

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

IN RE: Kettle Brook Care Center, LLC of East Windsor, CT d/b/a
Kettle Brook Care Center, LLC
96 Prospect Hill Road
East Windsor, CT 06088

CONSENT ORDER

WHEREAS, Kettle Brook Care Center, LLC (hereinafter the "Licensee"), has been issued License No.2219-C to operate a Chronic and Convalescent Nursing Home known as Kettle Brook Care Center, LLC, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Connecticut 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 on August 7, 2006 and concluding on September 7, 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 violations letters dated August 25, 2006 (Exhibit A, attached) and September 21, 2006 (Exhibit B, attached); and,

WHEREAS, on August 25, 2006, the Department issued a Summary Order against the Licensee based upon its findings that there were violations of the Regulations of Connecticut State Agencies which seriously jeopardized the health, safety and welfare of patients and which have resulted in serious negative patient outcomes. (Exhibit C, attached).

WHEREAS, on August 28, 2006, the Department issued a Statement of Charges against the Licensee (Exhibit D, attached); and,

WHEREAS, on September 21, 2006, the Department issued an Amended Summary Order to the Licensee (Exhibit E, attached); and,

WHEREAS, the Licensee 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 Chris S. Wright, the ~~Managing~~ ^{Manager} ~~Member~~, hereby stipulate and agree that in accordance with Connecticut General Statute Section 19a-494(a)(5), the license of Kettle Brook Care Center LLC of East Windsor is placed on probation for a period of two (2) years under the following terms and conditions:

1. The Licensee is hereby ordered to contract with a physician consultant, licensed in Connecticut and pre-approved by the Department (“Medical Consultant”), who will function separately and distinctly from the Licensee and the current medical director, who shall have the responsibility for assessing the quality of medical direction and/or care provided at the facility. The Medical Consultant shall confer with Kettle Brook’s Administrator, Director of Nursing Services, Medical Director and other staff, as the consultant deems appropriate concerning the consultant’s assessment of medical services:
 - a. The Medical Consultant shall perform the following duties:
 - i. Provide oversight and guidance to the Medical Director;
 - ii. Accompany the Medical Director on rounds;
 - iii. Audit at least 10 medical records per week;
 - iv. Review, analyze and offer recommendations regarding facility data, to include but not be limited to, pressure sore and infection control rates;
 - v. Review protocols for care and make specific recommendations as to the care of individual patients; and
 - vi. The Medical Consultant shall confer with the Licensee, Administrator, Director of Nursing Services, Medical Director and other staff determined by the Medical Consultant to be necessary to the assessment of the medical care.
 - b. The Medical Consultant shall make written recommendations to the Licensee’s Administrator, Director of Nurses and Medical Director for improvement in the delivery of medical care in the facility. If the Medical Consultant and the Licensee are unable to reach an agreement regarding the implementation of the Medical Consultant’s recommendation(s), the Department after meeting with the

- Licensee and the Medical Consultant shall make a final determination, which shall be binding on the Licensee and not subject to appeal in any forum;
- c. The Medical Consultant shall submit reports every other week to the Department, the Independent Nurse Consultant described below and the Wound/Infection Control Consultant described below documenting:
 - i. Assessments of the care and services provided to the patients;
 - ii. The Licensee's compliance with applicable federal and state statutes and regulations pertinent to the facility; and
 - iii. Recommendations made by the Medical Consultant and the Licensee's response to implementation of the recommendations.
 - d. The Medical Consultant shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
 - e. The Medical Consultant shall be contracted with for a period of at least six (6) months from the effective date of this Consent Order. The Department will evaluate the role of the Medical Consultant at the end of the six (6) month period and may, in its sole and absolute discretion, eliminate, reduce or increase the role of the Medical Consultant and/or his responsibilities, if the Department determines the reduction or increase is warranted. All decisions by the Department with respect to the Medical Consultant shall be final and not subject to further review or challenge in any forum.
2. The Licensee shall execute a contract with an Independent Nurse Consultant ("INC") pre-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.
 3. 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 or the staffing requirements of this Consent Order pursuant to Paragraphs 8 and 9 below;

- a. 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 forty (40) hours per week and 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 sole and absolute discretion, eliminate, 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 provisions of this paragraph 3 and Exhibit F of this Consent Order;
- b. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
- c. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director, the W/ICC and the Medical Consultant 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;
- d. The INC shall make written recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct:
 - i. 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 and not subject to appeal in any forum;.
- e. The INC shall submit written reports every other week to the Department, the Medical Consultant and the W/ICC documenting:
 - i. The INC's assessment of the care and services provided to patients;
 - ii. The Licensee's compliance with applicable federal and state statutes and regulations;

- iii. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations;
- iv. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
- v. The INC shall have the responsibility for:
 - i. 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. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - ii. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
 - iii. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
 - iv. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letters dated August 25, 2006 and September 21, 2006.
- f. The INC, the Licensee's Administrator, the W/ICC and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first six (6) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations;
- g. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department upon request; and

- vii. Conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, preventative protocols and assess patients at risk for pressure sores or vascular areas.
 - c. The Independent W/ICC contracted to provide wound care oversight shall provide reports, every other week, to the Department, the INC and the Medical Consultant regarding his/her responsibilities and an assessment of the facility's progress as related to issues of skin integrity;
 - d. The Independent W/ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation; and
 - e. The Independent W/ICC shall confer with Kettle Brook's Administrator, Director of Nursing Services, the INC and the Medical Consultant and other staff as the Consultant deems appropriate concerning the Consultant's assessment of nursing services and Kettle Brooks' continued compliance with the Public Health Code and applicable statutes. Said Consultant shall conduct meetings at the Department's request with the Department, the facility's Administrator, its Director of Nursing Services and its Licensee and make recommendations to such parties for improvement in the delivery of direct patient care in the facility.
 - f. The W/ICC shall be contracted with for a period of at least twelve (12) months from the effective date of this Consent Order. The Department will evaluate the hours of the W/ICC at the end of the twelve (12) month period and may, in its sole and absolute discretion, eliminate, reduce or increase the hours of the W/ICC and/or his responsibilities, if the Department determines the reduction or increase is warranted. All decisions by the Department with respect to the W/ICC shall be final and not subject to further review or challenge in any forum.
5. Effective immediately upon execution of the Consent Order, the Licensee shall employ a full time Infection Control Nurse, licensed in Connecticut and pre-approved by the Department, whose sole responsibility is to implement an infection prevention, surveillance and control program which shall have as its purpose the protection of patients and personnel. The registered nurse hired for this position must have expertise and experience specific to infection control. Should the registered nurse appointed to the

position of Infection Control Nurse lack professional work experience in the areas of infection control, as determined by the Department in its sole discretion, the Licensee shall ensure that the W/ICC provides oversight for this position. The Infection Control Nurse may also be responsible for staff education in the area of infection control. The Infection Control Nurse, in conjunction with the Director of Nurses, Medical Director and Administrator shall implement a mechanism to ensure that each patient with an infection is properly identified and receiving the appropriate care and services pertinent to the identified infection. The Infection Control Nurse shall ensure the following:

- a. Maintaining an effective infection control program;
 - b. Reviewing the facility's policies/procedures pursuant to infection control prevention, with the Director of Nurses, Medical Director and Administrator and revise as necessary;
 - c. Inservicing all staff pursuant to infection control principles and practices;
 - d. Evaluating patients on admission to determine the existence of an infection;
 - e. Developing of policies and procedures relative to assessing for appropriate room, roommate and isolation protocols;
 - f. Accurate line listings of patient infections to include date of onset of infection, type of infection, site of infection, treatment, room location and any culture/lab results; and
 - g. Evaluation of staff on a routine basis, on all three shifts, regarding the implementation of infection control techniques.
6. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
- a. Sufficient nursing personnel are available to meet the needs of the patients;
 - b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
 - c. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
 - d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
 - e. Nurse aide assignments accurately reflect patient needs;

- f. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
 - g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
 - h. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
 - i. Necessary supervision and assistive devices are provided to prevent accidents; and
 - j. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs.
7. The Licensee shall have a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any resident related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period. Nurse Supervisors shall be provided with the following:
- a. A job description, which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. An inservice training program, which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to resident and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitoring 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 a irregular schedule of visits. Records of such administrative visits and supervising shall be retained for the Department's review; and

- d. Nurse Supervisors shall be responsible for ensuring that all care is provided to residents by all caregivers in accordance with individual comprehensive care plans.
8. Kettle Brook Care Center, LLC is hereby ordered to develop and maintain a patient acuity system which shall identify the number and qualifications of nursing and ancillary staff necessary to meet the needs of patients housed in the facility. The Licensee shall, on a daily basis, utilize the acuity system to establish staffing ratios, except that when the Licensee has equal to or less than 155 residents, staffing ratios shall be maintained, at a minimum, as follows:
- a. 1st shift - 7:00 a.m. to 3:00 p.m.
9 licensed staff – to include two (2) free floating registered nurse supervisors and one (1) treatment nurse.
19 nurse aides.
 - b. 2nd shift - 3:00 p.m. to 11:00 p.m.
8 licensed staff – to include one (1) free floating registered nurse supervisor and one (1) treatment nurse.
17 nurse aides.
 - c. 3rd shift - 11:00 p.m. to 7:00 a.m.
7 licensed staff – to include one (1) free floating registered nurse supervisor.
10 nurse aides.
9. When the Licensee has more than 156 residents, staffing ratios shall be maintained, at a minimum, as follows:
- a. 1st shift - 7:00 a.m. to 3:00 p.m.
9 licensed staff – to include two (2) free floating registered nurse supervisors and one (1) treatment nurse.
20 nurse aides.
 - b. 2nd shift - 3:00 p.m. to 11:00 p.m.

8 licensed staff – to include one (1) free floating registered nurse supervisor and one (1) treatment nurse.

18 nurse aides.

c. 3rd shift - 11:00 p.m. to 7:00 a.m.

7 licensed staff – to include one (1) free floating registered nurse supervisor.

12 nurse aides (11 nurse aides if the total number of residents is between 156 and 160, inclusive).

