

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

IN RE: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
d/b/a Northbridge Healthcare Center
2875 Main Street
Bridgeport, CT 06606

CONSENT ORDER

WHEREAS, Northbridge Healthcare Center, Inc. of Bridgeport, CT. ("Licensee"), has been issued License No.2183-C to operate a Chronic and Convalescent Nursing Home under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on September 13, 14, 15 and 16, 2004; and

WHEREAS, the Department during the course of the aforementioned inspections identified alleged violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated November 5, 2004 (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 of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Director, and the Licensee, acting herein through Larry Santilli, its President, hereby stipulate and agree as follows:

1. In accordance with Connecticut General Statutes Section 19a-494(a)(5), the Department hereby places the license of Northbridge Health Care Center, Inc. of Bridgeport, CT. on probation for failure to comply with the stated requirements of the Regulations of Connecticut State Agencies for a period of two (2) years and subject to the requirements of this Consent Order.
2. The Licensee shall continue to contract with a registered nurse acceptable to the Department to serve as an Independent Nurse Consultant (INC). Based on the requirements of this Consent Order, the following shall be implemented:
 - a. The Licensee shall continue to contract, at its own expense, with a registered nurse acceptable to the Department to serve as an INC until such time as the Department identifies that the Facility is able to maintain continued compliance with the Regulations of Connecticut State Agencies and federal and state laws and regulations. The terms of the contract effected with the INC shall include all pertinent provisions contained in this Consent Order and provisions addressed in the Consent Order effected with the Licensee on September 9, 2003 (Exhibit B) unless otherwise stipulated in this document.
 - b. The INC shall be at the Facility thirty-two (32) hours per week. The Licensee may petition the Department to reduce the hours of service of the INC at the end of four (4) months. The duties of the INC may be fulfilled by more than one (1) individual upon approval by the Department. The Department may, in its discretion at any time or from time to time, reduce the INC's responsibilities and hours, if, in the Department's view, the reduction is warranted.
 - c. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation. The INC shall submit written weekly reports to the Department and Licensee identifying the Licensee'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 Licensee's response to implementation of said recommendations. Copies of the reports shall be provided to the Licensee. The INC's position shall be occupied and the duties of the INC shall be performed by a single individual unless otherwise approved by the Department. The INC shall confer with the Licensee's Administrator, Director of Nursing Services and other staff as the INC 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 Licensee's Administrator, Director of Nursing Services and the Licensee for improvement in the delivery of assessment and Resident Care Planning. The INC shall have a fiduciary responsibility to the Department.

- d. The INC shall make recommendations as necessary to ensure the Facility's conformance with applicable federal and state statutes and regulations. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department shall make a final determination which, during the term of this Consent Order shall be binding on the Licensee.
- e. The INC shall have the responsibility for assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on resident assessment and care planning.
- f. The INC shall review the violation letter dated November 5, 2004 and assume responsibility for monitoring, educating and evaluating the Facility's plan of correction.
- g. The INC shall implement the Department's Guidelines for INCs (Exhibit C).

3. The INC, the Licensee's Administrator, the Director of Nursing Services, and the Licensee or a designee of the Governing Authority shall meet with the Department every four (4) weeks after the effective date of this Consent Order during the tenure of the INC to discuss issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.
4. 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.
5. Within fourteen (14) days of the execution of this document, the Licensee shall:
 - a. Employ a qualified Infection Control Nurse (ICN) for no less than thirty-two (32) hours per week. Said ICN shall have credentials pertinent to infection control beyond those attained in the course of education as a registered nurse. Should the current ICN not have the credentials specified, he/she shall enroll in a program within the next nine (9) months. Until such time that the ICN completes an infection control program he/she shall have eight (8) hours of oversight by a registered nurse or other practitioners with credentials in infection control. Said Infection Control Consultant shall inservice, monitor and remediate staff regarding infection control and provide weekly reports to the Administrator, DNS, Licensee and the INC.
 - b. Contract with one (1) or more individuals with credentials in wound care (e.g. A.P.R.N. or R.N.) to consult with the Facility regarding wound care, make recommendations, inservice staff, observe patient wounds and, as applicable, document in medical records. Said consultant(s) shall work no less than eighteen (18) hours per week.

6. The Licensee shall within seven (7) days of the execution of this Consent Order designate an individual within the Facility who shall have responsibility for the full implementation of the components of this Consent Order.
7. The Licensee shall establish in-service programs within thirty (30) days of the execution of this Consent Order to include all topics set forth in this document.
8. Within forty-five (45) days of the execution of this Consent Order, the Licensee shall review its Quality Assurance Program and implement mechanisms that will review and evaluate staff performance, resident responses to care and services, infection control policies/procedures, tracking of pressure ulcers and educational needs of the staff.
9. The individual assigned to oversee the implementation of the requirements of this document shall submit monthly reports to the Department regarding the implementation of the Consent Order components and shall meet with a Department representative every month for the first six (6) months and every three (3) months thereafter for the duration of the Consent Order.
10. The provisions of this Consent Order, shall remain in effect for a period of two (2) years from the effective date of this document provided that the Department is satisfied that the Licensee has maintained substantial compliance with applicable State and Federal and regulations.
11. The Licensee shall pay a monetary fine of twenty-four thousand dollars (\$24,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The check shall be made payable to the Treasurer of the State of Connecticut.
12. The monetary fine and any other reports required by this document shall be directed to:

Lori Griffin, RN, Supervising Nurse Consultant,
Department of Public Health,
Division of Health Systems Regulation
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

13. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
14. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Order in the event the Licensee fails to comply with its terms.

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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.

NORTHBRIDGE HEALTHCARE CENTER, INC.
OF BRIDGEPORT, CT. - LICENSEE

1/27/2005
Date

By: [Signature]
Larry Santilli, President

State of Connecticut)
County of Hartford

ss Southington 1/31 2005

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

My Commission Expires: 12/31/05

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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/02/2005
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 13

November 5, 2004

Deborah Schmidt, Administrator
Northbridge Healthcare Center
2875 Main Street
Bridgeport, CT 06606

Dear Ms. Schmidt:

Unannounced visits were made to Northbridge Healthcare Center on September 13, 14, 15 and 16, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a licensure and certification inspection and multiple investigations.

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 for November 23, 2004 at 1:30 PM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Room E, Hartford, Connecticut.

