

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

IN RE: Five Star Quality Care – CT. LLC - Licensee
 d/b/a Health Center of Greater Waterbury
 177 Whitewood Road
 Waterbury, CT 06708

CONSENT ORDER

WHEREAS, Five Star Quality Care – CT., LLC, (hereinafter the “Licensee”) has been issued License No. 2272 to operate a Chronic and Convalescent Nursing Home known as Health Center of Greater Waterbury (hereinafter the “Facility”) by the Department of Public Health, (hereinafter the “Department”); and

WHEREAS, the Health Systems Regulation (“HSR”) of the Department conducted unannounced visits on various dates commencing on October 8, 2004 up to and including November 5, 2004 for the purpose of conducting multiple investigations; 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 the violation letter dated November 10, 2004 (Exhibit A- copy attached); and

WHEREAS, an informal conference with respect to the November 10, 2004 violation letter Was conducted on December 14, 2004 at the office of the Department; and

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

NOW THEREFORE, the Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Section Chief, and the Licensee, acting herein and through Everett Benton, its Managing Member, hereby stipulate and agree as follows:

1. 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 date of this Consent Order and thereafter at twelve (12) week intervals. 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.
2. 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.
3. 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 Department, upon request.
4. The Administrator 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. The Administrator shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
5. The Licensee represents, stipulates and agrees that at all times it will employ sufficient personnel to meet the needs of the patient population. The Licensee shall appoint a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. Such Nurse Supervisors shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made

available to the Department upon request and shall be retained for a three (3) year period of time.

6. Within fourteen (14) days of the execution of this Consent Order the Licensee shall provide to such Nurse Supervisors the following:
 - i. A job description which clearly identifies the supervisors' day-to-day duties and responsibilities;
 - ii. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
 - iii. Nurse Supervisors shall be supervised 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. Supervision by Administrative Staff shall be random and inclusive of evenings, nights, weekends and holidays. Records of such administrative visits and supervision shall be retained for the Department's review;
 - iv. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers in accordance with individual comprehensive care plans;
 - v. Nurse Supervisors shall not have administrative office duties.
7. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of residents with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to transferring of residents, respiratory assessments, care for residents refusing treatments and/or care, infection control protocols inclusive of, but not limited to, surveillance of infection control practices and infections.
8. Within twenty one (21) days of the effect of this Consent Order all Facility nursing staff shall be inserviced, as necessary, related to the policies and procedures listed in paragraph number 7.

9. The Facility shall appoint a Registered Nurse (RN) with credentials in Infection Control to serve a minimum of thirty-two (32) hours per week. The Infection Control Nurse (ICN) may not have any other duties except those relating to the monitoring of infection control principals/practices and the monitoring and training of the staff in areas related to infection control.
10. The facility shall contract with an Infection Control Consultant (ICC) for a period of six (6) months. The ICC shall serve a minimum of ten (10) hours a week providing the RN employed as the ICN has credentials as specified in paragraph 9. If the RN does not have the required credentials, the ICC shall serve a minimum of eighteen (18) hours per week. Until the designated ICN obtains the necessary credentials. The hours of the ICC may be reduced from eighteen (18) to ten (10) hours upon the ICN obtaining said credentials.
11. The Facility shall contract with an outside behavior specialist to provide inservicing to nursing staff (RNs, LPNs, Nurse Aides) regarding residents with challenging behaviors.
12. The Facility shall contract with an Advanced Practice Registered Nurse (APRN), credentialed in wound care. The APRN shall serve a minimum of twenty (20) hours weekly and shall conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores. The APRN shall remain in place for six (6) months.
13. If at any time, during the duration of the Consent Order that the Department finds the Facility to be in significant non-compliance with federal regulations and the Public Health Code, the length of the monitoring period for the ICC and/or the Wound Care Consultant may be extended and/or reinstated.
14. The Facility shall establish a Quality Assurance Program to review patient care issues inclusive of those identified in the November 10, 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.

15. Within seven (7) days of the execution of this Consent Order the Licensee shall identify the Facility's Administrative Staff responsible for monitoring the implementation of this document.
16. The Licensee shall pay a monetary fine to the Department in the amount of fifteen thousand dollars (\$15,000.00), 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:

Judy McDonald, R.N., SNC
Health Systems Regulation
Department of Public Health
410 Capitol Avenue, P.O. Box 340308
MS #12HSR
Hartford, CT 06134-0308
17. 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.
18. 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.
19. This requirement of this document shall remain in effect for a period of two (2) years from the effective date of this document.
20. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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.

FIVE STAR QUALITY CARE, CT. - LICENSEE

5/24/05
Date

By: *Evrett Benton*
Evrett Benton, its Managing Member

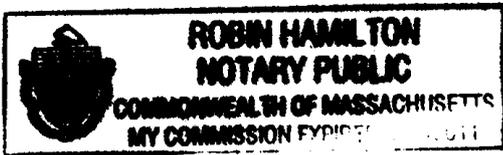
STATE OF Massachusetts

County of Middlesex ss May 24, 2005

Personally appeared the above named Evrett W. Benton and made oath to the truth of the statements contained herein.

