

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

In Re: Chelsea Place Care Center, LLC of Hartford, CT. d/b/a
Chelsea Place Care Center
25 Lorraine Street
Hartford, CT 06105

CONSENT ORDER

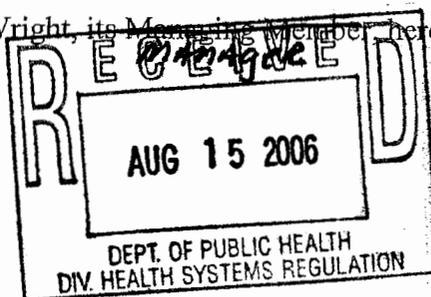
WHEREAS, Chelsea Place Care Center, LLC of Hartford, CT. (hereinafter the "Licensee") d/b/a as Chelsea Place Care Center (hereinafter the "Facility") has been issued License No.2220-C to operate a chronic and convalescent nursing home under Connecticut General Statutes Section 19a-490 by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing March 14, 2005 up to and including March 8, 2006 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 Citations #2005-19, #2005-55, #2005-153, (Exhibits A, B and C - copies attached) violation letters dated December 13, 2005 and March 10, 2006 – (Exhibits D and E - copies attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein without admitting any wrongdoing or violation of law.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut acting herein and through Joan Leavitt, Section Chief, and the Licensee, acting herein through Christopher Wright, its Managing Member, hereby stipulate and agree as follows:



1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.
2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit F – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility twenty-four (24) hours per week and shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order. The costs incurred as a result of the contractual agreement between the Licensee and the INC shall be assumed by the Licensee.
4. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of this document.
5. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations. The INC shall have a fiduciary responsibility to the Department.
6. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility. If the INC and the Licensee are unable to reach an agreement

regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

7. The INC shall submit weekly written reports to the Department documenting:
 - a. the INC's assessment of the care and services provided to patients;
 - b. the Licensee's compliance with applicable federal and state statutes and regulations; and
 - c. any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
8. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
9. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. This assessment will also focus on compliance with applicable federal and state laws and regulations and the Licensee's current patient care plans to include, but not limited to, identification of individual patient problems, goals and approaches. All treatment modalities and professional disciplines involved with the patient shall specify problems and the approaches they will utilize to attain stated goals. All patient care plans shall be specific to the patient problems, goals and interventions. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services; and
 - c. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letters dated December 13, 2005; March 10, 2006 and citations dated February 8; April 12 and September 29, 2005.
10. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks to discuss issues related to the care and

services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

11. The Licensee shall within fourteen (14) days after the execution of this Consent Order, review and revise, as necessary, to comply with applicable state and federal laws and regulations, the Licensee's current policies and procedures relative to patient care plans. The Licensee shall establish inservice education programs within thirty (30) days to include all topics set forth in this document. In-service education programs conducted as a result of this document shall include topics relative to Behavioral Health and shall be provided to all direct care staff. Additionally, all new employees shall be provided with a specific orientation program which shall be developed with and approved by the Medical Director, Independent Consultant and in conjunction with a physician specializing in psychiatry.
12. The Licensee shall appoint a free floating supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. Nurse Supervisors shall maintain a record of patient related issue(s) on problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period.
13. Nurse Supervisors shall be provided with the following:
 - a. A job description which clearly identified the supervisor's day-to-day duties and responsibilities;
 - b. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties which respect to patient and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitored by a representative of the Facility Administrative Staff (e.g. Director of Nursing Service, Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of

- visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
- d. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers in accordance with individual comprehensive care plans.
14. Within fourteen (14) days of the execution of this Consent Order, the Licensee shall review and revise, as applicable, all policies and procedures relative to patient smoking and emergency responses for a fire.
15. Within twenty-one (21) days of the execution of this document, all staff shall be inserviced to the policies and procedures identified in paragraph #14. Mock drills relative to the facility's emergency preparedness policy shall be conducted on each shift every month and on a rotating basis. All facility staff shall be inserviced, as to the Facility's policies and procedures.
16. Any records maintained in accordance with any state or federal laws or regulations or as required by this Consent Order shall at all times be made available to the INC(s) and the Department upon their request.
17. Chelsea Place Care Center of Hartford, CT., d/b/a Chelsea Place Care Center, the Licensee, agrees to pay a monetary payment to the Department in the amount of six thousand five hundred dollars (\$6,500.00), which shall be payable by check or money order to the Treasurer of the State of Connecticut and shall be posted to the Department within two (2) weeks of the effective date of this Consent Order. Said check shall be directed to:
- Donna Ortelle, R.N., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12HSR
Hartford, CT 06134
18. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Consent Order or of any other statutory or regulatory requirement. This

department may petition any court with proper jurisdiction for enforcement in the event the Licensee fails to comply with its terms.

19. 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 laws and regulations and the terms of this Consent Order.
20. The Execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau of the Department of Criminal Justice's Statewide Prosecution Bureau.
21. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.
22. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that may have under the laws of the State of Connecticut or of the United States.

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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.

CHELSEA PLACE CARE CENTER, LLC OF
HARTFORD, CT. - LICENSEE

8/15/06
Date

By: Chris S. Wright
Christopher Wright, its ~~Managing Member~~ **MANAGER**

STATE OF Connecticut

County of Hartford) ss Aug 15th 2006

Personally appeared the above named Chris S. Wright and made oath to the truth of the statements contained herein.

My Commission Expires: 4/30/07
(If Notary Public) Daniel Kinman
Notary Public []
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

8/21/06
Date

By: Joan Leavitt
Joan Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

EXHIBIT A

CERTIFIED MAIL**AMENDED CITATION**

In Re Citation No. 2005-19

**Classification of Violation
Pursuant to Connecticut
General Statutes Section 19a-527****Date:** February 8, 2005**Class:** B
Bed Capacity: 234
License Number: 2220-C**Licensee:** Chelsea Place Care Center, LLC., of Hartford, CT.
Facility Name: Chelsea Place Care Center, LLC.
Facility Address: 25 Lorraine Street
Hartford, CT 06105

This citation originally dated February 7, 2005 is hereby amended to provide as follows:

A. Nature and Scope of Violation(s):

1. An inspection of this facility which concluded on January 25, 2005 revealed the following:
 - a. Based on review of the medical record, review of facility documentation, review of facility policies, observations, and interviews, the facility failed to provide adequate supervision and/or to ensure that smoking aprons were applied consistently during supervised smoking sessions for five of nine residents, Residents #11, #12, and #13, 20, and 21 who required supervised smoking and/or protective devices to prevent burns. The findings included: Resident #11 (R #11) had diagnoses that included chronic schizophrenia. A smoking assessment dated 12/1/04 identified that R #11 required supervised smoking. Interview with R #11 on 12/20/04 at 9:35 AM identified that she had put a cigarette butt in her pocket upon return from a supervised smoking break on 12/15/04 and that it "inflamed my jacket." R #11 denied any injuries. Review of the nursing notes dated 12/15/04 identified that R #11 did not sustain any injuries as a result of the 12/15/04 incident. Review of facility documentation dated 12/15/04 identified that R #11 was observed to have a "puff of white smoke" coming from her coat pocket. The documentation identified that R #11 had placed a cigarette butt into her coat pocket and that paper tissues in

Licensee: Chelsea Place Care Center, LLC., of Hartford, CT.

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the pocket began to smolder. Interview with the Director of Recreation on 12/20/04 at 1:05 PM identified that he brought R #11's coat outdoors while other recreation staff checked R #11 for injuries and that the smoldering coat was extinguished. The Director of Recreation identified that he removed what looked like a paper napkin and a partially melted comb from R #11's coat pocket. Observation of the 1:30 PM supervised smoking break on 12/20/04 identified that approximately twenty residents were present on the patio for the supervised smoking session. Three staff members, the Director of Recreation and Nursing Assistant # 4 (NA #4) and NA #5, provided supervision during the session. Residents were observed to form a line and the Director of Recreation passed out and lit cigarettes for the residents. NA #4 and NA #5 moved about the patio throughout the session, redirected residents who wandered from their direct view, readjusted smoking aprons, and supervised that cigarette butts were placed in the appropriate receptacles. Interview with Recreation Therapist #1 on 12/21/04 at 9:30 AM identified that she was responsible for the supervision of the morning smoking break on 12/15/04. Recreation Therapist #1 identified that she supervised the smoking residents by standing out on the smoking patio with them, that she was responsible for passing out cigarettes, lighting them for the residents, and that she routinely supervised the smoking session alone.

