

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATIONS**

IN RE: Wilton Meadows Limited Partnership d/b/a
Wilton Meadows Health Care Center
439 Danbury Road (Route 7)
Wilton, CT. 06897

CONSENT ORDER

WHEREAS, Wilton Meadows Limited Partnership (hereinafter the "Licensee"), has been issued License No.2032-C to operate a Chronic and Convalescent Nursing Home known as Wilton Meadows Health Care Center, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Division of Health Systems Regulations (hereinafter "DHSR") of the Department conducted unannounced inspections on various dates commencing on October 4, 2004 and concluding on October 18, 2004; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter originally dated November 19, 2004 and amended on January 5, 2005 (Exhibit A – copy attached); and

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

NOW THEREFORE, the DHSR of the Department acting herein and through Marianne Horn, its Director, and the Licensee, acting herein through Mario Sinicariello, its Managing Partner, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order.
2. The INC shall serve for a minimum of four (4) months at the Facility unless the Department identifies through inspections that the continued presence of the INC is necessary to ensure substantial compliance with the provisions of the Regulations of Connecticut State Agencies or federal requirements (42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities). The INC shall be at the Facility forty (40) hours per week for two (2) weeks if the INC identifies through her assessment that the Facility has implemented measures and corrected the issues identified in the violation letter dated 11/19/04, then the hours of monitoring can be decreased to ten (10) hours per week for the remaining fourteen (14) weeks. The Department may, in its discretion, at any time, increase the hours of the INC and/or responsibilities, if, in the Department's view, the increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order. The INC shall function in accordance with DHSR's INC Guidelines (Exhibit B – copy attached).
3. The INC shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation within three (3) weeks of assumption of the position. The INC shall submit a weekly written report, thereafter, to the Department identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and the INC's assessment of the care and services provided to patients, subsequent recommendations made by the INC and the Facility's response to implementation of said recommendations. Copies of said reports shall be simultaneously provided to the Director of Nurses, Administrator and Medical Director.
4. The INC's position shall be occupied and the duties of said INC shall be performed by a single individual unless otherwise approved by the Department. The INC shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts inclusive of holidays and weekends. The Consultant shall confer with the

Facility's Administrator, Director of Nursing Services and other staff as the Consultant deems appropriate concerning the assessment of nursing services and the Facility's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Facility's Administrator and Director of Nursing Services for improvement in the delivery of direct patient care in the Facility. The INC shall have a fiduciary responsibility to the Department. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination which, during the term of this Consent Order shall be binding on the Facility.

5. The INC shall have the responsibility for:
 - i. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides and orderlies and implementing prompt training and/or remediation in the area in which said staff member demonstrated a deficit. Records of said training shall be maintained by the Facility for review by the Department;
 - ii. Recommending to the Department an increase in the INC's monitoring hours if unable to fulfill the responsibilities within the stipulated hours per week;
 - iii. Assessing, monitoring and evaluating the coordination of patient care and services delivered by the various health care professionals providing services within the Facility; and
 - iv. Monitoring the implementation of the Facility's plan of correction submitted for the violation letter dated November 19, 2004.
6. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
7. The INC, the Facility's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective of this Consent Order and thereafter at eight (8) week intervals throughout

the tenure of the INC. Said meetings shall include discussions of issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.

8. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon their request.
9. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in condition and/or failure to provide care and treatment to patients identified with unstable health conditions and/or failure to implement physician orders or plans of care.
Determination of compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
10. Director of Nursing Service/Assistant Director of Nursing Service shall conduct random unannounced visits to the Facility to assess care/services being provided. Said visits shall occur on holidays, weekends and shall include all three (3) shifts. Documentation of observations relative to these visits shall be maintained and available for Department review, upon request.
11. The Licensee shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, and/or Medical Director, the Infection Control Nurse and/or MDS Coordinator become vacant due to resignations. The Administrator shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
12. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall each ensure compliance with the following:

- a. Sufficient nursing personnel are available to meet the needs of the patients;
 - b. Patients are maintained, clean, comfortable and well groomed;
 - c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
 - d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
 - e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with Federal and State laws and regulations;
 - f. Nurse aide assignments accurately reflect patient needs;
 - g. Each patient's nutritional and hydration needs are assessed and monitored in accordance with their individual need and plan of care; and
 - h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition to include, but not be limited to, decline in skin integrity, presence of any infection and deterioration of mental, physician, nutritional or hydration status. In the event that the personal physician is not responsive to the patient's needs or if the patient requires immediate care, then the Medical Director is notified.
13. Appointment a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any resident 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.
14. Nurse Supervisors shall be provided with the following:
- a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. 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;
- c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitored by a representative of the Facility Administrative Staff, (e.g. Director of Nursing Service, Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and State and Federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
 - d. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers in accordance with individual comprehensive care plans.
15. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the facility to monitor the requirements of this Consent Order.
16. The Facility shall establish a Quality Assurance Program to review patient care issues inclusive of those identified in the November 19, 2004 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 measures. 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.
17. The Licensee shall pay a monetary fine to the Department in the amount of four (4) thousand dollars (\$4,000.00), 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

18. 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.
19. 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.
20. 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.
21. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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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.

5/4/05
Date

WILTON MEADOWS LIMITED PARTNERSHIP –
LICENSEE

By: [Signature]
Mario Sinicariello, its Manager Member
VICE PRESIDENT OF THE
GENERAL PARTNER

STATE OF CT

County of Fairfield) ss May 4 2005

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

My Commission Expires:
(If Notary Public)

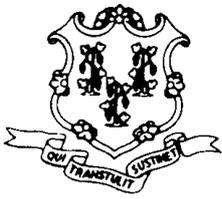
JUNE D. LAGAN
MY COMMISSION EXPIRES ON
JULY 31, 2005

[Signature]
 Notary Public
 Justice of the Peace
 Town Clerk
 Commissioner of the Superior Court

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

[Signature]
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 29

January 5, 2005

June Lagan, Administrator
Wilton Meadows Health Care Center
439 Danbury Road
Wilton, CT 06897

Dear Ms. Lagan:

This violation letter originally dated November 19, 2004 is hereby amended to provide as follows:

Unannounced visits were made to Wilton Meadows Health Care Center on October 4, 5, 6 and 7, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a certification inspection and multiple complaint investigations with additional information obtained on October 8 and 18, 2004.

Attached are 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 has been scheduled for December 6, 2004 at 1:00 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 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.



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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Wilton Meadows Health Care Center
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If there are any questions, please do not hesitate to contact this office.

Respectfully,

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

RAC/NJM/jf

c: Director of Nurses
Medical Director
President

CT#3268, CT#3190, CT#3353, CT#3171

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

1. Based on clinical record reviews, review of twenty four hour reports and interviews for four of twelve sampled residents with a significant change in condition (Residents #16, #5, #12 and #18), the facility failed to ensure that the resident's attending physician was immediately informed of the changes. The findings include:
 - a. Resident #18's assessment dated 6/11/04 identified that the resident was cognitively impaired and required assistance from staff for all activities of daily living. A nurse's note dated 8/21/04 identified that the resident had been pushed down by another resident. A nurse's note dated 8/24/04 identified that the resident complained of left leg pain and was noted to be limping. The medication administration records for 8/27, 8/31 and 9/2/04 noted that the resident continued to complain of left leg pain and was medicated with Tylenol. On 9/3/04 the physician was notified and x-rays and later a bone scan were ordered. The resident was diagnosed with a fracture of the left lesser trochanter. Interview and review of the clinical record with the director of nursing on 10/8/04 at 11:00 AM failed to provide evidence that the physician had been notified when the resident began to complain of pain and had difficulty ambulating on 8/24/04.
 - b. Resident #16's diagnoses included dementia, osteoporosis, aspiration pneumonia and cardiomyopathy. An assessment dated 10/28/03 identified that the resident was cognitively impaired and totally dependent on staff for all activities of daily living. Nurse's notes dated 10/28/03 identified the presence of a red, jelly like substance in the resident's diaper. A physician progress note dated 10/30/03 identified that the physician was first made aware that the resident had a questionable clot in the diaper. Labs and stool for blood was ordered. Review of the clinical record and twenty four hour reports and interview with the director of nursing on 10/8/04 at 10:15 AM failed to provide evidence that the physician was notified of the questionable blood clot from 10/28/03 through 10/30/03.
 - c. Resident #5's quarterly assessment dated 8/15/04 identified the resident as cognitively impaired, independent for transfer and ambulation, and had experienced a fracture in the previous 31-180 days. Review of the clinical record noted that on 7/6/04 at approximately 8 PM, the resident was involved in an altercation with his roommate. The resident sustained a laceration over the left eyebrow and complained of pain in the left wrist. Nurse's notes at 8 PM noted that the physician was notified and ordered an x-ray of the left wrist for the morning if pain and edema increase. Nurse's notes for 7/6/-7/7/04 identified that the resident continued to complain of pain in the left wrist. At 4 PM on 7/7/04 the x-ray company was notified of the need for the x-ray. The x-ray was not completed until 10:15 AM on 7/8/04 at which time the resident

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was diagnosed with an impacted fracture of the left wrist. Interview and review of the clinical record with the director of nursing on 10/6/04 at 1 PM failed to provide evidence that the physician was notified of the delay in obtaining the x-ray or of the resident's ongoing complaint of pain.