10. 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.
11. The Summary Order dated August 25, 2006 (Exhibit C) and the Amended Summary Order dated September 21, 2006 (Exhibit E) shall be vacated as of the effective date of this Consent Order.
12. The Licensee's census shall remain equal to or lower than one hundred fifty-five (155) patients until November 30, 2006.
13. The Licensee's census shall remain equal to or lower than one hundred sixty (160) patients until December 31, 2006.
14. The Licensee's census shall remain equal to or lower than one hundred sixty-five (165) until January 31, 2007.
15. The Licensee's census shall remain equal to or lower than one hundred seventy (170) patients until February 28, 2007.
16. The Licensee shall establish a Quality Assurance Program ("QAP") to review patient care issues including those identified in the August 25, 2006 and September 21, 2006 violation letters. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
17. If with the execution of this modified consent order the Licensee is unable to maintain substantial compliance for a period of at least sixty (60) days, determined

through onsite visits conducted by the Department, in its sole discretion, within thirty (30) days of that determination, the Licensee shall contract at its own expense with a Management Company unrelated to the Licensee, acceptable to the Department. The Management Company shall oversee operations of the Facility. In this circumstance, the Licensee shall have no direct input into the day to day operations.

18. In accordance with Connecticut General Statute Sections 19a-494 (4) and 19a-494 (7) the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a Chronic and Convalescent Nursing Home.
19. The Licensee shall pay a penalty to the Department in the amount of \$25,000.00 twenty-five thousand dollars, by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department at the time of the signing of this Consent Order.
20. The penalty and all reports required by this document shall be directed to:

Elizabeth S. Andstrom, R.N., M.S.
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

21. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

22. 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.
23. The terms of this Consent Order shall remain in effect for a period of three (3) years from the effective date of this document unless otherwise specified in this document.
24. 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 it may have under the laws of the State of Connecticut or of the United States.
25. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

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. I, Chris S. Wright, am authorized to sign this Consent Order on behalf of the Licensee, and I do so under my own free will.

KETTLE BROOK CARE CENTER, LLC OF
EAST WINDSOR, CT – LICENSEE

By: Chris S. Wright
Chris S. Wright, ~~Managing Member~~
MANAGER

Personally appeared Chris S. Wright on this 1ST day of November, 2006, and made oath to the truth of the statements contained herein.

My Commission Expires: 4/30/07
(If Notary Public)

M. Denise MacKinnon
Notary Public
Commissioner of the Superior Court

M. Denise MacKinnon
Notary Public
My Commission Exp. 4/30/2007

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

November 3, 2006

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

Janet Williams, RN
Public Health Services Manager

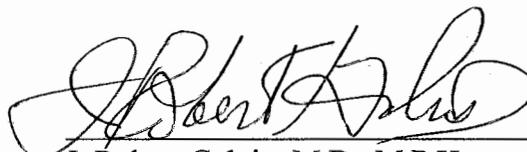
ORDER

The foregoing Consent Order, having been reviewed and considered, it is hereby approved on this 3rd day of November, 2006.



Olinda Morales, Esq.
Hearing Officer
Department of Public Health

FINAL ORDER OF THE CONNECTICUT DEPARTMENT OF PUBLIC HEALTH



J. Robert Galvin, M.D., M.P.H.
Commissioner
Department of Public Health

November 7, 2006



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 16

August 25, 2006

Heather Bray, Acting Administrator
Kettle Brook Care Center, Llc.
96 Prospect Hill Road
East Windsor, CT 06088

Dear Ms. Bray:

Unannounced visits were made to Kettle Brook Care Center, Llc on August 7, 8, 10, 11 and 17, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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

A plan of correction must be submitted by September 7, 2006.

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,

Elizabeth Andstrom, R.N.M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ESA:lsf

c. Director of Nurses
Medical Director
President
CT #5576



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: August 7, 8, 10, 11 and 17, 2006

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut General Statutes Section 19-13-D8t (e) Governing Body (1)(B).

1. The Governing Body failed to adequately oversee the management and operation of the facility in that it failed to review the facility's compliance with established policy as evidenced by the violations of the Public Health Code of the State of CT. identified in this document.

The following is a violation of the Regulations of Connecticut General Statutes Section 19-13-D8t (f) Administrator (3)(A).

2. The Administrator failed to adequately manage the facility in that the Administrator failed to ensure compliance with applicable State Regulations as evidenced by the violations of the Public Health Code of the State of CT. identified in this document.

The following is a violation of the Regulations of Connecticut General Statutes Section 19-13-D8t (h) Medical Director (2)(B).

3. The Medical Director failed to adequately oversee the provision of medical care provided in the facility as evidenced by the violations of the Public Health Code of the State of CT. identified in this document.

The following is a violation of the Regulations of Connecticut General Statutes Section 19-13-D8t (j) Director of Nurses (2).

4. The Director of Nurses failed to adequately oversee the provision and quality of nursing care provided in the facility as evidenced by the violations of the Public Health Code of the State of CT. identified in this document.

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

5. Based on clinical record review, observation and interview for one restrained resident (Resident #22), the facility failed to assess the Resident for the use of the restraint. The findings include:
 - a. Resident #22's diagnoses included Alzheimer's dementia and multiple falls. The assessment dated 6/6/06 identified that the Resident was moderately cognitively impaired, wandered, required extensive assistance for ambulation and restraints were not utilized. The physician order dated 8/10/06 directed out of bed to wheelchair with clip seatbelt. Intermittent observations on 8/17/06 from 5:12 AM to 7:40 AM noted the Resident self-propelled in another resident's wheelchair (name of other resident written on the back of the wheelchair). A seatbelt was also observed on the wheelchair and fastened in front of the Resident. Interviews with NA #2 on 8/17/06 at 6:10 AM and/or 7:20 AM reflected that the Resident was not in his own wheelchair because his own

DATES OF VISIT: August 7, 8, 10, 11 and 17, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

wheelchair had an alarm clip belt that he could remove that caused an alarm to frequently sound. She further indicated that Resident #22 could not remove the seatbelt from the chair he was presently sitting in. Review of the Resident's clinical record on 8/17/06 at 10:30 AM failed to reflect that Resident #22 had been assessed for the use of the restraining- type seatbelt when in the wheelchair.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (t) Infection Control (2)(A).

6. Based on observations, record reviews and staff interviews for two residents with pressure ulcers, the facility failed to ensure the residents were properly cared for and did not suffer from neglect. The findings include:
 - a. Review of the record identified that Resident #2 was admitted to the facility on 4/6/06 for rehabilitation with the diagnoses of stress fractures of the sacrum, left acetabulum and right symphysis pubis. Review of the record indicated the resident's skin was intact on admission and the resident's Braden Risk Scale was assessed at 18 (score ≤ 16 = significant risk of developing skin integrity problems). The Resident Care Plan (RCP) identified skin integrity as a problem on 4/17/06, however, discrepancies in skin assessments existed throughout the record. Those included: Nurses' Notes dated 4/20/06 identified a large necrotic area ~5 cm. noted over buttocks and Nurses' Notes dated 4/23/06 that identified a gluteal fold Stage III wound, whereas, review of the weekly Skin Integrity Report indicated a Stage II on 4/23/06. The RCP identified a Stage II buttock wound on 4/20/06 and Stage III on 4/23/06. Additionally, the RCP indicated the wound evolved to a Stage IV on 4/24/06 and the Skin Integrity Report indicated a Stage III from 5/8/06-5/21/06. APRN Progress Notes dated 5/1/06 indicated a Stage III-IV sacral decubiti with odor. APRN Notes dated 5/8/06 indicated the wound was Stage IV, malodorous and a wound culture was sent. Physician Orders dated 5/11/06 directed Keflex 500 mg four times per day (QID) for 10 days. Review of the facility's pressure ulcer master list for April 2006 failed to identify Resident #2. Review of the Nutrition Risk Assessment revealed the resident's admission assessment dated 4/10/06 identified Resident #2's overall risk category was moderate, regular diet ordered and skin was intact. A W-10 Interagency Referral Report dated 4/6/06 indicated the resident's weight was 170.9 pounds(lbs.). A dietary review conducted on May 8, 2006 identified the resident had a significant weight loss from 165 lbs. to 153 lbs. Review of the treatment record identified the weekly body checks were not performed on 5/8/06 and 5/15/06, weight was lacking for week 5/15/06 and an airmattress, although ordered 4/24/06, was not implemented until 5/10/06. Although review of the record and interview with RPT # 1 on 8/7/06 at 12:20 PM identified the resident was not always compliant with repositioning, the careplan failed to identify strategies to promote compliance. Review of the record revealed the resident became hypotensive and pulse oximetry was noted to

DATES OF VISIT: August 7, 8, 10, 11 and 17, 2006

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

be 72% on 2 liters of oxygen via nasal cannula on 5/21/06 at 3:30 PM, 911 was called and the resident was transferred emergently to an acute care hospital. The 24 Hour Nursing Shift Report dated 5/21/06 identified Resident #2 expired at the hospital.

- b. Review of the record identified Resident #3 diagnoses included CHF, chronic renal insufficiency, Type II diabetes mellitus and decubitus ulcer. Record review indicated the resident had a coccyx ulcer identified January 16, 2006 that developed into a Stage IV wound in May 2006. Review of the RCP dated 6/1/06 identified the care plan was not revised or updated to reflect the non healing wound. Although Monthly Nursing Summaries for January, February, March and May 2006 were completed, the record lacked Nursing Progress Notes for 4 months from 1/20/06 through 5/9/06. Review of the Medical Nutrition Quarterly Review dated 3/1/06 indicated the resident's skin was intact. Although review of the record identified the resident had a chronic non healing pressure wound, interview with the Registered Dietician on 8/8/06 at 1:15 PM revealed that she documented the skin was intact because she didn't think it was open. Physician Progress Notes dated 3/28/06 identified the wound was not visualized during the physical exam. APRN Progress Notes dated 4/5/06 indicated the coccyx wound was Stage II. Although APRN Progress Notes revealed the sacral wound was a Stage IV on 5/17/06, interview with LPN #2 on 8/8/06 indicated that the wound was never a Stage IV, that it was always a Stage II. APRN Progress Notes dated 5/17/06 identified the resident had intermittent episodes of lethargy, likely infected sacral decubitus and 5/19/06 questioned if the resident was septic secondary to the infected sacral decubitus. Furthermore, APRN Progress Notes dated 5/19/06 identified Resident #3 was in respiratory distress and the resident's chest x-ray demonstrated CHF. Subsequently, the resident was treated with Morphine and Lasix from 5/18/06 through 5/21/06. Review of the record indicated the resident expired on 5/21/06.