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

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

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

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

Respectfully,

Barbara Cass, R.N.,
Supervising Nurse Consultant
Division of Health Systems Regulation

BSC/LMF/jf

c: Director of Nurses
Medical Director
President
vlnbridgehcctrvlr.doc
#3058; #2993



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

FACILITY: Northbridge Healthcare Center

Page 2 of 18

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

1. Based on observation and interview, the facility failed to proximately display the most recent survey results in an easily accessible location. The findings include:
 - a. On 9/16/04 during tour of the facility, posted notices located on the nursing units announced that the latest survey results were located at the reception desk. Observation on 9/16/04 at 1:45 PM, identified that the most recent survey results were not visible at the reception desk. During an interview with the receptionist at that time, she noted that the results were located in a binder behind the desk; therefore the binder would have to be requested. The survey binder was noted to have on its cover a statement which read, "The administrator must be called when a visitor asks to see this book. Please ask the administrator, Director of Nursing Services, Assistant Director of Nursing Services or Supervisor to review this book with the visitor. Please update the log-in sheet inside the binder when the book is reviewed." During an interview with the Administrator on 9/16/04 at 1:50PM, she confirmed that survey results are made available in the previously stated manner. Following surveyor inquiry, the administrator said she would remove the survey binder cover statement and post surveys in a visible, easily accessible location.

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

2. Based on clinical record reviews, observation and interview for one of three sampled residents with restraints (Resident #8), the facility failed to provide documentation that a complete restraint assessment had been completed prior to initiating the restraint and/or that restraint reduction had been considered and/or attempted. The findings include:
 - a. Resident # 8's diagnoses included dementia, degenerative joint disease, and the resident was identified as legally blind. A Minimum Data Set (MDS) dated 8/19/04 identified short and long term memory problems, impaired cognition, and that the resident was totally dependent on staff for all Activities of Daily Living (ADL). The MDS assessment also identified that restraints and/or devices were not utilized. A care plan dated 8/30/04 reflected the utilization of two siderails for assistance with turning and positioning and that the resident was out of bed to wheel-chair with a tray table. Observations from 9/13/04 through 9/16/04 identified that the resident had two full siderails while in bed and the utilization of a tray table while in the geri-chair. Although an incomplete restraint assessment was identified in the clinical record, interview and further review of the clinical record on 9/16/04 with the Assistant Director of Nursing and the Director of Nursing failed to provide documentation that a complete restraint assessment had been completed prior to utilizing a restraint and/or that restraint reduction had been considered.

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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The above is a violation of the Connecticut General Statutes Section 19a-550 and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H).

3. Based on clinical record review, observation, and interview for 1 of 1 sampled residents who utilized an electric wheel chair and/or who had minimal movement of the upper extremities (Resident #2), the facility failed to ensure that the resident's specific needs were accommodated. The findings include:
 - a. Resident #2's diagnoses included multiple sclerosis. An assessment dated 7/28/04 identified that the resident was cognitively intact, totally dependent on staff for all Activities of Daily Living (ADL), and had full loss of range of motion on both sides of the upper and lower extremities. A Resident Care Plan (RCP) dated 8/10/04 identified a problem of impaired mobility with an intervention that included an electric customized wheel chair for self-mobility using a puff system. Observation on 9/13/04 at 2:25PM identified the resident in bed attempting to activate the call bell system however the resident was unable to move his fingers to press the call bell. Further observation identified the resident attempting to put the call bell in his mouth to bit down on the call button in an effort to activate the call bell system. Additional observation on 9/14/04 at 10:15AM identified that Resident #2 was lying in a recliner chair in front of his room and not in the customized electric wheel chair in accordance with the plan of care. During an interview with the Director of Nursing on 9/13/04 at 3:00 PM, she stated that she was aware that the resident had a decline since his last hospitalization and a new call bell was on back order. Further interview noted that no other intervention have been put in place in the interim to accommodate the resident's upper extremity weakness. Subsequent to surveyor inquiry a touch sensitive call bell was provided to the resident to be utilized under the chin area. During an interview with the charge nurse on 9/14/04 at 10:30AM, she stated that the evening staff did not charge the electric wheel chair on 9/13/04 and consequently it could not be utilized on 9/14/04

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

4. Based on clinical record review, observation, and interview, for one of one sampled resident with a catheter (Resident #13), the facility failed to ensure that resident equipment was maintained in a sanitary manner. The findings include:

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- a. Resident #13 was admitted with diagnoses inclusive of multiple sclerosis with paraplegia, chronic urinary track infections, and colonized Methicillin resistant Staph aureus. A significant change of condition assessment dated 7/20/04 identified that the resident had no cognitive impairment, was totally dependent on staff for Activities of Daily Living (ADL), and had a supra-pubic catheter. A Resident Care Plan (RCP) dated 7/20/04 identified the utilization of a supra-pubic catheter and potential for urinary track infections. Observations on 9/13/04 at 12:55PM, 9/14/04 at 3:00PM, and 9/16/04 at 8:45AM identified that the resident's privacy cover for the supra-pubic catheter drainage bag was observed to be soiled with streaks of white dried material. During an interview with the Infection Control Nurse on 9/16/04 at 8:45AM, she stated that additional covers were available and she would replace the soiled one.

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

5. Based on clinical record review and interviews for one of seven sampled residents who had a diagnosis of diabetes mellitus (Resident #18), the facility failed to ensure that assessments were conducted in accordance with professional standards of care. The findings included:
 - a. Resident #18 's diagnoses included diabetes mellitus. An admission assessment dated 8/11/04 identified that the resident was moderately cognitively impaired and required supervision with meals. A Resident Care Plan (RCP) dated 7/28/04 identified a potential for hypoglycemia and hyperglycemia with interventions which included to provide accuchecks four times a day, give prescribed medication as ordered, and observe for signs of hyper and hypoglycemia. Physician orders dated 8/19/04 directed to provide accucheck blood sugars before meals and at hour of sleep and give Lantus insulin 45 units subcutaneously at 9pm. Further orders directed to administer Humulog insulin per the sliding scale for blood sugar coverage. Nurse's notes dated 8/31/04 identified that the resident's blood sugar at 4:30PM was noted to be 42 mg/dl. The physician was notified and directed that Glucagon be administered and continue to monitor. Further review identified that the blood sugar result at 9:00PM was 276 mg/dl and required Humulog 8 units subcutaneously per the sliding scale. The medication administration record identified that Lantus insulin 45 units was administered at 9:00PM. A subsequent nursing note dated 9/1/04 identified that the resident was found unresponsive at 5:00AM with a blood sugar result of 40mg/dl. The resident was given medication but remained unresponsive and was transferred to the hospital. Review of the

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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clinical record failed to identify any further monitoring for signs and symptoms of hyperglycemia and/or hypoglycemia assessment subsequent to obtaining a blood glucose of 276 mg/dl until the resident was found unresponsive on 9/1/04 at 5:00AM. During an interview with the Director of Nursing on 9/21/04, she stated that there is no policy to monitor blood sugars except when the physician orders it, however the facility is working on a policy that is specific. According to Foundations of Nursing, Mosby, Second Edition, copyright 1995 (pages 976-977), The patient who is receiving Insulin should be watched very carefully for the development of hypoglycemia especially when the particular kind of Insulin is at it's peak time.

