

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

IN RE:           Haven Health Center of Litchfield Hills, LLC  
                  d/b/a Haven Health of Torrington  
                  225 Wyoming Avenue  
                  Torrington, CT 06790

CONSENT ORDER

WHEREAS, Haven Health Center of Litchfield Hills, LLC (hereinafter the "Licensee"), has been issued Licensee No. 2248 to operate a Chronic and Convalescent Nursing Home known as Haven Health of Torrington, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing April 3, 2006 and concluding on April 6, 2006; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated May 9, 2006 (Exhibit A – copy attached); and

WHEREAS, the Licensee makes no admission regarding any of the alleged violations but is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Raymond Termini, its Managing Partner, hereby stipulate and agree as follows:

1. The Licensee shall, within fourteen (14) days of the execution of this Consent Order, revise and revise, as applicable, policies and procedures relative to:
  - a. Resident assessment for untoward medication side effects, inclusive of, but not limited to, changes in cognition, behavior and/or physical functioning;
  - b. Parameters for pain control medication administration and administration of "as needed" medication;
  - c. Patient assessment prior to and post administration of pain control medications; and
  - d. Supervision of clinical staff adherence to policies and procedures relative to prescribing medications and remediation of staff for non-compliance with policies and procedures.
2. The Medical Director of the Facility shall review and approve any policy and procedure which is revised as a result of this Consent Order within thirty (30) days of said revisions.
3. Each patient who receives psychotropic and/or narcotic medication shall be assessed for side effect and/or change in cognition, behavior and/or physical functioning prior to the administration of such medication(s). The Licensee shall monitor compliance with this requirement through weekly audits.
4. The Medical Director shall perform audits of ten (10) Pharmacist reviews per month of residents receiving psychotropic and/or narcotic medications to evaluate whether the untoward side effects of such medications have been addressed or recommendations have been made based on the potential for such side effects. Documentation of these audits shall be maintained for a period of two (2) years.
5. The Licensee shall within thirty (30) days of the execution of this Consent Order provide inservice education to licensed nursing staff responsible for administering drugs which shall include, but not limited to:

- a. The Consulting Pharmacist and/or Psychiatric APRN shall provide mandatory inservices for licensed nursing staff responsible for administering medications. The inservice shall include the potential interactions of psychotropic and/or narcotic medications as well as the side effects of these medications (e.g. confusion, decline in functional abilities); and
  - b. Current standards of practice relative to physician orders and/or protocols for medication.
6. The Licensee's Quality Assurance Program shall, within fourteen (14) days of the execution of this Consent Order, be revised, as necessary to comply with applicable State and Federal laws and regulations, so that it has components which include, but are not limited to:
  - a. Reviewing all reportable events that involve the administration of medications to identify the risk of harm and recommend preventive measures to be implemented by staff, including but not limited to revision of policies and procedures, to assure compliance with applicable State and Federal statutes and regulations, and
  - b. Establishment of inservice education programs for licensed and unlicensed personnel which shall reflect topics pertinent to those identified by the Quality Assurance Committee.
7. Any record maintained in accordance with any State or Federal laws or regulations or as required by this Consent Order shall be made available to the Department upon request.
8. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
9. The Licensee shall pay a monetary penalty to the Department in the amount of four thousand dollars (\$4,000.00), by money order or bank check payable to the

Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Judy McDonald, R.N.  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section  
Department of Public Health  
410 Capitol Avenue, MS #12HSR, P.O. Box 340308  
Hartford, CT 06134-0308

10. All parties agree that this Consent Order is an Order in the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limited the Department's available legal remedies against the Licensee for violations of the Consent Order of any other statutory or regulatory requirements which may be sought in lieu of or in addition of the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
11. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
12. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
13. 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 or any other rights that it may have under the laws of the State of Connecticut or of the United States.

14. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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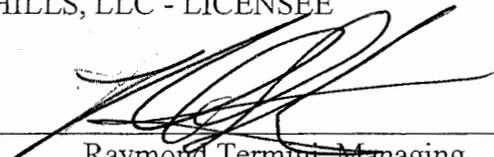
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Licensee: Haven Health Center of Litchfield Hills, LLC

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.