- d. Resident # 12's diagnoses included hypertension, diabetes and depression with psychotic features. A nurse's note dated 2/15/04 at 5 PM identified that the resident had a moderate amount of bright red blood in her diaper, that the nursing supervisor had been notified, and that a note had been placed in the doctor's book. There were no additional nurse's notes regarding the incident. A review of the 24 hour shift reports dated 2/15/04 through 2/17/04 had no documentation of the resident's bleeding episode. A review of the physician's progress notes noted no documentation of the resident's bleeding episode or evidence that the physician had been notified. Interview and review of the clinical record on 10/8/04 at 9:50 AM with the licensed nurse failed to provide evidence that the physician had been notified of the bleeding incident. The nurse stated that she had been discarding outdated doctor communication book sheets. During an interview and review of the clinical record on 10/8/04 at 10 AM with the Director of Staff Development, she stated that the nurse who wrote the note on 2/15/04 was a contracted travel nurse who is no longer employed by the facility. She also stated that the nursing supervisor was also a travel nurse no longer employed by the facility. She further stated that the medical director's rounds book had no documentation of the resident's bleeding episode. During an interview with the physician on 10/7/04 at 4:10 PM he stated that he was not notified of the resident's bleeding.

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 reviews, observations, and interviews for two sampled residents (Residents #17 and #25), the facility failed to ensure that the residents were treated with dignity and respect. The findings include:
 - a. Resident #25's diagnoses included hypertension, intracranial hemorrhage, non insulin dependent diabetes (NIDDM), coronary artery disease, and Alzheimer's disease. A significant change assessment dated 8/17/04 identified that the resident was moderately cognitively impaired, needed extensive staff assistance for dressing, bathing and hygiene and was incontinent of bowel and bladder. The care plan dated 8 25:04 identified that the resident was dependent for activities of daily living (ADL). The nurse aide assignment noted that the resident was incontinent, needed extensive staff assistance for dressing, transfer, toileting and hygiene. On

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10/04/04 at 12:46 PM the resident was observed seated in the dining room. It was noted that his coffee had spilled, soiling him from the waistband to the left thigh of his trousers with a puddle of the liquid noted underneath the wheelchair. Facility staff were present in the room. At 12:56 PM a facility staff member put paper towels under the wheelchair to absorb the coffee. At 2:50 PM the resident was observed sitting in an activity with the same stained trousers on. Subsequent to surveyor inquiry, the nurse aide assisted the resident to the toilet and changed his trousers. The resident's trousers and brief were noted to be coffee stained. During interview with the nurse aide at that time, he noted that no one had told him the resident had spilled the coffee on himself and that he (the NA) was making rounds after lunch and was checking on the residents, but had not yet provided care to Resident #25.

- b. Resident #17's diagnoses included Alzheimer's disease, hypertension, and arthritis. An admission assessment dated 11/28/03 identified that the resident was cognitively impaired, exhibited behaviors of being distracted, restless, asking repetitive questions and wandering and requiring extensive to total assistance for all activities of daily living except eating. A care plan dated 12/3/03 identified that the resident was recently diagnosed with Alzheimer's disease with a potential for adjustment issues. Approaches included to provide gentle reality orientation, a calm environment, and to speak calmly, clearly and slowly allowing the resident adequate time to respond. Nursing notes dated 12/10/03 through 12/12/03 identified that the resident was up in the wheelchair self-propelling, combative, agitated, uncooperative and difficult to redirect. Facility documentation dated 12/12/03 identified that on the afternoon of 12/11/03, the therapeutic recreation staff person (TR #1) reported that during a recreation program that afternoon, Nurse Aide #1 (NA #13) spoke inappropriately to the resident. During an interview on 10/13/04 at 10:30 AM with TR #1, she stated that on the afternoon of 12/11/03 she was conducting a recreation program in one of the activity rooms. Resident #17 was sitting in a wheelchair near the fish tank and NA #13, NA #12 and NA #7 were sitting in the same area doing charting. Resident #17 was offering to pay someone to take her home. NA #13 was asking questions of the resident such as how much money she had, when did she last have sex, and others. TR #1 clearly felt they were causing the resident to become more agitated and provided a written statement to the Administrator naming NA #13 as the perpetrator. During an interview with NA #12 on 10/8/04 at 2:10 PM, he stated that he was in the room while Resident #17 and NA #13 were there and that Resident #17 was upset and yelling. He further stated that Resident #17 was in the corner blocked in by another resident and NA #13. During an interview with NA #7 on 10/8/04 at 3:00 PM, she stated that she was the NA assigned to the

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resident and had brought the resident into the activity room and placed the resident's wheelchair next to the fish tank. NA #12 then left the room and returned hearing Resident #17 loudly saying that NA #13 was holding her hostage and that she (Resident #17) was going to call the police. NA #12 heard NA #13 tell the resident that another NA in the room was a security guard. At that point NA #12 told NA #13 she was crazy. NA #13 denied the allegations during an interview on 10/18/04 at 11:30 AM.

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

3. Based on clinical record review, interview, and review of facility documentation for one sampled resident with a request to be left alone (Resident #23), the facility failed to honor the resident's request during care. The findings include:
 - a. Resident #23's diagnoses included senile dementia, and a left cerebral vascular accident (CVA). An admission assessment dated 7/3/04 identified that the resident had modified independence for daily decision making, and required limited to extensive assistance for care needs. The care plan dated 7/3/04 identified that the resident had a history of anxiety and somatic complaints with interventions that included to acknowledge the importance of the resident's individual space and to manage situations that induce anxiety. Nursing notes dated 9/25/04 identified that a nurse overheard the resident being verbally abusive to a nurse aide (NA #14) with the resident heard stating to the aide "I am going to hit you". Nursing notes dated 9/26/04 identified that the resident voiced a complaint against a nurse aide (NA). Review of facility documentation identified that on 9/26/04, the resident alleged that the NA was verbally abusive during the provision of morning care. During an interview with the resident on 10/6/04 at 10:35 AM, she stated that when the nurse aide entered the room that day, she grabbed her feet and told the resident that it was time to get out of bed. The resident stated that the NA was very rude to her and she got upset and told the NA to leave her alone or I'll hit you. A nurse overheard the resident tell the NA that she would hit her. During an interview with the NA on 10/7/04 at 9:30 AM, she stated that when she went to give the resident morning care, the resident refused to get up so she proceeded to wash the resident in bed. She further stated that even though the resident was upset and told her to go away or she would hit her, she continued to wash her up.

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

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4. Based on clinical record review, review of facility documentation and interview for one of two sampled residents with allegation of mistreatment (Resident #17), the facility failed to ensure that the resident's psychosocial needs were assessed and monitored following the incident. The findings include:
 - a. Resident #17's diagnoses included Alzheimer's disease, hypertension, and arthritis. An admission assessment dated 11/28/03 identified that the resident was cognitively impaired, exhibited behaviors of being distracted, restless, asking repetitive questions and wandering and requiring extensive to total assistance for all activities of daily living except eating. A care plan dated 12/3/03 identified that the resident was recently diagnosed with Alzheimer's with a potential for adjustment issues. Approaches include to provide gentle reality orientation, to provide a calm environment, and to speak calmly, clearly and slowly allowing the resident adequate time to respond. Nursing notes dated 12/10/03 through 12/12/03 identify that the resident was up in the wheelchair self-propelling, combative, agitated, uncooperative and difficult to redirect. Facility documentation dated 12/12/03 identified that on 12/11/03 in the afternoon, the therapeutic recreation staff person (TR #1) reported that during a recreation program that afternoon, TR #1 heard Nurse Aide #13 (NA #13) speak inappropriately to the resident. Review of facility documentation identified that after an investigation was completed, the allegations were found to be substantiated and NA#13 was suspended without pay and provided with re-education prior to returning to work. Review of the clinical record with the Social Worker on 10/7/04 failed to provide evidence that any social work assessment and/or intervention had been provided to the resident at the time of the incident.