My Commission Expires: 03/10/2011
(If Notary Public)

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



STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

May 26, 2005
Date

By: *Marianne Horn*
Marianne Horn, R.N., J.D., Section Chief
Health Systems Regulation

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 16

November 10, 2004

Denise Quarles, Administrator
Health Center of Greater Waterbury
177 Whitewood Road
Waterbury, CT 06708

Dear Ms. Quarles:

Unannounced visits were made to Health Center of Greater Waterbury on October 8, 26, 27, 28 and November 5, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations with additional information received through November 5, 2004.

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

An office conference has been scheduled November 24, 2004 at 10:00 A.M. in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified during the inspection. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

(If applicable: No referrals of health care professionals were initiated as a result of this inspection.)

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

Respectfully,



Judy McDonald, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JFM:LLD:lsf

cc: Director of Nurses
Medical Director
President
vlhcgreatwaterlsl.doc
CT2936, #2937, #3414



Phone
Telephone Device for the Deaf: 860-509-7191
410 Capitol Avenue, MS #
P.O. Box 840508 Hartford, CT 06184
Connecticut, A State of Equal Opportunity Employer

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

1. Based on review of the medical record, review of facility policies, review of facility documentation, and interviews, one nursing assistant failed to provide services that included transfer to the commode to one resident, Resident #12, at the resident's request. The findings included:
 - a. Resident #12's diagnoses included arthritis, adjustment disorder with anxiety, and depression. Review of the assessment dated 3/9/04 identified the resident as alert, needing extensive assistance for transfer and toilet use and continent of urine. Review of the Resident Care Plan (RCP) dated 3/17/04 identified problems including the need to maintain present level of function as well as a neat, clean appearance, with interventions that included to keep the call light within reach and that Resident #12 utilized a commode at her bedside. In addition, the RCP identified issues related to Resident #12's pain due to arthritis with interventions that included gentle approach when providing care. Review of facility documentation dated 5/13/04 identified that Resident #12 reported that Nursing Assistant #11 (NA #11) refused to assist her onto the commode when she requested to use it at approximately 4:00 AM on 5/11/04. In addition, Resident #12 reported that NA #11 spoke to her in a loud voice earlier that same morning and had asked, "What the hell do you want now?" Interview with NA #11 on 10/13/04 at 12:30 PM identified that Resident #12 had asked to be transferred onto the commode at approximately 4:00 AM. NA #11 stated that Resident #12's routine included that when the resident was transferred to the commode on the night shift, she would stay up for the day and that it was too early. NA #11 stated that she had provided care for Resident #12 on many occasions prior to the incident and thought that she and Resident #12 "had an understanding." NA #11 stated that she did offer the bedpan to Resident #12 and that the resident didn't complain at the time. NA #11 adamantly denied speaking loudly and/or inappropriately to Resident #12. Resident #12 was unavailable for interview. Review of facility policies on Resident's Rights identified that a resident has a right to reasonable accommodation of their individual needs and preferences except when their health or safety or the health and safety of others would be endangered.

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

2. Based on clinical record review and interview for one sampled resident (Resident #2) the facility failed to accurately assess the resident for pressure ulcers. The findings include:

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

- a. Interview with the ICN on 10/27/04 identified that Resident #2 had two stage two pressure ulcers on the heels upon return from the hospital on 7/29/04. The weekly skin assessment identified that the resident had stage 1 pressure ulcers on bilateral heels on 8/2/04. Review of the 8/1/04 MDS assessment failed to identify the presence of the stage one and /or stage two pressure ulcers on the heels.

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

3. Based on clinical record reviews, and interviews for one sampled resident who refused care daily (Resident #1) the facility failed to revise the resident's plan of care to include new approaches to address the resident's ongoing refusal of care. The findings include:
 - a. Resident #1 was admitted to the facility 9/30/98 with diagnoses that included quadriplegia, pressure ulcers, and personality disorder. Interviews with facility staff on 10/26/04, 10/27/04, and 10/28/04 identified that the resident consistently refused care on a daily basis. Refusals included oral hygiene, bathing, shampooing, nail care, monthly weights, lab work, repositioning, and treatments to the leg wounds, and a sacral pressure ulcer. Resident assessments dated 12/10/03, 3/5/04, 6/2/04, and 8/27/04 indicated the resident was independent for cognition, totally dependent on staff for all care needs, refused care daily, and had multiple stage 1 to stage 3 pressure and/or stasis ulcers. RCPs from 1/1/04 to 10/12/04 directed staff to turn and reposition the resident every two hours, provide total assistance with AM and PM care, attempt/ encourage incontinent care immediately after bowel movements, feed resident meals, and psychiatric follow-up as needed. During this above-mentioned 9.5 months, the resident's care to ulcers and/or wounds was ordered to be done daily, however, care was only performed five times to the wounds on the fingers. Although the physician directed treatment to the sacral pressure ulcer on a daily basis, in 9.5 months care was only provided twice due to the resident's refusal of care. Lower extremities had open draining lesions from the knees to the ankles and treatments were ordered every other day, however, the resident only allowed care to be performed on thirteen occasions in 9.5 months. The care was not provided due to the resident's refusals. The resident's clinical record from 1/1/04 to 10/28/04 reflected the resident refused to be turned and repositioned, refused breakfast daily, accepted personal hygiene on a less than daily basis, and last accepted bathing on 10/12/04. Review of the resident's clinical record with the Resident Care Assistant on 10/28/04 identified that although the current approaches did not assist the