HAVEN HEALTH CENTER OF LITCHFIELD HILLS, LLC - LICENSEE

12-4-2006  
Date

By   
Raymond Termini, Managing Partner

State of Connecticut  
County of Middlesex

ss December 4 2006

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

My Commission Expires: \_\_\_\_\_  
~~Anthony K. Sclerka~~  
Justice of the Peace  
65 South Street  
Cromwell, CT 06416  
Term of Office expires December 31, 2008

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

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

12/5/06  
Date

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



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Exhibit A

May 9, 2006

Mr. Todd Gaertner, Administrator  
Haven Health Center Of Torrington  
225 Wyoming Avenue  
Torrington, CT 06790

Dear Mr. Gaertner:

Unannounced visits were made to Haven Health Center Of Torrington on April 3, 4, 5 and 6, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure and a certification inspection with additional information received through April 11, 2006.

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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 23, 2006 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address each violation 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,

*Karen Gworek R.N.S.N.C.*  
Karen Gworek, R.N.  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

KEG:VM:jpf

c. Director of Nurses  
Medical Director  
President



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

DATES OF VISIT: April 3, 4, 5 and 6, 2006

EXHIBIT A

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

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

1. Based on observation and interviews for 1 of 26 sampled residents (Resident #25), the facility failed to ensure that the area was maintained with privacy when the resident utilized a commode for toileting. The findings include:
  - a. Resident #25's diagnoses included contrast induced nephropathy. An admission assessment dated 3/7/06 identified that Resident #25 had no cognitive impairment, required staff assistance for activities of daily living including toilet use and was occasionally incontinent of bladder. The care plan dated 3/13/06 identified a problem related to incontinence. Interventions included to encourage the resident to call for assistance and to utilize a commode at the bedside. Observation on 4/3/06 at 9:00 AM from outside the facility, Resident #25 was noted standing in front of the window that faced the parking lot and driveway. The resident was observed to be wearing a johnnycoat and when the resident turned around the johnny was noted to be untied exposing Resident #25's back and buttocks as the resident proceeded to sit down. Upon observing Resident #25's room a commode was noted to be placed in front of the window where the resident had been observed. In an interview on 4/5/06 at 12:0 PM, Resident #25 identified she was unaware that she could be seen from the parking lot. In an interview on 4/6/06 at 9:45 AM, the Director of Nursing Services identified that the window curtain should have been closed for privacy to be maintained.

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

2. Based on clinical record review for one sampled resident (Resident #13) who had respiratory symptoms, the facility failed to monitor and/or conduct respiratory assessments. The findings include:
  - a. Resident #13's diagnoses of CVA, (Cerebral Vascular Accident) coronary artery disease, diabetes mellitus and schizophrenia. The quarterly assessment dated 1/30/06 identified the resident to have impaired decision making ability and had required extensive to total care by staff for all, activities of daily living. Nurses notes dated 2/26/06, 2/28/06 and 3/6/06 identified that the resident complained of chest pain and/or elevated temperature, heaviness in chest but there lacked an Registered Nurse's assessment. A chest x-ray dated 3/6/06 identified a questionable infiltrate in the left lower lobe (lung) and the physician directed the initiation of antibiotics. Nurse's notes from 3/8/06 (8:00 PM) through 3/11/06 identified "horse sounding voice" with some congestion and/or cough and/or malaise and there lacked a complete respiratory assessment. According to the Illustrated Manual of Nursing Practice, basis assessment of respiratory function requires determination of the rate, rhythm and quality of the patient's respirations.

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

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Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

3. Based on clinical record review and interview for 1 of 26 sampled residents (Resident #23) who required laboratory bloodwork, the facility failed to obtain the bloodwork when it was ordered and/or in a timely manner. The findings include:
- a. Resident #23's diagnoses included hypertension and cardiomegaly. The admission assessment dated 12/22/05 identified the resident with modified cognitive independence and occasionally incontinent of bladder. The physician's order dated 1/27/06 directed to obtain laboratory specimens that included a urinalysis and basic metabolic panel. Review of the laboratory section of the clinical record identified that the specimens were collected on 2/3/06 (seven days after the order). Interview and review of the clinical record on 4/6/06 at 1:25 PM, the Unit Charge Nurse identified that the laboratory service is at the facility daily including the weekends therefore specimens are obtained as soon as a physician's order was written. Further review identified that there was no evidence that bloodwork for Resident #23 was drawn between 1/27/06 to 2/3/06.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or 19-13-D8v (b) Pharmaceutical Services (2)(ii).