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

5. Based on observation and interview for one sampled resident whose personal commode was soiled (Resident #4), the facility failed to ensure the commode was kept clean for the resident. The findings include:
 - a. During observations on 10/4/04 and 10/5/04, a commode containing a pail soiled with urine was noted at Resident #4's bedside. During interview with the nurse aide on 10/5/04 at 11:45 AM, she noted that the resident had not used the commode since July when she was changed from a Sarita lift (standing) to a mechanical lift. During interview with the charge nurse on 10/5/04 at 12 Noon, she noted that the commode should have been removed from the room when the resident no longer used it.

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

6. Based on clinical record reviews, observations and interviews for three of eight residents identified as restrained with side rails and/or a custom wheelchair (Resident #7, Resident #20 and Resident #22), the facility failed to accurately assess the use of the device. The findings include:
 - a. Resident #7's assessment dated 9/2/04 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living and utilized a trunk restraint daily. The resident was observed on 10/5 and 10/6/04 seated in a custom wheelchair with a tray and seatbelt. Interview with the care plan coordinator on 10/6/04 at 11:49 AM noted that the custom wheelchair was not a restraint and that the assessment had been inaccurately coded as a restraint device.
 - b. Resident #20's assessment dated 7/3/04 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living and utilized full siderails as a restraint daily. The resident was observed on 10/5 and 10/6/04 in bed unable to reposition self. Interview with the care plan coordinator on 10/6/04 at 11:49 AM noted that the resident could not get out of bed without assistance or reposition independently and therefore the assessment had inaccurately coded the siderails as a restraint device.
 - c. Resident #22's assessment dated 8/19/04 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living and utilized a full siderails as a restraint daily. The resident was observed on 10/5 and 10/6/04 in bed unable to reposition independently. Interview with the care plan coordinator on 10/6/04 at 11:49 AM noted that the resident could not get out of bed without assistance or reposition independently and therefore the assessment had inaccurately coded the siderails as a restraint device.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H).

7. Based on clinical record reviews, observations and interviews for three of ten sampled residents who utilized support stockings and/or had pain on repositioning and/or had aggressive behaviors (Residents #1, #4 and #18), the facility failed to identify a plan of care to meet the residents' needs. The findings include:
 - a. Resident #1's diagnoses included hypertension, congestive heart failure, a pacemaker, and chronic obstructive pulmonary disease. A quarterly assessment dated 9/16/04 identified that the resident had cognitive difficulty in new

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situations, and needed limited assistance with activities of daily living. The care plan dated 9/27/04 identified a problem of venous stasis ulcers on both lower legs. Interventions included the use of cedapres stockings to both lower legs - apply before getting out of bed in the morning and remove at bedtime everyday. A physician order dated 9/13/04 directed that the resident's left leg ulcers be cleansed and covered with gauze everyday. A physician's progress note dated 9/24/04 noted the venous ulcers healing slowly - improved. Nurse's notes dated 7/28/04 through 8/30/04 identified open ulcers of the resident's lower left leg, noting dressing changes as ordered; with no notations of the non-use of the cedapress stockings. Observations on 10/4/04 at 12:30 PM noted the resident in her wheelchair using both feet to self propel down the corridor. Observations on 10/5/04 at 10:20 AM noted the resident in her room seated in a recliner chair with her left leg elevated upon the seat of her wheelchair. The left lower leg was noted to be shiny and edematous. The right lower leg was noted to be edematous, less than the left, and was not elevated. The resident's wheelchair did not have footrests that allow for the legs to be elevated. During an interview with the resident on 10/5/04 at 10:20 AM she stated that she refuses to wear those stockings because of her leg sores. During an interview with the licensed nurse on 10/7/04 she states that the resident is not wearing cedapres stockings due to her leg ulcers. Interview and review of the clinical record with the licensed nurse on 10/8/04 at 9:45 AM failed to provide evidence that the care plan addressed the nonuse of the cedapres stockings, or the edema related to the venous stasis of the legs with interventions to address the swelling and circulation.

- b. Resident #4's diagnoses included cerebral vascular accident with left hemiparesis. The assessment dated 7/22/04 identified that the resident had modified independence for cognitive skills for daily decision making, with no short or long term memory problems and had repetitive anxious complaints and sad expressions. The assessment further identified that the resident required extensive assistance from staff for bed mobility, dressing and personal hygiene and that the resident was totally dependent on staff for transfer and bathing and had moderate pain symptoms less than daily. The care plan dated 8/4/04 identified an alteration in comfort related to pain with interventions that included to monitor pain via assessment, change position according to resident comfort level and physical therapy to screen when appropriate. During observation of care, on 10/5/04 at 11:30 AM, the resident was repositioned in bed turning side to side. Each time the resident was turned, she cried out "Ow" and "You're hurting me." Interview with the nurse aide on 10/5/04 at 11:45 AM, noted that the nurse aide assignment did not address how to reposition the resident's left arm or indicate that the resident had left arm pain. Interviews with the Minimum Data Set Coordinator

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- and the Director of Rehabilitation on 10/5/04 at 1:50 PM and 2 PM respectively, identified no evidence that individualized measures to avoid the resident's left arm pain during repositioning had been addressed on the care plan.
- c. Resident #18's assessment dated 1/6/04 identified that the resident was moderately cognitively impaired and required supervision and limited assistance with ADL's. On 1/27/04 nurse's notes identified that the resident was aggressive towards another resident, scratching him on the throat and neck. Nurse's notes further identified aggressive behaviors towards other residents on 5/26/04, 5/31/04, 6/1/04, 6/6/04 and 6/7/04. Interview and review of the clinical record with the DNS on 10/8/04 at 9 AM failed to provide evidence that a care plan had been developed to address the resident's aggressive behaviors.

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

8. Based on clinical record reviews, review of facility documentation/investigations and interviews for three sampled residents (Residents #9, #11 and #18)), the facility failed to ensure that the residents were assessed after a fall and prior to moving the resident resulting in the residents being stood up fractured hips. The findings include:
- a. Resident #9's diagnoses included Alzheimer's disease. An assessment dated 6/18/04 identified that the resident was cognitively impaired and required assistance with all activities of daily living (ADL's). The care plan dated 6/24/04 noted that the resident had two recent falls. Interventions included to notify the charge nurse when a fall occurred. Nurse's notes dated 5/27/04 at 9 AM noted that a nurse aide observed the resident falling. Facility documentation identified that the NA picked the resident up from the floor. The resident was observed by the charge nurse to be limping while ambulating the resident was transferred to the hospital and diagnosed with a fractured hip. Interview with the charge nurse on 10/8/04 at 12:45 PM who was on duty at the time of the fall, noted that the NA never informed her that the resident had fallen and that the resident was not assessed until after the resident had been stood up. According to Expert Rapid Response by Mosby 1999, if you find the patient on the floor perform a rapid head to toe assessment no matter how insignificant the accident seems. Once the Patient is stabilized, help the patient back to bed or chair unless you suspect a fracture.
- b. Resident # 11's diagnoses included subdural hemorrhage, coronary artery disease, cerebral vascular accident and hypertension. An admission assessment dated 5-16-04 identified that the resident had some decision making difficult, required extensive assistance of one staff for transfer and toileting, was incontinent of

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bowel and bladder and had a fall in the last thirty days. The care plan dated 5/25/04 identified a problem of a potential for fall related to poor standing balance and stroke. Interventions included to assist the resident to the toilet and /or provide incontinent care per policy. Nursing notes dated 6/14/04 at 7:30 PM identified that the nurse aide (NA) reported that the resident had turned her ankle while standing in the bathroom. The nursing note documented that the resident was noted to be sitting in the wheelchair at the time the NA reported the incident to the nurse. The assessment by the licensed nurse noted pain in the right leg and an ice pack was applied according to physician's orders. Nursing notes on 6/15/04 at 9:30 AM noted that the resident refused to stand, and that pain was noted on palpation to the right knee and hip. X-Ray evaluation at the hospital revealed a fractured right hip. Interview and review of the clinical record with the licensed nurse who assessed the resident noted that the NA called her after the incident and, when questioned, told the licensed nurse that the resident had not fallen. Interview and review of the clinical record on 10/07/04 at 4:50 PM with the DNS, noted that facility investigation revealed the NA lowered the resident to the floor, picked up the resident and put her in the wheelchair before calling the licensed nurse for assessment. The DNS further noted that facility policy directs if a resident falls, the NA should call the licensed nurse to assess the resident before moving the resident. The NA was aware of the policy and was terminated for not following the policy. According to Clinical Nursing Skills, Fifth Edition, 2000, assessment requires skilled observation, reasoning, and a theoretical knowledge base to gather and differentiate, verify, and organize data, and document the findings. Assessment is a critical phase because all the other steps in the process depend on the accuracy and reliability of the assessment.