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7. For 2 of 22 residents with pressure sores and/or at risk for pressure sores, the facility failed to complete a comprehensive assessment of the resident's needs including the resident's skin condition.
- a. Resident #20 had diagnoses including dementia and urosepsis. Facility documentation (weekly pressure record) identified that the resident experienced a Stage I pressure ulcer of the right heel on 5/17/06 which progressed to a Stage II area on 5/25/06. Although wound tracking documentation identified pressure ulcers of the right heel continued through 8/7/06, a review of the resident's MDS of 7/11/06 identified that the resident had no open areas. The resident subsequently developed a Stage II pressure ulcer of the left heel on 7/21/06. Review of the resident's RCP identified that the pressure ulcers of both heels were not identified nor was the care plan updated to address current interventions to treat and prevent additional pressure areas.

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- b. Resident #19 had a re-admission date of 1/30/06. Diagnoses included Diabetes. The weekly pressure area flow record identified the Resident with a stage 1 pressure sore of the coccyx on 6/26/06. Although Resident #19 had documentation of a pressure sore since 6/26/06, the quarterly Minimum Data Set of 6/27/06 failed to indicate the presence of any pressure areas.

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8. Based on clinical record review and staff interviews, for one resident, Resident #26, the facility failed to ensure the accuracy of the resident's Braden Risk Assessment. Findings include:
 - a. Resident #26 was admitted on 4/14/06. Diagnoses included dementia and hypertension. The admission Braden Risk Assessment dated 4/14/06 identified the resident with a score of 19 (score ≤ 16 = significant risk of developing skin integrity problems). Documentation on the weekly wound flow sheet identified that the resident developed a Stage I pressure area of the back on 7/12/06 and a Stage II pressure area of the coccyx on 7/25/06. Although the Braden Risk Assessment identified that the resident had no limitations regarding mobility, the Resident Care Plan Dated 4/14/06 identified the resident with an alteration in skin integrity related to decreased bed mobility.

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9. Based on clinical record review and staff interviews, for 7 of 22 residents at risk for pressure sores and/or had pressure sores, Resident #5, Resident #7, Resident #12, Resident #17, Resident #18, Resident #19 and Resident #27, the facility failed to address the resident's pressure sores in the resident care plan. Findings include:
 - a. Resident #5, who was admitted on 7/30/06, had diagnoses that included acetabulum and sacral fractures. The admission nursing flow sheet dated 7/30/06, identified the resident with a 4 X 3 cm pressure sore of the left inner buttock and a 3 X 2 cm pressure sore of the right inner buttock. The resident's Braden score was 16. Although Resident #5 had been identified with pressure areas, a review of the residents' medical records identified that the facility failed to implement a resident care plan that addressed the problems of impaired skin integrity.
 - b. Resident #7, who was admitted on 8/8/06, had diagnoses of hypertension. The admission nursing flow sheet dated 8/8/06, identified the resident with a Stage II, 10 X 10 cm. decubitus of the coccyx. The resident's Braden score was 15. Although Resident #7 had been identified with pressure areas, a review of the residents' medical records identified that the facility failed to implement a resident care plan that addressed the problems of impaired skin integrity.

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- a. Resident #19 had a re-admission date of 1/30/06. Diagnoses included Diabetes. The weekly pressure area flow record identified the resident with a Stage I pressure sore of the coccyx on 6/26/06. Facility policy regarding wound and skin care protocols states that the interdisciplinary plan of care will address skin problems, with goals and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure ulcers. Although Resident #19 had been identified with pressure areas, a review of the residents' medical records identified that the facility failed to implement a resident care plan that addressed the problems of impaired skin integrity.
- d. Review of the record identified Resident #12 had the diagnoses of left parietal infarct, non-insulin dependent diabetes mellitus (NIDDM), hypertension (HTN), urosepsis, aspiration pneumonia and dehydration. Review of the nursing admission assessments dated 5/22/06, 7/7/06 and 8/8/06 identified the resident's Braden Scales were 12 (score ≤ 16 = significant risk of developing skin integrity problems). Review of the Skin and Wound Care Protocols indicated that the resident's plan of care would address impaired skin integrity and all wounds would have weekly documentation until healed. Review of Resident #12's Skin Integrity Reports indicated the resident had developed a Stage II coccyx wound identified on 6/15/06 that evolved into a Stage III on 7/17/06. The care plan failed to address the wound until 6/21/06 and review of the resident's Skin Integrity Report identified the resident lacked a wound assessment for the week of 7/31/06.
- e. Review of the record identified Resident #17 had diagnoses of decubitus ulcers, Alzheimer's dementia, hypoxemia, esophageal reflux, dehydration and acute renal failure. APRN Progress Notes dated 6/13/06 indicated the resident's pressure ulcers on the buttock and sacrum were slowly improving, however, the pressure ulcer on the left foot had worsened and a new ulcer was identified. APRN Progress Notes dated 7/26/06 revealed the left lateral foot had two gangrenous lesions, the inner aspect had necrotic black tissue, with odor and no palpable pedal pulse. Further review of the Progress Notes identified the coccyx/buttock wound was Stage II. Review of the nursing admission assessment dated 5/11/06 identified the resident's Braden Scale was 10 (score ≤ 16 = significant risk of developing skin integrity problems). Review of the Skin and Wound Care Protocols indicated that the resident's plan of care would address impaired skin integrity and all wounds would have weekly documentation until healed. Review of the Weekly Skin Integrity Reports identified that the left lateral foot wound assessment was not completed for the week of 6/19/06 and the buttock wound assessment was not completed for the weeks of 7/24/06 and 7/31/06. Although Resident #17's care plan identified alteration in skin integrity as a problem, the care plan was not revised and/or interventions individualized after 5/12/06 to indicate current interventions and goals for the resident's foot and buttock pressure ulcers.
- f. Review of the record identified Resident #18 had diagnoses of lower gastrointestinal bleeding, end stage renal disease (ERSD), ischemic colitis and HTN. Review of the Skin and Wound Care Protocols indicated that the resident's plan of care would address impaired skin integrity and all wounds would have weekly documentation until healed. Although review of the nursing admission assessment dated 6/30/06 identified the

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resident was extensive assist for mobility, transfer and toilet use, the Braden Scale was noted as 19 (score ≤ 16 = significant risk of developing skin integrity problems). Further review revealed Weekly Skin Integrity Reports identified a Stage II coccyx wound and blister on right buttock were noted on 8/4/06. Review of the record indicated the care plan did not include the alteration in skin integrity until the ulcers were identified on 8/4/06 because the assessment was inaccurate. The RCP failed to address the resident's risk for pressure sore development.

- g. Review of the record identified Resident #27 had diagnoses of dementia, coronary artery disease (CAD), aortic stenosis and peripheral vascular disease. Although APRN Progress Notes dated 7/31/06 indicated the resident's coccyx wound was improving, APRN Progress Notes dated 8/9/06 identified the Stage III coccyx wound appeared worse. Review of the Skin and Wound Care Protocols indicated that the resident's plan of care would address impaired skin integrity and all wounds would have weekly documentation until healed. Review of the resident's Weekly Skin Integrity Reports identified that a wound assessment was not completed the week of 7/31/06 and review of the care plan identified alteration in skin integrity as a problem on 4/2/06 had not been revised to reflect the resident's current wound status, interventions and goals.

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10. For one resident, the facility failed to ensure that the resident's care plan was revised when the resident experienced skin breakdown. The findings are based on clinical record review observations and staff interviews.
 - a. Resident #20 had diagnoses including dementia and urosepsis. The RCP of 1/23/06 identified the potential for skin breakdown and decreased mobility. Facility documentation identified that the resident experienced a stage I pressure ulcer of the right heel which progressed to a stage II area on 5/25/06. Review of the RCP for the period 1/23/06 through 7/24/06 indicated no changes to the RCP but to continue the problem "ongoing" with a target goal of skin integrity remaining dry and intact through 10/21/06. On 6/21/06, APRN progress notes identified a stage II pressure sore to the right heel with brownish eschar and yellow drainage. Legs were to be elevated in bed and recommendations for foam boots were made. On 7/26/06 a stage I pressure sore of the left heel was identified by the APRN. An interview with the NA assigned to the resident's care on 8/11/06 at approximately 12:30 p.m. identified that the NA was not familiar with the patient and a review of the NA assignment failed to identify the recommended intervention of foam boots. On 8/11/06 observation of the resident's heels revealed a full thickness crater of the right heel and eschar of the left heel. From 11:50 a.m. to 2:20 p.m., the resident was observed supine in bed with heels on the mattress without benefit of foam boots.

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11. For 10 of 16 residents (Residents #7, #12, #13, #14, #15, #16, #19, #20, #21, and #26) with pressure ulcers or a history of pressure ulcers, facility staff failed to ensure that treatment measures were implemented in accordance with the RCP.
 - a. Resident #14 had multiple stage II and stage IV pressure ulcers inclusive of the hips, ischium, sacrum, heels and knees. Physician orders of 8/4/06 included cleansing the left and right ischial wounds with normal saline followed by an allevyn dressing every day; and 8/2/06 physician orders directed the right and left hip wounds to be cleansed with normal saline followed by algisite and alleuyn dressing every day; physician orders also included cleansing the coccyx wound with normal saline followed by allevyn dressing every day. Upon review of the Treatment Kardex on 8/10/06 documentation was lacking that treatments for the ischial wounds was completed for 8/4, 8/7, and/or 8/9; documentation was lacking that treatment to the left and right hip was completed on 8/2, 8/4, 8/7, 8/8, or 8/9. In addition documentation of treatment to the resident 's bilateral heels was lacking on 8/4, 8/7, 8/8, 8/9 and 8/10. Documentation of treatment to the resident 's coccyx was lacking for 8/2, 8/5, 8/8 and 8/9; and treatment to the resident 's left knee was lacking for 8/9 and 8/10. Upon interview, the charge nurse was unable to explain whether or not the treatments had been completed.
 - b. Resident #15 had diagnoses that included a stage IV pressure ulcer of the sacrum and a stage II pressure ulcer of the the right heel. Upon review, the Treatment Kardex lacked documentation that irrigation of the sacral wound with normal saline and packing with mesalt alginate and application of a dressing was completed from 8/1/06 through 8/5/06. Upon interview, nursing staff were unable to explain whether or not the treatment had been completed. Upon interview on 8/10/06 at approximately 10:30 a.m., Resident #15 stated that the treatment is not always completed.
 - c. For six residents at risk for pressure sores staff failed to turn and reposition the residents in accordance with their plan of care.
 - i. Resident #7 was admitted on 8/8/06. The admission nursing flow sheet identified the resident had a Stage II 10 X 10 cm decubitis of the coccyx. Resident #13 was re-admitted to the facility on 7/28/06 with pressure sores of the left and right knee and a Stage IV coccyx wound. The Resident Care Plan dated 8/10/06 identified approaches that included turn and reposition every two hours.
 - ii. Resident #16 was admitted on 6/21/06. The Resident Care Plan dated 7/3/06 identified the resident with a Stage II pressure sore of both buttocks. Interventions included turn and reposition every two hours.
 - iii. Resident #19 had a re-admission date of 1/30/06. Diagnoses included Diabetes. The weekly pressure area flow record identified the Resident with a stage 1 pressure sore of the coccyx from 6/26/06 to 8/9/06.