4. Based on clinical record review, interviews and review of facility documentation for 1 of 9 sampled residents (Resident #16) who received pain medication as needed, the facility failed to ensure that the resident received the correct dosage. For 1 of 9 sampled residents (Resident #11) who had an alteration in skin integrity and/or respiratory status, the facility failed to apply pressure relieving boots and/or obtain a treatment for excoriated skin and/or conduct respiratory assessments. The findings include:
- a. Resident #16 was admitted to the facility with narcotic medication addiction. Admission orders dated 11/8/05 included Morphine Sulfate (MSIR) 120 milligrams (mg) every six hours and MSIR 30 mg every six hours as needed for breakthrough pain. Facility documentation identified that on 11/14/05 the resident received MSIR 60 mg at 10:00 AM for breakthrough pain instead of 30 mg as ordered. The resident experienced increased confusion requiring the administration of Narcan upon physician notification.
  - b. Resident #11 was admitted to the facility on 7/26/05 following hospitalization for an infected decubitus ulcer. Diagnoses included acute renal failure, congestive heart failure and depression. The MDS assessment dated 3/20/06 identified that the resident was cognitively impaired, had a urinary tract infection within the last thirty days, experienced a weight loss, was on intake and output monitoring and had a significant change in status, deterioration in cognition, mood, behavior, communication and activities of daily living. The care plan dated 3/20/06 identified that the resident was administered psychotropic medication for depression, anxiety delirium, dementia with behavioral disturbances. Interventions included to assess for dehydration. A review of nurses notes dated 3/17/06, 3/18/06, 3/20/06, 3/22/06 and 3/27/06 identified that the resident had lethargy and/or was refusing po (intake) and/or had a fever of 101 and/or intake was poor and/or that the

REGISTRY OF PROFESSIONAL HEALTH CARE OF CONNECTICUT  
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resident reluctantly took fluids. These notes lacked an assessment for dehydration. On 3/17/06. Resident #11 displayed lethargy, expiratory wheeze, fever of 101, had a respiratory rate of 36, required suctioning and had difficulty breathing. The care plan dated 3/17/06 directed to monitor breath sounds every shift and as needed. A chest x-ray identified a left lower lobe infiltrate and lab work reflected a WBC of 18,700 (white blood cell count normal 5,000-10,000). The clinical record lacked evidence that complete respiratory assessments were conducted every shift during the period of 3/18/06 through 3/22/06.

- c. Resident #11 was admitted to the facility on 7/26/05 following hospitalization for treatment of an infected decubitus ulcer. The resident's MDS assessment dated 3/26/06 identified that the resident was cognitively impaired and required staff assistance for bed mobility. The MDS assessment further identified that the resident had a stage four pressure ulcer. The care plan dated 3/20/06 identified a problem of potential for alteration in skin integrity with an intervention to utilize "Blue Booties" when in bed. Observation of the resident on 4/3/06 and 4/4/06 identified that while the resident was in bed no Blue Booties were in place. Interview with the ICN (Infection Control Nurse) on 4/4/06 (A.M.) identified that the resident doesn't keep the boots on. Review of the care plan lacked documentation that the resident didn't keep the booties on or that the resident refused to wear booties. During repositioning on 4/4/06 (AM) for a treatment to a pressure ulcer on the buttocks the residents heels were noted to be reddened. Upon inquire of the ICN to describe the resident's heels, she stated the heels are "a little red". On 4/5/06, the resident was observed to be in bed with the Blue Booties on her feet.
- d. Resident #11 was admitted to the facility from the hospital on 7/26/06 following treatment of an infected decubitus ulcer. The resident's MDS assessment dated 3/20/06 identified the resident as cognitively impaired and requiring extensive staff assistance with bathing, hygiene and toileting needs. The care plan dated 3/20/06 directed to provide incontinent care every two hours and as needed. During observation of care on 4/3/06 at 1:05 PM a reddened excoriated rash like area was noted in the groin and anal area. A diaper had been in place. On 4/3/06 (1:05 PM) upon inquiry of the nurse aide (providing and assigned to care for the resident) as to whether the resident had any cream or treatment to this rash like area, the nurse aide responded that she thought staff were putting a cream on the area. Interview with the treatment nurse on 4/4/06 (AM) identified that there was no treatment to the perineal rash noted on 4/3/06. At this time the ICN asked the LPN who was on duty on 4/3/06 if the aide had told her about the resident's rash and the LPN said no. Subsequent to this, a review of the physician's orders identified a new treatment (Lotrisone) to perineal rash.