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

9. Based on clinical record reviews, observations and interviews for two sampled residents who utilized hearing aides (Residents #15 and #47), the facility failed to implement the hearing aides according to the care plan. The findings include:
 - a. Resident #15's diagnoses included senile dementia. An annual assessment dated 3/01/04 and quarterly assessment dated 7/21/04 identified that the resident was moderately cognitively impaired, utilized a hearing aid, and was totally dependent on staff for personal care. The care plans dated 3/09/04, 5/25/04, and 8/03/04 identified that the resident frequently removed the hearing aid. Interventions included clipping the hearing aid to the resident to prevent the resident from losing it, to cue and redirect the resident to keep the hearing aid in place and to

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- lock the hearing aid in the med cart overnight. The June 2004, July 2004 and August 2004 Treatment Kardexes directed for the hearing aid to be inserted in the morning and removed in the afternoon. Interview and review of the June, July and August Treatment Kardexes with the director of nursing (DNS) on 10/07/04 at 4:45 PM noted several occasions when the hearing aide was circled as not removed and/or blank with no explanations provided. During interview with the DNS at that time she noted that if the treatment was circled as not done, an explanation should have been provided. There were no explanations documented on the back of the treatment kardex for the omitted hearing aide occasions.
- b. Resident #47's diagnoses included adjustment disorder with depressed mood and chronic pain. A significant change assessment dated 7/13/04 identified that the resident had some cognitive difficulties in new situations only, had difficulty hearing and a hearing aid was present and utilized. The assessment identified that the resident needed limited to extensive assistance for dressing and personal hygiene. The care plan dated 7/27/04 failed to identify the use of the hearing aides. The Treatment kardex directed for the hearing aids to be inserted in the morning and removed in the evening. Review of the September 2004 treatment kardexes noted multiple occasions when the hearing aids were circled as not inserted and/or removed and/or the signature blocks were blank documentation with no explanation given. On 10/08/04, review of the 10/04 treatment kardex noted there was no documentation of hearing aide use for the whole month. The resident was observed on 10/04/04 at 10:30 AM ambulating with a walker to the nursing station where she asked a surveyor who was near the desk for her hearing aids. The surveyor informed the nurse. The resident was observed at 1:45 PM wearing the hearing aides. During interview and review of the September and October treatment kardexes with the licensed nurse on 10/08/04 at 11:50 AM she noted that today she applied the hearing aides late because the resident had a shower, but noted that on the other occasions when the hearing aides were not used she should have documented the reason. During interview with the DNS on 10/08/04 at 12:05 PM she noted that if the treatment was circled as not done, an explanation should have been provided. There were no explanations documented on the back of the treatment kardex for the omitted hearing aide occasions.

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

10. Based on clinical record reviews and interviews for four sampled residents with a fracture of an extremity (Resident #16) and/or physician orders for decrease in antipsychotic medication (Resident #1), and/or an order for an X-Ray (Resident #5), and/or thickened

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liquids (Resident #38) the facility failed to ensure that physician orders were carried out. The findings include:

- a. Resident #16's diagnoses included dementia, osteoporosis, aspiration pneumonia and cardiomyopathy. An assessment dated 10/28/03 identified that the resident was cognitively impaired, incontinent of bowel and bladder, totally dependent on staff for all activities of daily living, and had no pressure sores. The care plan dated 10/29/03 noted the potential for skin breakdown due to incontinence and immobility. Interventions included to reposition and provide incontinent care every two hours and to perform weekly, full body examinations and document. The clinical record identified that on 11/9/03 the resident was transferred to the hospital for x-rays due to pain and swelling in the right lower extremity. The resident returned to the facility with a diagnosis of fractured tibial plateau. Review of the treatment kardex for March 2004 noted orders for elastic stockings on in the morning and off at bedtime and a right knee immobilizer on at all times. Both the stockings and immobilizer were noted to have been circled from 3/1/04 through 3/11/04. The reasons for not providing the treatments as ordered by the physician were not noted on the back of the kardex.
- b. Resident #1's diagnoses included dementia with delusions and anxiety, congestive heart failure, a pacemaker, and gastroesophageal reflux disease. An annual assessment dated 6/23/04 identified that the resident had cognitive difficulty in new situations and needed limited assistance with activities of daily living. A psychiatry progress note dated 7/26/04 directed the medication Haldol be decreased to 0.5 mg by mouth at bedtime, with a plan to discontinue the medication if tolerated by the resident because of noted hand tremors. A physician order dated 7/26/04 directed that Haldol 1.0 mg by mouth at bedtime be discontinued, and Haldol 0.5 mg by mouth at bedtime be started. During a review of the medication kardex on 10/7/04 for October 2004, it was noted that the resident was receiving Haldol 1 mg by mouth at 9 PM, and Haldol 0.5 mg by mouth at 5 PM. Review of the kardexes for August and September 2004 indicated that the resident had received the correct dosages of Haldol. During an interview and review of the clinical record on 10/7/04 at 3 PM with the licensed nurse, she stated that the resident should have only received Haldol 0.5 mg by mouth at bedtime.
- c. Resident #5's quarterly assessment dated 8/15/04 identified the resident as cognitively impaired, independent for transfer and ambulation, and had experienced a fracture in the previous 31-180 days. Review of the clinical record noted that on 7/6/04 at approximately 8 PM, the resident was involved in an altercation with his roommate. The resident sustained a laceration over the left eyebrow and complained of pain in the left wrist. Nurse's notes at 8 PM noted

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that the physician was notified and ordered an x-ray of the left wrist for the morning if pain and edema increase. Nurse's notes for 7/6/04-7/7/04 identified that the resident continued to complain of pain in the left wrist. At 4 PM on 7/7/04 the x-ray company was notified of the need for the x-ray. The x-ray was not completed until 10:15 AM on 7/8/04 at which time the resident was diagnosed with an impacted fracture of the left wrist. Interview and review of the clinical record with the director of nursing on 10/6/04 at 1 PM failed to provide evidence that the x-ray company had been notified of the order on the morning on 7/7/04 as ordered by the physician.

- d. Resident #38's diagnoses included dementia, legal blindness and pneumonia. The care plan dated 9/15/04 identified that choking, dysphagia and aspiration as problems. Interventions included providing a pureed diet with honey thickened liquids. Current physician orders directed that the resident receive honey thickened liquids and a pureed diet. On 10/6/04 during the noon meal, a nurse aide was observed feeding the resident unthickened juice. The resident was observed to cough 5 times after one sip of the unthickened juice. While the surveyor sought assistance from licensed staff, the nurse aide fed the resident unthickened milk through a straw and again the resident was observed to have a wet, loose cough. Subsequent to surveyor inquiry, the licensed nurse thickened the resident's fluids.

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).