And/or

- b. Resident #11 (R #11) had an assessment dated 12/1/04 identified that R #11 was cognitively impaired and independent in most Activities of Daily Living (ADLs). Review of the Resident Care Plan (RCP) dated 12/2/04 identified R #11 with behaviors that included a history of non-compliance with the facility smoking policies and carelessness with smoking materials. Interventions included supervision for smoking and to provide a smoking apron. Observation of R #11's personal clothing on 12/20/04 identified a purple jacket with multiple burn holes on the bilateral front panels of the jacket and on the left sleeve. A blue jacket with red lining was observed in the same condition with multiple burn holes. In addition, R #11's sweater was observed to have a small burn hole on the right front chest area. Interview with the Recreation Therapist #1 on 12/21/04 at 9:30 AM identified that she had never applied a smoking apron to R #11 during any of the smoking sessions that she had been assigned to supervise. And/or
- c. Resident # 12 (R #12) had diagnoses that included schizophrenia. A smoking assessment dated 10/4/04 identified that R #12 required supervised smoking. R #12 was observed outside on the smoking patio on 12/20/04 at 10:05 AM smoking a cigarette without supervision. R #12 identified himself to the surveyor as not requiring supervision for smoking. At 1:30 PM on 12/20/04, R #12 was observed to be in line to receive his cigarettes during the supervised smoking break. Interview with NA #4 identified that R #12 required supervised smoking. And/or
- d. Resident #13 (R #13) had diagnoses that included chronic paranoid schizophrenia. A smoking assessment dated 8/7/04 identified that R #13 required supervised smoking. On 12/20/04 at 1:50 PM, following a supervised smoking break, R #13 was observed to be in front of the building and obtained a cigarette from R #16. Although R #16 was assessed to be an independent smoker, facility policy directed

Licensee: **Chelsea Place Care Center, LLC., of Hartford, CT.**

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that residents who carry their own cigarettes must not give them to nor light them for, other residents. R #13 was observed to ambulate to the side of the building with the lit cigarette and was out of view of staff. Interview with NA #4 identified that R #13 required supervised smoking. Interview with R #13 identified that R #16 had given him the cigarette, that R #16 had lit the cigarette for him, and that he smoked the cigarette while out of facility staff's view. And/or

- e. Resident # 20 (R #20) had diagnoses that included schizophrenia. A smoking assessment dated 12/3/04 identified that R #20 required supervised smoking and in addition, required a smoking apron during the supervised sessions. Interview with Recreation Therapist #1 on 12/20/04 at 10:50 AM identified that on 12/15/04, R #20 was smoking without a smoking apron because the apron was unavailable. And/or
- f. Resident # 21 (R #21) had diagnoses that included schizophrenia. A smoking assessment dated 12/1/04 identified that R #21 required supervised smoking. Review of the RCP identified the need for supervised smoking with a smoking apron. Observation of R #21 on 12/20/04 at 12:05 PM identified that R #21 was wearing gray sweatpants and a multicolored sweater. Multiple burn holes were noted across the bilateral lap panels of the sweat pants and on the chest area of the sweater. Observations of the supervised smoking session at 1:30 PM at 12/20/04 identified that smoking aprons were provided for Residents #11, #20, and #21. Observation of the aprons applied identified that the aprons were in excellent condition without burn holes, discolorations, or soiled areas. And/or

B. Statutes and/or Regulations Violated:

Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D8t (j)(2) and/or (m)(2)(C).

C. Classification of Violation(s)

Class B in accordance with Section 19a-527-1 (b)(6)(8) of the Regulations of Connecticut State Agencies (Public Health Code).

D. Amount of Civil Penalty to be imposed in accordance with Connecticut General Statutes Sections 19a-527 and 19a-528: \$3000.00

Licensee: Chelsea Place Care Center, LLC., of Hartford, CT.

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NOTIFICATION OF ELECTION TO CONTEST CITATION

If the licensee wishes to contest this Citation, the administrator or his designee must within three days, excluding Saturdays, Sundays and holidays, of receipt of the Citation by the licensee, shall notify the Supervising Nurse Consultant who signed the citation by contacting the Division of Health Systems Regulation (DHSR), Department of Public Health, 410 Capitol Avenue, MS#12 HSR, P.O. Box 340308, Hartford, Connecticut 06134-0308, telephone number (860) 509-7400 or any Supervising Nurse Consultant within DHSR (same address, same telephone number).

ELECTION NOT TO CONTEST CITATION

Should the licensee not wish to contest this Citation and pay the civil penalty, check or money order should be made payable to: Treasurer, State of Connecticut, attention Joan D. Leavitt, PHSM and sent to the above identified address.

IF THE ADMINISTRATOR FAILS TO SO NOTIFY THE DEPARTMENT, THE CITATION SHALL BE DEEMED A FINAL ORDER OF THE COMMISSIONER OF PUBLIC HEALTH, EFFECTIVE UPON THE EXPIRATION OF THE THREE DAY PERIOD REFERENCED ABOVE. CONNECTICUT GENERAL STATUTES SECTION 19a-525(a).

INFORMAL CONFERENCE

If the administrator has notified the Department in accordance with the procedure set forth above, an informal conference will be conducted as required by Section 19a-525(b) between the licensee and the Commissioner or his designee. The facility may wish to be represented by an attorney.

POSTING REQUIREMENT

Each Class A or Class B Citation shall be prominently posted in the nursing home cited so as to be visible to any resident, including those in wheelchairs and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the Commissioner of Public Health or the Citation has been vacated by the Commissioner. Failure to comply with this requirement constitutes a violation of Connecticut General Statutes Section 19a-540.

Signature: Taryn M. Williams SHC

Date: 2/8/05

Licensee: Chelsea Place Care Center, LLC., of Hartford, CT.

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JMW:LLD:lsf

cc: David Pistrutto, Administrator
Richard Lynch, Assistant Attorney General
Marianne Horn, Director
Joan D. Leavitt, Public Health Services Manager
Janet Williams, Supervising Nurse Consultant
Laura Doyle, Patricia Gannon, Nurse Consultants
David DeMaio, Health Program Associate

EXHIBIT B

CERTIFIED MAIL**CITATION****In Re Citation No. 2005-55****Classification of Violation
Pursuant to Connecticut
General Statutes Section 19a-527****Date: April 12, 2005****Class: B
Bed Capacity: CCNH 234
License Number: 2220-C****Licensee: Chelsea Place Care Center, LLC of Hartford, CT
Facility Name: Chelsea Place Care Center
Facility Address: 25 Lorraine Street
Hartford, CT 06105**

The following citation is issued pursuant to Sections 19a-524 through 19a-528, inclusive of the Connecticut General Statutes (Copy of Statutes Attached):

A. Nature and Scope of Violation(s):

1. Inspections of this facility on March 14, 15, 16 and 17, 2005 revealed the following:
 - a. Resident # 19's diagnoses included schizoaffective and hypertension. The physician's order and care plan dated 1/10/05 identified that the resident was to be a supervised smoker. The smoking assessment dated 3/2/05 identified that the resident was a non-smoker. The nurse's notes dated 11/9/04 through 2/16/05 identified that the resident was found on multiple occasions to be smoking unsupervised. The facility policy identifies that all residents are to be supervised smokers. Observation of the resident on 3/14/05 identified the resident was smoking unsupervised outside and had possession of his own smoking materials. Interview with the charge nurse on 3/16/05 at 11:30 AM identified that the smoking assessment was not correct. Subsequent to surveyor inquiry, the nurse changed the smoking assessment to identify the resident as a supervised smoker.

Licensee Name: **Chelsea Place Care Center, LLC of Hartford, CT**

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- b. Resident # 20's diagnosis included schizophrenia. The physician orders dated 2/10/05 identified that the resident was a supervised smoker. The smoking assessment and/or current care plan identified that the resident needed to be supervised while smoking. Observation of the resident on 3/14/05 identified the resident was smoking independently and was in possession of her own smoking materials. Subsequent to the surveyor inquiry, the facility removed smoking materials and placed the resident on every fifteen-minute check. Review of the every fifteen-minute check sheets identified that the resident was not consistently monitored on 3/17/05.
- c. Resident # 31's clinical record identified a quarterly smoking assessment dated 1/10/05 that identified the resident as a supervised smoker. The resident care plan dated 1/10/05 identified the resident required supervision with smoking and to monitor the resident for compliance to the smoking policy. Observation of the resident on 3/16/05 at 9:00 PM identified the resident was sitting in the wheelchair, outside the main entrance, smoking independently.
- d. Review of Resident# 32's clinical record identified a smoking evaluation dated 2/2/05 that identified the resident as a supervised smoking and the need to monitor the resident for compliance to smoking policy. Observation to the resident on 3/16/05 at 9:00 PM identified the resident was standing outside the main entrance, in the company of another resident and was smoking independently. An interview on 3/16/05 at 9:05 PM with the nursing supervisor identified that neither Resident # 31 nor Resident# 32 should have been smoking without the benefit of supervision and that everybody is supposed to be on supervised smoking.
- e. Resident # 21 was admitted to the facility on 2/2/05 with diagnoses that included depression, bipolar disorder and substance abuse. A pre-admission screen dated 12/13/04 identified a history of wandering with a continued risk due to cognitive issues. An admission wander risk assessment dated 2/2/05 identified that although, independent mobility was indicated on the assessment, other areas were not completed or a wander risk score identified. A temporary admission care plan (not dated) failed to reflect Resident # 21's cognitive and behavior status. A nurse's note dated 2/14/05 at 10:00 PM identified Resident # 21 walked about aimlessly at times and confused. Facility documentation dated 3/6/05 identified Resident # 21 was found walking on an adjacent street to the facility following a friend that had recently visited the facility. The physician was notified and a wanderguard device and every fifteen-minute monitoring were implemented. In an interview with the Unit

Licensee Name: **Chelsea Place Care Center, LLC of Hartford, CT**

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Manager on 3/16/05 at 3:00 PM, she identified the admission nurse is responsible to complete the wander risk assessment upon admission.