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

resident to meet all goals, new interventions were not instituted from 11/7/03 to 10/11/04 and not until maggots were observed on the resident's body. Interview with the Resident Care Assistant on 10/28/04 noted she did not change interventions to the resident's plan of care because the resident had not met the goals and the goals were still realistic.

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

4. Based on clinical record review the facility failed to ensure that consistent respiratory assessments were performed on one sampled resident (Resident #7) who had experienced signs and symptoms of a respiratory infection. The findings include:
 - a. Resident #7 was admitted to the nursing home on 5/13/03. Resident diagnoses included pneumonia, depression, hypothyroidism, chronic renal failure, urinary tract infection and MRSA. Nurses' notes dated 10/18/04 identified that at 8 PM, the resident had a fever of 102.1 degrees F., a congested cough and "bilateral middle lobes-diminished bibasilar". Although the physician was notified of above findings at 10AM on 10/19/04, complete respiratory assessments were lacking on the evening of 10/19/04, night shift of 10/20/04, and day shift of 10/20/04. The physician ordered a chest x-ray and lab work on 10/19/04 which identified that the resident had a "left base pulmonary process" and a white blood cell count of 17,600 (reference range-3.8-10.8 thous/mcL). The resident was sent to the hospital at 10:45 PM on 10/20/04. A review of the resident's hospital record identified that the resident had a left lower lung infiltrate and as of 11/3/04 remained hospitalized.

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

5. Based on review of the medical record, review of facility documentation, review of facility policies, and interviews, the facility failed to provide pressure ulcer treatments, turning and repositioning, and hygiene according to the resident's plan of care for one resident (Resident #1) who had resistive behaviors and/or to provide an appropriate diet for one resident who required a diet of a puree consistency (Resident #11). The findings included:
 - a. Resident #1 was admitted to the facility 9/30/98 with diagnoses that included quadriplegia, pressure ulcers, and personality disorder. Interviews with facility

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

staff on 10/26/04, 10/27/04, and 10/28/04 identified that the resident consistently refused care on a daily basis. Refusals included oral hygiene, bathing, shampooing, nail care, weights, lab work, repositioning, incontinent care, and treatments to the leg and/or hand wounds and/or sacral pressure ulcer. Resident assessments dated 12/10/03, 3/5/04, 6/2/04, and 8/27/04 indicated the resident was independent for cognition, totally dependent on staff for all care needs, refused care daily, and had multiple stage 1 to stage 3 pressure and/or stasis ulcers. RCPs from 1/1/04 to 10/12/04 directed staff to turn and reposition the resident every two hours, provide total assistance with AM and PM care, attempt/encourage incontinent care immediately after bowel movements, feed resident meals, and psychiatric follow-up as needed. During a 9.5 month period, the resident's care to ulcers and/or wounds was ordered to be done daily, however, care was only performed five times to the wounds on the fingers. Although the physician directed treatment to the sacral pressure ulcer on a daily basis, in 9.5 months care was only provided twice due to the resident refusal of care. Lower extremities had open draining lesions from the knees to the ankles and treatments were ordered every other day, however, the resident only allowed care to be performed on thirteen occasions in 9.5 months. The care was not provided due to the resident's refusals. The resident's clinical record from 1/1/04 to 10/28/04 reflected the resident refused to be turned and repositioned, refused breakfast daily, accepted personal hygiene on a less than daily basis, and last accepted bathing on 10/12/04 (last prior bathing documented on 4/22/04). Psychiatric notes dated 1/6/04 and 2/26/04 identified the resident had poor insight and judgment. Staff requested the psychiatric evaluations to address the resident's refusals, further psychiatric interventions were not implemented to address the resident's ongoing refusal of care until 10/13/04. On 10/12/04 fifty-four maggots were observed on the resident's skin and wounds and eight were noted on the resident's floor. Upon the identification of maggots Psychiatrist (Physician #5) saw the resident on 10/13/04 and made the determination that the resident does not have the capacity to make safe decisions and recommended that a conservator be appointed. Multiple interviews with the Administrator, Physician # 1, # 2, # 4, # 5, Social Worker and staff nurses identified that Resident # 1 was not making safe decisions regarding his health care. Interviews with RN#1 and # 2, LPN # 1, and NA # 3 on 10/27/04 and 10/28/04 noted the resident's lower legs had green drainage and/or blood and pus, had a foul smell, and actively bled when cleaned. Interviews with RN# 1 and # 2, LPN # 1, and NA# 3, #4, and # 8 indicated the resident refused to be repositioned, laid in stool for up to a week, and the sacral

