

FACILITY: Wethersfield Health Care Center

DATE(S) OF VISIT: January 19, 23, 24, 25, 26 and 27, 2006

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

- that ambulation did not occur. Another care plan dated 11/2/05 related to a risk to fall identified that the resident was to ambulate with the assist of one staff member. Resident #14 ' s care plan also failed to address the resident ' s need to participate in a restorative ambulation program. Please see F318.
- b. Resident #16 had a diagnosis of cerebral vascular accident. An assessment dated 12/30/05 identified the resident as having some short-term memory impairment and requiring limited assistance with eating. Although care plans dating from 10/17/05 and 1/4/06 identified a potential for poor intake and for staff to monitor the resident ' s weight and/or offer thin liquids, the care plans were not reviewed and/or revised in a comprehensive manner when laboratory blood work dated 10/21/05, 1/9/06 and 1/13/06 were indicative of actual dehydration by respective BUN ' s of 38 on 10/21/05, 82 on 1/9/06 and 75 on 1/13/06. Please see F325 and F327.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (2)(C) and/or (f) Administrator (3)(D) and/or (h) Medical Director (2)(B) and/or (i) Medical Staff (4)(c)(i) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (1) and/or (s) Social Work (7).

4. Based on clinical record review and interviews, the facility failed to ensure that a comprehensive care plan was periodically reviewed and revised, for 3 residents, Residents #11, 13 & 15, whose care plans failed to reflect current facility practice regarding visitation and/or reflect fluid needs. The findings include:
- a. Resident #11 had diagnoses of dementia and cerebral vascular accident with left hemi paresis. A quarterly assessment dated 11/23/05 identified that the resident was cognitively impaired, had periods of lethargy and required total staff assistance with eating. Although the resident had care plans in place regarding food and fluid concerns dated 12/6/05 and 12/22/05 respectively, the care plans were not reviewed and/or revised in a comprehensive manner to address the resident ' s changing food and fluid requirements, specific to dehydration and weight loss as evidenced by weight fluctuations from 1/4/06 (138 lbs), to 1/20/06 (155 lbs) and 1/24/06 (121 lbs); and by increasing BUN's of 32 and a slightly elevated sodium level of 154 on 1/11/06 to a BUN of 58 and a sodium level at a critical level of 165. Please refer to F325 and F327.
- b. Resident #13 was identified as having problems with depression and anxiety. A quarterly assessment dated 11/8/05 identified the resident as alert and oriented and independent with activities of daily living (ADL). A care plan dated 1/5/06

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- identified that " another episode " occurred with the resident ' s family member. Interventions included the initiation of protective measures that included notifying the family member in writing regarding " no trespassing " and that police will become involved if the family member trespassed. Interviews on 1/24/06 with the social worker, RN #1 (the unit manager) and the Assistant Administrator identified that the care plan and interventions were inaccurate and should have been discontinued. The protective order was never obtained and the family member was free to visit without restriction.
- c. Resident #15 had diagnoses of dementia, a healing fracture of the pubic ramus and had a 12/6/05 to 12/28/05 hospitalization that included treatment of dehydration. An assessment dated 1/6/06 identified the resident as cognitively impaired, had periods of lethargy and required total staff assistance with eating. Although a care plan dated 1/3/06 identified the resident had a potential for dehydration, the care plan was not reviewed and/or revised in a comprehensive manner when the resident was identified with laboratory blood values, all indicative of progressive dehydration. During a hospitalization, the resident was identified as being overdried with diuretics and had a BUN of 84 and a sodium level of 150. The resident was readmitted to the facility on 1/16/06 and on 1/20/06, the resident ' s BUN was at a critical level of 121. The resident was re-hospitalized, diagnosed with renal failure, returned on 1/23/06 and expired on 1/24/06. Please see F327.