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- iv. Resident #20 's diagnoses included peripheral vascular disease and dementia. The assessment dated 7/11/06 identified the Resident was moderately cognitively impaired, required extensive assistance for bed mobility. The weekly wound documentation flow sheet identified the Resident had a Stage II pressure sore to the right and the left heels.
- v. Resident #21 was re-admitted on 8/14/06. The Resident Care Plan dated 8/1/06 identified the resident with a Stage IV area of the buttocks. Interventions included to position as per positioning plan.
- vi. Resident #26's diagnoses included dementia. Progress notes dated 8/9/06 identified the Resident had a Stage II pressure sore to the coccyx.

Surveyor constant observation on 8/17/06 from 5:05 AM through 8:40 AM identified that although the NA provided incontinent care for Residents #7, #12, #13, #16, #19, #20, #21, and #26, the NA did not reposition the Residents and/or encourage the Residents to change their position. Resident #7 was in bed on his back from 5:20 AM through 8:26 AM. Resident #13 was in bed, on her back from 5:15 AM through 8:30 AM. Resident #16 remained in bed on his back from 5:10 AM through 8:25 AM, Resident #21 remained in bed on his back from 5:05 AM through 8:40 AM, and Resident #19, #20 and #26 were in bed on their backs from 5:15 AM through 9 AM.

- d. Review of the record identified Resident #12 had the diagnoses of left parietal infarct, non-insulin dependent diabetes mellitus (NIDDM), hypertension (HTN), urosepsis, aspiration pneumonia and dehydration. The resident's care plan dated 8/8/06 identified the resident had a Stage III coccyx wound and interventions included turn and reposition every 2 hours. Constant observation of the resident on 8/17/06 identified Resident #12 remained in bed on her back from 5:13 AM through 8:15 AM.
- e. Review of the record identified Resident #12 had the diagnoses of left parietal infarct, non-insulin dependent diabetes mellitus (NIDDM), hypertension (HTN), urosepsis, aspiration pneumonia and dehydration. The resident's care plan dated 8/8/06 identified the resident had a Stage III coccyx pressure ulcer and Physician Orders dated 8/8/06 directed oxygen be administered at 2 liters via nasal cannula at all times. Interviews with facility staff and observation of Resident #12 on 8/17/06 at 5:25 AM identified the oxygen tank was empty and the resident was not receiving oxygen as per physician order.
- f. Review of the record identified Resident #17 had diagnoses of decubitus ulcers, Alzheimer's dementia, hypoxemia, esophageal reflux, dehydration and acute renal failure. Review of the Progress Notes dated 8/9/06 identified the resident had Stage IV pressure ulcers and gangrene of the left foot. Physician Orders dated 8/3/06 directed bilateral foam suspension boots when in bed. Interview with LPN # 6 at 7:30 AM and observation of Resident #17 in bed on 8/17/06 identified the resident lacked the foam suspension boots while in bed.

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Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (m) Nursing Staff (2)(C).

12. Based on observations, record review and interviews for 10 of 22 residents at risk for pressure ulcers and/or identified with a pressure ulcer, the facility failed to implement measures to prevent pressure ulcers from occurring and/or from becoming worse. The findings include:
- a. Resident #28 had diagnoses including vascular dementia, urinary incontinence, lacunar infarct, and diabetes mellitus. On 1/17/06 the resident was identified with right heel blister and left heel blister. Physician orders on 1/27/06 directed staff to elevate the resident 's heels off the mattress at all times when in bed and on 3/27/06 to turn and reposition the resident every two hours at night and when in bed. On 4/10/06 the Resident Care Plan identified a stage II pressure ulcer to the coccyx with orders to obtain and alternating air mattress when available. Documentation of the ulcers size and appearance were noted sporadically through 5/9/06 with various treatment modalities used. On 7/15/06, a " black dark " area of the left heel and " spongy " area of the right heel were identified. No further documented assessment of the impaired skin areas were noted until 8/9/06 when stage II ulcers of the buttocks and coccyx were identified. Further review of skin integrity reports for the pressure ulcers of the heels identified no tracking of size or appearance after 7/15/06. Observation of the left heel on 8/9/06 identified a dry eschar of the left lateral heel. Upon observation and interview with the unit charge nurse on 8/9/06 at approximately, it was noted the alternating air mattress had not been obtained since ordered on 4/10/06 although the charge nurse did not know why it had not been obtained. On 8/17/06 an air mattress was observed on the resident ' s bed.
 - b. Resident #28 with pressure ulcers of the left and right buttock and coccyx area had physician orders of 8/9/06 that included cleansing the buttock with normal saline and applying xenaderm to ulcer area with a non stick gauze dressing. Observation of the resident ' s coccyx area on 8/9/06 identified that although cream had been applied, no dressing covered the area as ordered. Upon interview, the nurse stated she did not think the area needed a dressing and would contact the APRN to change the order.
 - c. Resident #20 had diagnoses including dementia and urosepsis. The RCP of 1/23/06 identified the potential for skin breakdown and decreased mobility. Facility documentation identified that the resident experienced a stage I pressure ulcer of the right heel which progressed to a stage II area on 5/25/06. No changes to the resident ' s RCP were identified at that time and APRN progress notes of 6/21/06 identified a stage II pressure sore to the right heel with brownish eschar and yellow drainage. Legs were to be elevated in bed and a recommendation for foam boot to the right foot was noted. On 7/26/06 a stage I pressure sore of the left heel was identified by the APRN and wound documentation directed the use of foam boots when in bed. On 8/11/06 observation of the resident ' s heels revealed a full thickness crater of the right heel and eschar of the left heel. From 11:50 a.m. to 2:20 p.m., the resident was observed supine in bed with heels on the mattress without benefit of foam boots. Upon interview, the NA assigned to his care stated she was not familiar with the resident and a review of the NA

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- assignment sheet failed to identify the need for foam boots when the resident was in bed. Constant observation on 8/17/06 from 5:15 AM to 9AM noted the Resident was in the supine position and the bilateral heel dressings were observed to be just above the Resident ' s ankles instead of on the heels. Although the nurse aides checked the Resident for incontinence at 6:28 AM, the nurse aides had not informed the nurse of the location of the heel dressings and positioned the Resident back in the supine position.
- d. Resident #15 was admitted to the facility on 1/31/06 after a fall at home resulting in a stage IV pressure ulcer of the sacrum and a stage II pressure ulcer of the right heel. The most recent MDS of 7/27/06 indicated that the resident required extensive assistance to turn in bed and the RCP identified interventions including turning and repositioning the resident every two hours. Review of the resident ' s care plan identified the sacral pressure ulcer and the development of a stage II ulcer of the second toe, however, the care plan failed to identify the stage II ulcer of the right heel. Although the resident's treatment record identified treatment to the right heel that included irrigation with normal saline and application of Duoderm every two days, documentation that the treatment was completed on the day shift was lacking from 8/2/06 through 8/8/06. Review of monitoring sheets on 8/9/06 indicated that the wound was last measured on 7/31/06 as 1 cm. By 1.4 cm. Additional information submitted by the facility on 8/14/06 reflected that on 8/14/06 the wound measured 1 cm by 2.5 cm. Additionally, facility documentation last indicated measurement of the right second toe on on 7/10/06 as a stage II " scabbed area. " Upon request, a full body audit of all residents on 8/18/06 identified the right second toe as unstageable and the right heel wound was not identified at this time. Observations of the resident on 8/10/06 throughout the morning hours and on 8/17/06, intermittently from 5:10 a.m. through 8:45 a.m. revealed that although the resident had an air mattress in place, the resident remained on her back without benefit of a position change and without heels elevated. Upon interview, the resident reported that she could not turn by herself and stated that she had not been repositioned that morning.
- e. Resident #5, who was admitted on 7/30/06, had diagnoses that included acetabulum and sacrum fractures. The admission nursing flow sheet dated 7/30/06, identified the resident with a 4 X 3 cm pressure sore of the left inner buttock and a 3 X 2 cm pressure sore of the right inner buttock. The residents' medical record was reviewed with LPN #7 on 8/11/06 at 11:10 am. Although LPN #7 stated that the pressure area had improved, there was no indication that the resident's wounds were added to the weekly wound flow record to assure assessment and monitoring of the wounds.
- f. Resident #13 was re-admitted to the facility on 7/28/06 with pressure sores of the right hip and left knee. The skin integrity sheet dated 7/28/06 identified a stage 1 area of the right hip that measured 5 X 3 cm and a stage 1 area of the left inner knee that measured 2 X 1 cm. A review of the weekly wound documentation flow sheet failed to identify any wound tracking was completed until 8/10/06. Documentation of the right hip measurement identified that the wound increased in size and measured 10 X 10 cm. The flow sheet lacked documentation to indicate that the left inner pressure sore was

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monitored. Facility policy regarding skin and wound care states that all wounds will have weekly documentation until healed. The criteria for weekly wound documentation will include site/location, size, appearance of wound bed, drainage, etc. On 8/17/06, surveyor constant observation identified that Resident #13 was in bed and on her back from 5:15 AM through 8:30 AM without any change of position.