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

5. Based on clinical record review, observation and interview for 1 of 5 sampled residents (Resident #11) who had an open area, the facility failed to conduct assessments to promote healing and

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prevent further breakdown. The findings include:

- a. Resident #11 was admitted to the facility from the hospital on 7/26/05 following treatment of an infected decubitus ulcer. MDS assessments identified the presence of the pressure ulcer through March 2006. The treatment kardex through April 5, 2006 identified that treatments were being provided to the resident's pressure ulcer. A review of the pressure ulcer tracking form with the Assistant Director of Nursing Service on 4/5/06 identified that the clinical record lacked an assessment of the resident's stage four pressure ulcer of the buttocks during the period of 3/2/06 through 3/14/06 for a total of thirteen days. The facility's policy directed weekly assessment of pressure ulcers.

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).

6. Based on clinical record review and staff interviews, the facility failed to ensure that for 1 of 3 sampled residents (Resident #16) who entered the facility with a foley catheter and/or had a foley catheter inserted after admission, the facility failed to provide medical justification for the continued use of the catheter. The findings include:
  - a. Resident #16 was admitted to the facility following a hospitalization of 11/23/05. The resident was readmitted with a Foley catheter, which was discontinued on 12/2/05. The resident had no genitourinary diagnosis related to the need for catheterization and the MDS of 2/6/06 indicated that the resident was continent. A bladder assessment dated 11/12/05 indicated that the resident was able to use the bathroom with assistance and no precipitating factors for urinary incontinence were identified. The Resident Care Plan of 11/9/05 through 2/5/06 indicated that the resident had episodes of incontinence, and on multiple occasions including 12/5/05, 12/19/05, and 1/6/06 physician orders were noted to insert Foley catheter. Attempts at bladder retraining were discontinued. Nurses notes of 3/16/06 through 3/19/06 indicated that the foley catheter was either discontinued or reinserted, respectively, upon the patient's request and was last discontinued on 3/23/06. Although the resident had episodes of skin impairment, which responded to treatment, the RCP identified that the Foley catheter was utilized for wound healing and comfort upon resident's request. Upon interview, the attending physician indicated that the resident requested the use of the foley catheter for comfort. The physician stated that the resident required the catheter because of obesity and that without it the resident's skin would break down. Medical justification for ongoing use of the foley catheter was lacking.

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

7. Based on clinical record review, observation and interviews for 1 of 2 sampled residents (Resident #11) who required weekly weights, the facility failed to utilize one specific scale to obtain accurate weights and/or to monitor the resident's weight loss. The findings include:
  - a. Resident #11 was admitted to the nursing home on 7/26/05 following hospitalization for treatment of an infected decubitus ulcer. Diagnoses included Insulin Dependent Diabetes