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).

6. Based on clinical record review and interview for one sampled resident who had a diagnosis of Methicillin Resistant Staph Aureus (MRSA) (Resident #21), the facility failed to ensure that a wound culture and sensitivity was obtained in accordance with physician orders. The findings include:
 - a. Resident #21 was admitted with diagnoses inclusive of respiratory failure, persistent vegetative state, anoxic encephalopathy, and bilateral popliteal tendon release. An initial assessment dated 5/18/04 identified a persistent vegetative state, full loss of functional range of motion in bilateral arms, hands leg, and feet, and without pressure ulcers. A Resident Care Plan (RCP) dated 5/20/04 identified a problem of bilateral hand and knee contractures. Physician order's dated 5/21/04 ordered an immediate culture and sensitivity of a left popliteal wound. A subsequent physician order dated 5/22/04 directed that a re-culture of the wound be obtained in fourteen (14) days on 6/5/04. Although a culture and sensitivity report of the left popliteal wound dated 5/25/04 identified the presence of MRSA in the wound, review of the clinical record with the licensed nurse failed to identify that a re-culture had been obtained on 6/5/04 in accordance with physician orders.

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

7. Based on clinical record reviews, observation, and interview for three of twelve sampled residents who were incontinent (Residents #33, #34, and #35), the facility failed to provide incontinent care in accordance with the policy and procedure. The findings include:

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- a. Resident #33's assessment dated 7/13/04 identified that the resident had a short-term memory problem, total dependence on staff for hygiene, and incontinence of bowel and bladder functions. A Resident Care Plan (RCP) dated 8/10/04 identified that the resident was incontinent of bowel with interventions that included to provide perineal care after each incontinent episode. Observation on 9/16/04 at 5:45AM noted that the resident was provided incontinent care with soap and water but without the benefit of rinsing. The nurse aide was also observed to provide perineal care washing the resident in a back to front direction.
- b. Resident # 34 's annual assessment dated 7/29/04 identified that the resident was severely cognitively impaired, totally dependent on staff for hygiene, and incontinent of bowel and bladder. A RCP dated 8/10/04 identified a problem of bladder and bowel incontinence with interventions which included to provide perineal care after each incontinence episode. Observation on 9/16/04 at 5:00AM noted the resident was incontinent of a large amount of urine and stool. The nurse aide was noted to wash the resident with soap and water but without the benefit of rinsing.
- c. Resident #35's quarterly assessment dated 6/22/04 identified that the resident was severely cognitively impaired, totally dependent on staff for hygiene, and incontinent of bowel and bladder. A RCP dated 7/21/04 identified a problem of bowel and bladder incontinence with interventions that included to provide incontinent care every two hours. Observation on 9/16/04 at 5:25AM noted that the resident was saturated with a large amount of urine. The nurse aide was noted to wash the resident with soap and water but was not provided with the benefit of rinsing.

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).

8. Based on clinical record reviews, observations and interviews for thirteen of fifteen sampled residents with pressure sores and/or recent history of healed pressure sores (Residents #2, #10, #11, #12, #13, #18, #20, #21, #23, 24, #26, #27 and #30, the facility failed to ensure that the wounds were assessed at least weekly, that resident's were repositioned at least every two hours, and that incontinent care was provided appropriately. The findings include:
 - a. Resident #2 's diagnoses included urosepsis and progressive multiple sclerosis. A quarterly assessment dated 5/11/04 identified that the resident was cognitively intact, resistive to care at times, incontinent, and totally dependent on staff for bed mobility and transfers. The assessment further identified that the resident had a

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

Stage II pressure ulcer. Review of weekly pressure sore reports dated 6/16/04 identified a Stage IV pressure sore of the right gluteal fold. A Resident Care Plan (RCP) dated 8/10/04 identified a problem of impaired mobility and actual skin breakdown to the right gluteal folds. Interventions included a 24 hour positioning plan for the custom wheelchair, turn and reposition every two hours, and if refuses leave room and try again. A subsequent weekly pressure report dated 9/8/04 identified a Stage IV on the right gluteal fold that measured 1.6cm by .8 with 1.6 cm of depth. Observation on 9/14/04 from 10:15 AM to 12:55 PM (two hours and forty minutes) noted the resident laying in a recliner chair. Interview with the Nurse Aide on 9/14/04 at 1:00 PM noted that the resident had been in the recliner chair since 9:15 AM and returned to bed at 1:00 PM (three hours and forty five minutes). She further stated that the resident was repositioned at 11:30 AM by "pulling him up under his arms in the chair". Interview and review of the 24 hour positioning plan with the Physical Therapy Manager on 9/16/04 at 10:15 AM noted she was not aware of the stage IV pressure sore and did not revise the positioning plan which had the resident out of bed from 8:00 AM to 2:00 PM and 4:00 PM to 9:00PM.

- b. Resident #10 was admitted with diagnoses of fractured humerus, coronary artery disease, and congestive heart disease. A Minimum Data Set (MDS) dated 8/24/04 identified no cognitive impairment.
 - i. An admission assessment dated 8/8/04 revealed that the resident had a 3cm x 1cm open area on the right posterior thigh. A skin assessment dated 8/12/04 identified that the resident was a high risk for pressure sore development. Constant observation on 9/16/04 from 5:30AM to 8:30AM (three hours) identified the resident on her back without the benefit of repositioning. Although the admission assessment identified an open area on the right posterior thigh on 8/8/04, review of the clinical record and interview with the Assistant Director of Nursing on 9/16/04 at 10:30AM identified that wound monitoring and/or tracking had not begun until 9/9/04 (thirty one days later). Further review identified that care-planning interventions had not been developed to address the impaired skin integrity.
 - ii. An MDS assessment dated 8/24/04 indicated that the resident was usually continent of urine, was an assist of one for hygiene, and an assist of two for toileting. Observation on 9/16/04 at 5:10AM identified the resident crying out for assistance. The Nurse Aide proceeded with providing incontinent care. The perineum was washed with water and soap and dried without the benefit of rinsing. During an interview with the Nurse Aide on 9/16/04 at 5:30AM, she