- g. Resident #26's diagnoses included dementia. The assessment dated 5/30/06 identified that the Resident was moderately cognitively impaired, was totally dependent for bed mobility and was free of pressure ulcers. The Resident Care Plan (RCP) in place from 3/14/06 to 7/25/06 noted the resident had impaired mobility and interventions included to turn and reposition every two hours, monitor skin weekly and notify the physician of any changes. The RCP entry dated 7/25/06 reflected the Resident had a 1 centimeter (cm) Stage II coccyx pressure ulcer with an approach to apply a dressing (Allevyn) every three days. The progress note written by Advanced Practice Registered Nurse (APRN) #2 and dated 7/26/06 indicated the Resident's coccyx ulcer was approximately nickel sized, had an approximate 1/8 inch depth and to evaluate the area in one week. Review of the weekly skin documentation noted the Resident's pressure ulcer had not been reassessed until 8/7/06 (13 days after the ulcer was last assessed) and measured 2cm long by 1cm wide and had a depth of 1.5cm. The APRN further identified that the ulcer had worsened and directed a change in treatment to the coccyx " Stage II-III " ulcer. Review of the facility skin and wound care protocols noted that all wounds would have weekly documentation until healed. The protocols identified ulcer Stages I through IV and failed to identify that a pressure ulcer could be documented as a both a Stage II and Stage III concurrently. Constant observation for Resident #26 on 8/17/06 identified the following: The Resident was on the back in bed from 5:10 AM to 6:40 AM and per interview care was last administered to the Resident between 2:30 AM and 3:30 AM. (3 hours lying on back). Incontinent care was administered at 6:40 AM and identified the Resident's buttocks had deep demarcations from bed linens and a dressing to the Resident's coccyx. Although the Resident was quickly repositioned from side to side for incontinent care, the Resident was positioned on the back after the care was administered. The Resident was observed in the back lying position from 6:45 AM to the time the observation ceased, 9 AM and was without the benefit of repositioning for a time period of 5 hours or greater. Interview with RN #1 on 8/17/06 at 10:30 AM noted she provided treatment as ordered to the Resident's coccyx ulcer on 8/17/06 after 9 AM and observed a darkened area in the center of the Resident's coccyx ulcer that would require a debriding agent. She further indicated the ulcer was a stage 2-pressure ulcer although she could not identify the wound depth. Review of the facility skin and wound care protocols reflected all residents be repositioned at least every two hours. The protocols also identified necrotic tissue in part as soft or hard black tissue that when present rendered the wound unstageable until the necrotic tissue was debrided.
- h. Review of the record identified Resident #17 had diagnoses of decubitus ulcers, Alzheimer's dementia, hypoxemia, esophageal reflux, dehydration and acute renal failure. Observation of Resident #17 on 8/17/06 at 5:44 AM identified the resident's

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- Stage III coccyx pressure ulcer lacked a dressing and the wound was open to air. Further observation of incontinent care administered to Resident #17 on 8/17/06 at 5:44 AM identified that CNA #3 cleansed the resident's perineum and then dabbed the resident's bloody Stage III coccyx wound with the same wash towel. Interview with CNA #3 identified that, although CNA #3 was not taught to touch a pressure ulcer with the same towel after incontinent care, she "patted the wound because it was bleeding".
- i. Review of the record identified Resident #12 had the diagnoses of left parietal infarct, non-insulin dependent diabetes mellitus (NIDDM), hypertension (HTN), urosepsis, aspiration pneumonia and dehydration. Physician orders dated 8/9/06 directed sterile wet to dry dressing with normal saline to coccyx decubiti twice per day. Review of the APRN Progress Notes dated 8/9/06 indicated the Stage III wound was 5 x 5.5 x 1 cm, red bed with green yellow tissue and bleeding. Observation of a dressing change on 8/10/06 identified LPN #4 was wearing clean gloves for the procedure rather than sterile gloves. Review of the Skin and Wound Protocol identified clean technique for dressing changes unless directed otherwise. Although the order specified sterile wet to dry dressing, interview with LPN #4 indicated clean technique was acceptable. Subsequent to surveyor inquiry, the sterile dressing order was discontinued and changed to clean.
 - j. Resident #7 was admitted on 8/6/06. Diagnoses included hypertension. The admission nursing flow sheet dated 8/8/06, identified the resident with a Stage II, 10 X 10 cm decubitis of the coccyx. The residents' medical record was reviewed with LPN #7 on 8/11/06 at 11:05 AM. LPN #7 stated that the resident's wound was not documented and/or added to the weekly wound flow record because the wound was not open.
 - k. Review of the record identified Resident #18 had diagnoses of lower gastrointestinal bleeding, end stage renal disease (ERSD), ischemic colitis and HTN. Review of the record indicated the resident had a Stage II coccyx and Stage II right buttock pressure sores noted on 8/4/06 and treatment included cleanse with normal saline and apply Allewyn dressing to both. Observation of the resident on 8/17/06 at 7:40 AM identified the resident lacked a dressing that covered the Stage II coccyx wound. Interview with CNA #6 and LPN #6 identified the Stage II coccyx wound lacked a dressing that covered the wound and LPN #6 proceeded to reapply a dressing after cleansing the wound with normal saline.

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

13. Based on record reviews, observations and staff interviews, the facility lacked sufficient staffing to provide care to meet the needs of the residents. The findings include:
 - a. Interview with the DNS identified the the facility lacked a licensed administrator, an assistant director of nurses and infection control nurse at the facility and the DNS was in

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the role of "Acting Administrator". Tours of the facility, review of clinical records and observations made during 8/9/06, 8/10/06 and 8/17/06 revealed that facility systems were lacking for 22 of 27 residents at risk for developing pressure sores and/or with pressure sores (Residents #2, #3, #5, #7, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #26, #27, #28, #30, #31, #32, #33, #34) in that assessments were inaccurate and/or lacking, resident care plans were not implemented including repositioning of residents, application of pressure relieving devices, and/or administration of treatments, and wound monitoring was inaccurate and/or lacking.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (t) Infection Control (1) and/or (t) Infection Control (2)(A) and/or (t) Infection Control (3).

14. Based on record reviews, observations and interviews, the facility lacked an effective infection control program that ensures safe and sanitary environment for the residents. The findings include:
- a. Review of facility documentation and record reviews since the 7/11/06 and interview with the DNS identified the facility lacked an effective infection control program as evidenced by a lack of complete and concise resident pressure sore listings. Additionally, interview with the DNS indicated the infection control program lacked an infection control nurse. The infection control nurse had been terminated due lack of attendance. According to the facility's job description, the infection control nurse was responsible for ensuring the development and delivery of a quality infection control program and was responsible for the overall coordination and implementation of the infection control program at the facility. Moreover, the job description indicated the infection control nurse was responsible for continually reviewing all pressure sores, supplying documentation, monitoring procedures, identifying trends and providing the reports to the Administrator and DNS.
 - b. Review of facility documentation identified 2 residents (#5 & #7) with pressure ulcers that were not originally identified on the Weekly Wound Flow Records (facility tracking mechanism). The Weekly Wound Flow Records were the reports the infection control nurse was responsible for developing and that were used for report information provided to the Administrator and DNS. Additionally, a body audit of all facility residents requested by survey staff on 8/17/06 identified five residents (#30, #31, #32, #33, #34) with stage II pressure ulcers not previously identified in the facility's weekly wound flow record of 8/10/06.

b.

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

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Administrator (3) and/or (g) Reportable Events (3).

15. Based on record review and interviews for one resident, the facility failed to report omission of a resident's medication. The findings include:
- Review of the record identified Resident #1 diagnoses included schizophrenia, dementia, anemia and atrial fibrillation. Daily medications included Diltiazem HCL 60 mg by mouth (po) every 6 hours and Sotalol 40 mg po twice per day. Review of the record and interview with facility staff indicated Resident #1 became hypotensive and bradycardic on 5/24/06. Further record review and interview identified the APRN held the Diltiazem on 5/24/06 and ordered Diltiazem 30 mg po every 6 hours to be started on 5/25/06. Review of the record and the Medication Administration Record (MAR) identified the Diltiazem was not administered to the resident for 48 hours from 5/25/06 through 5/26/06. The APRN Progress Notes dated 5/26/06 indicated the resident became tachycardic, hypotensive and experienced a sudden onset of jaw pain. A Discharge Summary dated 5/28/06 identified Resident #1 was hospitalized on 5/26/06 with atrial fibrillation with a ventricular response of 140. Review of the record, facility documentation and interviews with facility staff failed to identify why the Diltiazem was not administered on 5/25/06 and 5/26/06, lacked evidence why the omissions were not communicated to the resident's physician/APRN on 5/25/06 and failed to report the event to the state agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(B).

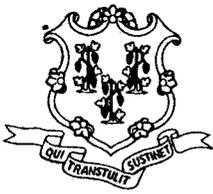
16. The facility medical director failed to coordinate the medical care of residents by lack of providing oversight and supervision of care to residents within the facility. Based on clinical record review, tours of the facility, interviews with staff and a review of facility documentation, 16 residents were identified as sustaining pressure ulcers that were avoidable and/or existing pressure ulcers that became worse and/or lacked appropriate assessment and treatment. Upon interview on 8/17/06, the Medical Director indicated that he was unaware of the prevalence and/or severity of pressure ulcers within the facility until recent surveys by the state agency. Although the DNS reported that the Medical Director was appraised of pressure ulcers weekly with wound tracking sheets, the Medical Director was unable to state how information was presented to him regarding pressure ulcers. The Medical Director further stated that he did not recall discussing pressure ulcer information with the infection control nurse and related that there was no consistency in staff. Although the Medical Director stated that he reviewed pressure ulcer treatment protocols, he was unable to identify what protocols were in use in the facility. The Medical Director further indicated that he was unaware of any septic wounds within the facility and stated that the APRN 's usually monitor wounds but would call him if necessary. The Medical Director further acknowledged poor communication within the facility regarding pressure ulcers. Review of Medical Staff meeting minutes identified that during the medical staff meeting of 6/14/06 a resident roster identifying pressure ulcers within the facility

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failed to identify Resident #2 who developed a facility acquired pressure ulcer that progressed to a stage IV pressure ulcer within a three week period of time and for whom the Medical Director was the attending physician. Additionally, a body audit of all facility residents requested by survey staff on 8/17/06 identified five residents (#30, #31, #32, #33, and #34) with stage II pressure ulcers not previously identified in the facility ' s weekly wound flow record of 8/10/06.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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September 21, 2006

Mary Uschman, Administrator
Kettle Brook Care Center, Llc
96 Prospect Hill Road
East Windsor, CT 06088

Dear Ms. Uschman:

An unannounced visit was made to Kettle Brook Care Center, Llc on September 6, 2006 by representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, a certification inspection and a monitoring compliance with summary order dated August 25, 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 visit.