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Mellitus, Anxiety Disorder, Depression hypothyroidism, depression, chronic obstructive pulmonary disease, obesity and gastric esophageal reflux disease. During the period of 7/05 through 12/05 the resident was noted to be on numerous psychotropic medications. The 11 and 12/05 progress notes identified a tremor which was worse during an activity - i.e. eating. The resident's weigh on admission was 283 pounds (lbs.). The December weight was 229 lbs. a loss of 54 lbs. since admission. Although the care plan addressed the weight loss of 54 lbs. in December 2005, it was identified as "desirable". A review of the monthly weight record identified that the resident's August 2005 weight was 296 1/2 lbs. The December 2005 weight was 229 lbs., a loss of 67 lbs. in four months and/or 54 lb weight loss since admission. Interview with the Assistant Director of Nursing Service on 4/6/06 identified that a weight was done weekly. A review of the dietitian's weight record identified the following weights: for admission, 283 lbs., October 2005, 228 lbs., November 2005, 228 lbs., December 2005 229 lbs., January 2006 230 lbs. to 288 lbs., February 2006 288 lbs., March 2006, 262 lbs., and because the resident was weighed using different scales there were discrepancies in the resident's weight. Observation on 4/5/06 identified the resident to be weighed via a left scale. The nurse identified the resident's weight to be 274 lbs. (36 pound weight loss since the July 05 admission).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2)(A) and/or (m) Nursing Staff (2)(A) and/or 19-13-D8v (b) Pharmaceutical Services (2)(C)(ii).

8. Based on clinical record review, facility documentation, observations and interviews for 7 of 13 sampled residents (Residents #9, #11, #14, #16, #17, #18 and #24) who received antipsychotic medications, the facility failed to ensure that the residents were monitored and/or assessed for targeted behavior and/or reviewed for dose reduction and/or had appropriate diagnoses that warranted the medications. The findings include:
  - a. Resident #11 was admitted to the facility from the hospital on 7/26/05 following treatment of an infected decubitus ulcer. The resident's past diagnoses included acute renal failure, congestive heart failure, chronic pain, urinary tract infections, anemia and depression. The resident was discharged from the hospital with documentation that identified the resident was administered Risperdal, (at hour of sleep). A review of physician orders, physician progress notes and the Medication Administration Record (MAR) identified that the resident received Risperdal 0.5 milligrams (mg) every night, however there lacked a diagnosis for the rationale to utilize this antipsychotic medication. The physician's order dated 9/1/05 identified an increase in the Risperdal (antipsychotic medication) to twice a day. Upon request of facility staff for the behavior monitoring of the antipsychotic medication, the facility could not provide documentation that the behavior was monitored from July 2005 to September 2005. The October 2005 medication administration record identified that the resident had delusions and/or hallucinations on one shift on 10/2/05 but did not have any additional delusions or hallucinations during the period of 10/3 through 10/30/05. The Risperdal was

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discontinued on 10/20/05. The April 2006 MAR identified that the resident was administered Haldol twice a day and as needed for anxiety and agitation. The April 2006 behavior monitoring sheet identified that the resident was combative on the 7-3 PM shift on 4/1 through 4/3/06. Observation of the resident on 4/3/06, 4/4/06, 4/5/06 and 4/6/06 during the period of 9:30 AM through 7:30 PM revealed the resident to be sedated and/or lethargic and/or frequently calling out for staff, occasionally restless, and cooperative with care. No combative episodes were observed. Review of nurse's notes lacked documentation of combative behaviors. Interview with nurse aides and Licensed Practical Nurses assigned to the resident's unit failed to identify any combative behavior.