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- indicated that she was aware of the correct procedure for incontinent care, but realized she had not followed the procedure as she had been instructed.
- c. Resident #11's diagnoses included dementia with agitation, Cerebral Vascular Accident (CVA) and hypertension. An annual assessment dated 7/20/04 identified the resident as severely cognitively impaired and totally dependent on facility staff for Activities of Daily Living (ADL). It further identified that the resident had a Stage I pressure ulcer. A RCP dated 8/17/04 identified a problem with impaired physical mobility related to a diagnosis of CVA and potential for skin breakdown. Interventions included tilt Custom Wheel Chair (CWC) every two hours. Physician orders dated 8/26/04 directed the application of a Duoderm dressing to the resident's left buttock for protection and changing of the dressing every three days and as necessary. Review of facility documentation noted a stage I pressure ulcer on the left buttock that was identified as healed on 8/2/04. A subsequent RCP dated 9/14/04 identified that the resident had a new Stage II pressure ulcer located on the left buttock that measured 2.0 cm by 3.0 cm. Interventions included turn and reposition every two hours. Continuous observation on 9/16/04 from 5:45AM through 8:45AM (three hours) identified the resident laying in bed supine without the benefit of repositioning.
- d. Resident #12's diagnoses included osteoarthritis, cystitis, and ulcerative colitis. A Minimum Data Set (MDS) assessment dated 1/22/04 identified no cognitive impairment, that the resident was totally dependent on staff for all Activities of Daily Living (ADL), was incontinent of stool, and had a foley catheter. Nurses notes dated 4/10/04 identified open areas on both calves. The physician was notified and a treatment was ordered. A Resident Care Plan (RCP) dated 4/26/04 directed wound measurement every week, repositioning every two hours, and also identified that the resident was refusing to get out of bed. Intermittent observations from 9/13/04 through 9/16/04 identified Resident # 12 on his back; on a pressure reducing mattress with both calves resting on a pillow. Observation and review of facility documentation on 9/14/04 identified three, Stage III, pressure sores on the resident's calves with measurements as follows: right calf: #1: 12 centimeters (cm) by 3 cm, right calf #2: 2cm by 2.5cm with foul smelling drainage, and the left calf pressure sore measured 3cm by 3cm. Constant observation on 9/16/04 from 5:00AM to 8:30AM (three hours and thirty minutes) identified the resident on his back without any attempt to reposition his legs. Interview and review of the clinical record with the Infection Control Nurse and the Assistant Director of Nursing on 9/15/04 identified that there were no strategies attempted or care plan revisions to address the pressure sores and non-compliance with positioning and/or failed to identify that the pressure sores had been consistently monitored and/or assessed.

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

- e. Resident #13's diagnoses included multiple sclerosis with paraplegia, chronic urinary track infections, and colonized methycillin resistant staphylococcus aureus. A significant change of condition assessment dated 7/20/04 identified that the resident had no cognitive impairment, was totally dependent on staff for bed mobility, transfers, and personal hygiene, and had 3, stage 2 pressure ulcers. A RCP dated 7/20/04 identified problems of impaired mobility, actual skin breakdown, and a potential for adverse effects of immobility related to the resident refusing to get out of bed. Interventions included to turn and position every 2 hours, document the appearance of impaired skin integrity sites weekly, and to notify the medical doctor of the resident's refusals to interventions. Physician order's dated 7/1/04 directed treatment to the right buttock and coccyx area including cleansing with normal saline and application of Safe Gel and a Duoderm dressing. Review of facility pressure sore reports from 7/1/04 to 7/15/04 failed to provide evidence that the pressure areas were assessed and monitored at least weekly. Weekly pressure sore reports dated 9/2/04 and 9/9/04 identified 4, stage II pressure ulcers on the right buttock and coccyx. Observation on 9/16/04 from 5:16 AM to 8:40 AM, (3 hours and 24 minutes) identified the resident lying supine in bed with the head of the bed raised to a 45 degree angle without the benefit of a position change. During an interview with the 11:00 PM to 7:00 AM nurse aide on 9/16/04 at 6:58 AM, she indicated that although the resident's position is changed, they don't usually do anything for her because the resident has a colostomy and a foley catheter. Following surveyor interventions and inquiry at 8:4 AM with the Director of Nurses; the nurse aide and licensed staff reported that the resident refused, and has a history of refusing to turn and position in bed; and to get out of bed. Nurses' notes and/or the RCP dated 9/6/04 to 9/14/04 failed to identify documentation that the resident had refused to turn and position in bed and/or to get out of bed.
- f. Resident #18 was admitted to the facility on 7/28/04 and readmitted on 8/19/04 with diagnoses which included diabetes mellitus and cellulitis. An admission assessment dated 8/11/04 identified that the resident was moderately cognitively impaired, totally dependent on staff for transfers, required extensive assistance with bed mobility, and incontinence of bowel and bladder. The assessment further indicated a Stage I and Stage II pressure ulcers. A RCP dated 8/11/04 identified a problem with skin integrity with interventions that included pressure relieving device to the bed, monitor the healing progress or lack of and contact the physician for condition update, treatment change as needed and turn and position every two hours. A nursing re-admission assessment dated 8/19/04 identified a scab on the right heel, which measured 1cm by 4cm. Physician order's dated 8/19/04 directed

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- to apply skin prep to the right heel every shift and to use heel boots in bed. Review of a weekly pressure sore report dated 8/31/04 failed to document any description of the right heel scab. Although the resident was admitted to the hospital on 9/1/04 and re-admitted to the facility on 9/6/04, no documented monitoring of the right heel was noted until 9/15/04 upon surveyor inquiry. The weekly pressure sore report dated 9/15/04 documented a 2cm by 1.5cm reddened heel with a blackened area which measured 1cm by 0.5cm and a scabbed area which measured 1cm by 0.75cm. Interview and review of the clinical record with the Charge Nurse on 9/15/04 at 12:00PM failed to provide evidence that weekly pressure sore monitoring of the right heel was done. Review of the clinical record identified that the resident had a history of a Stage II pressure ulcer on the coccyx on 8/8/04 which subsequently healed on 8/31/04. Weekly pressure sore reports dated 9/15/04 identified a Stage II pressure ulcer on the coccyx which measured 0.5 cm x .75 cm. Intermittent observation of the resident in bed on 9/16/04 from 5:17AM until 8:40AM, (total of 3hours and 25 minutes), identified the resident laying on her back with the head of the bed elevated. Interview with the Nurse Aide on 9/16/04 noted that although she stated she attempted to try to turn her a little, no relief off the coccyx was noted.
- g. Resident #20s diagnoses included congestive heart failure with exacerbation, type 2 diabetes mellitus, bilateral leg cellulitis, shortness of breath, and anemia. A nursing admission assessment dated 8/11/04 identified a 1.0cm x 1.0cm, stage 2 pressure ulcer of the right buttock. Physician order's dated 8/12/04 identified a treatment for the bilateral lower leg cellulitis, but did not address the stage 2 open area of the right buttock. A weekly pressure sore report dated 8/14/04 identified a stage 2 area of the right gluteal fold which measured 2.0 cm x 2.0 cm. On 9/15/04 at 10:10AM during an interview and review of the clinical record with the Infection Control Nurse: the doctors orders, treatment kardexes, nursing notes, wound pressure monitoring reports, and the resident care plans; all failed to provide documentation that the 8/11/04 stage 2 open area of 1.0cm x 1.0 cm of the right buttock had been assessed, treated or monitored until 8/14/04 when the area was assessed to be a stage 2 open area of 2.0cm x 2.0cm. In addition, the resident was intermittently observed on 9/13/04 and 9/14/04 reclining in bed on a regular mattress. During an interview on 9/14/04 at 4:45 PM and review of the mattress, the licensed staff identified that it was a regular (green) non-pressure reducing mattress. On 9/15/04 at 8:40 AM the resident's bed was noted to have a pressure reducing mattress. During an interview on 9/15/04 at 2:30PM the licensed staff noted that the resident's mattress had been replaced with a pressure reducing mattress