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 October 5, 2006 or if a request for a meeting is not made by the stipulated date, the violations 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,

Elizabeth S. Andstrom, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ESA:JFM:DH:lsf

c. Director of Nurses
Medical Director
President
CT #5576



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 19a-550 (b)(10) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

1. Based on review of the medical record, review of facility policies, and interviews, the facility failed to ensure that one resident, Resident #3, was spoken to in a dignified manner. The findings included:
 - a. Resident #36 (R #36) had diagnoses that included somatoform disorder and paranoia. Review of the assessment dated 7/6/06 identified that R #36 had no problems with short or long term memory. On 9/5/06, R #36 reported in writing to the Social Worker that she felt harassed when LPN #15 had accused her inappropriately of hiding the Hoyer pad of R #33, R #36's roommate. On 9/6/06 at 9:00 AM R #36 reported to the surveyor that after finding the pad that staff had been searching for earlier on 9/4/06, LPN #15 came into the room, spoke to her in a demeaning manner, and made accusations about hiding her roommate's Hoyer pad. R #36 stated that she began to cry and became hysterical over the way that LPN #15 spoke to her, that she approached LPN #15 about the interaction, but that LPN #15 did not apologize and just told her that "it's over now" and to forget about it. Interview with R #33 on 9/6/06 at 9:55 AM identified that she witnessed the conversation between LPN #15 and R #36 and that LPN #15 spoke to R #36 on 9/4/06 regarding the Hoyer pad in a manner that was "uncalled for." Interview with LPN #15 on 9/7/06 at 1:30 PM identified that she did speak to the resident about hiding the Hoyer pad because staff had already looked in the room that day, had not found the pad, and that the nursing assistant reported to her that they once observed that R #36 had placed the Hoyer pad between the mattress of her bed. LPN #15 stated that she did observe R #36 crying over the incident but denied that she spoke inappropriately to the resident. In an additional interview with R #36 on 9/7/06, R #36 expressed that she remained very upset over the way she was spoken to and only wanted LPN to treat her respectfully. Review of facility policies on Resident Rights identified that all residents would be treated with respect and dignity at all times.

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

2. Based on review of the medical record, review of facility policies, and interviews, the facility failed to ensure that an individualized plan of care was developed for three residents, Resident #36, who had a history of reporting feelings of harassment by facility staff and for Resident #38 who had a change in ambulatory status and/or Resident #14 who experienced pedal edema. The findings included:
 - a. Resident #36 (R #36) had diagnoses that included somatoform disorder and paranoia. Review of the Resident Care Plan (RCP) last updated 6/22/06 identified that R #36 had episodes of inappropriate behavior that included becoming easily paranoid with

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verbalization of feelings that staff did not like her. Interventions included psychiatric consults as needed, that the resident schedule times with the licensed nurse throughout the day to discuss her feelings, and that the resident would attempt to maintain a journal regarding her feelings. Review of the assessment dated 7/6/06 identified that R #36 had no problems with short or long term memory. Review of facility documentation identified that on 8/24/06, R #36 alleged that LPN #17 was rude to her and that during a verbal confrontation, LPN #17 placed her hand over the top of R #36's hand as the resident pointed to a bulletin board that held a copy of the facility's Resident 's Bill of Rights. In a written statement by LPN #17, dated 8/24/06, LPN #17 denied that she ever touched R #36. Review of the facility's investigation documentation identified that there were no witnesses to the alleged incident and subsequently failed to substantiate R #36's allegation. Although review of the RCP dated 8/24/06 identified R #36's allegation of mistreatment by facility staff, the care plan lacked documentation to reflect individualized interventions were developed to assist facility staff in their approach to R #36 in order to assist the resident to feel comfortable during the provision of care and services. Subsequent to surveyor inquiry on 9/7/06, an individualized plan of care with measurable goals and revision of interventions was developed.

- b. Resident #38 had Alzheimer's dementia and recent surgery for repair of a fractured hip (July 2006). The resident's care plan identified that the resident developed a stage two pressure ulcer of the heel on 8/31/06 and a pressure ulcer on the coccyx on 9/5/06. On 9/4/06 there was worsening of the heel pressure ulcer and as a result a decision to hold ambulation for a week was made. The rehab progress note dated 9/4/06 identified that after a conversation with the Wound Care Consultant and nursing staff that the resident's ambulation would be held for one week. (9/4-9/11/06) Although the care plan dated 8/31/06 and 9/4/06 identified that the resident be repositioned every two hours, there lacked a specific intervention for repositioning once the resident was placed in the wheelchair. Upon inquiry of the nurse aide, (on 9/7/06) assigned to care for Resident #38 on 9/7/06 as to how he was repositioning R #38 in the wheelchair, he responded that he would lift the resident up in the wheelchair and stand the resident up and then put him back in the wheelchair. Observation of the resident on 9/6/06 identified that the resident was seated upright in the wheelchair without the benefit of repositioning off the buttocks for a period of three hours and fifteen minutes (7:30 AM to 10:45 AM). Interview with the Independent Nurse Consultant and facility nursing staff identified that there was not a specific plan to move the resident while in the wheelchair, but there was an intervention to turn and reposition every two hours. Subsequent to this interview on 9/7/06, the facility staff identified that the care plan was revised to include ambulation of R #38 every two hours while positioned in the chair to relieve pressure.
- c. Resident #14 had a recent hospitalization in August 2006 for aspiration pneumonia and sepsis. During an observation on 9/6/06 the resident was noted to have some congestion, pitting edema of bilateral feet with some edema noted in the ankles. Areas of discoloration on the right outer foot and small toe were noted. This resident also had multiple pressure ulcers on the left heel (stage 3), coccyx (stage 4), left and right

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buttocks (stage 4), left and right trochanter, right ankle (unstageable) and right calf. Although nursing documentation identified the presence of pitting lower extremity edema during the period of 9/1/06 through 9/6/06, there lacked a care plan intervention to address this problem. On 9/6/06 the resident was sent to the hospital and admitted with pneumonia.

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).

3. Based on observation, interview and clinical record review, for Resident #14, the facility failed to ensure that professional standards of care were implemented for two residents (Resident #14 and Resident #32) who was receiving a respiratory treatment and/or who had a change in skin condition and/or had a change in respiratory status. The findings include the following:
 - a. Resident #14 required hospitalization during August 2006 for aspiration pneumonia and sepsis. The resident's MDS assessment dated 8/2/06 identified that the resident was cognitively impaired, required total care by staff, had a feeding tube and was in an unstable condition. Review of the clinical record identified that the resident required continuous tube feedings via a gastrostomy tube. Observation of the resident on 9/6/06 at 5:20 AM identified that the resident was lying in bed with the head of bed elevated and the resident's feeding tube was shut off. Upon inquiry as to why the resident's tube feeding tube feeding was not running, the LPN responded that the resident was congested and the feeding tube had been shut off since 5 AM. The LPN stated that the resident was finishing a respiratory treatment and the LPN was observed removing the treatment mask utilized for the respiratory treatment. Although the LPN tested the resident's pulse ox level (89 percent) and took the resident's pulse and blood pressure, the LPN failed to listen to the resident's lungs following the completion of the respiratory treatment. The LPN proceeded with the assistance of the Supervisor to change the resident's multiple pressure ulcer dressings. The LPN's 8 AM note dated 9/6/06 identified that the resident had increased congestion and the tube feeding was shut off from 5 AM to 5:30 AM. There lacked documentation that an RN performed a complete respiratory assessment. Nurses notes dated 9/6/06 at 7 PM identified that the resident had a pulse ox level of 80 percent, used excessory muscles to breathe and had "rhonchi throughout" and "audible wheezes". The physician and supervisor were notified and the resident was transferred to the hospital and admitted with aspiration pneumonia. According to Best Practices: A Guide to Excellence in Nursing Care by Lippincott Williams & Wilkins, 2003, Before beginning nebulizer treatment, auscultate lung fields to establish baseline, remain with the patient during the treatment, encourage the patient to cough and listen to the patient's lungs to evaluate the effectiveness of therapy and to record breath sounds and the patient's response to treatment. According to American Nurses' Association Standards of Nursing Practice, 2004, the nurse collects data in a systematic and ongoing process, uses appropriate evidence-based assessment techniques in collecting pertinent data and documents relevant data in a retrievable

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- format.
- b. Resident #14 required hospitalization during August 2006 for aspiration pneumonia and sepsis. The resident's MDS assessment dated 8/2/06 identified that the resident was cognitively impaired, required total care by staff, had a feeding tube and was in an unstable condition. Observation of the resident on 9/6/06 identified that the resident had multiple pressure ulcers of the buttocks, coccyx, trochanters, heel, calf, and ankle. Although there were several areas of discoloration on the right outer foot and right fifth toe, there lacked an assessment of these areas. Interview with the nursing supervisor on 9/6/06 identified that skin prep was applied to these areas of discoloration. Upon inquiry of the Wound Care Consultant, an assessment of these areas was performed which identified the right fifth toe area as unstageable and 0.5 cm by 0.3 cm in size. The area on the right lateral foot below the toe was 1.1 cm by 3 cm in size. Both areas were classified as "vascular" and recommendations were made for a protective dressing and daily monitoring. According to American Nurses' Association Standards of Nursing Practice, 2004, the nurse collects data in a systematic and ongoing process, uses appropriate evidence-based assessment techniques in collecting pertinent data and documents relevant data in a retrievable format.
- c. Resident #32 had diagnoses including cerebral vascular accident. The resident took nothing by mouth and had a gastrostomy tube in place for nutrition. The RCP dated 5/25/06 identified that the resident should be free from signs and symptoms of aspiration pneumonia including fever, cough, congestion, etc., with interventions that included assessing for signs and symptoms of aspiration pneumonia. Observation of the resident on 9/6/06 throughout the morning hours revealed the resident with a frequent, loose, congested cough. The resident was also observed to slide down in the bed at times. Review of the resident's clinical record on 9/6/06 indicated that although congestion was identified by nursing staff on 9/1/06 and 9/3/06, a full respiratory assessment of the resident's lungs was evident only on the evening of 9/2/06 and the day shift of 9/4/06. No further lung assessments were noted in the clinical record through 9/6/06. Upon interview, the charge nurse stated on 9/6/06 at approximately 10:00 a.m. that the resident's cough was "baseline" due to allergies. The charge nurse later indicated that the resident's physician would be alerted. According to Lippincott Manual of Nursing Practice, eighth edition 2006, a respiratory assessment includes auscultation to determine respiratory status and differentiate primary lung problems from cardiac problems. According to Patient Care Standards, Collaborative Planning and Nursing Interventions, Mosby, Inc., 2000, risk for aspiration related to reduced level of consciousness, diminished or absent cough and gag reflexes, incompetent esophageal sphincter, delayed gastric emptying or displaced tube should be considered during enteral feeding. Assessment for signs and symptoms of aspiration includes assessment of the patient for diminished breath sounds and rales/rhonchi.