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

dressing would be black with stool. On 11/1/04 the resident had blood work drawn and results of 11/2/04 identified the resident had critical levels of hemoglobin and hematocrit. Resident # 1 had hemoglobin of 3.5g/dl (normal value range = 13.2 to 17.1) and a hematocrit of 11.6 %(normal value range = 38.5 to 50). Physician # 2 tried to get the resident to go to the hospital for a blood transfusion on 11/3/04 and the resident stated he would do it the following week. On 11/3/04 the resident agreed to a transfusion and was admitted to the hospital on this date. The facility informed the Department of Public Health on 11/3/04 that Resident # 1 had a conservator appointed by the court effective 11/3/04. The Administrator and/or Physician # 1 (Medical Director) identified that they sought out numerous resources to address the resident's refusal of care to include corporate lawyers, Ombudsman, and a Psychiatrist (Physician # 5) on more than one occasion and met informally on numerous occasions to discuss Resident # 1's ongoing refusal of care.

- b. Resident #11 (R #11) diagnoses included severe dementia with dysphasia. Review of the physician's order sheet dated 4/12/04 included orders for a pureed diet consistency with thickened liquids. Review of the Resident Care Plan (RCP) dated 4/16/04 identified a goal of no signs and symptoms of aspiration pneumonia with interventions that included staff assistance with a pureed diet. Review of the assessment dated 4/30/04 identified Resident #11 with cognitive impairments and in need of assistance for eating. Review of facility documentation identified that on 5/10/04, Resident #11 was fed "a few spoonfuls" of chopped noodles from a tuna noodle casserole by Nursing Assistant #12 (NA #12). The documentation identified that when Resident #11 began to cough, NA #12 attempted to call the dietary department to question the consistency sent by the department. Interview with NA #12 on 10/13/04 at 9:00 AM identified that Resident #11 was the only resident in the dining room when she began to feed her and had no opportunity to observe any other residents' pureed food trays. NA #12 stated that she was initially told that because the noodles were soft, that the diet consistency was okay. NA #12 stated that she did not continue to feed Resident #11 as the resident continued to cough and because the consistency "didn't look right." NA #12 notified the charge nurse. Review of the medical record identified that LPN #1 observed Resident #11 in the dining room, that the resident was coughing, and producing mucous mixed with noodles. LPN #11 notified the supervisor. Resident #11 was transferred to the Emergency Department (ED) on 5/10/04 for evaluation and returned to the facility that same evening with orders to monitor for signs of aspiration pneumonia. Interview with the Food Service Supervisor (FSS) on

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

10/8/04 identified that he was also called to the unit on the evening of the incident and that he inspected the remaining food on Resident #11's plate. The FSS stated that the dietary department had inadvertently sent a regular consistency diet rather than a pureed consistency for Resident #1 and that he observed that approximately one fifth of the meal had been consumed. On 5/12/04, Resident #11 developed an elevated temperature of 101.5 (Normal 98.6) and was again transferred to the ED. Review of the chest x-ray dated 5/12/04 identified a patchy pneumonic infiltrate at the right base of the lung. Resident #11 returned to the facility on 5/12/04 with diagnoses that included aspiration pneumonia with orders for antibiotic therapy. Interview with MD #1 on 10/27/04 at 2:05 PM identified that although it was most likely that the resident's aspiration pneumonia was caused by the aspiration of the noodles, that it could have also been just a pneumonia due to an unrelated cause.

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

6. Based on observations, clinical record reviews and interviews, the facility failed to maintain a system to track pressure ulcers. In addition for 8 of 8 residents with pressure ulcers the facility failed to reposition residents every two hours and/or failed to provide physician directed treatments to pressure ulcers. The findings include:
 - a. Resident #2 was admitted to the nursing home on 5/2/83. The resident had coronary artery disease, congestive heart failure, schizophrenia and fractured hip (7/04). Observation of the resident on 10/27/04, in the morning, identified that the resident had bulky dressings to bilateral heels and had protective heel pads in place. RN #2 while removing the right heel dressing identified a large amount, of dried brown drainage from the heel and stated that there was an "odor of rotting flesh" noted from the right heel the skin was macerated, described the staging as 4 and identified the size of the pressure ulcer as being 8cm long by 4" wide. Observation identified full thickness of skin and subcutaneous tissue was noted to be lost. The nurse was observed to wash this pressure ulcer off with normal saline and place a moist normal saline dressing on the right heel. The nurse failed to follow the physicians order for treatment to the right heel which directed a dry bulky dressing. Following the completion of the dressing, the surveyor intervened and identified the wrong treatment had been applied. The nurse identified she would removed the new dressing and apply the appropriate dressing.