B. Statutes and/or Regulations Violated:

Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D8t (f)(3) and/or (j)(2).

C. Classification of Violation(s)

Class B in accordance with Section 19a-527-1 (b)(3) and/or (b)(6) of the Regulations of Connecticut State Agencies (Public Health Code).

D. Amount of Civil Penalty to be imposed in accordance with Connecticut General Statutes Sections 19a-527 and 19a-528: \$460.00.

NOTIFICATION OF ELECTION TO CONTEST CITATION

If the licensee wishes to contest this Citation, the administrator or his designee must within three days, excluding Saturdays, Sundays and holidays, of receipt of the Citation by the licensee, shall notify the Supervising Nurse Consultant who signed the citation by contacting the Division of Health Systems Regulation (DHSR), Department of Public Health, 410 Capitol Avenue, MS#12 HSR, P.O. Box 340308, Hartford, Connecticut 06134-0308, telephone number (860) 509-7400 or any Supervising Nurse Consultant within DHSR (same address, same telephone number).

ELECTION NOT TO CONTEST CITATION

Should the licensee not wish to contest this Citation and pay the civil penalty, check or money order should be made payable to: Treasurer, State of Connecticut, attention Joan D. Leavitt, PHSM and sent to the above identified address.

Licensee Name: Chelsea Place Care Center, LLC of Hartford, CT

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IF THE ADMINISTRATOR FAILS TO SO NOTIFY THE DEPARTMENT, THE CITATION SHALL BE DEEMED A FINAL ORDER OF THE COMMISSIONER OF PUBLIC HEALTH, EFFECTIVE UPON THE EXPIRATION OF THE THREE-DAY PERIOD REFERENCED ABOVE. CONNECTICUT GENERAL STATUTES SECTION 19a-525(a).

INFORMAL CONFERENCE

If the administrator has notified the Department in accordance with the procedure set forth above, an informal conference will be conducted as required by Section 19a-525(b) between the licensee and the Commissioner or his designee. The facility may wish to be represented by an attorney.

POSTING REQUIREMENT

Each Class A or Class B Citation shall be prominently posted in the nursing home cited so as to be visible to any resident, including those in wheelchairs and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the Commissioner of Public Health or the Citation has been vacated by the Commissioner. Failure to comply with this requirement constitutes a violation of Connecticut General Statutes Section 19a-540.

Signature: Maureen H Klett, RN, C, MSNc

Date: 4/12/05

MHK: aij

cc: David Pistrutto, Administrator
Richard Lynch, Assistant Attorney General
Wendy Furniss, Bureau Chief
Marianne Horn, Director
Joan D. Leavitt, Public Health Services Manager
Maureen H. Klett, RN, C, MSNc, Supervising Nurse Consultant
Denise Soja, Nurse Consultant
David DeMaio, Health Program Associate

Exhibit C

CERTIFIED MAIL

CITATION

In Re Citation No. 2005-153

**Classification of Violation
Pursuant to Connecticut
General Statutes Section 19a-527**

Date: September 29, 2005

**Class: B
Bed Capacity: 234
License Number: 2220-C**

**Licensee: Chelsea Place Care Center, LLC of Hartford CT
Facility Name: Chelsea Place Care Center, LLC
Facility Address: 25 Lorraine Street
Hartford, CT 06105**

The following citation is issued pursuant to Sections 19a-524 through 19a-528, inclusive of the Connecticut General Statutes:

A. Nature and Scope of Violation(s):

1. An inspection of this facility which concluded on (date) revealed the following:
 - a. Resident #1 had a history of chronic undifferentiated schizophrenia, encopresis, and high cholesterol and was admitted to the facility from a group home on 8/2/05 due to inability to be independent with ADL's (activities of daily living) and the need for closer supervision and dietary management. A review of physician orders identified the resident required supervised smoking, could be on an LOA with a responsible party, and had a smoking assessment done. A review of nurse's notes dated 8/14/05 written by LPN #1 at 8:30 a.m. identified upon entering the resident's room a strong cigarette odor was detected coming from the bathroom. The resident was in the bathroom with both doors locked and did not respond to requests to come out. The door was unlocked by staff and the resident flushed a cigarette down the toilet. The resident was placed on every fifteen-minute checks and a room search done did not

locate any smoking materials. Documentation was lacking to reflect that the resident had been reassessed regarding his smoking capabilities at this time. Resident #1 denied he was smoking. At 10:48 a.m., NA #1 identified the smoke alarm in the resident's room, 419, was activated. Upon investigation the wastebasket in the bathroom was on fire with heavy smoke filling the bathroom and bedroom. LPN #1 put out the fire with an extinguisher, and the fire department responded and no other interventions were needed. The physician was notified, and the resident was transferred to an acute care facility for a psychiatric evaluation. During an interview NA #1 stated she saw the resident running out of his room and checked the bathroom in his room as a result of the smoke alarm sounding, observed a cigarette in the wastebasket which had smoke coming from it but no flame, and did not see any smoke in the bathroom itself. During an interview NA #2 stated she observed LPN #1 and other staff finding cigarettes, matches and a lighter in the drawer in the patient's room while packing up his belongings. During an interview the Director of Nursing and RN #2 stated no smoking materials were found during room search and the resident had not been on any LOA's since his admission. Resident #1 stated that he left the nursing home by himself and purchased the cigarettes. During an interview on 8/16/05, Resident #1 stated he snuck a smoke at 8:30 a.m. and flushed the cigarette down the toilet. He had purchased two packs of cigarettes at a store but only gave one pack to the facility, had two lighters he came to the facility with, hid the smoking materials in his robe pocket but denied starting the wastebasket fire identified at 10:48 a.m. Resident #1 also stated he had a problem with the strict smoking times of only four times a day at the facility because it was too strict. Smoking was a hobby of his and he could smoke anytime he wanted to at his previous group home. Documentation in the medical record identified that although the resident acknowledge the facility's smoking policies and procedures on admission, there was no evidence that an individualized assessment had been completed to reflect the resident's past history regarding his smoking habits. Documentation was also lacking to reflect that the smoking assessment included information relative to the resident's assessed abilities and needs which would have demonstrated the resident's level of supervision required for smoking; e.g. cognition, physical capabilities, etc.

B. Statutes and/or Regulations Violated:

Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D8t (j) (2) and/or (m) (2) (c).

- C. **Classification of Violation(s)**
Class B in accordance with Section 19a-527-1 (b) (6) (8) of the Regulations of Connecticut State Agencies (Public Health Code).
- D. **Amount of Civil Penalty to be imposed in accordance with Connecticut General Statutes Sections 19a-527 and 19a-528: \$3000.00.**

NOTIFICATION OF ELECTION TO CONTEST CITATION

If the licensee wishes to contest this Citation, the administrator or his designee must within three days, excluding Saturdays, Sundays and holidays, of receipt of the Citation by the licensee, shall notify the Supervising Nurse Consultant who signed the citation by contacting Facility Licensing and Investigations Section (FLIS), Department of Public Health, 410 Capitol Avenue, MS#12 HSR, P.O. Box 340308, Hartford, Connecticut 06134-0308, telephone number (860) 509-7400 or any Supervising Nurse Consultant within HSR (same address, same telephone number).

ELECTION NOT TO CONTEST CITATION

Should the licensee not wish to contest this Citation and pay the civil penalty, check or money order should be made payable to: Treasurer, State of Connecticut, attention Joan D. Leavitt, PHSM and sent to the above identified address.

IF THE ADMINISTRATOR FAILS TO SO NOTIFY THE DEPARTMENT, THE CITATION SHALL BE DEEMED A FINAL ORDER OF THE COMMISSIONER OF PUBLIC HEALTH, EFFECTIVE UPON THE EXPIRATION OF THE THREE DAY PERIOD REFERENCED ABOVE. CONNECTICUT GENERAL STATUTES SECTION 19a-525(a).

INFORMAL CONFERENCE

If the administrator has notified the Department in accordance with the procedure set forth above, an informal conference will be conducted as required by Section 19a-525(b) between the licensee and the Commissioner or his designee. The facility may wish to be represented by an attorney.

POSTING REQUIREMENT

Each Class A or Class B Citation shall be prominently posted in the nursing home cited so as to be visible to any resident, including those in wheelchairs and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the Commissioner of Public Health or the Citation has been vacated by the Commissioner. Failure to comply with this requirement constitutes a violation of Connecticut General Statutes Section 19a-540.

Signature:

Janet M. Williams

Date:

9/29/05

SNC:

cc: David Pistrutto, Administrator
Richard Lynch, Assistant Attorney General
Marianne Horn, Section Chief
Joan D. Leavitt, Public Health Services Manager
Janet M. Williams, Supervising Nurse Consultant
Diane Robillard, Nurse Consultant
David DeMaio, Health Program Associate

Exhibit D

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



December 13, 2005

Mr. David Pistrutto, Administrator
 Chelsea Place Care Center
 25 Lorraine Street
 Hartford, CT 06105

Dear Mr. Pistrutto:

Unannounced visits were made to Chelsea Place Care Center on October 7, 11, 12, 13, 15, 27, 28, November 1, 2, 3 and 4, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through October 14, 2005.

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 December 28, 2005 at 10:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned 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 at (860) 509-7400.