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

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4. Based on review of the medical record, review of facility policies, observations, and interviews, the facility failed to provide wound care to two of 18 residents, Residents #29 and #33, who required wound care and/or treatments for pressure areas; and/or failed to administer a medication patch to one resident, Resident #33 in accordance with physician orders; and/or failed to provide a pressure relieving device recommended by physical therapy. The findings included:
- a. Resident #29 (R #29) had diagnoses that included Peripheral Vascular Disease (PVD) and a history of a right above the knee amputation. Review of the assessment dated 5/23/06 identified that the resident was cognitively impaired and required extensive to total assistance from staff. Review of physician orders dated 8/31/06 directed daily care to the left heel area that included skin prep be applied to the left heel followed by a dry, protective dressing. Review of the weekly wound documentation flow sheet dated 9/4/06 identified that R #29 had a facility acquired unstagable pressure area on the left heel that measured 0.3 centimeters (cm.) by 0.5 cm. Intermittent observation of R #29's left heel on 9/6/06 from 5:38 AM to 10:40 AM identified that the left heel protective dressing was lacking. In addition, observation of R #29's left foot dressing changes by LPN #16 on 9/6/06 at 10:40 AM identified that although LPN #16 completed wound care to R #29's left medial foot bunion area as directed by physician orders, LPN #16 did not provide care to the resident's left heel area. Review of the treatment kardex with LPN #16 and subsequent interview following the observation identified that LPN #16 still did not recognize the need for the treatment to R #29's left heel area. Subsequent to surveyor inquiry, R #29's heel treatment was provided by LPN #16.
 - b. Resident #33 (R #33) had diagnoses that included Multiple Sclerosis and Peripheral Vascular Disease (PVD). Review of the weekly wound documentation flow sheet dated 9/4/06 identified that R #33 had developed a 1.0 by 1.5 cm. open area at the left buttocks related to a fungal rash. Review of physician orders dated 8/29/06 directed that antifungal extra thick topical cream be applied to R #33's buttocks and coccyx every shift and as needed for fourteen days with additional orders that the licensed nurse was to provide the application of the cream. During the observation of incontinent care on 9/6/06 at 5:50 PM, Nursing Assistant #15 (NA #15) was observed to gently cleanse the site of the resident's fungal rash at the buttocks and coccyx area and then to apply the extra thick topical cream to the same areas including the open area at the left buttocks. Interview with the day shift supervisor at 8:00 AM on 9/6/06 identified that although NAs may apply the antifungal topical cream to rash like areas if directed by physician order, NAs may not apply the cream to any open areas. Review of facility policy directed that wound care would be provided in accordance with physician orders.
 - c. Resident #33 (R #33) had diagnoses that included Multiple Sclerosis, Peripheral Vascular Disease (PVD), and a history of bilateral above the knee amputations. Review of the assessment dated 7/26/06 identified that R #33 required extensive to total assistance for all Activities of Daily Living (ADLs). Review of physician orders dated 8/17/06 directed that two Lidoderm 5% adhesive patches be applied to the top of R #33's

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right stump daily at 9:00 AM and that the patches be removed at 9:00 PM (a twelve hour period on and twelve hours off). Observation of R #33's right stump area on 9/6/06 at 5:59 AM identified that both Lidoderm patches were present on the right stump. Interview with LPN #15 on 9/6/06 at 8:15 AM identified that the patches were to be removed on the evening shift and that she had not yet applied R #33's Lidoderm patch for 9/6/06.

- d. Resident #32 had diagnoses including cerebral vascular accident and traumatic brain injury. The resident 's Minimum Data Assessment (MDS) of 5/19/06 identified that the resident was totally dependent in bed mobility and the Resident Care Plan of 8/18/06 indicated the resident had a stage II pressure ulcer of the right buttock. Interventions included an overlay mattress for the resident 's bed and a specialty cushion for the wheelchair. Physical Therapy progress notes of 8/21/06 indicated that the resident tended to be a sacral sitter and identified that although the resident currently had an air overlay in bed, increased pressure relief in bed was recommended. Observation of the resident in bed on 9/6/06 and 9/7/07 revealed that the resident continued to have an air overlay on the bed. Interview with the Director of Nures on 9/6/06 indicated that although a specialty mattress had been ordered for the resident it had not yet arrived and no other interim interventions had been implemented. On 9/7/06, the DNS indicated that the mattress had arrived and would be placed on the resident 's bed.

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

5. Based on review of the medical record, review of facility policies, observations, and interviews, the facility failed to provide wound care to an existing pressure ulcer of one resident, Residents #29 and/or failed to reposition Resident #38 (pressure ulcer on coccyx) while in the wheelchair. The findings included:
 - a. Resident #29 (R #29) had diagnoses that included a history of a Cerebral Vascular Accident (CVA) and Peripheral Vascular Disease (PVD). Review of the assessment dated 5/23/06 identified that R #29 was cognitively impaired and required extensive to total assistance from staff for all Activities of Daily Living (ADLs). Review of the weekly wound documentation flow sheet dated 9/4/06 identified that R #29 had a facility acquired unstagable pressure area on the left heel that measured 0.3 centimeters (cm.) by 0.5 cm. Physician orders dated 8/31/06 directed daily care to the left heel area that included skin prep be applied to the left heel followed by a dry, protective dressing. Intermittent observation of R #29's left heel on 9/6/06 from 5:38 AM to 10:40 AM identified that the left heel protective dressing was lacking. In addition, observation of R #29's left foot dressing changes by LPN #16 on 9/6/06 at 10:40 AM identified that although LPN #16 completed wound care to R #29's left medial foot bunion area as directed by physician orders, LPN #16 did not provide care to the resident 's left heel area. Review of the treatment kardex with LPN #16 and subsequent interview following the observation identified that LPN #16 still did not recognize the need for the treatment

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WERE IDENTIFIED

to R #29's left heel area. Subsequent to surveyor inquiry, R #29's heel treatment was provided by LPN #16. Review of facility policy directed that wound care would be provided in accordance with physician orders. In addition, facility wound care protocol directed that the facility would prevent the development of pressure ulcers, promote the healing of pressure ulcers that are already present, and prevent the development of additional pressure ulcers.

- b. Resident #38 fell at the nursing home in July 2006 and required surgery for a fractured hip. The resident also had Alzheimer's dementia. The MDS assessment dated 8/2/06 identified that the resident required extensive staff assistance for mobility needs. The physician order dated 8/28/06 directed that the resident ambulate 50 to 200 feet twice a day with the assistance of staff. On 8/31/06 the resident developed a stage two pressure ulcer of the left heel and the physician ordered a treatment to the area. On 9/4/06 the wound care consultant identified the heel ulcer as unstageable and the physician was informed. As a result of the deterioration in the heel pressure ulcer, the resident's ambulation was held for one week (9/4/06-9/11/06). The care plan dated 9/5/06 identified that the resident developed a stage two pressure ulcer on the coccyx. Observation of the resident on 9/6/06 between the period of 7:30 AM through 10:45 AM identified the resident to be in the wheelchair without the benefit of repositioning off the resident's buttocks for a period of three hours and fifteen minutes. Interview (on 9/6/06) with the nurse aide assigned to care for the resident on 9/6/06 identified that she provided care to the resident while in bed between 7 to 7:20 am and then got the resident up to the wheelchair. The nurse aide stated that she was then transferred to another unit at 7:30 AM. Interview (on 9/6/06) with a nurse aide identified that she fed the resident between 8 and 8:15 AM on 9/6/06 while the resident was in the wheelchair. Interview with the Recreation Aide on 9/6/06 at 10:45 AM identified that Resident #38 had been in the Recreation room since 9am. Interview with facility staff and the Independent Nurse Consultant identified that although the care plan addressed turning and repositioning, once the resident's ambulation program was held on 9/4/06, there was not a specific plan to move the resident while in the wheelchair.

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

6. Based on observation, interview and clinical record review, an LPN failed to implement appropriate infection control practices when performing dressing change procedures on Resident #38. The findings include the following:
- a. Resident #38 had Alzheimer's dementia and recent surgical repair of a fractured hip. The MDS assessment dated 8/2/06 identified that the resident had a cognitive impairment and required staff assistance for care needs. The resident's clinical record identified that the resident required a daily treatment to the stage two pressure ulcer on the coccyx as well as a treatment to the unstageable pressure ulcer on the left heel. Observation of the

DATE OF VISIT: September 6, 2006

EXHIBIT B

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

dressing changes on 9/7/06 by the LPN identified that the nurse washed the skin on the resident's buttocks around the coccyx and with the same contaminated gloves, accessed the clean package of gauze pads to obtain a clean gauze pad. Upon finishing the dressing change procedure, the LPN was about to place the contaminated package of gauze pads in the community supply of clean dressing products when the surveyor intervened. The Independent Nurse Consultant, who also witnessed the dressing change procedure directed the LPN to discard all dressing products which were on the resident's bedside table as well as in the community supply of dressing products which was placed on the resident's chair. In addition, the LPN utilized the community set of scissors to cut the soiled heel dressing off Resident #38's left foot. Without cleansing the scissors, the LPN placed the contaminated scissors in the community supply of clean dressing products utilized for other resident dressing change procedures. Again, the surveyor intervened and the Independent Nurse Consultant instructed the LPN to discard all dressing products. Th Corporate Nurse identified that the LPN was removed from performing dressing change procedures and the nurse would be inserviced and monitored closely.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H) and/or (M) and/or (q) Dietary Services (2)(C).