11. Based on clinical record review, observation and interview for one of five sampled residents with a decline in ambulation ability (Resident #13), the facility failed to reassess the resident following the decline. The findings include:
 - a. Resident #13's diagnoses included Multiple Sclerosis, dementia, delusions, and hypertension. A significant change assessment dated 5/27/04 and quarterly assessment dated 8/19/04 identified that the resident was severely cognitively impaired, totally dependent on one staff for transfer and ambulation and utilized either a cane or walker for locomotion. The care plan dated 9/01/04 identified that the resident was totally dependent on staff for activities of daily living and at risk for skin breakdown. Interventions included to ambulate the resident with two staff assisting to the bathroom and in the hall. The most recent Physical Therapy Discharge Summary dated 11/16/01 identified that the resident's ambulation status was a minimum assist of one staff with a walker about 100 feet. During interview with the Rehabilitation Program Director Occupational Therapist (OT) on 10/07/04 at 10:30 AM, she noted that she was unable to locate evidence that any

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additional Physical Therapy screens had been done for the resident. Review of the August 2004, September 2004 and October 2004 flow sheets for ambulation noted that during August 2004, the resident was noted to "ambulate with one assist" but failed to indicate the distance. The September 2004 flow sheet indicated that the resident ambulated 10 to 15 feet occasionally; and the October 2004 flow sheet noted that the resident ambulated with one assist, but again failed to indicate the distance. On 10/18/04 at 9:10 AM during interview and review of the flow sheets with the Administrator, she noted that the distance the resident ambulated was not documented. Review of the nurse aide assignment directed for the resident to be ambulated with assist of one but failed to indicate the number of feet (distance). Following surveyor inquiry, the Rehabilitation Program Director/Occupational Therapist (OT) and the licensed nurse assisted the resident to ambulate. On 10/07/04 at 10:30 AM the resident was observed to ambulate approximately 20 to 25 feet with the two staff. Following the ambulation, the OT noted that the resident still had his ambulation function left, that the resident ambulated quite well and that the facility should make the most of the resident's ability to walk. During interview on 10/18/04 at 12:30 PM with the OT she noted that during a subsequent screening the resident ambulated 50 feet and that she would request an order for Physical Therapy treatments.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H).

12. Based on clinical record reviews, observations and interviews for two of seven sampled residents who required assistance with meals (Resident #8 and Resident #43), the facility failed to ensure that the resident received the assistance necessary to ensure adequate nutrition. The findings include:
 - a. Resident #8's diagnoses included Alzheimer's disease with delusions and behaviors. The annual assessment dated 9/8/04 identified that the resident was cognitively impaired, displayed wandering, socially inappropriate and abusive behaviors, and required assistance with eating. The care plan dated 9/20/04 identified the need for assistance with activities of daily living. Interventions included to set up for meals and frequently cue the resident. Observations of breakfast on 10/5/04 at 8:10 AM noted that the resident's meal was set up on the overbed table. The resident was observed from 8:10 AM to 8:26 AM alone in her room with the curtain closed. The meal was untouched. The resident was observed with her eyes closed. At 8:28 AM the tray was noted to have been removed from the resident and was located in the meal cart. Observation of the meal tray noted that no food had been consumed. Review of the nurse aide flow

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sheet for 10/5/04 on 10/7/04 with the director of nursing noted that the nurse aide had documented that the resident had consumed 50-75% of the meal. Observation of the noon meal on 10/5/04 noted the resident sitting with the tray in front of her from 12:42 PM to 1:26 PM without the benefit of staff assistance or feeding. The resident did not consume any of the tray. At 1:26, a nurse aide was observed to attempt to feed the resident without heating up the food. The tray was observed to be removed at 1:33 PM with less than 25 % of the meal consumed. Interview with the nurse aide at 2 PM noted that the resident had been sleepy after her noon medications and that she had informed the nurse.

- b. Resident #43's assessment dated 8/20/04 identified that the resident was severely cognitively impaired and dependent on staff for all ADL's. Observation of the resident on 10/7/04 at 12:35 PM during lunch noted that the resident was seated at a table in the dining room with a tray being placed in front of her. The resident was observed from 12:35 PM until 1 PM attempting to feed herself the vegetable lasagna with a spoon. The resident was unable to bring the spoon to her mouth. At 1 PM a nurse aide was observed to feed the resident one spoonful of lasagna and walk away. The temperature of the food was down to 86 degrees at that time. The resident was provided assistance with feeding at 1:25 PM. Interview with the resident's nurse aide on 10/8/04 at 9:30 AM noted that the resident would not eat without cueing and assistance from staff. Review of the care plan with the director of nursing on 10/8/04 at 10 AM failed to provide evidence that a care plan had been developed to address the resident's feeding needs.

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)(B).

13. Based on clinical record review and interview for one of five sampled residents with a history of pressure sores (Resident #16), the facility failed to ensure that interventions to prevent pressure sores were initiated when the resident developed a tibial plateau fracture that required immobilization. The findings include:
 - a. Resident #16's diagnoses included dementia, osteoporosis, aspiration pneumonia and cardiomyopathy. An assessment dated 10/28/03 identified that the resident was cognitively impaired, incontinent of bowel and bladder, totally dependent on staff for all activities of daily living, and had no pressure sores. The care plan dated 10/29/03 noted the potential for skin breakdown due to incontinence and immobility. Interventions included to reposition and provide incontinent care every two hours and to perform weekly, full body examinations and document. The clinical record identified that on 11/9/03 the resident was transferred to the hospital for x-rays due to pain and swelling in the right lower extremity. The

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resident returned to the facility with a diagnosis of fractured tibial plateau and orders to keep a knee immobilizer in place with bedrest for ten days. Nurse's notes dated 11/25/03 identified the presence of a blister to the right heel measuring 5 cm and that heel lift boots had been applied. The right heel wound progressed to a stage IV pressure sore. Interview and review of the clinical record with the DNS on 10/8/04 at 10:15 AM failed to provide evidence that any interventions such as heel elevation, inspection and/or specialty heel protectors had been initiated when the resident returned from the hospital with orders for bedrest and immobilization.

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

14. Based on clinical record review, observation and interviews for the only sampled resident with a gastrostomy tube (Resident #10), the facility failed to ensure that the resident, who was physically capable of consuming food/fluids, was offered nourishment and/or that interventions to prevent aspiration were in place at all times. The findings include:
- a. Resident #10's assessment dated 10/10/03 identified that the resident was cognitively impaired and totally dependent on staff for all activities of daily living except eating for which she required supervision. Dietary progress notes dated 10/31/03 noted that the resident's appetite had declined and on 12/15/03 the resident had been placed on a full liquid diet. Dietary notes further identified that a gastrostomy tube (G-tube) was placed on 1/19/04.
 - b. Observation of the resident on all days of the survey (10/4-8/04) noted the resident receiving enteral feedings and nothing by mouth. Interview with the charge nurse on 10/6/04 at 12:05 PM noted that she was not aware that the resident could have anything by mouth. Interview with the dietitian on 10/6/04 at 12:45 PM noted that there was no assessment performed since insertion of the G-tube to determine if the resident would accept food and/or fluids. Subsequent to surveyor inquiry, the physician was contacted and ordered that the resident be offered food/fluids.
 - c. The resident's care plan dated 4/6/04 identified the need for G-tube feedings. Interventions included keeping the head of the bed elevated greater than 30 degrees at all times. Observation of the resident on 10/7/04 at 11 AM noted the resident lying in bed with the head of the bed elevated only 10 degrees with the G-Tube running. The surveyor sought assistance for the resident from the charge nurse who immediately elevated the head of the bed.

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15. Based on clinical record review, observation, interview and review of facility policy for the only sampled resident who smoked (Resident #24), the facility failed to ensure the resident was smoking safely. The findings include:
- a. Resident #24's diagnoses included Chronic Obstructive Pulmonary Disease and depression. The assessment dated 8/5/04 identified the resident had modified independence with cognitive skills for daily decision making and short term memory problem and indicators of sadness and anger. Further assessment identified that the resident required extensive assistance for bathing, was independent for transfer, and required supervision for locomotion on and off the unit. The care plan dated 8/17/04 identified that the resident had a problem with safety awareness regarding smoking with interventions that included provide the resident with one cigarette at a time and assist resident as needed to access the patio to go outside to smoke. During observations on 10/4/04 at 2:30 PM and 10/6/04 at 10:45 AM, the resident was observed self-propelling his wheelchair to the patio exit door, lighting the cigarette while inside the building, and then exiting the building. Interview with the Director of Nursing on 10/6/04 at 11:30 AM, identified that the resident is to light the cigarette when he is outdoors, not in the facility.

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)(C) and/or (o) Medical Records (2)(C).