In addition, during the period of 7/05 through 4/06 Resident #11 received the antidepressant Cymbalta on a daily basis. During the period of 10/05 through 3/17/06 the resident also received Wellbutrin, also an antidepressant medication on a daily basis. In January 2006 the resident had acute mental status changes and was identified as having confusion, increased sedation, lethargy, delusions and increased agitation. The resident was sent to the hospital on 2/1/06 through 2/6/06. On 2/2/06 the hospital psychiatrist identified that the patient was "on too much antidepressants" and recommended a reduction in these medications. On 2/6/06 the psychiatrist did a follow-up visit and identified that the patient was much better, more alert, oriented and responded to questions. During the period of February 2006 through March 2006, physician orders continued to identify that the resident was on Haldol and/or Zyprexa and/or Cymbalta, and/or Wellbutrin and/or Ativan and/or Trazodone and/or Ambien and/or Duragesic Patch and/or Oxycodone and/or Roxanol and/or Cogentin and/or Klonopin and/or Depakote and/or Scopolamine Patch. On 3/27/06 Resident #11 was placed on Hospice VNA Services for a diagnosis of "General Debility". Recommendations by the Hospice nurse and implemented by the physician included a Scopolamine Patch (as needed for excessive secretions) and Roxanol (morphine) 20 mg SL every one hours as needed for breakthrough pain and labored respirations. In addition, during the period of 3/24/06 through 4/4/06 the resident's Duragesic Patch was increased from 25 mcg to 300 mcg every 72 hours. The Hospice nurse's note dated 4/3/06 identified that during the period of 4/1/06 through 4/3/06, the resident received ten doses of Ativan. This note further identified that the resident's respirations were irregular, shallow and the resident had short periods of apnea. In this note the Hospice nurse made a recommendation to increase the Duragesic Patch to 300 mcg and increase the Roxanol to 30 mg every one hour as needed. On 4/1/06 and 4/3/06 the resident received a Scopolamine Patch, seven doses of Roxanol, nine doses of Haldol and Ativan as noted above. Upon discussion with the Administrator regarding the deterioration in the resident's status and medication usage, the facility submitted an action plan that identified that the attending physician conducted a review of all the resident's medications on 4/10/06 and reduced the Duragesic Patch, discontinued the Ativan, Scopolamine Patch, Risperdal and Lidoderm patch. In addition, the Cymbalta, Roxanol and Haldol were reduced and Klonopin was added. tranquilizers for a long period.

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Upon inquiry of the Administrator on 4/19/06 of Resident #11's current status, the Administrator responded that the psychosis was clearing, that the agitation and anxiety are gone, the resident is much more alert, vital signs are stable, the resident is standing with walker and uses commode and the psychiatrist made additional medication adjustments/reductions.

- b. Resident #9 had diagnoses including pneumonia, cerebral anoxia, hypertension, cerebral vascular accident, senile dementia and depression. The resident's current psychotropic medications included Lexapro 10 mg every day; Aricept 10 mg at night; Zyprexa 5 mg at 5:00 PM and Lorazepam 0.25 mg every eight hours as needed for restlessness. The MDS of 12/19/05 and 3/14/06 indicated that the resident had no symptoms of delirium, disordered thinking, depression or behavioral symptoms. Behavioral Health Assessments identified the resident was withdrawn, isolative and depressed and on 3/17/06 the resident was described as intrusive and difficult to redirect. Psychiatric assessments varied as to the presence of delusions, which were not specifically identified in psychiatric assessments. Targeted behaviors monitored by staff included restlessness and agitation. When asked how the resident exhibited restless/agitated behavior, the charge nurse stated that although the resident was "pretty stable" she frequently rocked in her wheelchair and cried out "hello". The charge nurse stated she often gave the resident Ativan on a routine basis to control these behaviors. Observation of the resident intermittently between 4/3/06 and 4/6/06 revealed the resident as withdrawn, subdued and occasionally irritable. Rationale for use of antipsychotics and monitoring of specific behaviors relating to the use of Ativan was lacking.
- c. Resident #14 had depression, psychosis anxiety, traumatic brain injury and hemiplegia. The care plan dated 2/3/06 had an intervention to perform AIMS (Abnormal Involuntary Movement Scale) testing every six months. The MAR identified that the resident was on Zyprexa 10 mg every night. The clinical record lacked documentation that AIMS testing was conducted every six months. Documentation in the clinical record reflected that AIMS testing was done on 5/19/05 and nine months later on February 2006. The pharmacy review identify that the six months AIMS testing was overdue.
- d. Resident #16 was admitted to the facility on 11/8/05 with diagnoses that included chronic obstructive pulmonary disease, depression, unspecified neurotic disorder and addiction to narcotic pain medication. The Minimum Data Set (MDS) of 11/14/05 and 2/6/06 indicated that the resident had no symptoms of delirium, disordered thinking, depression, anxiety and exhibited no behavioral symptoms. Psychotropic medications at the time of admission included Seroquel 25 mg twice per day and 300 mg at bedtime; Ativan 1.0 mg every six hours as needed for anxiety, Neurontin 300 mg three times per day and Ambien 10 mg as needed for sleep. The resident also continued to receive high doses of narcotic analgesics upon admission to the facility. Although the initial psychiatric assessment identified an unspecified psychosis and depression as an initial diagnoses, only depression and medication addiction were addressed as diagnoses on subsequent psychiatric assessments on 12/5/05 and 3/3/06. Review of the clinical record and MAR identified that behaviors related to symptoms of depression were monitored

