9/5/03 identified that the record lacked 24 hour totals and multiple instances of incomplete shift documentation. Review of the resident's meal percentage documentation from 8/19/03 to 8/29/03 identified that the resident consumed up to an average of 85% to 100% of each meal. From 8/30/03 to 9/5/03, the resident consumed 50% or less of each meal and refused five meals. Review of the clinical record on 9/5/03 at 1:30 PM with the nurse manager failed to provide evidence that the resident had been assessed for signs and symptoms of dehydration or that new interventions had been put in place to prevent dehydration. Laboratory results dated 9/5/03 identified a BUN of 40 (normal 7.0-18.0). The resident was transferred to an acute care facility on 9/5/03 for refusing to eat and take medications and was admitted.
 - f. Resident #8's diagnoses included Parkinson's disease, congestive heart failure, dementia and failure to thrive. A Minimum Data Set (MDS) dated 5/1/03 identified the resident had moderately impaired cognition, required extensive assistance with activities of daily living and was dependent on staff for eating. The resident care plan dated 6/17/03 identified the resident was at risk for fluid volume imbalance with interventions that included monitoring of the resident's intake and output and assessing for signs and symptoms of dehydration. A dietary progress note dated 6/2/03 identified a daily fluid requirement of 1473 to 1727 cc and recommended encouraging an increase of food and fluids. Review of the intake and output record from 6/2/03 to 6/24/03 identified no totals of the resident's daily fluid intake and numerous blanks in shift documentation. The percentage of meal consumption documentation from 6/16/03 to 6/20/03 identified the resident's food intake was 50% or less at all meals. Review of the clinical record on 9/4/03 at 6:30 PM with the nurse manager identified no evidence that the resident had been assessed for signs and symptoms of dehydration. Laboratory results dated 6/20/03 identified a BUN of 48, (normal 7.0-18.0) Review of the physician progress notes dated 6/20/03 identified a diagnosis of dehydration with orders to start intravenous hydration.
 - g. Resident #15's diagnoses included dementia, congestive heart failure, stroke, left above the knee amputation and a history of dehydration. A quarterly assessment dated 3/4/03 identified that the resident was cognitively impaired and dependent on staff for all activities of daily living except eating. The care plan dated 3/14/03 identified impaired swallowing with interventions that included to record intake of food and fluids and to

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

encourage fluid intake. Review of intake and output records for the period of 4/19/03-4/23/03 identified fluid intakes from 820 cc-1,280 cc. The resident's fluid needs were noted to be 1372-1647 cc in twenty four hours. Meal intake records from 4/01/03 to 4/23/03 identified that the resident ate 50% or less of 46 of 68 meals. The resident was noted to have a urinary tract infection on 4/22/03 and antibiotics were ordered. On 4/23/03 the resident was noted to have an altered mental status and was unable to hold a cup. On 4/24/03 the resident was noted to have food falling out of her mouth and poor fluid intake. The resident was transferred to the hospital where she was admitted with a diagnosis of "severe dehydration". The resident's BUN was noted to be 106 (normal 7-18) and physical examination documented dry oral mucosa. Review of the clinical record with the director of nursing on 9/4/03 at 7:45 PM failed to provide evidence that the resident was assessed for signs and symptoms of dehydration or that interventions to prevent dehydration were put in place when the resident's intake was not meeting the fluid needs.

- h. Resident #17's diagnoses included dementia and a history of pneumonia and urinary tract infections. An assessment dated 1/6/03 identified that the resident was totally dependent on staff for all activities of daily living except eating. The care plan dated 1/15/03 identified the risk for dehydration with interventions that included to monitor of symptoms of dehydration including urinary output, skin turgor and thirst and to record intake and output. Nursing notes dated 2/26/03 identified that the resident was short of breath and was incontinent of loose stool. A note dated 2/28/03 identified that the resident was straight catheterized for 100 cc of cloudy, foul smelling urine. Antibiotic therapy was ordered to treat a urinary tract infection. A note on 3/6/03 identified that the resident's fluid intake was small to moderate and that she had upper extremity tremors. On 3/12/03 the resident did not void and was documented to have a poor intake. Intravenous hydration was initiated. On 3/12/03 the care plan was updated to reflect that intravenous hydration was being initiated with interventions that included to monitor for signs and symptoms of dehydration. Physician orders dated 3/7/03 directed that the resident receive Megace daily. Review of the resident's meal intakes for March 2003 identified that the resident usually took in 50-100% of meals prior to 3/7/03 at which time intake declined to 25-50% of most meals. Review of intake and output records for March 1-23 noted that none of the intakes were totaled. The assessment/evaluation of fluid intake on the intake and output forms were blank. Multiple shifts were missing intakes. Parenteral fluids were not recorded on the intake and output forms or IV flow sheets. A dietary note dated 2/28/03 identified that the resident had been placed on a pureed diet and was now a total feed. No assessment of food or fluid intake was noted in the note.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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