Respectfully,

Janet M. Williams, R.N.
 Janet M. Williams, R.N.
 Public Health Services Manager
 Facility Licensing and Investigations Section

JMW:LLD:lsf

- c. Director of Nurses
 Medical Director
 President
 vichelseaplacecareclsl.doc
 CT #4108, 4181, #4508, #4511
 #4557, #4593, #4668, #4685



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

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The following is a violation of the Connecticut General Statutes Section 19a-550 (12) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D).

1. Based on observation and staff interview, the facility failed to identify that the residents' had reasonable access for telephone utilization. The findings include:
 - a. Observation on 10/15/05 at 11:00AM identified that the public telephone located in the secured behavioral unit lounge area was inoperable. Interview with Licensed Practical Nurse #2 on 10/15/05 at 11:30AM identified that the residents could use the unit telephone located at the nursing station from 10:00AM-11:00AM. She further indicated that after that time they could not utilize the telephone unless the Program Manager was in, at which time they would utilize the Manager's telephone.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Event (3).

2. Based on clinical record reviews, review of facility documentation and interviews for three of four residents (R#7, # 22, #23) the facility failed to report and/or timely report incidents of alleged mistreatment to the Department of Public Health (DPH). The findings include:
 - a. Resident #7's diagnoses included schizoaffective disorder- bipolar type and arthritis. The Minimum Data Set (MDS) dated 9/26/05 identified that the resident was cognitively independent, had short-term memory problems and was without behaviors in the last seven days. The Resident Care Plan (RCP) dated 9/27/05 reflected that the resident had a history of confabulation and approaches that included encourage verbalization of feelings/concerns. Nursing narratives and/or facility documentation dated 10/22/05 indicated that R#7 alleged that LPN #2 twisted her wrist when she attempted to pour coffee and police were notified. Interview with R#7 on 10/27/05 at 12PM noted that LPN #2 grabbed and twisted her wrist on 10/22/05 and that R#6 witnessed the event. Interview with R#6 on 10/27/05 at 12:35PM and/or LPN #2 on 11/1/05 at 10:30AM identified that LPN #2 instructed the resident she would pour the resident coffee and lightly brushed the resident's hand away as she tried to pour the coffee herself. The interviews further reflected that staff assist residents with the coffee for safety reasons. Review of facility policy on 11/3/05 with the Director of Nursing (DON) noted that allegations of abuse will be reported to the DPH within 24 hours by phone and a written report will follow in 72 hours. Review of DPH and/or facility documentation identified that the DON notified the DPH of the allegation on 10/27/05 via telephone and in writing via a fax.
 - b. Resident #22's diagnoses included a history of substance abuse and a right above the knee amputation. Resident #23's diagnoses included substance abuse, major depression with psychotic features and a right below the knee amputation. On 7/31/05 at 12:30PM

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nursing narratives for R#22 identified that a resident (R#23) used facial gestures and taunted Resident #22. Resident #23's nursing narratives at 2:50PM indicated that the resident was involved with an altercation with another resident (R#22), the resident's threatened one another, the incident required staff intervention, and police were called to the facility. Interview with the ADON on 11/2/05 at 12:50PM noted that Resident #22 continued to verbalize that Resident #23 "was bugging him", said he was going to "beat up" R#23 and continued making threats. Review of the facility accident and incident log failed to reflect that the alleged event had been logged and/or reported to the DPH. Interview with the ADON on 11/2/05 at 1:40PM reflected that you do not have to log and/or document and/or report an altercation "just because the police were called". Interview with the Administrator on 11/4/05 at 12PM noted the facility had a difficult population and questioned if a report had to be generated and/or if the DPH had to be notified every time a resident threatened another resident. Review of facility policy on 11/4/05 reflected in part that verbal abuse was defined as the use of any verbal or gestured language that included disparaging and derogatory terms to residents.

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

3. Based on clinical record review and interview the facility failed to assess the resident's smoking history to include the daily number of cigarettes and/or smoking time preferences to reasonably accommodate the resident's smoking needs. The findings include:
 - a. Resident #1's diagnoses included schizoaffective disorder. Resident #1 resided on the second floor, locked, behavioral unit. The MDS dated 9/22/05 identified that the resident was resistive to care. The RCP dated 9/27/05 reflected that the resident was a supervised smoker and to monitor for compliance to the smoking policy. Facility documentation and/or policy noted that all smoking was supervised, smoking sessions were scheduled outdoors every day at 9 AM, 1:15 PM, 3:30 PM and 7 PM. Nursing narratives and/or facility documentation dated 10/6/05 indicated that the resident attempted to light two cigarette butts in the bathroom using the electrical outlet and the lead from a pencil at 4 AM and activated the bathroom smoke detector. Observation of the smoking session on 10/12/05 at 9:35 AM identified that the residents were given one cigarette at a time and allowed a total of two cigarettes. Interview with Resident #1 on 10/13/05 at 1:25 PM noted he was trying to light cigarette butts he had found outside. He further indicated that prior to residing at the facility, he smoked two packs of cigarettes a day, is now given only two cigarettes four times a day (total = 8 cigarettes/day) and cannot have a cigarette after the 7 PM smoking time. Review of facility documentation and/or survey history identified multiple reoccurrences of non-conformity to the smoking policy by facility residents. Please refer to deficiency F279.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o)

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

4. Based on review of the medical record, review of facility policies and procedures, and staff interviews for one resident (Resident #29), the facility failed to assess the resident's psychosocial needs following an allegation of abuse. The findings include:
 - a. Resident #29's diagnoses included dementia and chronic renal failure. The Minimum Data Set (MDS) dated 9/6/05 identified that the resident had impaired cognition. Facility documentation dated 9/19/05 identified that after an attempt to draw blood work by a laboratory technician, the resident was noted to have a one inch laceration on the chin which required sutures. The facility investigation identified that the resident reported that "the man did it". Nurses' notes and social service notes dated 9/19/05 to 9/21/05 lacked documentation that the resident's psychosocial status was assessed in relation to the resident's injury and/or allegation of abuse. The Director of Nurses stated that social service is made aware of incidents during the morning report. Social Worker #2 stated that she was unaware of the incident until surveyor inquiry on 11/3/05 and would have assessed the resident if she had been aware.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (c)(4).

5. Based on observation and interview the facility failed to ensure that towels were available for residents. The findings include:
 - a. During a tour of the facility on 10/7/05 with the Director of Housekeeping and Laundry at 10:25AM NA #3 was observed standing by the linen cart. Per interview at this time, NA #3 indicated that towels were not available and she was awaiting their delivery from laundry. She further stated that towels were not always on the unit and/or readily available from laundry upon request. Review of documentation from Resident #2 noted that there was a shortage of linen. Interview with Laundry Personnel on 10/7/05 indicated that at times there were not enough clean linens available, like towels and that they do the best that they could. Observation of the linen storage closet noted additional washcloths, bed linens and/or nightgowns however, towels were not available. Interview with the Director of Housekeeping and Laundry on 10/7/05 at 10:10AM and/or 11:15AM indicated that there was a problem in the past with dirty linen not being sent to laundry until the end of each shift but that this had improved. He further noted he did not have any towels stored for future service because two other sister facilities ran out of towels last Monday and Thursday and had borrowed his facility towels and had not yet replaced them.

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

6. Based on review of the clinical record, the facility failed to assess and/or accurately assess one

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resident who exhibited unsafe smoking behaviors(R#9) and/or one resident (R#23) who sustained a fracture and/or questionable fracture following a physical altercation. The findings include:

- a. Resident #9 was admitted with diagnoses inclusive of chronic schizophrenia and dementia. A Minimum Data Set (MDS) assessment dated 7/27/05 identified short and long-term memory problems and moderate impairment with decision making ability. Although a smoking assessment dated 10/6/05 identified that the resident demonstrated safety with smoking including proper ash disposal and that the resident keeps the cigarette away from self/clothing or other flammable objects, an observation on 10/15/05 at 9:45 AM identified Resident #9 seated on a bench with a smoking apron applied, smoking a cigarette which was lit by the nurse aide. Additional observations noted that ashes were falling on to the smoking apron during the smoking activity and that the resident had smoked the cigarette until the lit portion of the cigarette was in contact with the resident ' s first and second digits of the right hand.
- b. Resident #23 was admitted to the facility on 7/30/05 with diagnoses that included substance abuse and major depression with psychotic features and a right below the knee amputation. Review of the resident's clinical and acute care record dated 8/1/05 indicated that the resident was wheelchair dependent, had an altercation with another resident on 8/1/05 and was sent to the Emergency Department (ED). Review of the Resident's ED transfer documentation dated 8/1/05 indicated that the resident had a fractured finger and pelvis and required an orthopedic follow- up in seven days. The readmission nursing assessment dated 8/3/05 and/or nursing narratives from 8/3/05 to 8/10/05 failed to reflect that the finger and/or possible pelvic fracture had been assessed to include pain with or changes in range of motion and/or mobility. A care plan to address the fractures had not been developed. Although the resident's clinical record contained the resident's discharge instructions regarding the fractures, interviews with LPN #2 and RN #4 (nursing staff present upon resident's readmission) on 11/3/05 indicated that they were unaware of the presence of the instructions and/or the resident's fractures and identified that they could not obtain information from the Resident's ED visit.