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- h. Resident #21's diagnoses included respiratory failure, persistent vegetative state, and anoxic encephalopathy. An initial assessment dated 5/10/04 identified the persistent vegetative state and full loss of functional range of motion in bilateral arms, hands, leg and knee contractures. A RCP dated 5/20/04 identified a problem of hand and knee contractures. Interventions included the use of palm guards under the hands and to monitor for evidence of complications of the contractures. The twenty-four hour nursing report dated 7/20/04, 7-3, identified that the physician was called to obtain treatment for an excoriation on the left palm. Multiple physician orders dated 7/20/04, 8/11/04, 9/2/04, and 9/8/04 directed treatment to the left palm to include in part Bacitracin to the left palm and the open area on the finger and palmer guards to bilateral hands at all times. Observation on 9/13, 9/14, 9/15, and 9/16/04 identified that the resident was utilizing palmer guards along with a mitt covering the left hand. On 9/16/04 at 8:15AM observation of the left palm identified that the fingers were severely flexed into the palm, so much so that the middle finger, distal joint was flexed back on itself with the skin at the joint creased. The skin in the left palm was noted to be beefy red over the breadth of the palm. During an interview with the Infection Control Nurse on 9/15/04 at 10:50AM, she stated that the staffs vary in ability to extend the resident's fingers to assess the palm. In addition, the Infection Control Nurse was unable to provide documentation that the resident's left palm and finger had been assessed and monitored weekly from 7/20/04 through 9/9/04. Interview and review of the clinical record with licensed staff on 9/16/04 at 12:25PM identified that the RCP lacked interventions and/or approaches to monitor the resident's bilateral palms.
- i. Resident #23's diagnoses include bilateral chronic rotator cuff tears, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). An annual assessment dated 7/28/04 identified the resident as cognitively intact and totally dependent on staff for Activities of Daily Living (ADL) including bed mobility. A Resident Care Plan (RCP) dated 8/4/04 identified a problem with a potential for skin breakdown. Interventions included provision of thorough perineal care after each incontinent episode and to turn and reposition every two (2) hours. Review of facility documentation noted that a stage two (2) pressure sore had healed on 9/9/04. Continuous observation on 9/16/04 from 5:10 AM to 8:10 AM (three hours) identified the resident in bed on her back without the benefit of repositioning. Interview and review of the Resident Care Plan (RCP) and clinical record with the Nursing Supervisor and Unit Nurse on 9/16/04 at 8:25AM identified that although the care plan addressed a problem with skin integrity, it did not address the resident's refusals to reposition and/or education related to the implications of not repositioning. Subsequent review of facility documentation

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- 9/16/04 identified a reopening of a stage two (2) pressure ulcer measuring 2 cm x 1cm. It further identified a physician treatment order for the newly opened area.
- j. Resident #24's diagnoses included dementia and depression. A quarterly assessment dated 12/3/03 identified the resident as cognitively impaired and totally dependent on staff for Activities of Daily Living (ADL) including bed mobility, and the presence of two (2), stage two (2) pressure ulcers. A resident care plan dated 12/10/03 identified a problem with a potential for skin breakdown. Interventions included provisions for thorough perineal care after each incontinent episode, encourage the resident to turn and reposition in bed, follow (2) hour positioning plan, and weekly body checks. Review of facility documentation dated 12/03 through 5/04 identified the presence of two (2) stage (2) two pressure sores on the resident's right buttock, a stage one (1) on the coccyx and a stage two (2) on the left buttock. Subsequent review of facility documentation with the Director of Nurses on 9/16/04 at 11:00 AM failed to provide evidence that the pressure sores had been assessed at least weekly.
- k. Resident #26's diagnoses include Parkinsons Disease, acute renal failure, and pulmonary embolism. An annual assessment dated 8/25/04 identified the resident as having difficulty with short-term memory, difficulty with new situations, and the presence of a stage two (2) pressure sore. It further identified that the resident required limited to total assistance from staff for Activities of Daily Living (ADL) including mobility. A Resident Care Plan (RCP) dated 9/2/04 identified a problem with a potential for skin breakdown and a stage two (2) pressure ulcer on the resident's left buttock. Interventions included measure weekly and to turn and reposition every two (2) hours. Review of facility documentation noted a stage two (2) pressure sore had healed on 9/1/04. Continuous observation of the resident on 9/15/04 from 10:00AM through 12:40PM (2 hours 40 minutes) identified that the resident had been sitting in wheel chair without the benefit of repositioning and/or a pressure-relieving device on his chair. Interview with the Charge Nurse on 9/15/04 at 1:00PM identified that new, stage two (2) pressure sores had been identified on the resident's right and left buttock. The left buttock pressure sore measured 1.0 cm x 0.8 cm. and the second left buttocks pressure sore measured 0.7 cm x 0.5 cm. Subsequent continuous observation on 9/16/04 from 5:12AM to 8:40AM identified the resident in bed, on his back without the benefit of turning and/or repositioning for (3 hours 28 minutes).
- l. Resident #27 was admitted with diagnoses of clostridium difficile, dehydration, and atrial fibrillation. An admission assessment dated 7/23/04 identified one, Stage 1 pressure area and one, Stage 2 pressure sore. A MDS assessment dated 8/5/04 identified that the resident required limited assistance with bed mobility and one,

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

stage II pressure ulcer. A Resident Care Plan (RCP) dated 8/9/04 identified a problem with impaired skin integrity. Interventions included relieving pressure on the coccyx and back every two hours. Wound monitoring and tracking was documented on 7/23/04, was incomplete on 8/16/04, and the wound was identified as healed on 8/30/04, and reappeared on 9/6/04. Constant observation on 9/16/04 from 5:00AM to 8:30AM (three hours and thirty minutes) revealed that the resident was not afforded a position change. At 7:00AM the resident was transferred out of bed to sit in a wheelchair without a pressure-relieving device. Observation on 9/16/04 at 1:00PM identified Duoderm on the mid-back over the bony prominence and Duoderm over the coccyx. Interview with the Assistant Director of Nursing on 9/16/04 at 11:30 identified that the wound tracking was not complete.