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

5. Based on clinical record review and interviews, the facility failed to ensure that a resident with limited range of motion received appropriate treatment to prevent further decrease in range of motion, for one resident, Resident #14, who experienced a decline in range of motion when restorative ambulation measures were not implemented. The findings include:
- a. Resident #14 had diagnoses of dementia and depression. A quarterly assessment dated 7/26/05 identified the resident as cognitively impaired, requires extensive assistance in transfer, supervision ambulating in the room and limited assistance ambulating in the corridor. A full assessment dated 10/18/05 identified the resident experienced a decline in ambulation and that ambulation no longer occurred in the room or corridor. A care plan dated 11/2/05 identified an alteration in ambulation

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and that ambulation did not occur. Another care plan dated 11/2/05 related to a risk to fall identified that the resident was to ambulate with the assist of one staff member. Interview with the Director of Rehabilitation services on 1/24/06 identified that Resident #14 was evaluated in November 2005 and discharged from therapy requiring minimal assistance to transfer and ambulation with a rolling walker. Once discharged, it was nursing staff ' s responsibility to initiate a restorative ambulation program with the resident based on physical therapy ' s recommendations. Interview with the ADNS on 1/24/06 identified that the nursing department had an ambulation program for residents, following physical therapy ' s instructions, and there was a book where this was documented. Interview on 1/24/06 with RN #1, D-Wing unit manager, identified that there was no ambulation book to document ambulation. RN #1 further identified that physical therapy staff tell the NA ' s what to do with the residents but there is no nursing documentation of the ambulation instructions or that ambulation actually occurred. Despite having a nursing policy for a restorative program, there was no evidence that an active restorative ambulation program existed. Interview with RN #1 and LPN #1 on 1/27/06 identified that Resident #14 was assessed by physical therapy staff, was no longer able to ambulate, and is now a transfer from bed to chair via hooyer lift.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (2)(C ) and/or (f) Administrator (3)(D) and/or (h) Medical Director (2)(B) and/or (i) Medical Staff (4)(c)(i) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (1).

6. Based on clinical record review and interviews, the facility failed to maintain acceptable parameters of nutritional status, for 3 resident, Residents #11, 14, & 16, who experienced weight losses, were inconsistently monitored and lacked consistent and appropriate documentation. The findings include:
  - a. Resident #11 had diagnoses of dementia and cerebral vascular accident with left hemi paresis. A quarterly assessment dated 11/23/05 identified the resident as cognitively impaired, had periods of lethargy and required total staff assistance with eating. A care plan dated 12/6/05 identified the resident had an alteration in nutrition related to swallowing and required weekly weights. Another nutritional care plan dated 12/6/05 identified the need for monthly weights and also identified the need for staff to record meal intakes. A review of the resident ' s weight sheet identified one weight was obtained for the month of December 2005 that was 138

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lbs. Subsequent weight monitoring included 138 lbs on 1/4/06, 155lbs on 1/20/06 and 121lbs on 1/24/06. In addition, between 1/1/06 and 1/15/06 there was inconsistent documentation of meal intakes, bedtime nourishments and evening house supplements in the MAR (medication administration record), as per facility practice. There was also a noted decrease in the MAR of the percentage of meal intakes. Interview with RN #1 on 1/25/06 identified that Resident #11 's weights were obtained inconsistently and identified the need to use the same scale in the future.

- b. Resident #14 had a diagnosis of dementia. An assessment dated 7/26/05 identified the resident was cognitively impaired and was independent with eating. An assessment dated 10/18/05 identified the resident now required supervision while eating and for staff to set up her meals. A care plan dated 10/13/05 identified a potential for weight loss with interventions to weigh as ordered, encourage foods and fluids and record meal intakes. Review of the resident 's weight sheet identified a 5lb weight loss in the month of October 2005. Review of nursing notes identified that there were no nursing notes during the month of October 2005. Although a nurse 's note dated 12/14/05 identified that the resident 's weight loss was discussed with the resident 's conservator, between 12/1/05 and 1/24/06, there was inconsistent documentation of meal intakes in the MAR, as per facility practice as evidenced by multiple blank spaces. RN #2 identified that there is a minimum of monthly documentation on a resident and a note should have been written in October 2005, when the resident experienced the weight loss.
- c. Resident #16 a diagnosis of cerebral vascular accident. An assessment dated 12/30/05 identified the resident as having some short-term memory impairment and requiring limited assistance with eating. A care plan dated 10/17/05 and updated on 1/4/06 identified a potential for poor intake and for staff to monitor the resident 's weight every week. Review of the resident 's weight sheet identified that only one weight was obtained in October, November and December 2005, and 3 times in January 2006. The resident 's weight in October 2005 was 183lbs and on 1/16/06 the resident 's weight was 165lbs.