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

7. Based on clinical record reviews, and interviews for five of eight sampled residents (R#1, #5, #6, #7, #8) the facility failed to develop comprehensive care plans that included specific interventions and/or measurable objectives. The findings include:
 - a. Resident #1's diagnoses included schizoaffective disorder and polysubstance abuse. The Minimum Data Set (MDS) dated 9/22/05 identified that the resident had modified independence for cognition and exhibited angry mood and/or resistive behavior. The Resident Care Plan (RCP) dated 9/27/05 identified, in part, that the resident had increased verbal aggression and expressed suicidal thoughts to gain attention.

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Interventions included providing redirection and assisting with recognition of triggers. Additional interventions included observe closely (place on 15 minute location checks or one to one supervision as warranted until seen by psychiatry). These interventions were not specific as to when to use the varying degrees of monitoring and/or the specific recognized triggers and/or the specific interventions to utilize when these triggers were present. Furthermore, the facility failed to identify specific treatment interventions to address the resident's aggressive behavior but included the following non-specific interventions, assist with utilizing healthy outlets for stress, anger or frustration and obtain psych consult as needed. Although the physician orders dated 8/1/05 and/or 9/15/05 indicated that the resident may have Tier 3 status (facility program distinctive for residents on locked unit outlining varying degrees of required resident supervision) the resident's plan of care failed to identify specifics on how the resident would achieve and/or maintain each level. Although program notes reflected resident participation in the level program, documentation was lacking to indicate that the resident had been assessed prior to participation in the "Tier Program" and how the program was incorporated into the overall plan of care.

- b. Resident #5 had a diagnosis of schizoaffective disorder, assessed on 6/16/05 as having problems with confusion, anxiety, agitation, was unable to demonstrate an accurate understanding of the smoking policy or safety issues and required supervised smoking. The resident was also assessed as being a high risk for the potential to violate the smoking policy. Resident #5 was found smoking outside unattended on 9/4/05 and was placed on every 15- minute checks. Although staff identified that the patient required the 15-minute checks, the checks were stopped on 9/5/05 without a documented assessment or revision to the plan of care. Subsequently, the resident was found smoking unsupervised on 9/11/05, 9/21/05, 9/22/05 and 9/29/05. The clinical record lacked an assessment of the resident regarding the 9/21/05 and 9/22/05 smoking episodes and although the care plan was updated to include the 4 smoking episodes including to reeducate on the smoking policy, conduct room checks and monitor every 15-minutes, a behavioral plan was not developed until 9/22/05. Although the behavioral plan included the possibility of moving the resident to a secured unit or initiating an involuntary discharge, observations made on 10/12/05 and 10/13/05 identified that Resident #5 had not been moved to the secured unit or involuntarily discharged despite violating the smoking policy again on 9/29/05. Interviews with the Director of Nurses (DNS), Assistant Director of Nurses (ADNS) and/or the Program Director on 10/13/05 identified that the resident 's 15-minute checks established on 9/4/05 should not have been discontinued on 9/5/05, the resident was a repeat violator of the smoking policy and documentation of an assessment regarding each violation of the smoking policy was lacking including where the resident obtained the cigarettes. On 9/11/05, after violating the smoking policy, Resident #5 stated that she was going to " set this place on fire. " A room search revealed a partially smoked cigarette, no matches or lighters were found, and staff identified that the resident required a psychiatric consult. The psychiatric consult did not occur until 9/16/05. The psychiatric APRN identified that the resident

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- had impaired memory and concentration, was experiencing delirium, and was angry regarding her smoking issues. Medication changes were made. Resident #5's psychiatric consult was reviewed with the ADNS and found to lack reference to the resident's statement that she would set the facility on fire and did not identify the type of supervision the resident may have required. Resident #5's care plan dated 9/11/05 identified that the resident was to be monitored every 15 minutes. The 15-minute check sheets were reviewed with the ADNS and identified that staff were making entries documenting that the resident was "down stairs," "out side" and/or "off unit" and then arrowed through subsequent 15-minute time frames. The documentation lacked specific locations/observations of the resident for up to one full hour at a time.
- c. Resident #6's diagnoses included depression and drug dependence. An assessment dated 8/8/05 identified no cognitive impairment or behavioral symptoms and that the resident required supervision when smoking. On 6/27/05, the resident was identified as having an off-unit pass. According to the Program Director, an off-unit pass means that a resident is on a Tier III privilege system. These residents are allowed off the unit unsupervised for a total of 4 hours a day. The facility lacked a policy, procedure or instructions for staff to follow in regards to the use of a tier system. Resident #6's clinical record was reviewed with the Program Director and Administrator and found to lack an assessment of the resident, in relation to the appropriateness of 4 hours of unsupervised time off the unit. According to the Program Director, a resident's tier level is not documented in the care plan but rather, staff on the unit know who is on a tier III based on information in a gray book that is updated weekly and as needed. The gray book was reviewed with the Program Director on 10/12/05 and identified that the tier list of resident's was last updated on 9/14/05. Resident #6's off-unit pass had a line drawn through it. According to the Program Director, a line through the off-unit pass means that the Tier III privilege is revoked. There was no date to indicate when this privilege was revoked. On 10/6/05, Resident #6 was observed selling cigarettes to other residents. The resident was transferred to a secured unit within the facility and placed in a "small smoking group." The resident's clinical record was reviewed with the Program Director and noted to lack an assessment of the resident in relation to the smoking violation. The care plan was not updated to include the resident's need for the small smoking group. On 10/9/05, Resident #6 was found smoking in a bathroom on the secured unit, with another resident. Again the record lacked an assessment of the resident in relation to the smoking violation. Following the smoking violation on 10/9/05, the resident's care plan was updated to identify that the smoking privilege was suspended. Review of the resident's clinical record on 10/13/05 failed to identify what Resident #6's current smoking status was. According to the Program Director, Resident #6 was currently allowed to smoke and continued to be a member of the small smoking group, despite the care plan identifying that smoking privileges were suspended. In addition, residents requiring small smoking groups were not included in the unit's gray book. On 10/6/05, Resident #6 told staff that she had used Heroin that same day, at the facility. The clinical record was reviewed with the Program Director

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and Administrator and lacked an assessment of the resident in relation to the alleged Heroin use. There was no reference to physician notification and the care plan lacked an update to include measures staff would take to monitor the resident's condition in relation to the Heroin use. On 10/6/05, while on the secured unit, Resident #6 threatened to kill herself by using a pair of surgical scissors. Staff conducted a room search and found a pair of surgical scissors, surgical clamps and nail clippers. The Program Director was unable to identify how the resident had surgical scissors in her possession, on a secured unit.

- d. Resident #7's diagnoses included dementia, schizoaffective and bipolar disorders. On 10/6/05 Resident #7 was assessed as a moderate risk to smoke inappropriately or violate the smoking policy. According to the facility smoking policy, if a resident is a moderate or high risk to violate the policy, an intervention sheet, side 2 of the smoking policy assessment, is to be completed. The intervention sheet was reviewed with the Program Director and Administrator and identified that the interventions had not been completed, per policy. Also, staff identified that the resident requiring a small smoking group, but this smoking intervention was not addressed in the care plan. Resident #7 was identified as having an "off-unit pass" dated 6/6/05. According to the Program Director, having the pass identified the resident as being on a Tier III and able to be off the unit unsupervised for 4 hours a day. Review of Resident #7's clinical record identified that there was no documented assessment of the resident in regards to the off-unit pass. In addition, on 10/9/05 the resident was found smoking in a bathroom on the secured unit and the care plan was updated to identify that the resident's tier III was suspended. The off-unit pass dated 6/6/05 was reviewed with the Program Director and Administrator and failed to include a slash across the page, indicating that the pass was discontinued, as the Program Director had indicated. On 10/6/05, Resident #7 identified that she was having difficulty sleeping and was very angry that nothing had been done about it. On 10/9/05, the resident was found smoking in the bathroom of the secured unit with another resident. Cigarettes and matches were found in Resident #7's closet. Again the resident stated that she could not sleep. The resident further stated that because she could not sleep, she would get up to smoke. Review of the clinical record identified that there was no nursing assessment related to the resident's inability to sleep. After the resident was found smoking, Resident #7 assaulted the other resident who was smoking with her, by throwing a glass of ice water in her face while she laid in bed. Due to the assault, Resident #7 was evaluated at an acute care hospital and returned with orders to administer sleeping medications.
- e. Resident #8's diagnoses included paranoid schizophrenia, post traumatic stress disorder and dementia with delusions. The resident was identified as having an off-unit pass on 3/29/05, a tier III. According to guidelines for a tier III, a resident is able to off the unit, unsupervised for 4 hours a day and a treatment team would evaluate the resident's current functioning status including insight, judgment and decision making abilities. On 4/7/05 the resident became delusional stating that he was being shot at and making references to the television. Psychiatric consults dated 4/19/05 and 5/3/05 identified that

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the patient had increased paranoia and delusions and medication changes were made. The resident's clinical record was reviewed with the Program Director and Administrator and lacked assessments of the resident in relation to the 3/29/05 tier III designation and the resident's safety needs and appropriateness of continuing as a tier III between April and May 2005. On 10/14/05 the facility submitted an action plan to address the Tier system to include evaluation of the system and/or revision of policies and procedures related to the Tier system.