- On 3/23/03 the resident was admitted to the hospital with a diagnoses that included a fungemia (fungal blood infection). Hospital records identified that the resident's oral mucosa was dry on admission and the physician documented that the resident appeared dehydrated clinically. The resident's BUN on admission to the hospital was 24 (normal 7-18). Review of the clinical record with the director of nursing on 9/04/03 at 7:45 PM, and 9/10/03 at 8 AM failed to provide evidence that the resident had been assessed for dehydration or that the resident's intake and output had been monitored from 3/1/03 through 3/23/03, when she was hospitalized.
- i. Resident #27's diagnoses included status post acute renal failure, congestive heart failure, atrial fibrillation and a stasis ulcer of the lower extremity. The assessment dated 7/27/03 identified that the resident was not cognitively impaired and required assistance with all activities of daily living. The care plan dated 2/23/03 and updated on 7/28/03 identified a problem with decreased cardiac output and congestive heart failure. Interventions included to monitor for signs and symptoms of dehydration. Review of the daily flow sheets with the unit manager and corporate nurse on 9/11/03 at 10:45 AM noted that from 8/1/03 through 8/19/03, the resident consumed from 50-100% of all meals. The flow sheets from 8/20/03-8/31/03 identified a decline in intake to less than 50% of each meal. The dietitian assessments dated 2/5/03 and 6/13/03 noted that the resident required 2,040 cc of fluid a day. Physician progress notes from 8/1/03 through 8/29/03 were reviewed and although there were multiple visits by the physician and/or APRN, the resident's poor intake was not noted until 8/29/03. Nurse's notes dated 8/25/03 and 8/26/03 note that the resident had declined in functioning and cognition and that the resident's wound was getting worse. Intake and output records from 8/21/03 (when the resident's intake declined) through 9/2/03 (thirteen days) noted fluid intakes of 600-1,000 cc per day. There was no evidence that the resident was assessed for dehydration or that alternative interventions were attempted when the resident's intake declined on 8/21/03. ON 9/2/03 laboratory reports identified that the resident's BUN had risen from 25 on 8/5/03 to 44. On 9/3/03 IV hydration was begun to treat the resident's dehydration with a return to normal of the resident's BUN on 9/8/03.
- j. Resident #11's diagnoses included a history of dehydration in 2/03 requiring IV hydration, pneumonia, and mitral valve replacement. An assessment dated 2/2/03 identified that the resident was cognitively impaired, required supervision for eating and left 25% or more of food uneaten and had experienced a significant weight loss. Physician progress notes dated 2/19/03 identified a diagnosis of dehydration which was treated with IV hydration. The care plan dated 2/19/03 identified the problem of fluid volume deficit with interventions that included to monitor for signs and symptoms of dehydration and

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- monitor intake and output. A nurse's note dated 7/8/03 identified that the resident was vomiting. On 7/9/03 the resident was admitted to the hospital with a diagnosis of mild gastrointestinal bleed. Review of the hospital admission history and physical identified that the resident's BUN was 65 upon admission and that the resident had evidence of dehydration. Review of the clinical record with the ADNS on 9/16/03 at 7:45 AM failed to provide evidence that the resident's I&O had been monitored from 3/28/03 through 7/9/03, that the resident had been assessed for signs and symptoms of dehydration or that interventions were put in place to prevent reoccurrence of dehydration. Review of the I&O records from 7/22/03 through 9/11/03 noted that most were incomplete, not totaled and the hydration assessments were blank.
- k. Resident #20 was admitted to the facility on 8/27/03 with diagnoses that included congestive heart failure, history of dehydration and diabetes. The dietitian's admission assessment dated 8/27/03 identified an elevated BUN of 67.0, diuretic use and the risk for dehydration. The fluid needs estimate for the resident was 1, 844 - 2, 220 cc per day. The care plan dated 8/29/03 identified the risk for dehydration with interventions that included to monitor for signs of dehydration and to monitor intake and output. Intake and output records dated 8/28/03 to 9/3/03 reflected that the resident did not meet the fluid needs on any day. A physician order dated 9/2/03 directed that the resident receive IV hydration. The resident's BUN on 9/3/03 was noted to be 72. Review of the intake and output records and nurse's notes with the unit manager on 9/4/03 at 11:15 AM failed to provide evidence that the resident's intake and output was monitored and/or met the fluid needs of the resident. The review further failed to provide evidence that the resident was assessed for signs and symptoms of dehydration or that interventions to prevent dehydration were initiated.
- l. Resident #19's diagnosis included necrotizing fasciitis, with wound debridement, wound infections, parasitic disease, diabetes mellitus, stage II and stage IV pressure ulcers. The initial assessment dated 5/27/03 and quarterly dated 8/18/03 noted that the resident had no short term or long term memory problems, required assistance for transfer out of bed, was independent for eating, incontinent of bowel, utilized a Foley catheter, intake and output was monitored, and was being monitored for an acute medical condition. The care plan dated 7/21/03 identified problems related to diarrhea, decreased mobility, risk for dehydration and risk for infections with approaches in part to monitor intake and output. Registered Dietitian's calculated fluid needs based on a weight of 79 kg were 2370 cc of fluid per day. Review of the intake and output sheets from 5/21/03 through 8/17/03 noted that only four days were completed and totaled out of 88 opportunities/days. The totaled days indicated that the resident consumed less than the required fluid needs amount.