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

- b. In addition although Resident #2 was observed on the morning of 10/27/04 to have a pressure ulcer on the right lateral ankle, there was no specific treatment to this pressure ulcer from 10/14/04 through 10/27/04. The treatment kardex prior to 10/14/04 identified a specific treatment to the ankle which was discontinued on 10/14/04 on the treatment kardex, however there was no physician's order on 10/14/04 to discontinue the treatment to the pressure ulcer. On 10/27/04 the nurse described the right lateral ankle pressure ulcer as being 3.0cm by 3.5cm in size and having a dark eschar covering ulcer and could not measure depth as a result of this eschar. RN #2 described the left heel as having odor with necrotic edges and being a stage 4 pressure ulcer.
- c. In addition observation identified on 10/27/04 (AM) that Resident #2 had two additional pressure ulcer were observed and identified by RN # 2 as having dark eschars located along the lateral area of the right foot (1cm in size) and the other area was proximal to the right lateral ankle and was approximately 0.5 cm in size. There were no documented treatments and/or physician orders to these areas.
- d. In addition during a constant observation of Resident #2 during the period of 5:55 AM through 10 AM on 10/28/04 the resident was observed to be in bed on her back, heels resting on the bed with heelbos in place. The resident was without the benefit of repositioning off her back for three hours and fifty-five minutes (3 hrs 55 minutes). At 9 AM, Resident #2 yelled out "Help, I want to get washed and get out of here." Upon discussing with NA #5 regarding the issue of repositioning the aide responded that it's hard to turn everybody. A review of the clinical record identified that Resident #2 MDS assessment dated 8/1/04 and 9/23/04 identified the resident as cognitively impaired requiring extensive staff assistance for bed mobility and extensive assistance of staff for hygiene and bathing needs. The resident's care plan dated 8/17/04, directed that the resident had open areas on the heels and required repositioning every two hours. Nurse's notes dated 10/19/04 identified that the resident required a surgical debridement. Interview with the ICN on 10/27/04 identified that this resident had several pressure ulcers, a surgeon had performed a debridement on 9/24/04 and that the surgeon ordered a testing of Resident #2's circulation to determine if the resident had peripheral vascular disease (no results as of 10/29/04). The ICN further identified that Resident #2 had an odor and drainage from the heel and there had been a discussion of a possible amputation. Interview with MD # 2 (Surgeon) on 11/2/04 identified that the result of testing indicated the resident had poor circulation and was scheduled for a below the knee amputation of the right leg on 11/5/04.

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

- e. Although the facility's policy was to complete weekly wound progress notes identifying the date, location, where ulcer was acquired, stage, length width, depth undermining, tunneling and description of wound, the facility failed to provide documentation that Resident #2's multiple pressure ulcers were assessed to include above criteria during the period of 7/29/04 through 10/26/04. Upon request of above facility wound tracking on 10/26/04, interview with the infection control nurse/wound care nurse identified, she was behind on her tracking and completion of pressure ulcer documentation, but that she frequently (weekly) observed pressure ulcers and communicated with physician on a regular basis on the status of pressure ulcers. The ICN identified that unit staff nurses were responsible for completing required documentation of pressure ulcers and this information was part of the treatment administration record. Upon review of the treatment administration record, the only wound documentation found during the period of 7/29/04 through 10/26/04 included incomplete documentation in that they lacked the stage and/or length and/or width and/or depth, and/or undermining and/or tunneling and/or presence of drainage and/or odor and/or description and/or signature of the nurse completing the assessment. Interview with the Medical Director on 11/3/04 identified that recently the ICN did not provide him with weekly reports related to improvement or deterioration in pressure ulcers but had informed him verbally of the status of ulcers. Upon identifying to the administrative and corporate staff of the facility these above mentioned concerns, an action plan was submitted to the Department which identified that they would reassess all residents currently with pressure ulcers utilizing the facility's Weekly Wound Tracking Note. The facility further identified it would complete a facility wide audit of all residents to assure that weekly body audits are accurate and complete. The plan further identified that the ICN would submit a completed report each week to the DNS and corporate nurse to identify each resident with pressure ulcers. The ICN shall also submit a report to the Quality Assurance Committee on a monthly basis to include wound treatments, progress or deterioration in any pressure ulcers. The facility planned mandatory RN inservices on performing accurate assessments of pressure ulcers. the DNS, ADNS and Corporate Nurses will conduct weekly wounds rounds with supervisor to ensure appropriate treatment and documentation of wounds. Weekly skin committee meetings will also be held.
- f. Interview with the Infection Control Nurse on 10/27/04 identified upon inquiry that Resident #5 had hospital acquired "darkened blisters on heels". Resident #5 was admitted to the facility on 7/19/04 with atrial fibrillation, coronary artery