- m. Resident #30's diagnoses included bilateral amputation and Cerebral Vascular Accident (CVA). A quarterly assessment dated 7/6/04 identified that the resident had a memory deficit, was totally dependent of staff for bed mobility, and was frequently incontinent of bowel and bladder. A Resident Care Plan (RCP) dated 7/22/04 identified problems with impaired physical mobility and a potential for skin breakdown with interventions that included to turn and reposition every two hours and incontinent care every two hours. Review of the weekly pressure sore report, dated 8/27/04, identified that the resident had a Stage II pressure area on the right thigh that measured .05cm and was currently healed. Observation on 9/16/04 from 5:17AM until 8:20AM, (total of 2 hours and fifty seven minutes) noted the resident in bed positioned on her back. Further observation of incontinent care noted the nurse aide provided incontinent care with soap and water, however failed to rinse the resident's skin after the application of soap. Although observations identified that the resident had been positioned on her back for greater than two hours, interview and review of the clinical record and nurse aide documentation with the Director of Nursing on 9/16/04 at 6:00AM identified that the resident should have been repositioned earlier and that the nurse aide had coded the resident as being repositioned on her side during that time period.

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

9. Based on clinical record review and staff interview for one of four sampled residents who had a weight loss (Resident #20), the facility failed to ensure that the diet was provided in accordance with the plan of care. The findings include:

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- a. Resident #20 diagnoses included Congestive Heart Failure (CHF) with exacerbation, type II diabetes mellitus, bilateral leg cellulitis, anemia, and shortness of breath. An admission weight on 8/11/04 was documented as 139.2 pounds. A Registered Dietician assessment dated 8/19/04 identified a desirable body weight range of 144 to 176 pounds. A dietary assessment dated 9/2/04 identified a weight loss of 5.2 pounds, from 139.2 pounds to 134 pounds and recommended large entree portions. Observation of the evening meal on 9/14/04 and the afternoon meal on 9/15/04 identified that the resident received a regular portion size of the entree. The resident was observed to consume 100% of the food and fluids provided. During an interview with the Food Service Supervisor (FSS) on 9/16/04 at 9:15AM, he stated that the Registered Dietician's recommendation had been received by the dietary department however had not been implemented. Subsequent to surveyor inquiry the FSS identified that the diet had been corrected and the resident would be receiving large portions as of the afternoon meal.

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

10. Based on clinical record review, review of facility policy/procedure, and interview for one of three sampled residents with a diagnosis of dehydration (Resident #29), the facility failed to assess the resident and develop interventions to prevent the dehydration when the resident's intake of fluid was below the resident's estimated daily fluid needs. The findings include:
 - a. Resident #29's diagnoses included diabetes, stroke, congestive heart failure, and peripheral vascular disease. In addition, the resident had a hospital admission in April 2004 with diagnoses that included dehydration and renal failure. A quarterly assessment dated 7/6/04 identified that the resident was cognitively impaired, totally dependent on two staff for all mobility, and required assistance with eating. A Resident Care Plan (RCP) dated 7/22/04 identified a potential for dehydration with interventions that included monitoring intake and output, encouraging fluids, keeping physician and family updated, and to complete a dehydration assessment "quarterly". Although the dietitian's assessment dated 4/27/04 identified that the resident's fluid needs were 1,875 cc per day, the resident's September 2004 weight was noted as 203 pounds which calculates to an estimated fluid need of 2,306 cc-2,768cc. Review of intake and output records identified that from 9/1/04 through 9/8/04 the resident's daily intake ranged from 760 cc-1,240 cc. Nurse's notes on 9/6/04 and 9/7/04 noted that the resident ate poorly/refused meals and medications. The physician was notified on 9/7/04 on the evening shift and directed to continue

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

to encourage the resident to take fluids. On 9/8/04 the resident complained of an upset stomach and not feeling well and was transferred to the hospital for evaluation. The hospital discharge summary dated 9/15/04 identified that the resident was admitted with "extremely severe dehydration". Hospital laboratory data identified a BUN on admission of 122 (normal 6-20) and a creatinine of 3.5 (normal 0.9-1.3). The discharge summary identified that with intravenous hydration the resident's BUN and creatinine "quickly improved and the last BUN and creatinine was close to normal". Review of the clinical record with the Assistant Director of Nursing (ADNS) on 9/16/04 at 11:00AM failed to provide documentation that the resident was assessed for signs and symptoms of dehydration from 9/1-9/8/04 and/or that interventions to prevent dehydration had been initiated when the resident's fluid intakes were below estimated needs. The ADNS stated that the physician had refused to send the resident to the hospital for evaluation and that she had directed staff to send the resident when she assessed him and thought he was dehydrated.

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

11. Based on clinical record review, observations, and interview for three errors of forty-two medication administration opportunities for Resident #'s 25 and 31 with an error rate of 7.1%, the facility failed to ensure that the medications were administered in accordance with physician orders and appropriate procedures. The findings include:
 - a. Resident #25's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), irregular heartbeat, Peripheral Vascular Disease (PVD), and cancer. Physician order's dated 8/20/04 directed Digitek 0.125 milligrams (mg). A subsequent order dated 8/20/04 directed decreasing the Digitek to every other day. Review of the Medication Administration Record (MAR) dated 9/13/04 identified that the dose had been administered that morning. Observation on 9/14/04 at 9:46AM identified that the licensed nurse had prepared the medications including the Digitek, crushed them in applesauce, and was ready to administer them to Resident #25. Following surveyor intervention, the MAR was reviewed with the licensed nurse. After identifying that Digitek was administered on 9/13/04 the licensed nurse discarded the medications and re-poured the medications absent the Digitek.
 - b. Resident #31's diagnoses included COPD, Congestive Heart Failure (CHF), respiratory failure, and pneumonia. Physician orders dated 8/15/04 directed Flovent (steroid) 110 micrograms, one puff every twelve hours, Ambivent (bronchodilator)

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

inhaler, two puffs every four hours, and that the resident may self administer medications. Observation on 9/14/04 at 9:12AM identified that the licensed nurse gave the Flovent (steroid) inhaler to the resident. The resident self-administered one puff. Approximately one minute and five seconds later, the licensed nurse gave the resident the Ambivent (bronchodilator) inhaler. The resident self-administered one puff, then approximately nine seconds later administered the second puff. During an interview with the licensed nurse on 9/14/04 at 12:20PM she stated that the bronchodilator should be administered prior to the steroidal inhaler. In addition, the nurse was aware that one-minute should lapse between puffs and thought that she had done that. During an interview with the Registered Pharmacist on 9/14/04 at 1:00PM, she stated that bronchodilators are administered prior to the steroidal inhalers. Review of guidelines for medication administration for respiratory inhalers noted progressive sequential administration, wait five minutes between different medications and wait one minute between puffs. A physician order dated 9/14/04 directed to administer Combivent inhaler prior to the Flovent inhaler and to wait one minute between puffs.