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- During interview on 9/04/03 and review of the intake and monitoring flow sheets with the ADNS at 2:45 PM and DNS at 7:45 PM, it was noted that the intake and output sheets generally were incomplete and that weekly monitoring for dehydration was blank.
- m. Resident #16's diagnoses included malnutrition, cancer of the rectum with a colostomy, diabetes, congestive heart failure and requiring total parenteral nutrition (TPN). The care plan dated 7/15/03 identified the potential for dehydration with interventions that included monitoring intake and output. Review of the intake and output flow sheets with the ADNS on 9/4/03 at 3:40 PM failed to provide evidence that the resident's intake and output were monitored, that the resident's hydration status was assessed at least weekly or that the parenteral intake had been recorded/included in the intake and output records.

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

15. Based on clinical record reviews, observations, and interviews for six of six sampled residents who received intravenous therapy (R#2, 3, 5, 16, 17, 20), the facility failed to ensure that the residents were monitored in accordance with facility policy related to vital signs, intake and output and/or failed to obtain complete physician orders prior to initiating the therapy and for one of one sampled resident with a feeding tube (R#14), the facility failed to ensure the placement of the tube prior to instilling medications/fluids. The findings include:
- Resident #2 was admitted on 5/28/03 with osteomyelitis and an infected ulcer of the left foot. Physician orders dated 5/29/03 directed that the resident receive Vancomycin intravenously, but failed to include a diluent, flow rate or the duration of the therapy. Physician orders dated 6/19/03 directed that the resident receive Levaquin intravenously, but failed to include a diluent, flow rate or the duration of the therapy. The IV flow sheets were incomplete for all days of therapy.
 - Resident #5 had physician orders dated 9/3/03 for intravenous hydration (IV). The IV flow sheet for 9/3/03 was reviewed with licensed staff on 9/4/03 and noted to be incomplete.
 - Resident #17 was placed in intravenous therapy (IV) for hydration on 3/12/03. Review of the IV flow records for 3/12-3/22/03 noted that all were incomplete in the areas of site checks, vital signs, and amounts infused. Review of the clinical record with the director of nursing on 9/10/03 at 8 AM failed to provide evidence that the physician orders were complete for the IV therapy, that intake and output was monitored or that IV flow records were maintained and/or completed in accordance with facility policy.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- d. Resident #3's physician order dated 9/2/03 directed that the resident receive IV therapy. Review of the clinical record with the licensed staff failed to provide evidence that the physician orders were complete for total amount to be infused, or that the flow sheets indicating monitoring of the therapy had been completed.
- e. Resident #16's physician order dated 7/15/03 directed that the resident receive total parenteral nutrition (TPN) at 52 cc per hour around the clock. Review of the IV flow records for 7/12/03-7/15/03 with the assistant director of nursing on 9/4/03 at 3:45 PM failed to provide evidence that the flow records were completed related to vital signs and intake documentation. Four shifts out of twelve were noted to lack any documentation.
- f. Resident #20's diagnoses included dehydration. Physician orders dated 9/2/03 directed that the resident receive IV hydration. Review of the clinical record with the unit manager on 9/4/03 at 11:15 AM failed to provide evidence that the physician orders for IV therapy were complete including volume to be infused and route of administration or that the IV flow records had been initiated on 9/2/03 and maintained complete throughout the therapy. Review of the IV physician orders and IV flow sheets with the DNS and ADNS/IV Therapy Nurse on 9/04/03 at 7:45 PM and 2:45 PM, respectively, noted that the physician orders and IV flow sheets were incomplete and that although they were aware of problems, they were not aware of the extent. Interview with the IV therapy nurse on 9/4/03 at 3:15 PM noted that she does not routinely monitor compliance with physician order or flow sheet documentation.
- g. Resident #14's diagnosis included Multiple Sclerosis, septicemia, gastrointestinal bleed, and seizure disorder. The assessment dated 7/17/03 identified that the resident was severely cognitively impaired, totally dependent on staff for activities of daily living and received nourishment from a feeding tube. The care plan dated 7/23/03 identified a goal for the resident to be free from complications related to the feeding tube and to receive adequate nutrition with approaches which included to provide tube feeding as ordered and per policy. On 8/18/03, physician's progress notes documented that a chest x-ray report had identified a left lower lobe pneumonia, questionably due to aspiration, and an antibiotic was ordered. On 9/04/03 at approximately 9 AM, the medication nurse was observed administering the resident's medication. During the administration the licensed nurse failed to ascertain the location of the g-tube prior to the administration of the medication. Facility policy directs the verification of the placement of the tube by injecting 10-30 cc of air into the tube while listening to the abdomen with a stethoscope for a bubbling sound.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t
(j) Director of Nurses (2).