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

disease with bypass surgery and peripheral vascular disease. The MDS Assessment dated 9/10/04 identified that the resident required total care from staff for bed mobility, bathing and hygiene needs. The care plan dated 8/9/04 identified that the resident had bilateral lower extremity blisters (both heels) and that the resident was at risk for open areas. Interventions included to reposition the resident every two hours and observe for red/open areas. The care plan of 10/12/04 identified an open area on the right heel with treatment as ordered. Observation of Resident #5's heels on 10/28/04 (in afternoon) reflected that the resident lacked a dressing, as ordered to the right heel. Interview with the charge nurse (LPN #2) on 10/28/04 at approximately 3 PM identified that when the ICN wrote orders on 10/26/04 for treatments to the wound on the right lower leg and left heel the ICN did not write an order for treatment to the right heel. The resident lacked a treatment to the right heel for 10/26, 10/27 and upon interview with the charge nurse on the afternoon of 10/28/04 the nurse also identified that she witnessed the infection control nurse on 10/28/04 "squeeze" in a physician's order for a right heel dressing to the 10/26/04 physician's order making it seem like the order had been present and overlooked by the nursing staff. The nurse upon observation of the right heel identified that the heel pressure had an area of skin that looked "raw" and was 2.5cm by 2cm in size.

- g. In addition constant observation of Resident #5 on 10/28/04 between the period of 5:45 AM through 9:55 AM identified that the resident was sitting on his buttocks in a wheelchair with a tray in place and following the breakfast meal was placed on his back/buttocks in bed without the benefit of repositioning off his back/buttocks for four hours and fifty five minute. Interview with the night NA #3 identified that Resident #5 had been placed in the wheelchair t 5 AM on 10/28/04. Observation of the resident during care identified that the resident had a one cm round pressure ulcer on the left inner buttocks fold and another slit like crusted area 3/4 " long on the right buttocks. Interview with the nurse regarding the above pressure ulcer on the left inner buttocks fold identified that the order for this treatment was discontinued in error on 10/13/04. The resident lacked a treatment to this pressure ulcer during the period of 10/14/04 through 10/27/04 for thirteen (13) days.

In addition, upon request of the pressure ulcer tracking for Resident #5 no documentation was able to be produced on 10/28/04. On 11/2/04, a note identified that Resident #5 had (R) medial , L20x5w". This documentation was incomplete and failed to identify all open areas/pressure ulcers. Another

FACILITY: Health Center of Greater Waterbury

Page 11 of 16

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

document dated 10/14/04 identified skin tears but lacked documentation of pressure ulcers.

- h. Resident #4's diagnoses included polio with left foot drop, congestive heart failure, and dementia. The quarterly assessment dated 8/11/04 identified the resident was moderately cognitively impaired, independent for bed mobility and non-ambulatory. The assessment also indicated the resident was incontinent of bowel and bladder and free from pressure and/or stasis ulcers. The RCP dated 8/18/04 reflected the resident was at risk for developing "open areas" with approaches that included to turn and position every two hours. Nursing Narratives dated 9/12/04 identified treatment to the right heel tolerated well. The RCP dated 9/13/04 noted approaches that included to monitor for signs of infection, document weekly on the size of the area, and update the physician as needed. Nursing narratives and/or physician orders dated 9/14/04 indicated the right heel was assessed by the ICN (2 days later), the physician was notified (2 days later) and a treatment for the right heel was obtained that directed Accuzyme be applied to the necrotic tissue. The assessment lacked a description of the ulcer and the assessment had a hand drawn picture of the parameters of the wound. The physician's orders also directed a treatment to the left lateral foot. Nursing narratives dated 9/24/04 reflected the right heel was draining foul serous drainage and required evaluation by the ICN. Nursing narratives dated 9/24/04 to 9/27/04 failed to provide evidence that the wound was assessed by the ICN and or physician was notified of the foul drainage until 9/27/04 (3 days later). Physician orders dated 9/27/04 included treatments to the above-mentioned areas and also included a new treatment to the left heel. The resident was admitted to the hospital on 10/10/04 to 10/22/04 with a diagnosis of infected right heel ulcer that required debridement. Readmission orders and/or nursing narratives dated 10/22/04 included treatments to both feet and a protective dressing to the unopened coccyx area. Constant observation of the resident on 10/28/04 noted the resident in the bed, on her back, dressings to both feet, and without the benefit of repositioning from 5:45 AM to 9:10 AM (3 hours and 25 minutes). Interview with the RN # 5 on 10/28/04 at 11:30 AM noted the resident had not been able to reposition herself in bed since her return from the hospital. Review of the wound tracking sheets and/or Nursing narratives with the Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) on 10/28/04 at 11:50 AM and 12 PM failed to provide evidence that the right heel ulcer was consistently treated from 9/12/04 to 9/14/04 and/or monitored from 9/12/04 to 10/28/04. Further

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

review of the resident's clinical record on 10/28/04 failed to provide documentation that the resident's left heel ulcer and/ or left lateral foot ulcer were ever assessed to include measurements and/ or monitored consistently since their development.