7. Based on clinical record review, observations, and interviews, the facility failed to provide each resident with sufficient fluid intake to maintain proper hydration and health, for 2 of 4 residents, Residents #11 & 15, whose fluid needs were not assessed and/or documented appropriately, and/or interventions not initiated timely, resulting in hospitalization for treatment of dehydration. The findings include:

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- a. Resident #11 had diagnoses of dementia and cerebral vascular accident with left hemi paresis. A quarterly assessment dated 11/23/05 identified the resident as cognitively impaired, had periods of lethargy and required total staff assistance with eating. A care plan dated 12/22/05 identified the resident had a potential for dehydration with interventions to monitor laboratory blood work, weigh weekly, and to record fluid intake and output. On 1/11/06, Resident #11's Laboratory blood work identified a BUN (blood urea and nitrogen) level of 32, double the recommended value, and a slightly elevated sodium level of 154. A physician was notified of the laboratory values on 1/11/06 and recommended to increase fluids and repeat the laboratory test in one week. Review of the resident's clinical record and interview with RN #1 on 1/25/06 identified that staff did not initiate fluid intake monitoring until the evening of 1/13/06. On 1/15/06, blood work was repeated and the BUN was 58, 3 1/2 times the recommended high level, and the sodium level was at a critical level of 165. Resident #11 was admitted to a hospital from 1/15/06 to 1/20/06 and treated for dehydration. Interview with MD #1 on 1/25/06 identified that based on the BUN of 1/11/06, the resident was dehydrated and monitoring and treatment should have been initiated at that time.
- b. Resident #15 had diagnoses of dementia, a healing fracture of the pubic ramus and had a 12/6/05 to 12/28/05 hospitalization that included treatment of dehydration. An assessment dated 1/6/06 identified the resident as cognitively impaired, had periods of lethargy and required total staff assistance with eating. Care plans dated 1/3/06 identified the resident had a potential for dehydration, had a feeding tube placed, required documentation of fluid intakes including feedings and flushes and staff were to observe for signs of dehydration. Resident #15 was hospitalized again from 1/11/06 to 1/16/06 for treatment of congestive heart failure. During this hospitalization, the resident was identified as being over dried with diuretics and had a BUN of 84 and a sodium level of 150. Between readmission to the facility on 1/16/06 and 1/20/06, staff failed to complete a dehydration assessment, per policy. On 1/20/06, the resident's BUN was at a critical level of 121, the resident was re-hospitalized, diagnosed with renal failure, returned on 1/23/06 and expired on 1/24/06.
- c. Resident #16 had diagnoses of dementia and cerebral vascular accident. An assessment dated 12/30/05 identified the resident as having some short-term memory impairment and required limited assistance with eating. A care plan dating from 10/17/05 identified the resident was at risk for dehydration and identified to monitor laboratory blood work, and encourage fluids. A care plan dated 1/4/06

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identified a potential for poor intake and identified to offer thin liquids, provide adequate fluids and record meals. On 10/21/05, Resident #16 's BUN was 38, on 1/9/06 the BUN was 82 and on 1/13/06 the BUN was 75. Although there were nursing notes indicating that fluids were being offered and an IV was initiated from 1/11/06 to 1/13/06, there was no documented hydration assessment initiated per facility policy. In addition, on 1/19/06, NA #1 was observed to have entered the 7-3 shift fluid intakes on all of her assigned residents who required intake monitoring, prior to 1:15 PM. NA #1 provided a written statement that identified that she documents the shifts intakes at this time of day every day. Interview with NA #2 on 1/19/06 identified that she did not document her resident ' s fluid intakes on her assignment sheet, or anywhere else, throughout the day. NA #2 identified that at the end of the shift, she remembers what fluids the residents consumed and writes it down. The facility initiated a new 24-hour fluid intake and output sheet on 1/19/06 and immediately began inservicing staff regarding its use.

FLIS 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.