16. Based on clinical record reviews, review of facility investigations and interviews for fourteen of nineteen residents with a history of falls and/or assaultive behaviors (Residents #3, #8, #10, #23, #27, #47, #48, #49, #50, #51, #52, #53, #54 and #55), the facility failed to provide the necessary supervision for residents with aggressive and/or combative behaviors to prevent further injuries to other residents and/or failed to assess the reasons for repeated falls and develop/implement new interventions to prevent further falls which resulted in falls with injuries. The findings include:
- a. Resident #55 was admitted on 9/25/01 with a diagnosis that included dementia. The Minimum Data Set of 4/28/04 identified the resident was totally dependent on staff for care. The Resident Care Plan of 5/6/04 identified the resident had the potential for injury. Interventions included transfer to reclining chair with lap tray. A facility report dated 6/11/04 identified Resident #55 was found on the

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floor in front of the reclining geril chair. The resident's nose was bleeding and a hospital evaluation identified a laceration at the medial corner of the right eye and a non-displaced fracture of the face, anterior maxillary and left posterior maxillary. NA #2 stated that she provided AM care for Resident #55 and placed the resident in a geril recliner chair. NA #2 reclined the resident in the chair but forgot to lock the chair. NA #2 stated the chair did not have a tray on it. LPN #1 stated she was summoned to the resident's room by a staff person and when she arrived she observed Resident #55 lying on the floor and bleeding profusely. The geril recliner chair was in an upright position and there was no lap tray in place. The Director of Nurses stated she was summoned by the charge nurse. She observed Resident #55 lying on the left side, on the floor in front of the geri chair. The resident was bleeding from the nose and the chair was in an upright position. Although NA #2 stated that she reclined the resident, locked the chair into position and locked the wheels on the chair, the DNS found the chair and the wheels were unlocked. The DNS stated a lap tray was also not in place and following a facility investigation, the NA was found to be neglectful and was terminated.

- b. Resident #8's diagnoses included Alzheimer's disease with delusions and behaviors. The quarterly assessment dated 6/16/04 identified that the resident was cognitively impaired, displayed wandering and socially inappropriate abusive behaviors, and required assistance with transfers and supervision with ambulation. The care plan originally dated 10/14/03 and updated through 6/24/04 identified the potential for injury due to Alzheimer's disease and poor safety awareness. Interventions included to remind resident to use the call bell, frequent rest periods, ambulate with a rolling walker and assistance and thirty minute checks. Multiple interim care plans that identified that the resident had fallen were present in the care plan. No new interventions were noted to have been added to any of the care plans. Review of nursing notes and facility documentation and/or investigations noted that the resident sustained falls on 5/23/04 at 3 PM, 5/29/04 at 12 AM, 6/1/04 at 2:15 PM, 6/8/04 at 5:15 PM, 6/10/04 at 4 PM, 6/21/04 at 4 PM, 6/21/04 at 4 PM, 7/7/04 at 5:10 PM and on 7/16/04 at 4:15 PM. Nurse's notes identified that on 7/16/04 the resident was found face down in the television room with a laceration to the right temple and one under the eye that required 20 sutures. Review of the clinical record and documentation with the director of nursing on 10/8/04 at 10 AM failed to provide evidence that assessments of the resident's fall pattern (mostly afternoons from 2-5 PM) had been completed and interventions initiated to prevent further falls. After the fall on 7/16/04, the resident was placed in a wheelchair with a seatbelt.

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- c. Resident #27 was admitted on 8/13/04 with a diagnosis of dementia. The MDS of 8/21/04 identified the resident as having periods of restlessness, some difficulty in understanding others, insomnia, depressed mood, short term memory problems, wandering behavior and exhibiting verbally abusive behavioral symptoms. He was also noted to have a deterioration in ADL function in the last ninety days. A psychiatric evaluation dated 3/23/04 and prior to admission identified the patient as having an increase in paranoia. At the time of the evaluation, the resident had been described as having short term memory problems which exacerbated his paranoia. The RCP of 8/16/04 identified problems relative to dementia, psychotic behaviors secondary to paranoid focuses and dementia with delusions. RCP interventions included approaches such as provide reality orientation prn, provide validation prn, praise all efforts, establish cause of psychotic behaviors, rule out medical condition, monitor for psychotic episodes as per goal, and psychiatric evaluation prn. Documentation was lacking in the clinical record to reflect that staff had attempted to determine the psychotic behaviors as identified on the RCP and/or had identified specific behaviors to monitor. A review of nursing narrative notes identified that the resident was periodically resistive to care, refusing PM care and refusing to take off daytime clothing to go to bed. Documentation also reflected that Resident #27 and Resident #28 had gotten into a verbal argument during the PM of 8/23/04 over Resident #27 going into the roommate's closet. Further review identified that on 8/26/04, Resident 27 and Resident #28 had gotten into an argument over shaving cream. On 8/27/04, documentation reflected that the two residents were still arguing over shaving cream. Social Service notes dated 8/31/04 identified that Resident #27 has been restless at night needing redirection to bed. He continued to be resistive to PM care choosing to sleep in his clothes. Documentation was lacking in the medical record to reflect that despite the observed and documented behavioral problems exhibited by Resident #27, the facility provided the resident with a current psychiatric evaluation as per the RCP and/or instituted effective psychiatric interventions to manage his behaviors. A facility report dated 9/26/04 at 12:15 am, identified Resident #27 was found standing in his room with blood on his shirt and hands. Resident #28 was found lying on the floor of his room, covered with blood and no vital signs were obtainable. The supervisor called 911. Resident #27 was brought to the hospital with a police escort and Resident #28's body was transferred to the Medical Examiner Office. NA #5 stated that on 9/26/04 between 11:30 PM and 12 midnight, when she entered the room of Resident #27 and Resident #28, she observed Resident #27 sitting in the chair with blood on his clothing. Resident #27 stated he had to "hit him" and NA #5 observed Resident #28 lying on the floor. She immediately summoned RN #4.

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- RN #4 stated she observed Resident #27 standing by the door with blood on his shirt. Resident #28 was lying on the floor with blood on his face and pillow case and she was unable to obtain a pulse. Resident #27 stated he hit Resident #28 with a board.
- d. A review of the hospital information identified that Resident #28 had been killed by Resident #27. He denied other paranoid thoughts but felt that Resident #28 had been stealing his possessions and that they had gotten into a fight because of this.
 - e. Resident #50's assessment dated 6/19/04 identified that the resident was without cognitive impairment, displayed no negative behaviors and required assistance from staff with activities of daily living. Nurse's notes identified that on 7/14/04 at 12:45 PM in the dining room, Resident #8 grabbed the residents first and second fingers of the left hand and bent them back. The resident complained of pain, ice was applied and an x-ray was taken which was negative for fracture. Nurse's notes on 7/15/04 identify the presence of bruising of the fingers. Please refer to Resident #8's information below.
 - f. Resident #51's assessment dated 6/2/04 identified that the resident was cognitively impaired, resisted care occasionally, and required staff assistance with ADL's. Nursing notes dated 8/5/04 at 4:30 PM identified that the resident's left thumb had been twisted by another resident (Resident #8) while the resident was in her room (Resident #8 had entered Resident #51's room). The note described the thumb as painful, reddened and edematous. Please refer to Resident #8's information below.
 - g. Resident #52's assessment dated 7/30/04 identified that the resident had impaired short term memory, no problem behaviors and required supervision with ADL's. A nursing note dated 8/6/04 at 2:30 PM noted that while the resident was speaking with staff at the nursing station, Resident #8 approached the resident with a wheelchair and stuck the resident in the right upper thigh with the wheelchair. Please refer to Resident #8's information below.
 - h. Resident #47's assessment dated 7/13/04 identified that the resident was without significant cognitive impairment, had no problem behaviors and required staff assistance for all ADL's. Nursing notes dated 8/8/04 at 12:20 PM noted that another resident (Resident #8) grabbed the resident's arm and twisted it. When the resident tried to free herself, Resident #8 grabbed her right thumb and pulled it. There were no nursing notes subsequent to the incident until 8/10/04 at which time staff noted that the bruise to the right arm was resolving. Please refer to Resident #8's information below.
 - i. Resident #23's diagnoses included senile dementia, and a left cerebral vascular accident (CVA). An admission assessment dated 7/3/04 identified that the

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resident had modified independence for daily decision making, and required limited to extensive assistance for care needs. The care plan dated 7/3/04 identified that the resident had a history of anxiety and somatic complaints with an intervention to acknowledge the importance of the resident's individual space and to manage situations that induce anxiety. Nursing notes dated 8/17/04 identify that while the resident was sitting in the hall, another resident (Resident #8) approached Resident #23 and twisted and pulled her right hand. During an interview with the resident on 10/6/04 at 10:35 AM, the resident stated that when her arm was pulled and twisted it made her very afraid and made her arm swell up and become black and blue. During an interview with the resident's son on 10/6/04 at 1:10 PM he stated that his mother was very afraid after being grabbed by the other resident and that she had swelling and discoloration of that hand. During a review of the record with the charge nurse on 10/6/04 at 1:10 PM she stated that although the resident and son complained of swelling and discoloration of the hand, she did not recall observing that. The charge nurse did note that she had documented in the nurse's notes dated 8/18/04 that the resident was complaining of pain in the hand and that there was slight swelling. Please refer to Resident #8's information below.