- i. Resident #3 was admitted to the facility on 7/23/04 with diagnoses that included osteomyelitis and a stage four sacral pressure ulcer. The initial care plan dated 7/25/04 identified approaches that included to document the size of the pressure sore weekly, and inform the physician of the effectiveness of treatment. Initial wound documentation identified the wound measured 6.5 centimeters (CM) in length by 2.5cm in depth and had drainage and tunneling. The initial assessment failed to identify the characteristics of the drainage and/ or the measurement(s) of the tunneling present. Wound documentation identified the wound was measured on 8/2/04, 8/9/04 and 8/16/04 and were incomplete for drainage description and/ or were signed as performed by LPN # 3 and # 4. Documentation that the RN had assessed and documented the assessment of the wound during this time period could not be provided. The pressure sore was measured weekly by LPN # 3 and # 4 from 8/23/04 to 9/13/04. Although the pressure sore was noted to have increased in size to measure 6.4cm in length by 5.8cm in width on 9/13/04, evidence the wound had been assessed by the RN and/ or that the resident's physician had been notified could not be provided. The physician progress notes dated 10/4/04 identified there were no wound measurements found in the ulcer notes (last prior documentation was done by LPN #3 on 9/28/04 and did not include descriptions of the wound bed and/ or undermining). The Physician wrote an order on 10/4/04 directing the pressure sore be measured, and the treatment was changed on 10/5/04 to include the application of a debriding agent (Accuzyme) per the Resident's physician.
- j. Resident #1's diagnoses included quadriplegia, personality disorder, and a history of Methicillin Resistant Staphylococcus Aureus (MRSA) in the respiratory tract and in the skin ulcers. The Minimum Data Set (MDS) dated 6/2/04 identified the resident was cognitively intact, resisted care daily, and required total assistance for all care. The MDS also reflected the resident was incontinent of bowel daily and had multiple stasis and/ or pressure areas ranging from stage 1 to stage 3. The physician orders dated 6/8/04 directed treatments to the fingers and sacral pressure ulcer daily and every other day to the lower extremities. The RCP dated 6/10/04 indicated dressing changes would be done to the pressure ulcer on the sacrum on Monday, the fingers on Wednesday, and the lower extremities on Friday, all on the 11 PM to 7 AM shift and per the resident's agreement (not in

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

accordance with the physician's order). The RCP also noted to reposition the resident every two hours and as needed. Treatment Records from 6/1/04 to 10/11/04 identified that out of the 134 days the resident refused all but 1 (7/24/04) dressing change to the sacral pressure ulcer. Nursing Narratives dated 10/12/04 reflected the resident had maggots in the wounds and on the body and the stage 3 sacral ulcer had extended laterally to measure 10 centimeters (cm) in length, by 10.2 cm in width to 0.5cm in depth. Interview with RN # 1 on 10/28/04 identified that when the resident was incontinent of stool, up to three shifts would go by before the resident allowed staff to clean him. She further indicated stool would get on the sacral pressure ulcer dressing and the dressing would be covered with stool. Interview with Physician # 5 on 10/27/04 noted that Resident # 1 would lay in stool for up to a week before the resident would allow staff to provide incontinent care. Constant observation of the resident on 10/28/04 from 5:45 AM to 9:30 AM noted the resident's door closed and the NA assigned to care for Resident # 1 did not enter Resident # 1's room, nor attempt turning and repositioning and/ or to determine if incontinent care needed to be provided. On 10/28/04 interview with NA # 9 identified care was last provided to Resident # 1 at 2:30 AM. Interview with NA # 7 on 10/28/04 at 9:30AM noted that care was not provided to Resident # 1 from 6am to 9:30AM because the resident did not put on the call light. Although interview with the Corporate Nurse on 10/28/04 indicated that LPN#5 had inquired if the resident would allow care and/ or to be repositioned on 10/ 28/04, she noted the NA should have offered care per the resident's care plan as well.

- k. Resident #6 was admitted to the facility on 10/6/04 with seizure disorder, Neuroplegia, COPD (chronic obstructive pulmonary disease) and asthma. The admission assessment dated 10/6/04 was incomplete in the area of skin condition and lacked documentation of any wounds or skin conditions. An undated wound initial evaluation identified that Resident #6 had a 1.0cm open area on the mid back. This evaluation lacked staging of the area. A Duoderm treatment was applied to the back. The Admission MDS dated 10/18/04 identified the resident as cognitively impaired, having a stage 2 pressure ulcer, and requiring total care by staff for mobility, hygiene, and bathing. Upon inquiry of subsequent wound pressure ulcer assessments of this area, the facility was unable to produce documentation of assessments of this pressure ulcer during the period of 10/7/04 through 10/27/04, although the treatment record indicated the Duoderm had been changed every three days during this time frame .