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

8. Based on clinical record review and interview for one sampled resident (R#22), the facility failed to revise the resident's behavioral plan of care after the resident was assessed for and/or exhibited changes in behavior. The findings include:
 - a. Resident #22's diagnoses included a history of substance abuse. The MDS dated 7/28/05 identified that the resident had socially inappropriate and verbally abusive behaviors and resisted care. Review of the resident's clinical record reflected that the resident intermittently refused medications, yelled very loudly and wheeled his wheelchair very quickly toward a nurse on 5/29/05 and was verbally abusive toward a NA on 6/11/05. Interview with the ADON on 11/2/05 at 12:50PM noted that on 7/31/05 Resident #22 threatened Resident #23, continued to verbalize that Resident #23 "was bugging him", said he was going to "beat up" R#23 and continued making threats. Review of the resident's clinical record with RN #2 11/1/05 at 2:50PM indicated that although the resident's care plan reflected behaviors in regards to smoking, the RCP dated 7/28/05 lacked interventions and/or approaches to address the resident's socially inappropriate and verbally abusive behaviors. Further review of the Resident #22's clinical record and/or facility documentation dated 8/1/05 identified that Resident #22 and Resident #23 were involved in a physical altercation, Resident #22 was taken to the police department and Resident #23 was taken to the Emergency Department.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I)

9. Based on clinical record review and interview for one of eight sampled residents with inappropriate behaviors (R#1), the facility failed to obtain a urology and/or psychiatric consult and/or monitor the resident's behavior per the resident's plan of care. The findings include:
 - a. Resident #1's diagnoses included schizoaffective disorder. A urology consult dated 7/18/04 reflected a problem of urinary incontinence at night and a follow-up appointment for 1/17/05. The Urology consult dated 1/17/05 recommended urology follow up as needed. The MDS dated 9/22/05 identified that the resident was modified independent for cognition and occasionally incontinent of urine. The RCP dated 9/27/05 reflected a problem with urinary incontinence especially at night with approaches that

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included obtain urology consult. Nursing narratives dated 10/2/05 noted that the resident called the police because he needed to go to the bathroom and a resident who shared the bathroom knew he needed to use it and would not vacate the bathroom quick enough. Although nursing narratives reflected that the resident agreed to track the times he needed to void and try to use the bathroom 30 minutes earlier, interview with Resident #1 on 10/13/05 at 1:25PM noted when he is aware of the need to urinate the need is urgent. Nursing narratives dated 10/5/05 indicated that the resident's independent off-unit privileges were suspended because the resident urinated in an off-unit trashcan. During the same afore mentioned interview, Resident #1 indicated that when tried to use the off-unit bathroom on 10/5/05, the bathroom was occupied, and when he gets the felling that he's "got to go" then he's "got to go".

- b. Resident #1's psychiatric notes dated 9/15/05 identified discontinuancethe resident's Depakote medication and if the resident becomes more delusional and/or agitated will try to increase the resident's anti-psychotic medication (Seroquel). The RCP dated 9/27/05 identified psychotropic medication usage for schizoffective disorder with approaches that included administer medications as ordered, psych consult for medication review as needed and monitor for mood and behavior changes every shift. The September medication record reflected that the resident's Depakote had been tapered per physician orders and that the resident last received Depakote on 9/29/05. Nursing narratives and/or facility documentation dated 10/6/05 reflected that the resident was up and pacing at 3:30AM and caused the activation of the bathroom smoke alarm at 4AM. Interview with LPN #1 on 10/13/05 at 11:15AM noted that the resident used to sleep most of the night but for one week prior to 10/6/05 the resident would awaken in the early morning hours and "pace" and that he reports those residents who were up during the night to the supervisor. Interview with Psychiatrist #1 on 10/13/05 identified that the discontinuation of the resident's Depakote could have lead to the resident's decompensation. Review of the resident's clinical record with the Director of Nursing on 10/13/05 failed to provide documentation that the resident was monitored every shift for mood or behavioral changes and/or reevaluated by psychiatry after changes in the resident's sleeping pattern and pacing were noted.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I) and/or (s) Social Work (7).

10. Based on clinical record review and interview for one of two sampled residents who were responsible for self, the facility failed to start proceedings for a conservator per the physician order. The findings include:
- a. Resident #2's diagnoses included delusional disorder and schizoffective disorder-bipolar type. The admission MDS dated 8/9/05 identified that the resident was responsible for self. The physician order and/or physician progress notes dated 9/14/05 directed that the resident needed to have conservatorship in place and/or needed to be seen by Social Services for conservatorship. Physician progress notes dated 9/19/05

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reflected it was unclear from social service notes that arrangements are being made for conservatorship. Interview with Social Worker #1 on 10/11/05 at 12:10PM noted that she was unaware of physician's order for conservatorship for Resident #2 and would usually hear of such a need during morning report. She further indicated that she would have been the one to petition the court for the conservatorship and that the entire process could take four weeks.

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

11. Based on clinical record review, observation, and interview the facility failed to follow the facility fire/disaster policy following the activation of the smoke alarm. The findings include:
- a. Resident #1's diagnoses included schizoaffective disorder. The MDS dated 9/22/05 identified that the resident was resistive to care. The RCP dated 9/27/05 reflected that the resident was a supervised smoker and to monitor for compliance to the smoking policy. Nursing narratives and/or facility documentation dated 10/6/05 indicated that the resident attempted to light two cigarette butts in the bathroom using the electrical outlet and the lead from a pencil and activated the bathroom smoke detector. The documentation further noted that two objects were observed protruding from the wall socket, the wall socket and wall above the socket were charred and paper ashes were observed in the bathroom. Observation on 10/7/05 identified that the wall above the resident's bathroom electrical outlet remained faintly charred. Interview with RN #1 and/or LPN #1 and/or NA #1 on 10/7/05 and/or 10/13/05 reflected that the fire alarm was not manually activated because there wasn't a fire when they checked the area and/or everything was contained. Interview with Resident #1 on 10/13/05 at 1:25PM noted he was trying to light cigarette butts he had found on the ground outside. He smoked the first one but with the second one a spark was caused and the smoke alarm (battery powered, store bought) went off. Interview with the Maintenance Director (performs facility fire drills and in servicing) on 10/13/05 at 10:50AM indicated that when smoke is detected inside the building, staff is expected to pull the fire alarm, clear hallways and close resident bedroom doors. Review of the facility fire/disaster policy with the Director of Nursing (DON) on 10/13/05 at 12:20PM identified that in all occurrences; notification to the local fire department will be made by activation of the fire alarm at the time of the event and then by telephone, if needed.

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

12. Based on clinical record review, observation, and interview the facility failed to provide the necessary supervision during smoking sessions and/or for one resident who exhibited escalating behaviors. The findings include:

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- a. Review of the facility smoking policy on 10/12/05 identified in part that all residents were to be supervised during smoking, at no time will residents be allowed to provide lighting materials for others, and staff will supervise/assist during smoking sessions. Observation of the 9:30 AM smoking session revealed that at 9:35 AM on 10/12/05 noted approximately 30 residents in the smoking area with three staff in attendance. One staff member handed out the cigarettes, a second staff member lit the residents' cigarettes, and the third staff member assisted residents to don smoking aprons and/or observed residents smoking. One resident was observed to relight another resident's cigarette with his own cigarette. Six and seven residents were observed smoking in an area that did not have an ashtray close by and deposited their cigarettes on the pavement. Residents who had smoked their first cigarette, returned to the line to receive a second cigarette while some of those in line had not even received their first cigarette, which left only the third staff member to directly observe the residents who were smoking. The facility submitted an immediate action plan on 10/14/05 to include evaluation of the facility smoking policies and/or inservicing.
- b. Resident #9 was admitted with diagnoses inclusive of chronic schizophrenia and dementia. A Minimum Data Set (MDS) assessment dated 7/27/05 identified short and long-term memory problems and moderate impairment with decision making ability. A Resident Care Plan (RCP) dated 8/10/05 identified a behavior problem and a history of unsafe smoking with interventions that included supervised smoking and the utilization of a smoking apron when smoking. A smoking assessment dated 10/6/05 identified that the resident demonstrated safety with smoking including proper ash disposal and that the resident keeps the cigarette away from self/clothing or other flammable objects. An observation on 10/15/05 at 9:45AM identified Resident #9 seated on a bench with a smoking apron applied, smoking a cigarette which was lit by the nurse aide. Further observation identified that although the resident required supervision, the nurse aide had her back to the resident during the entire smoking activity. Additional observations of Resident #9 noted that ashes were falling on to the smoking apron during the smoking activity and that the resident had smoked the cigarette until the lit portion of the cigarette was in contact with the resident's first and second digit of the right hand. Upon further observation, deep brown discolored and hardened skin was noted on Resident #9's second digit of both hands.
- c. Resident #10 was admitted with diagnoses inclusive of schizophrenia and depression. An MDS assessment dated 9/22/05 identified a short and long-term memory problem with moderately impaired decision making ability. A smoking assessment dated 9/29/05 identified that the resident had impaired judgement, and required supervision with smoking. A RCP dated 9/29/05 identified that the resident required supervision while smoking with interventions that included supervise at all times during the smoking breaks and monitor for compliance with smoking policy. Observation on 10/15/05 at 9:45 AM identified that thirty nine (39) residents were participating in the smoking session with three (3) nurse aides supervising the activity with the nursing supervisor participating in the supervising half way through the activity. Further observation

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identified that Resident #10 was seated at the table located in the far left corner of the patio with his back to the group smoking a cigarette that had been lit by the nurse aide at the smoking cart without the benefit of any clear supervision. At the conclusion of smoking the cigarette, Resident #10 threw the cigarette on the ground without extinguishing and proceeded to the smoking cart and requested a second cigarette. Upon inquiry, the resident was directed to return to the unit as he was only allowed one (1) cigarette. Although the plan dated 10/14/05 identified that during the supervised smoking session residents will demonstrate that they are not in possession of any cigarettes by returning their cigarette butt to staff for disposal prior to receiving their second cigarette and/or before leaving the smoking area, staff failed to make an inquiry as to where the first cigarette was extinguished and/or located.