- j. Resident #53's assessment dated 6/30/04 identified that the resident was cognitively impaired, had no problem behaviors and required only supervision for ADLs. Nursing notes dated 8/28/04 at 3:00 PM noted that the resident was kicked from behind and engaged in a "fight" with Resident #8. There were no injuries documented. Please refer to Resident #8's information below.
- k. Resident # 54's assessment dated 8/11/04 identified the resident as having impaired memory, no negative behaviors and requiring assistance from staff for all ADL's. A nursing note dated 9/11/04 at 5:30 PM noted that another resident (Resident #8) was observed twisting the resident's right arm. There were no injuries documented. Please refer to Resident #8's information below. Resident #8's diagnoses included Alzheimer's disease with delusions and behaviors. The quarterly assessment dated 6/16/04 identified that the resident was cognitively impaired, displayed wandering and socially inappropriate abusive behaviors, and required assistance with transfers and supervision with ambulation. The care plan of 6/25/04 noted a tendency towards easily annoyed behavior directed at staff and peers. Interventions included providing for the safety of the resident and others during periods of combativeness. Review of nursing notes and facility documentation and/or investigations noted that the resident began in May 2004, displaying frequent, aggressive behaviors towards staff and other residents, mostly in the afternoon early evening including, grabbing and twisting arms/fingers, wandering into other resident's rooms, pushing her walker or wheelchair into other

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residents, throwing items at staff, and threatening to stab staff and/or other residents with fork/knife. Review of the resident's clinical record and documentation with the DNS on 10/7/04 at 1 PM noted seven documented incidents of the resident grabbing, twisting limbs, kicking, bending fingers, etc. of other residents from 7/14/04 through 9/11/04. Although the record identified multiple medication changes ordered by the attending physician and fifteen minute checks initiated in August 2004, the DNS failed to provide evidence that the resident was supervised to prevent the ongoing, repeated assaultive behaviors towards other residents as listed below. Review of the care plan and interview with the DNS failed to provide evidence that alternative methods of monitoring the resident's whereabouts had been initiated and/or attempted by the facility. The resident was evaluated by the consultant psychiatrist after the incident on 9/11/04 and medication adjustments were implemented. There were no further incidents after that. The resident was observed during the survey to be frequently sleepy/sedated and calm.

- l. Resident #3's quarterly assessment dated 7/1/04 identified the resident as severely cognitively impaired, totally dependent on staff for transfers and toileting. The care plan dated 7/22/04 identified falls as a problem with interventions that included to stand/pivot transfer with the assist of one staff and to use a mechanical lift if resistant to care. The nurse aide assignment included the use of a Sarita (standing assist) lift when necessary. On 10/5/04 at 11:30 AM, when the surveyor entered the room, the resident was observed standing on the Sarita lift platform receiving incontinent care from a nurse aide. The nurse aide was observed to leave the resident unattended in the lift and proceed to the bathroom to dispose of a brief. Interview with the staff development nurse on 10/6/04 at 1:30 PM noted that although the facility did allow incontinent care to be provided while standing in the lift, staff were not to leave residents unattended at any time while still being supported by the lift.
- m. Resident #49's diagnoses included dementia, head trauma, rhabdomyolysis, and supranuclear palsy. A quarterly assessment dated 8/25/04 identified that the resident had cognitive difficulty in new situations only, needed limited assistance with transfers, was dependent for toileting and had experienced falls within the previous 30-180 days. A fall risk assessment dated 8/31/04 identified that the resident was at high risk for falls. The care plan dated 9/7/04 identified the risk for falls with interventions that included the use of a clip seat belt in the wheelchair. Current physician orders directed the application of a clip belt in the wheelchair. Nursing notes identified that the resident had fallen on 7/21/04, 8/10/04, 8/11/04 (sustained a head laceration), and again on 8/21/04. Observations on 10/5/04 at 1:10 PM noted the resident calling for help from his

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- room. No alarms were heard. The resident was noted lying on the floor with a superficial laceration to the top of the head. The wheelchair was positioned at the resident's feet. Review of the investigation and interview with the director of nursing on 10/18/04 at 10 AM noted that the nurse aide neglected to place the alarmed seat belt on the resident when he had been placed in the wheelchair.
- n. Resident #10's diagnoses included Alzheimer's disease. An assessment dated 1/10/04 identified that the resident was cognitively impaired and totally dependent on staff for all activities of daily living. A care plan dated 4/6/04 identified that the resident was at risk for injury due to impulsive behavior with interventions that included transferring the resident with the assist of two and affixing a bed alarm when the resident was in bed. Nurse's notes dated 4/13/04 on the 7 AM- 3 PM shift noted the resident with the legs over the siderails nearly falling out of the bed. A bed behavior monitoring form dated 5/3-6/04 noted the resident restless and/or agitated at times and sliding to the edge of the bed. A nurse's note dated 8/23/04 at 11:10 PM noted that the resident was found on the floor next to the bed sustaining a 4 cm hematoma to the forehead. Interview with the nurse aide on 10/6/04 at 11:20 AM who had been assigned to the resident on 8/23/04 noted that when she found the resident on the floor, there was no bed alarm on the bed. Observation of the resident in bed on 10/7/04 at 9:30 AM noted that the resident lacked a bed alarm.
- o. Resident #48's diagnoses included dementia. An assessment dated 2/10/04 identified that the resident was cognitively impaired and required assistance from staff for all ADL's. Nursing notes dated 6/7/04 at 10:30 PM noted that the resident had an altercation with Resident #18 resulting in Resident #48 falling and sustaining two skin tears. Investigation noted that Resident #18 pushed Resident #48 out of her room. The investigation further identified that there had been previous altercations whereby Resident #18 became aggressive towards other residents when she was protecting her room from other residents. Interview and review of the clinical record with the director of nursing on 10/8/04 failed to provide evidence that a care plan had been developed to address Resident #18's aggressive behavior when other resident's entered her room.

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

17. Based on clinical record reviews, observations and interviews for two of seven sampled residents on full liquid diets (Residents #20 and #22), the facility failed to ensure that all residents were offered meals of the appropriate consistency in accordance with

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recommended daily servings from all food groups or nutritionally equivalent substitutes and/or failed to provide a variety of foods daily and/or failed to ensure that residents were receiving vitamins and minerals as recommended in the Long Term Care diet manual for residents on full liquid diets. The findings include:

- a. Resident #20's diagnoses included dementia, and oral-facial dyskinesia. An annual assessment dated 7/3/04 identified the resident as severely cognitively impaired, totally dependent for all ADL, had difficulty swallowing, had a mechanically altered diet and had not experienced weight loss or gain in the past 180 days. The care plan dated 7/21/04 identified nutrition, a history of weight loss, risk of aspiration/choking/dysphagia, and total feeding as problems. Interventions included to provide a full liquid diet with pudding thickened liquids, promote 75 % of meal intake, keep the resident upright for meals, assess for sign and symptoms of aspiration, assess incoming lab data for nutritional status, and to feed the resident. Review of dietary notes noted that in April 2004 the dietitian recommended and the physician ordered a full liquid diet for the resident. The resident's weight for January 2004 was 128#. The resident's weight in 9/04 was documented as 96 pounds. Review of the lab data for 2004 noted that in May 2004 the resident's Albumin level was 2.6 and total protein was 6.1. On 10/4/04 the resident's albumin level was reported at 1.6 (3.2-4.6) and total protein level was 4.8 (6.0-8.3). On 10/5/04 the resident was observed being fed by the licensed nurse. The resident consumed between 75%-100% of the noon meal. The meal consisted of pudding, milk, soup, and health shake all thickened to pudding consistency (like pureed food). Physician orders dated for 10/04 did not include the administration of vitamins or iron supplements.
- b. Resident #22's diagnoses included Alzheimer's with paranoia and agitation. An assessment dated 8/19/04 identified the resident as severely cognitively impaired and unable to communicate needs, totally dependent on staff for all activities of daily living (ADL) and had not experienced any weight loss or gain in the previous 180 days. The care plan last revised on 9/1/04 included nutrition and skin integrity as issues with approaches to assess nutritional needs at least quarterly, monitor food/fluid intake, feed slowly, and provide a full liquid diet with thickened liquids. Current physician orders included providing a full liquid diet with pudding-thickened liquids. No vitamin or mineral supplements were ordered. Review of dietary assessments revealed that on 7/7/03 the resident was placed on a full liquid diet with pudding thick liquids and supplements three times a day. Dietary notes dated 1/5/04, 6/10/04 and 8/26/04 documented that there was no updated lab data to review. The last laboratory data to review was dated 9/16/03 with an Albumin level at 3.7 and a total protein level at 6.5. On 10/4/04 and 10/5/04 the resident was observed being fed the noon meal. The meal tray