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EXHIBIT A

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(crying/weeping), however, behaviors related to psychosis were not identified. When asked if the resident required antipsychotic medication, the attending physician stated that the resident had "a psychiatric diagnosis" and although antipsychotics were initially prescribed by another physician during hospitalization in November 2005, they were continued at this time to stabilize the resident's depressed mood resulting from a recent loss. Rationale for the use of antipsychotic medication was lacking.

- e. Resident #17's diagnoses included chronic depression. The quarterly assessment dated 1/23/06 identified that Resident #17 had no memory deficits with modified cognitive impairment, displayed no mood or behavioral symptoms and received antidepressant, antipsychotic and antianxiety medications. Observation from 4/5/06 through 4/6/06 during the 7-3 PM shift, Resident #17 was observed seated in a wheelchair self propelling throughout the facility. The Resident Care Plan (RCP) dated 1/26/06 identified the utilization of psychotropic medication related to depression. Interventions directed to administer educations as ordered, psychiatric evaluation as needed, monitor for therapeutic effectiveness and complete behavior tracking sheet every shift per policy. Review of the Medication Administration Record (MAR) identified that the resident received Zoloft 100 mg daily and Risperdal 0.25 mg at bedtime daily. The Behavioral Health Follow-Up Consultation dated 1/6/06 identified that Zoloft and Risperdal were utilized for psychiatric treatment and although a dose reduction was recommended for the next visit, the consultation report lacked evidence of the next follow-up date. Review of the psychiatric consultations from 6/23/05 through 1/6/06 identified that a dose reduction had been initiated on 6/23/05 at which time the Risperdal was been decreased from 0.5 mg to 0.25 mg, Resident #17 was seen monthly until 9/29/05 and the last visit was 1/6/06. Review of the clinical record and MAR from 3/1/06 through 4/5/06 lacked documentation of targeted behaviors and that Resident #17 had been monitored every shift. In an interview on 4/6/06 at 11:40 AM, the charge nurse was unable to explain what were Resident #17's targeted behaviors and to provide evidence that monitoring of the resident's behaviors had been conducted.
- f. Resident #18's diagnoses included dementia with behavioral disturbances. The quarterly assessment dated 2/28/06 identified that Resident #18 had memory deficits, moderate cognitive impairment, displayed no mood or behavioral symptoms and received antidepressant and antipsychotic medications. The RCP dated 3/2/06 identified the utilization of psychotropic medications Seroquel and Lexapro. Interventions directed to administer the medications as ordered, psychiatric evaluation as needed, monitor for therapeutic effectiveness of medication and complete behavior tracking sheet every shift per policy. The Behavioral Health Follow-Up Consultation dated 1/6/06 recommended no change in current treatment, dose reduction contraindicated and to monitor for changes in behavior and mood. Review of the clinical record and MAR from 3/1/06 through 4/5/06 lacked documentation of targeted behaviors and that Resident #18 had been monitored every shift. In an interview on 4/6/06 at 11:40 AM, the charge nurse was unable to explain Resident #18's targeted behaviors and to provide evidence that monitoring of the resident's behaviors had been

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conducted.