- d. Resident #23 was admitted to the facility on 7/30/05 with diagnoses that included substance abuse and major depression with psychotic features. The nursing assessment dated 7/30/05 identified that the resident was forgetful, experiencing feelings of anger, fear or abandonment, and was currently taking antipsychotic medication. The RCP dated 7/31/05 reflected that the resident had a verbal altercation with peer, resident will remove self from situation with staff direction and staff to redirect resident in a non-harmful manner. Nursing narratives dated 7/31/05 indicated that peers accused the resident of having confrontational behavior on three occasions on the 7AM to 3PM shift. Nursing narratives dated 8/1/05 at 11:45AM noted that the resident continued to exhibit threatening and confrontational behavior and was to be transferred to the locked unit. The narrative further reflected that the resident wanted to shower before he transferred to the other unit. Interview with RN #2 on 11/2/05 at 12:10PM identified that Resident #23 exhibited changes in behavior on 7/31/05 and 8/1/05, did not want to be transferred to the locked unit initially but, agreed to go after he had showered. Interview with LPN #5 on 11/2/05 at 12PM indicated that she was made aware of Resident #23's impending transfer to the locked unit through morning report on 8/1/05, saw the resident in the shower room later in the day and the resident was outside and involved in an altercation shortly after that. Further review of the resident's clinical and acute care record dated 8/1/05 indicated that the resident was sent to the ED after the altercation and sustained a fractured finger and a fresh fracture of the metallic pelvic bar with possible fracture of bone.

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

13. Based on clinical record review and interview for one sampled resident who received antipsychotic medication (R#26), the facility failed to adequately monitor serum levels of the medication. The findings include:
- a. Resident #26's diagnoses included bipolar disorder. The MDS dated 2/28/05 identified that the resident was cognitively independent, exhibited a sad or withdrawn mood and received antipsychotic medication daily. The RCP at this time reflected that the resident

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would receive the lowest therapeutic dosage of psychotropic medication. Physician orders dated 1/6/05 directed Lithium Carbonate 300mg by mouth twice daily. Nursing Narratives dated 3/17/05 and/or the hospital discharge summary dated 3/21/05 noted that the resident was lethargic and was admitted to the hospital with diagnoses that included Lithium toxicity. The hospital discharge summary further reflected that the resident's serum Lithium level was 2.6 (normal = 0.6 to 1.2). Interview with Pharmacist #1 on 11/2/05 at 3:10PM identified that Serum Lithium levels should be performed on a monthly basis. Further review of the resident's clinical record on 11/2/05 indicated that the resident's Lithium level was 0.8 meq/ml on 2/4/05 and the level had not been checked on a monthly basis. Review of the facility policy for monitoring medications with the DON on 11/3/05 reflected it was facility policy to obtain lithium levels every month for those residents who are stabilized. In addition, Resident #26 was readmitted to the facility on 3/21/05 and the Lithium had been discontinued during the resident's hospital stay. Physician orders dated 6/8/05 directed Lithium Carbonate 450mg by mouth twice daily and a Lithium level be obtained on 6/15/05 (1 week later). Laboratory data dated 6/15/05 noted that the resident's Lithium level was 0.7 meq/ml (within normal limits) and a physician order was obtained on 6/15/05 to increase the resident's Lithium to 600mg twice daily. Physician orders dated 6/15/05 also directed that a Lithium level be obtained on 6/22/05 (1 week later). Laboratory data dated 6/22/05 indicated that the resident's Lithium level was high (1.4) and the resident Lithium dosage was decreased at this time per physician order. A subsequent Lithium level was obtained per physician order on 6/22/05 (1.1), a Lithium level was not done for the month of July, and the resident was sent to the crisis center on 8/5/05 with an elevated Lithium level of 1.5. Interview with Pharmacist #1 on 11/2/05 at 3:10PM indicated that when a resident is placed back on lithium after not taking the medication for several months or had medication readjustments, the level should be checked 2 to 3 times a week until stable and then on a monthly basis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (q) Dietary Services (2)(D)

14. Based on documentation review, observation and interview the facility failed to ensure meals were delivered according to schedule and/or in a timely manner. The findings include:
 - a. Review of food committee and/or resident council meetings from 6/27/05 to 9/28/05 identified consistent complaints that breakfast and/or lunch and/or supper food deliveries on the second and/or third and/or fourth floors are late. Observation on 10/7/05 identified that the 3C unit breakfast trays arrived on the unit at 8:55AM. (Scheduled delivery time = 8:40AM). Interview with nursing staff at this time reflected that breakfast trays usually arrive on the unit at 9AM. On 10/7/05 observation of the noon meal from 12:10PM to 12:58PM noted that unit 2B, 4B, 3AB, 2C, and 4C meal carts were 16 minutes to 38 minutes late in leaving the kitchen for unit delivery. Observation on 10/11/05 indicated that the 4C unit did not receive meal delivery until

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1:18PM (38 minutes late) and Resident #3's tray was served at 1:30PM. The resident was observed to eat in hurried manner, finished his meal at 1:38PM and rushed to the elevator with coat on to participate in the scheduled 1:30PM smoking session. Interview with the Administrator on 10/7/05 at 12:43PM identified that the 3C wing accommodated 23 residents and opened a year ago in September. Interview with the Dietary Supervisor on 10/7/05 indicated meal delivery is usually late except for the 2C behavioral unit and the delivery times do not reflect the approximate 20 trays required for early delivery. When questioned, the supervisor further noted that although the 2C and 3C units had opened in the past three or so years (to accommodate a total of 48 resident's), the dietary supportive staff had not been increased.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (q) Dietary Services (2)(D) and/or 19-13-B42 (m)(1).

15. Based on documentation review, observation and interview the facility failed to ensure that hot food was served at preferable temperatures as discerned by residents. The findings include:
- a. Review of food committee and/or resident council meetings from 6/27/05 to 9/28/05 identified multiple complaints regarding hot foods not being served hot enough. Observations on 10/7/05 at 8:30AM noted that scrambled eggs and cooked cereal left the kitchen below 140 degrees. Observations on 10/7/05 and/or 10/12/05 reflected that breakfast and/or lunch trays were immediately served to residents by nursing staff as soon as the food cart was delivered to the unit. Interview with Resident #2 and #3 on 10/7/05 and/or 10/11/05 indicated that eggs were served moderately warm and/or that food was served cold especially breakfast. Interview with the Director of recreation on 10/7/05 at 9:50AM indicated that cold food complaints are common and that he tries to explain to the residents that it may be a dietary and/or nursing delivery issue.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-B42 (m)(1) and/or (t)(2)(A)

16. Based on documentation review, observation and interview the facility failed to ensure that food temperatures were maintained and/or was served under sanitary conditions. The findings include:
- a. Review of facility documentation reflected the morning temperatures of the scrambled eggs was recorded to be 175 degrees and the hot cereal to be 185 degrees before food service commenced on 10/7/05. Observation on 10/7/05 at 8:30AM reflected that the temperature of the cheese flavored scrambled eggs over the warming table was 168 degrees, the plain scrambled eggs had a temperature of 120 degrees and lacked a direct source of heat to maintain temperature and the hot cereal had a temperature of 134 degrees prior to leaving the kitchen. The observation also noted a large fan blowing on the food during the food service observation. Observation of the fan in the off position at 12:43PM noted the outside metal and inner blades of the fan to have a build-up of dust

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and hanging strands of dust debris. Interview with the Administrator at this time indicated that dietary was responsible to clean the outside of the fan and the cleaning of the fan blades was the maintenance departments responsibility. Interview with the Dietary Supervisor on 10/7/05 at 9:02AM and/or 9:40AM identified that food should be maintained at a temperature between 140 to 145 degrees in the kitchen and that the fan was not to be when food was being served. She further noted that when food is kept warm in the oven like the plain scrambled eggs, it should be put back into the oven after the serving is taken.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8u (2)(c)(ii).