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

12. Based on clinical record review, observation, and staff interview for one of three sampled residents who were observed to receive medication, (Resident #25), the facility failed to ensure that the resident was free from a significant medication error. The findings include:
 - a. Resident #25 's diagnoses included dysphagia, Chronic Obstructive Pulmonary Disease (COPD), arthritis, and an irregular heartbeat. A significant change of condition assessment dated 6/14/04 identified some cognitive impairment and the use of a feeding tube. Physician order's dated 8/20/04 directed a puree diet with thin liquids and Digitek 0.125 milligrams (mg); one tablet every day. A subsequent order dated 8/20/04 directed to decrease the Digitek to every other day. Review of the Medication Administration Record (MAR) dated 9/13/04 identified that Digitek 0.125mg had been administered. Observation on 9/14/04 at 9:46AM during the medication pass identified that the licensed nurse crushed Digitek 0.125mg, mixed it with the remainder of the morning medications in applesauce, and prepared to administer the medications to Resident #25. Following surveyor intervention, the MAR was reviewed with the licensed nurse and identified that Digitek had been administered on 9/13/04 and was to be omitted on 9/14/04. The MAR noted that the next scheduled dose was to be administered on 9/15/04. During an interview

FACILITY: Northbridge Healthcare Center

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

with the Registered Pharmacist on 9/14/04 at 1:00PM, she stated that an extra dose of Digitek could cause bradycardia and/or increase the Digoxin blood level.

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)

13. Based on clinical record review and interview for one sampled resident that had been recently admitted (Resident #15), the facility failed to ensure that medications were acquired from the pharmacy for administration in a timely manner. The findings include:
 - a. Resident #15 was admitted to the facility on 8/18/04 at approximately 2:30PM. Nurse's notes dated 8/18/04 at 2:45PM noted that the physician had been called and verified the medication orders and that the orders for the medications had been faxed to the pharmacy. A nurse's note dated 8/19/04 at 3:55AM noted that the medications had not arrived from the pharmacy. A note dated 8/19/04 at 3:00PM noted that the pharmacy had been called with the estimated arrival time of the medications and that the pharmacy had not received the medication order. The orders were then clarified with the physician and faxed to the pharmacy. Review and interview of the medication administration record with the Director of Nursing (DNS) on 9/16/04 at 12:00PM failed to provide documentation that the resident received the following doses of medication as ordered by the physician: Heparin subcutaneously at 9:00PM on 8/18/04 or 9AM on 8/19/04, Protonix on 8/19/04 at 9:00AM, Megace on 8/19/04 at 9:00AM, Singulair, on 8/19/04 at 9:00AM, and Cardizem CD, 8/19/04 at 9:00AM.

The above is a violation of the Regulations of Connecticut State Agencies Section 18-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8v Pharmaceutical Services in Chronic Convalescent Nursing Homes and Rest Homes with Nursing Supervision (b) Pharmaceutical Services (1).

14. Based on clinical record reviews, review of the facility infection control program, and interviews, the facility failed to ensure that accurate tracking and cohorting of residents with multi-drug resistant bacterial infections and/or colonizations were maintained in accordance with current standards of practice and/or failed to maintain an active, current infection prevention/identification program in accordance with current standards of practice related to investigation and trending of infection data. The findings include:

FACILITY: Northbridge Healthcare Center

Page 18 of 18

DATES OF VISITS: September 13, 14, 15 and 16 and 2004 with additional information October 12, 2004

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

- a. Review of the facility infection log noted that there were no line listings of residents known to have a history of Methicillin Resistant Staph Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE) and/or Clostridium Difficile (C-diff). Upon interview, the Infection Control Nurse (ICN) noted that she had just started in July, that line listings were not kept, and that infections had not been logged since January 2004. She further noted that she had attempted to complete a log of infections based on information she had on hand, but upon review it was noted that Resident #16 who was admitted on 3/10/04 with a VRE infection of the urine, was not included on the log. On 9/16/04, the log did not contain information on any infections for the month of August 2004. When asked to provide a list of residents with histories of MRSA, VRE and C-diff, the facility staff was unable to do so. Upon subsequent investigation, it was noted that Resident #29 who was readmitted on 9/15/04 with multiple stage two pressure sores, had been placed in a room with Resident #3 who had MRSA. Subsequent to surveyor inquiry, the residents were placed in different rooms. Review of the infection log and program noted that monthly statistics had not been calculated or investigated during 2004 in accordance with facility policy. Review of the records and interview with the ICN on 9/16/04 noted that she only calculates statistics for the quarterly meeting. When asked to provide evidence of environmental rounds for 2004, the facility was only able to provide June and July rounds.

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

15. Based on interview, the facility staff were not fully aware of the facility's emergency fire procedure and how to respond to the facility's fire alarm system in the event of a fire.

The findings include:

- a. During an interview related to emergency preparedness on 9/14/04 at 9:32AM with the Nursing Supervisor, she was unable to accurately describe what to do if the fire alarm system activated, specific to the facility's fire alarm system. She was unable to convey the facility's fire alarm announcement and how to indicate the location of the emergency and/or fire. Subsequent to surveyor inquiry, licensed staff were inserviced on the response to the fire alarm system in accordance with the policy and procedure.

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

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

**IN-RE: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
d/b/a Northbridge Healthcare Center
2875 Main Street
Bridgeport, CT 06606**

CONSENT ORDER

WHEREAS, Northbridge Healthcare Center, Inc. of Bridgeport, CT. ("Licensee"), has been issued License No.2183-C to operate a Chronic and Convalescent Nursing Home under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on March 11, 2003 up to and including April 22, 2003 for the purpose of conducting multiple investigations; and

WHEREAS, the Department during the course of the aforementioned inspections identified alleged violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated May 1, 2003 (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 of Public Health of the State of Connecticut acting herein and through Wendy H. Furniss, Acting Bureau Chief, and the Licensee, acting herein through Ann Marie Murray, its President, hereby stipulate and agree as follows:

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 2

1. The Licensee shall contract with a registered nurse acceptable to the Department to serve as an Independent Nurse Consultant (INC). The requirement for an Independent Nurse Consultant identified within this order shall become effective within two (2) weeks of the effective date of this Consent Order. Based on the requirements of this Consent Order, the following shall be implemented:
 - a. The Licensee shall contract, at its own expense, with a registered nurse acceptable to the Department to serve as an Independent Nurse Consultant for a minimum of five (5) months. The terms of the contract effected with the Independent Nurse Consultant shall include all pertinent provisions contained in this Consent Order. The Independent Nurse Consultant shall be at the Facility fourteen (14) hours per week. At the end of the five (5) month period, the Licensee shall no longer be obligated to contract with the Independent Nurse Consultant unless the Department identifies through inspections and/or the Independent Nurse Consultant's reports identify that the continued presence of the Independent Nurse Consultant is necessary to ensure substantial compliance with the provisions of the regulations of the Connecticut State Agencies or federal requirements (42 CFR Part 483 Subpart B requirements for Long Term Care Facilities). The Licensee may petition the Department to reduce the hours of service of the Independent Nurse Consultant at the end of two (2) months and at the end of three (3) months may petition the Department to discharge the Facility's obligation to continue said services of the INC. The Department may, in its discretion at any time or from time to time, reduce the Independent Nurse Consultant's responsibilities and hours, if, in the Department's view, the reduction is warranted.
 - b. The Independent Nurse Consultant shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation. The Independent Nurse

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 3

Consultant shall submit written weekly reports to the Department and Facility identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and the Independent Nurse Consultant's assessment of the care and services provided to patients, subsequent recommendations made by the Independent Nurse Consultant and the Facility's response to implementation of said recommendations. Copies of said reports shall be provided to the Licensee. The Independent Nurse Consultant's position shall be occupied and the duties of said Independent Nurse Consultant shall be performed by a single individual unless otherwise approved by the Department. Said 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. Said Independent Nurse Consultant shall make recommendations to the Facility's Administrator, Director of Nursing Services and the Licensee for improvement in the delivery of assessment and Resident Care Planning. The Independent Nurse Consultant shall have a fiduciary responsibility to the Department.

- c. The Independent Nurse Consultant shall make recommendations as necessary to ensure the Facility's conformance with applicable federal and state statutes and regulations. If the Independent Nurse Consultant and the Licensee are unable to reach an agreement regarding the Independent Nurse Consultant's recommendation(s), the Department shall make a final determination which, during the term of this Consent Order shall be binding on the Licensee.
- d. The Independent Nurse Consultant shall have the responsibility for assessing, monitoring and evaluating the delivery of direct patient care

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 4

with particular emphasis and focus on resident assessment and care planning.

2. The Independent Nurse Consultant, the Facility's Administrator, the Director of Nursing Services, and the Licensee or a designee of the Governing Authority shall meet with the Department every four (4) weeks after the effective date of this Consent Order and at continued four (4) week intervals throughout the tenure of the Independent Nurse Consultant's engagement. Said meetings will discuss issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.
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 Independent Nurse Consultant and the Department, upon their request.
4. The Department shall retain the authority to extend the period the Independent Nurse Consultant functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations.
5. Within fourteen (14) days of the execution of this Consent Order the Licensee shall review and revise, as necessary, current policies and procedures relative to resident care plans to include identification of individual resident problems, goals and approaches. All treatments, modalities and professional disciplines involved with the resident shall specify the specific problem and the approaches they will utilize to attain stated goals. All resident care plans shall be specific to the resident problems, goals and/or interventions.
6. The Licensee shall within fourteen (14) days after the execution of this Consent Order review and revise, as applicable, the care plans of the residents who have psychosocial needs.

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 5

7. Within fourteen (14) of the execution of this document, the Facility shall contract with a licensed health care professional with credentials in mental health who shall:
 - a. Be present at the Facility twelve (12) hours per week for a minimum of two (2) months, thereafter time frames to be determined post negotiations with the Department.
 - b. Review the Facility's policies and procedures relative to the patients with psychosocial/mental health issues and revise said documents, as applicable, to reflect current state and federal laws and regulations.
 - c. Conduct inservice presentations for all Facility staff who have direct patient care duties including, but not limited to, licensed nurses, therapeutic recreation, social service and psychosocial/mental health assessments, care planning interventions and implementation.
 - d. Individually assess and review the care plans of a minimum of six (6) weeks to include accuracy of care plans interventions and implementation of said interventions.
 - e. Assist the Facility to develop and implement a continuing program to assess the quality of psychosocial/mental health services provided to patients.
8. The Licensee shall establish in-service programs within twenty-one (21) days of the execution of this Consent Order to include all topics set forth in this document.
9. Within forty-five (45) days of the execution of this Consent Order, the Licensee shall institute a Quality Assurance Program whereby medical records of residents who have psychosocial needs are reviewed for:
 - a. Adherence to Facility policies and procedures;
 - b. Compliance with federal and state laws and regulations regarding assessments and resident care planning;

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 6

- c. Implementation of RCP approaches regarding psychosocial needs;
 - d. Audit five (5) percent of medical records monthly inclusive of accuracy of MDS and implementation of individual care plans.
10. The Licensee shall within seven (7) days of the execution of this Consent Order designate an individual within the Facility who shall have responsibility for the full implementation of the components of this Consent Order.
 11. The individual assigned to oversee the implementation of the requirements of this document shall submit monthly reports to the Department regarding the implementation of the Consent Order components and shall meet with a Department representative every month for the first six (6) months and every three (3) months thereafter for the duration of the Consent Order.
 12. The provisions of this Consent Order, shall remain in effect for a period of two (2) years from the effective date of this document provided that the Department is satisfied that the Licensee has maintained substantial compliance with applicable State and Federal and regulations.
 13. The Licensee shall pay a monetary fine of ten thousand dollars (\$10,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The check shall be made payable to the Treasurer of the State of Connecticut.
 14. In accordance with Connecticut General Statutes Section 19a-494, the Department hereby issues a reprimand to Northbridge Health Care Center, Inc. of Bridgeport, CT. for failure to comply with the stated requirements of the Regulations of Connecticut State Agencies.
 15. The monetary fine and any other reports required by this document shall be directed to:

Rosella Crowley, RN
Supervising Nurse Consultant, Department of Public Health,
Division of Health Systems Regulation
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 7

16. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
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 this document or of any other statutory or regulatory requirements. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Order in the event the Licensee fails to comply with its terms.

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Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 8

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.

NORTHBRIDGE HEALTHCARE CENTER, INC.
OF BRIDGEPORT, CT.

By: [Signature]
Ann Marie Murray, President

Date

State of Connecticut
County of Hartford

ss Southampton August 27 2003

Personally appeared the above named Ann Marie Murray and made oath to the truth of the statements contained herein.

My Commission Expires: 3-31-04

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

9-10-03
Date

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH
By: Wendy H. Furniss
Wendy H. Furniss, R.N.C., M.S.,
Acting Bureau Chief, Health Care Systems

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.