- g. Resident #24's diagnoses included mental retardation. An admission assessment dated 11/22/05 identified that Resident #24 had severe cognitive impairment, no indicators of depression, anxiety, sad mood and/or behavioral symptoms were displayed, aphasic and received antipsychotic and antidepressant medications. The RCP dated 11/17/05 identified psychotropic drug use related to mental retardation. Interventions included to administer medication per physicians's order and complete the behavior tracking sheet every shift per policy. Physician orders dated 1/06 directed that resident receive Risperdal 0.5 mg twice a day and Trazodone HCL 50 mg at bedtime. Review of the nurse's notes from 11/21/05 through 1/24/06 identified no targeted behaviors for Resident #24. Review of the MAR from November 2005 through January 2006 lacked documentation of behavior monitoring. Interview and review of the clinical record on 4/6/06, the Director of Nursing Services failed to provide evidence that the resident was assessed and/or monitored for targeted behaviors and/or that the resident had an appropriate diagnoses that warranted the medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or 19-13-D8v (b) Pharmaceutical Services (2)(C)(ii)

9. Based on clinical record review and interview for 2 of 26 sampled residents (Residents #7 and #11) who required monthly medication regimen review by the pharmacist, the facility failed to ensure that the pharmacy recommendations were reviewed and acted upon by the physician related to routine hypnotic medication and/or that the pharmacist questioned the change in mentation as a possible adverse effect of multiple medications. The findings include:
- a. Resident #7 had diagnoses including hypertension, diabetes and cardiovascular disease. The resident's current medications included Ambien 5 milligrams every night. Although the pharmacist consultant recommended on 2/14/06 that the Ambien be prescribed on an "as needed" basis, no response and/or change in the order was made by the primary physician who visited the resident on 2/22/06 and renewed orders on 3/24/06.
  - b. During the period of 7/05 through 3/06 Resident #11 was receiving numerous medications, inclusive of anti-psychotropics and/or antidepressants, and/or anti-anxiety, and/or narcotics. Although the resident experienced a significant decline in mental and physical status on the March 20, 2006 MDS assessment, the pharmacy review of 3/20/06 lacked documentation to address the medications and possible adverse affects. During an interview with with the Med Options psychiatrist on 4/5/06 he identified that he was very concerned about all the medications and wanted to get the resident into a hospital (psychiatric unit) to reduce medications.

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 (t) Infection Control (2)(A).

10. Based on clinical record review, observation and interview for 1 of 2 sampled residents (Resident

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#12) who had a foley catheter, the facility failed to maintain appropriate infection control techniques to prevent a possible infection. The findings include:

- a. Observation on 4/3/06 at approximately 10:00 AM identified Resident #12 to lying in bed and her foley catheter drainage bag was lying on the floor. Observation at 10:10 AM identified that the catheter drainage bag remained on the floor. Upon surveyor intervention on 4/3/06 at 10:10 AM the Nursing Supervisor directed the nurse aide to replace the catheter drainage bag.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1).

11. Based on clinical record review, observations and interviews for one sampled resident (Resident #17) who self administered medications, the facility failed to ensure that the most current quarterly assessments were maintained in the clinical record. The findings include:
  - a. Resident #17's diagnoses included, in part, cerebral palsy, chronic obstructive pulmonary disease, seizure disorder and chronic depression. The quarterly assessment dated 1/23/06 identified that Resident #17 had no memory deficits, modified cognitive impairments, and required some assistance with activities of daily living. The Evaluation of Resident's Ability to Safely Administer Medication assessment dated 11/29/04, conducted on admission, identified that Resident #17 had expressed the desire for the nurses to administer medications at present and the clinical record lacked evidence that quarterly assessments had been conducted thereafter. Review of the Medication Administration Records from November 2005 through April 2006 identified that Resident #17 received Albuterol inhaler two puffs as needed for shortness of breath "may keep at bedside-may self administer" and documentation identified that the inhaler was utilized on four occasions in the six months reviewed. Observation and interview on 4/5/06 at 2:00 PM, Resident #17 explained that he keeps the inhaler in the back pocket of the wheelchair and had utilized the medication on occasions, the last being a few weeks prior. The resident indicated that the nurses do not question if he had utilized the inhaler nor does he inform the nurses when he had self administered the inhaler. In an interview on 4/6/06 at 11:10 AM, the Resident Care Plan Coordinator identified that Resident #17 had been assessed quarterly for self administration, the information should be located in the current chart and subsequent to inquiry obtained the assessments that were conducted from 2/7/05 through 1/26/06 from the overflow record that was stored off the nursing unit.