17. Based on clinical record review and interview for one sampled resident who received antipsychotic medication (R#22), the contracted pharmacy consultant failed to identify that Lithium levels were not being monitored per standard and/or policy. The findings include:
- a. Resident #22's diagnoses included Lithium toxicity. Physician orders dated 1/6/05 directed Lithium Carbonate 300mg by mouth twice daily. Resident #22 was readmitted to the facility on 3/21/05 and the Lithium had been discontinued during the resident's hospital stay. The Resident was restarted on Lithium via a physician order dated 6/8/05 that directed Lithium Carbonate 450mg by mouth twice daily. Review of the Resident's clinical record on 11/2/05 noted that serum Lithium levels were not obtained on a monthly basis from 1/05 to 3/05 and from 6/05 to 8/05 and the resident's lithium levels were not stable. Daily and/or monthly physician orders failed to direct that monthly serum Lithium levels be obtained. Pharmacy medication review sheets reflected that the resident's medication regime review was conducted on a monthly basis during these time periods per policy yet failed to identify the recommendation for monthly lithium levels. Interview with Pharmacist #1 on 11/2/05 at 2:20PM identified that the pharmacy medication review included making clinical and regulatory observations to include the need for laboratory testing.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (2)(E) and/or (f) Administrator (3).

18. Based on clinical record review and interview the Administrator failed to ensure that the facility fire and disaster plan and/or smoking policy were followed. The findings include:
- a. Facility documentation dated 10/6/05 indicated that the bathroom smoke detector on the second floor locked unit had been activated. The documentation further noted that two objects were observed protruding from the wall socket, the wall socket and wall above the socket were charred and paper ashes were observed in the bathroom. Observation on 10/7/05 identified that the wall above the resident's bathroom electrical outlet remained faintly charred. Interview with RN #1 and/or LPN #1 and/or NA #1 on 10/7/05 and/or 10/13/05 reflected that the fire alarm was not manually activated because there wasn't a

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fire when they checked the area and/or everything was contained. Interview with Resident #1 on 10/13/05 at 1:25PM noted he was trying to light a cigarette butt in the bathroom, a spark was caused and the smoke alarm (battery powered, store bought) went off. Interview with the Maintenance Director (performs facility fire drills and in servicing) on 10/13/05 at 10:50AM indicated that when smoke is detected inside the building, staff is expected to pull the fire alarm, clear hallways and close resident bedroom doors. Review of the facility fire/disaster policy with the Director of Nursing (DON) on 10/13/05 at 12:20PM identified that in all occurrences; notification to the local fire department will be made by activation of the fire alarm at the time of the event and then by telephone, if needed. Further review of facility policy indicated that when the fire alarm is pulled, staff in the facility will ensure all windows and fire doors are closed.

- b. Review of the facility smoking policy on 10/12/05 identified in part that all residents were to be supervised during smoking, at no time will residents be allowed to provide lighting materials for others, and staff will supervise/assist during smoking sessions. Observation of the 9:30AM smoking session at 9:35AM on 10/12/05 noted approximately 30 residents in the outside smoking area with three staff in attendance. One staff member handed out the cigarettes, a second staff member lit the residents' cigarettes, and the third staff member donned resident smoking aprons and/or observed residents smoking. Observation on 10/15/05 at 9:45AM identified that thirty nine (39) residents were participating in the smoking session with three (3) nurse aides supervising the activity with the nursing supervisor participating in the supervising half way through the activity. During the observation on 10/12/05 and/or 10/15/05 residents were observed smoking in an area that did not have an ashtray close by and/or depositing remaining portions of cigarettes on the ground and/or lighting other resident's cigarettes with their cigarettes and/or smoking in an unsafe manner. Observations of the smoking sessions on the above dates also failed to reflect that during these sessions, all residents had direct/clear supervision. Please reference also F323 and F324.

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

19. Based on a review of facility documentation and interview the facility failed to provide the documentation for the completion of the required yearly twelve hours of in-service training for three of three nurse aides. The findings include:
- a. A sampled review of the facility in-service training log on 10/28/05 identified that NA#1 had six hours and twenty minutes, NA#4 had seven hours and 40 minutes, and NA had eight hours and thirty minutes of recorded in- service training in the year 2004. Interview with the In- Service Coordinator (ADON) on 10/28/05 at 12:20PM indicated that she might not have logged all in-services for the year 2004 and that accrual of in-service hours begins and ends during the month in which the staff member was hired. Review of NA #1's personnel record on 10/28/05 reflected she was hired during the month of

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August 2004 and the performance evaluation dated 10/27/05 noted that mandatory in-services had been completed. During an hour long review of all recorded and unrecorded in-services from 8/2004 to 8/2005 with the ADON on 10/28/05 from 1PM to 2PM identified that NA#1 had a total of 9 hours and 10 minutes of in-service training and did not meet the required 12 hours. Review of the mandatory in-services required by the facility with the ADON at this time further indicated that NA #1 had not received all of the mandatory in-services prior to her 2005 performance evaluation per facility policy as was identified on the performance evaluation.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT E

March 10, 2006

Mr. David Pistrutto, Administrator
Chelsea Place Care Center
25 Lorraine Street
Hartford, CT 06105

Dear Mr. Pistrutto:

An unannounced visit was made to Chelsea Place Care Center on December 5, 2005 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through March 6, 2006.

Attached is a violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

An office conference has been scheduled for March 24, 2006 at 2:00 P.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Judy McDonald, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

JFM:PMG:ls1

c. Director of Nurses
Medical Director
President
CT #4997, #5172



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

FACILITY: Chelsea Place Care Center

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

1. Based on review of medical records, review of facility policies, review of facility documentation, and interviews, the facility failed to ensure that all staff responded appropriately to safeguard residents in the facility when a fire was discovered in a resident bathroom and/or failed to implement appropriate measures to safeguard residents after a staff member was suspected of starting a fire in a resident bathroom. The findings included:
 - a. Review of facility documentation dated 3/3/06 identified that facility staff responded to an activated smoke detector alarm. Staff members observed that a roll of toilet tissue propped on the towel bar in the bathroom was on fire. Interview with Nursing Assistant #1 (NA #1) on 3/6/06 at 10:10 AM identified that when she entered the room, she saw that both doors of the bathroom that adjoined Rooms 445 and 447 " were opened all the way " and that she observed the toilet tissue roll in flames. NA #1 stated that she tried to get the two residents in the adjoining rooms, Residents # 23 and # 26, out of their rooms. Although NA #1 knew she should have closed the door, she stated that she was frightened and panicked when she saw the flames and that she did not close the doors to the bathroom to keep the fire in. Review of facility policy directed that in the event of a fire occurrence staff would utilize common sense and sound judgment in determining the procedure to be utilized. The policy directed that Rescue, Alarm, Contain, Extinguish, or Evacuate (RACE) or components of RACE would be implemented pending the severity of the situation.
 - b. Review of facility documentation identified that on 3/3/06 at 1:55 PM, a smoke detector on the fourth floor A unit was activated. Multiple staff members who responded to the alarm observed that a roll of toilet tissue, propped up on a towel bar, was on fire in the bathroom shared by residents of Rooms 445 and 447. Interview with the Fire Department Inspector on 3/3/06 at 3:15 PM identified that an investigation was conducted and that the fire was a result of a direct flame to the roll of tissue and not caused by cigarette smoking. The Fire Inspector stated that based on the investigation, it was her opinion that the fire was unlikely started by a resident and more likely started by a staff member. An Immediate Action Plan submitted to the Department of Public Health (DPH) on 3/3/06 included inservice education of all staff to discuss safety issues and criminal consequences of arson, room searches of all rooms on the affected unit, more frequent room searches of the affected rooms (every shift for seventy two hours), initiating an investigation inclusive of interviewing all staff on duty on 3/3/06, and the possibility of conducting background checks of employees. The facility continued the inservice education through the weekend shifts and a security person was hired for the 7:00 AM through 9:00 PM shifts beginning 3/5/06 (the facility routinely has security personnel in place from 9:00 PM through 7:00 AM). Interview with the Administrator on 3/6/06 identified that he had attempted to contact the Arson Division of the Hartford Police Department on two occasions over the weekend and again on 3/6/06 but had not

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED**

received a response. The Administrator stated that administrative staff members worked through the weekend hours to provide the inservice education and made rounds throughout the building. On 3/7/06, the Administrator stated that all staff on duty on 3/3/06 would be interviewed regarding the fire incident prior to working. Review of facility documentation identified that the facility interviewed staff members on the unit as well as some staff members in the building following the incident on 3/3/06. On 3/7/06, the Administrator was asked to provide all interviews conducted as of 3/7/06. Review of the documentation provided identified that interviews of all staff prior to working were not conducted. Although no conclusion was drawn as a result of the 3/3/06 staff interviews and having had knowledge of the Fire Inspector's verbal report that the fire was likely started by a staff person, the facility failed to continue additional interviews of staff members on other units in the building who may have had access to the area to determine if any other staff members had information about who may have started the fire. In addition, the facility failed to include the possible involvement of other residents and/or staff on other units and limited their specific monitoring to the rooms and/or residents where the fire was discovered. In addition, the facility failed to develop and/or implement additional measures to safeguard residents from the possibility that smoking materials that included lighters and matches might be brought into the facility by staff and/or visitors until 3/6/06. On 3/6/06, the facility prepared a written memo to all employees that included information about the fire on 3/3/06 and requested that staff and visitors refrain from bringing any source of ignition into the building. In addition, signs (dated 3/6/06) were posted that requested visitors to leave lighters and matches with the receptionist or door attendant while in the building.

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.