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

- i. Constant observation of resident #6 on 10/28/04 during the period of 6:10 AM through 10:02 AM revealed the resident to be in bed, lying on her back without the benefit of repositioning for three hours and fifty-two minutes (3 hrs 52 min).
- m. Resident #7 was admitted to the nursing home on 5/13/03. Resident diagnosis included pneumonia, depression, hypothyroidism, chronic renal failure, urinary tract infection and MRSA (methicillin resistant staph aureus). A review of the resident's clinical record identified that the resident had a stage two pressure ulcer of the left hip on 5/29/04. On 6/7/04, the pressure ulcer was a stage three. On 6/7/04, the pressure ulcer was a stage three. On 6/10/04, a debridement of the ulcer was performed and the pressure ulcer was subsequently identified as being a stage -4 pressure ulcer. A review documentation of the pressure ulcer noted the documentation was not complete to include size, and/or depth, and/or presence of tunneling, and/or odor, and/or color, and/or drainage and/or signature of the person performing the pressure ulcer assessment. On 9/28/04 the pressure ulcer assessment identified that there was a foul odor and a large amount of drainage. On 10/7/04, there was also documentation of a foul odor and on 10/8/04 a new physician's order for wound care was identified. Interview with MD # 1 on 11/3/04 identified that he did not recall being informed on 9/28/04 of the odor and drainage.
- n. Resident # 8's diagnoses included Diabetes Mellitus, obesity, hypertension, and Alzheimer's Dementia. Physician orders dated 3/22/04 directed to cleanse the left heel with normal saline followed by a dressing every day. Although wound documentation records dated 4/15/04 identified the resident had a stage 1 pressure area to the left heel, a complete assessment of the pressure ulcer was not performed. Subsequent weekly monitoring of the resident's left heel could not be provided from 4/16/04 to 9/12/04 despite the continuation of the above daily treatment to the area. R #8 was hospitalized on 9/12/04 for pneumonia and returned to the facility on 9/15/04. The Nursing Narratives dated 9/15/04 identified the resident had a purple area to the left heel, the ICN was notified and "saw" the resident. The RCP dated 9/16/04 noted dry bulky dressings to the heels every other day, monitor the heels, elevate the heels, and update the physician as needed. Treatment records from 9/15/04 to 10/28/04 reflected the resident's left heel was treated daily with the above mentioned treatment order. Physician orders dated 10/29/04 directed a new treatment to the left heel every shift (skin prep). Physician orders dated 11/1/04 directed bacitracin to the area of eschar on the left heel and skin prep to the surrounding skin. Subsequent to an immediate facility action plan, the resident's left heel was assessed by the Corporate Nurse on

FACILITY: Health Center of Greater Waterbury

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

11/2/04 and documented as a 2.2cm in length by 2cm in width stage 4-pressure ulcer. Physician orders dated 11/3/04 directed to change the resident's left heel treatment to normal saline followed by a debriding agent (accuzyme) and a dressing twice a day. Observation of the resident's left heel with the ADON on 11/5/04 noted the resident's left heel to have an area of dark tissue resembling a dried blood blister with an area of surrounding, light redness. Interview with the ADON on 11/5/04 failed to provide documentation that the resident's left heel had been consistently monitored and/ or assessed until 11/2/04.

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

7. Based on a review of facility documentation, and interviews, the facility failed to maintain an infection control program to include a consistent record of infections, staff surveillance of infection control practices, and quarterly meetings to include dietary, housekeeping and maintenance staff. The findings include:
 - a. On 10/28/04 the facility was asked to provide a list of residents with current infections to include the onset date and type of infection, organism identified, and treatment ordered. The facility was also asked to provide a list of resident's who had a history or current infection with a highly resistive organism (MRSA and/or Vancomycin Resistant Enterococcus- VRE), quarterly infection control meeting minutes, and staff surveillance of compliance with infection control practices. The following was observed: infection logs regarding residents with infection could not be provided from 8/1/04 to 10/27/04, a current list of residents with a history or current infection with MRSA and/or VRE could not be provided, although environmental infection control rounds were conducted, staff surveillance of compliance to infection control policies were not provided, and although quarterly infection control meetings were held, they did not include the presence of the dietary, housekeeping and/or maintenance departments. Interview with the Infection Control Nurse (ICN) on 10/28/ 04 at 12:15PM noted she was behind on her infection control duties. Interview with the Corporate Nurse on 10/28/04 at 3:10PM reflected she never questioned the ICN because she always seemed to have the answers during morning report. Subsequently, on 10/28/04 the facility assessed all residents in the facility and compiled a list of residents with infections, and supplied a record of the necessary infection control meetings. An action plan was also submitted by the facility on 10/28/04 to include immediate

FACILITY: Health Center of Greater Waterbury

Page 16 of 16

DATES OF VISIT: October 8, 26, 27, 28 and November 5, 2004

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

reassignment of infection control responsibilities to the Corporate Nurse, solicitation by the facility for candidates to fill the ICN position, staff in servicing on the policy regarding the infection communication sheet, and the presentation of facility infections and trends at the quarterly quality assurance meetings during morning report. Subsequently, on 10/28/04 the facility assessed all residents in the facility .

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

8. Resident #2 had physician orders for treatments to multiple pressure ulcers. A review of the October 2004 treatment Kardex identified that there was no documentation on 10/26/04 to indicate that a nurse performed physician ordered treatments to pressure ulcers on both heels.
In addition on 10/10 and 10/11/04 (evening shift) there lacked documentation that the heel treatments were done. On 10/6, 10/7, 10/9 and 10/10/04 there lacked documentation that documentation that a Hydrotera-Blue treatment was done as physician ordered on the left heel.

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