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consisted of milk, juice, pudding, ice cream, yogurt and soup. With every spoonful the thickened liquids ran down the resident's chin and dropped on to the bib. The resident had difficulty with forming an adequate lip seal and thus the full liquid diet was running out of her mouth. Two bibs were placed on the resident prior to the meal and the top bib was removed (saturated) during the middle of the meal. The resident's meal tray had approximately 50-75% of the liquid diet missing at the end of the meal. Interview with the dietician on 10/5/04 noted that because residents with dementia like "sweet things", she developed and implemented this full liquid diet plan. A review of the full liquid diet meal plan noted that the residents were served the same meal every day with the exception of different soups and flavors of yogurt, etc. The food service supervisor was unable to provide a break down menu that identified a variety of foods meeting the daily recommendations for all food groups.

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 (m) Nursing Staff (2)(B) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (q) Dietary Services (2)(A).

18. Based upon observations, interview, and review of the clinical record for one of ten sampled residents receiving antipsychotic medications (Resident #12), the facility failed to monitor the resident for side effects of the medication (increased lethargy) and/or failed to provide evidence that the resident exhibited any behaviors that required medication and/or failed to initiate dose reductions of the medication.
 - a. Resident #12's diagnoses included a cerebral vascular accident and depression with psychotic features. A quarterly assessment dated 6/30/04 identified that the resident was moderately cognitively impaired, did not display problem behaviors, needed extensive assistance with activities of daily living, and had been on antipsychotic / antidepressant type medications for the last 7 days. A care plan dated 7/13/04 identified a problem of potential for undesirable side effects related to psychotropic drug therapy. Interventions included observing the resident for involuntary movements, monitoring and charting of target behaviors, and consulting with the physician as needed. A psychiatry progress note dated 11/19/03 identified increased tremors with activity, possibly related to risperdal with an order to decrease the dosage. Psychiatry progress notes dated 12/15/03 and 1/19/04 noted no increased aggression or agitation, and decreased tremors after the risperdal had been decreased. The last psychiatry progress note dated 4/12/04 noted the resident to be stable. Pharmacist consultations dated 1/23/04 noted no aggression since risperdal decreased, and on 9/23/04 recommended a

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review of current dose of risperdal for a trial discontinuance. Nursing medication records for June, July, and August 2004 identified no aggressive or agitated behaviors. Observations on 10/4/04 at 1:06 and 1:22 PM noted a slight tremor to the resident's right hand while attempting to feed herself. Observations of the resident on 10/4/04 through 10/7/04 noted the resident to be asleep on numerous occasions in her wheelchair throughout the day with staff persons having to wake her during meals and for activities. During a conversation with a nurse aide on 10/5/04 at 8:40 AM she stated that the resident is very sleepy all the time, and that her hands are too shaky to feed herself. During an interview with the licensed nurse on 10/8/04 at 10:55 AM she stated that the resident's target behaviors had been good for the past 6 months. She also stated that although not documented, she has spoken to the physician about the increased lethargy and its relationship to the medications being taken.

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

19. Based on observations, review of clinical records and interviews for five of eight residents observed (Residents #33, #34, #35, #36, and #7) during medication pass, the facility failed to ensure that the medication error rate was below 5%. The findings include:
- a. Observation of medication pass on 10/5/04 from 8:04 AM through 9:10 AM noted an error rate of 14.6%. The errors were as follows:
 - i. Resident #33's current physician orders directed the administration of Colace liquid 100 mg twice a day and enteric coated aspirin 325 mg daily. The resident was observed to receive a Colace capsule and regular (not coated) aspirin.
 - ii. Resident #37's current physician orders directed the administration of 81 mg of chewable aspirin daily. The resident was observed to receive 81 mg of enteric coated aspirin.
 - iii. Resident #36's current physician orders directed the administration of Depakote Extended Release 1000 mg. The resident was observed to receive two Depakote Extended Release 500 mg tablets that were crushed and added to applesauce.
 - iv. Resident #34's current physician orders directed the administration of 81 mg of chewable aspirin daily. The resident was observed to receive 81 mg of enteric coated aspirin.

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- v. Resident #35's current physician orders directed the administration of Ferrous Sulfate 325 mg tablets twice a day. The resident was observed to receive 220 mg of Feosol liquid instead.

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).

20. Based on observations and interview the facility failed to ensure that name bands/identification bands were present for residents (Residents #11, #14, #21, #36, #39, #40, #41 and #42). The findings include:
- a. During the initial tour of the facility on 10/4/04 from 9:30 AM - 10:30 AM, with the licensed nurse and recreation director, eight cognitively impaired residents (Residents #11, #14, #21, #36, #39, #40, #41 and #42) were observed to be without the benefit of identification bands in place on their arms and/or legs. Interview with the director of nursing on 10/7/04 at 10 AM noted that medication nurses were to check for the presence of name bands during medication pass.

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

21. Based on closed record review and interview, the facility failed to ensure that records were closed in chronological order and were maintained complete and orderly. The findings include:
- a. Review of Resident #16's closed record noted that the record had not been assembled in an orderly manner according to types of records and dates, making it difficult to locate specific items for review in seven years of closed records. Interview with the administrator on 10/7/04 noted that there had been no staff available to close charts properly.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (4).

22. Based on clinical record review and staff interviews, for one resident, Resident #1, the facility failed to follow facility policies. The findings include:
- a. Resident #1 was admitted on 10/8/04. Diagnoses included dementia. The Resident Care Plan of 10/21/04 identified the resident with a history of being affectionate with peers. Interventions included redirection and 15 minute checks. Resident #2 was admitted on 4/11/04. Diagnoses included dementia with behavior disturbances. The Resident Care Plan of 10/19/04 identified the resident

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with inappropriate sexual behavior. Interventions included 15-minute checks. A facility report dated 10/26/04 identified that the police department arrived at the facility to investigate reported allegations of sexual assault that involved Resident #1 and Resident #2. The facility investigation identified that Resident #1 was found asleep, fully clothed on the bed of Resident #2 and was taken to the hospital for examination. NA #2 stated when she arrived on the unit at 3:00 pm on 10/24/04 Resident #1 was not sitting at the nurses station as she usually did. NA #2 checked the resident's room and the lounge and reported to LPN #1 that she was unable to find the resident. NA #2 enlisted the help of other nurse aides to find Resident #1. At 3:30 pm NA #1 found the resident fully clothed, lying on the bed of Resident #2. Resident #2 was not in the room. NA #1 assisted the resident to her wheelchair and brought her to the nurses' station. At 3:45 pm NA #2 changed the resident's brief and performed peri care. NA #2 stated she gave Resident #1 a bed bath at 7:30 pm and assisted the resident to bed. LPN #1 stated when she arrived on the unit at 2:45 pm, Resident #1 was not at the nurses station. NA #1 found the resident on another resident's bed. When the resident was found she notified the supervisor that Resident #1 had been missing. NA #2 stated she was concerned about Resident #1's whereabouts when she noted that the 15-minute check off sheet for the 7-3 shift indicated that the resident was last seen at 1:30 pm. RN #1 stated that the 7-3 shift 15 minute monitoring sheet for 10/24/04 for Resident #1 was not completed. She contacted the 7-3 NA to determine the whereabouts of Resident #1 and entered the information as a late entry. Facility policy regarding 15-minute checks states that the completed monitor sheets will be completed every shift. RN #2 stated that although Resident #1 was missing for 45 minutes, LPN #1 did not notify her and failed to follow facility policy for missing residents. Facility policy regarding missing residents states the NA will notify the charge nurse and the charge nurse will then announce "Dr. Hunt", a room check will be done and all personnel will be alerted to look for the missing resident.

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 (m) Nursing staff (2)(C).

DHSR Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
 - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
 - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
 - Assessing administration's ability to manage and the care/services being provided by staff.
 - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.