16. Based on review of inservice documentation and interview for five of five sampled nurse aides, the facility failed to ensure that all nurse aides received at least twelve hours of inservice education per year. The findings include:
- a. Review of inservice records on 9/16/03 with the staff development coordinator and director of nursing, failed to provide evidence that the five random nurse aides reviewed had received a minimum of twelve hours of inservice education in the previous year.

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

17. Based on clinical record review and interview for one sampled resident (R#14), the facility failed to ensure the safeguarding and completeness of clinical records. The findings include:
- a. Resident #14's diagnosis included Multiple Sclerosis, septicemia, gastrointestinal bleed, and seizure disorder. Review of the intake and output monitoring record from 6/12/03 to 8/27/03 noted that, although there were occasional incompletely documented shifts, the monitoring for the week of 7/1/03 to 7/17/03 was unavailable for review on 9/05/03 at 4:10 PM. During interview at that time with the Unit Secretary, she stated she was unable to find that page and she would not have thinned it.

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

18. A tour of the facility on 9/05/03 revealed the following:
- a. It was observed that the North-2 fire doors across from the Nursing Station did not self-close in order to maintain the integrity of the barrier at this opening
 - b. It was observed that positive latching was not functioning on the door to the Second floor Electrical Room #246 in order to maintain the required fire resistance rating at this fire rated assembly in an opening to a hazardous area
 - c. It was observed that a door closer was not provided on the door to the janitors closet in the Dietary Department in order to maintain the required fire resistance rating at this fire rated assembly in an opening to a hazardous area.

DATE(S) OF VISIT: September 8, 10, 11 and 12, 2003 and with additional information obtained on September 17, 2003

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- d. It was observed that door to the Main Oxygen Room had a large gap on the top of the door and did not close properly in order to maintain the required fire resistance rating at this fire rated assembly in an opening to a hazardous area.
 - e. Documentation was not provided that smoke detector sensitivity testing was being performed per NFPA 72E 8-2.4.2 and 8-3.4 as part of the facility's preventive maintenance program.
 - f. It was observed that the linen chute door in the Soiled Utility Rooms on the First and Second floors were severely damaged and failed to close and latch properly after they were released in order to provide the proper vertical fire and smoke protection between floors.
19. During a tour of the facility on 09/05/03, the following was observed:
- a. The wallpaper in the Stairwells of the facility had wallpaper peeling.
 - b. There was wall damage in Resident Room #212 and #127.
 - c. The windows in Resident Room # 208, First Floor TV Lounge and the South Stairwell were fogged and deteriorated.
 - d. There were stained ceiling tiles throughout the entire facility corridors.
 - e. There were biohazard storage boxes located in the Electrical Rooms next to the soiled utility rooms.
 - f. There was frayed and ripped carpet in Resident room # 236.
 - g. The second floor MDS office had a large hole in the wall by the window and the wall was severely moldy; the carpet was ripped.
 - h. The floor in Resident Rooms #112 and 134 showed signs of structural failure and had major cracks in the tiles
 - i. The main electrical room on the First Floor had wall damage near the exterior door.
 - j. There was water damage to the ceiling throughout the Main Dining room on the first floor.
 - k. The Main Lobby had water stains and damage to the ceiling area.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t
(f) Administrator (3)(A):