7. Based on review of the clinical record and staff interviews, the facility failed to ensure for 3 of 22 residents identified with alteration in skin integrity, dietary assessments were documented in the clinical record. The findings include:
 - a. Resident #10 (R#10) had an assessment dated 8/1/06 that identified two stage three stasis ulcers to the right lower extremity. Facility documentation of residents with pressure ulcers dated 8/18/06 identified R#10 with a stage two pressure ulcer on the right buttock. Although R#10 physician's orders dated 8/31/06 directed the addition of multivitamins, zinc and to increase the resident's protein supplement, there was no documentation in the clinical record of a nutritional evaluation by the RD.
 - b. Facility documentation dated 8/18/06 identified Resident # 28 (R#28) with a stage two pressure ulcer on th right buttock. On 9/6/06 there was no documentation in R#28's clinical record of the nutritional evaluation by the RD. On 9/6/06 at 9:30 AM the acting Director of Nursing (DNS) stated that all residents identified on 8/18/06 should have been screened by the Dietician (RD) and recommendations made. The DNS provided documentation of an interdisciplinary meeting dated 9/4/06 that included an evaluation of each resident's nutritional status by the RD, however, the evaluations had not been incorporated into the the residents' clinical records.
 - c. Resident #39 (R# 39) was admitted on 8/10/06 with diagnoses that included rhabdomyositis and renal insufficiency. Nursing narrative notes dated 8/19/06 identified R#39 with an intact blister on the right lower extremity. On 8/21/06 the blister was noted to be open with a wound care treatment initiated. In a review of R#39's clinical record on 9/6/06 with the Regional Clinical Nurse, there was no documentation of a

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EXHIBIT B

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dietary assessment on admission or subsequent to the development of the open area. On 9/6/06 at 9:40 AM, the RD stated an assessment had been completed but could not explain why it was not documented.

TO: Kettle Brook Care Center, LLC of East Windsor, CT
Kettle Brook Care Center, LLC
96 Prospect Hill Road
East Windsor, CT 06088

EXHIBIT C
PAGE 1 OF 8

SUMMARY ORDER

WHEREAS, pursuant to Connecticut General Statutes, Section 19a-493, Kettle Brook Care Center, LLC of East Windsor, CT has been issued a License No. 2219-C by the State Department of Public Health, to operate a "Chronic and Convalescent Nursing Home facility known as Kettle Brook Care Center, LLC (Kettle Brook); and

WHEREAS, Connecticut General Statutes, Section 19a-534a authorizes the Commissioner of Public Health to issue a Summary Order if the Commissioner finds that the health, safety or welfare of any patient or patients in any nursing home facility imperatively requires emergency action and incorporate findings to that effect into the order.

WHEREAS, in response to complaints received by the Department of Public Health regarding care and services provided by Kettle Brook Care Center, LLC investigations were initiated on various dates commencing on August 7, 2006 up to and including August 17, 2006 by representatives of the Department's Facility Licensing and Investigations Section; and

WHEREAS, pursuant to Connecticut General Statutes, Sections 19a-495 and 19a-496, nursing home facilities are required to comply with all pertinent regulations promulgated by the Department of Public Health; and

WHEREAS, during the course of the aforementioned inspections at Kettle Brook Care Center violations of Section 19-13-D8t (e) Governing Body (1)(B) and /or (2)(B) and/or (2)(D) and/or (2)(E); (f) Administrator (3) and/or (3)(A); and/or (h) Medical Director (2)(A) and (2)(B) and (2)(J); and/or (j) Director of Nurses (2); and/or (k) Nurse Supervisor (1); and/or (m) Nursing Staff (1) and/or (2)(A) and/or (2)(B) and/or (2)(C); and/or (o) Medical Records (2)(H) and/or (2)(I) and/or (2)(K); and/or (t) Infection Control (2)(A) and/or (3) of the Regulations of Connecticut State Agencies were identified which seriously jeopardize the health, safety and welfare of patients at Kettle Brook Care Center, LLC and have resulted in serious negative patient outcomes.

WHEREAS, the Department will issue a statement of charges seeking disciplinary action pursuant to Connecticut General Statutes Section 19a-494 to be served separately asserting the violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies (Public Health Code) set forth in the violation letter dated August 25, 2006 (attached hereto) and a Notice of Hearing.

WHEREAS, in light of the above violations the patients of Kettle Brook Care Center, LLC are in jeopardy and it is imperative that the Department of Public Health summarily impose the following actions:

1. Kettle Brook Care Center, LLC is hereby prohibited from admitting new patients.
2. Kettle Brook Care Center, LLC is hereby summarily ordered to comply with Section as above 19-13-D8t (e) Governing Body (1)(B) and/or (2)(B) and/or (2)(D) and/or (2)(E); (f) Administrator (3) and/or (3)(A); and/or (h) Medical Director (2)(A) and (2)(B) and (2)(J); and/or (j) Director of Nurses (2); and/or (k) Nurse Supervisor (1); and/or (m) Nursing Staff (1) and/or (2)(A) and/or (2)(B) and/or (2)(C); and/or (o) Medical Records (2)(H) and/or (2)(I) and/or (2)(K); and/or (t) Infection Control (2)(A) and/or (3) of the (Public Health Code).
3. Kettle Brook Care Center, LLC is hereby ordered to contract with a physician consultant, who will function separate and distinct from the Licensee and the

current medical director, who shall have the responsibility assessing the quality of medical direction and/or care provided at the facility. The physician consultant shall confer with Kettle Brook's Administrator, Director of Nursing Services, Medical Director and other staff, as the consultant deems appropriate concerning the consultant's assessment of medical services.

- a. The Medical Consultant shall perform the following duties:
 - i. Provide oversight and guidance to the Medical Director;
 - ii. Accompany the Medical Director on rounds;
 - iii. Audit at least 10 medical records per week;
 - iv. Review, analyze and offer recommendations regarding facility data, to include but not be limited to, pressure sore and infection control rates; and
 - v. Review protocols for care and make specific recommendations as to the care of individual patients.
- b. The Medical Consultant shall confer with the Licensee, Administrator, Director of Nursing Services, Medical Director and other staff determined by the Medical Consultant to be necessary to the assessment of the medical care.
- c. The Medical Consultant shall make recommendations to the Licensee's Administrator, Director of Nurses and Medical Director for improvement in the delivery of medical care in the facility. If the Medical Consultant and the Licensee are unable to reach an agreement regarding the implementation of the Medical Consultant's recommendation(s), the Department after meeting with the Licensee and the Medical Consultant shall make a final determination which shall be binding on the Licensee.
- d. The Medical Consultant shall submit weekly reports to the Department documenting:
 - i. Assessments of the care and services provided to the patients;
 - ii. The Licensee's compliance with applicable federal and state statutes and regulations pertinent to the facility; and

- iii. Recommendations made by the Medical Consultant and the Licensee's response to implementation of the recommendations.
 - e. The Medical Consultant shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
4. Kettle Brook Care Center, LLC is hereby ordered to contract with/and employ one individual who is licensed in the State of Connecticut as an Administrator and who will serve at Kettle Brook Care Center, LLC in that capacity on a full time basis in accordance with state law within 5 business days of this order and identity of this individual needs to be reported to the Department upon retention.
5. Kettle Brook Care Center, LLC is ordered to ensure that the positions of Director of Nursing Services, Assistant Director of Nurses and Infection Control Nurse are filled and that the individuals who are in these positions are serving in that capacity on a full time basis.
6. Upon receipt of this order, Kettle Brook Care Center, LLC is to contract in 5 business days with a Registered Nurse, pre approved by the Department of Public Health, who is not an employee of the nursing home facility or it's parent corporation. Said Registered Nurse will function separately and distinct from the Licensee and will serve as Wound/Infection Control Consultant (W/ICC) forty hours per week. Prior to formally contracting with said consultant the facility shall submit to the Facility Licensing and Investigations Section of the Department of Public Health the curriculum vitae of the potential consultant for review and approval or disapproval by the Facility Licensing and Investigations staff.

- a. The W/ICC shall evaluate the facility's infection control and wound care program.
- b. The W/ICC shall perform the following duties:
 - i. Evaluation of the facility's Infection Control Program;
 - ii. Maintaining an effective Infection Control Program;
 - iii. Review facilities infection control policies/procedures pursuant to infection control practices;
 - iv. Evaluation of the implementation of the facility's infection control policies and procedures;
 - v. Determining compliance with the facility's policies and procedures for cohorting of patient's with infections;
 - vi. Evaluation of the facility's wound care program;
 - vii. Education and remediation of staff relevant to infection control and wound care; and
 - viii. Conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, preventative protocols and assess patients at risk for pressure sores or vascular areas.
- c. Independent W/ICC contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
- d. The Independent W/ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not except any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
- e. The Independent W/ICC shall prepare and submit to the Department weekly written reports concerning Kettle Brook's continued compliance with the applicable statutes and regulations of the Department of Health and the performance of the duties set forth in this order. Copies of said

reports shall be provided to the Licensee. The Independent W/ICC shall be present at the facility forty (40) hours per week. The Independent W/ICC shall arrange his/her schedule in order to be present at various times on all three shifts.

- f. The Independent W/ICC shall confer with Kettle Brook's Administrator, Director of Nursing Services and other staff as the Consultant deems appropriate concerning the Consultant's assessment of nursing services and Kettle Brooks' continued compliance with the Public Health Code and applicable statutes. Said Consultant shall conduct meetings at the Department's request with the Department, the facility's Administrator, its Director of Nursing Services and its Licensee and make recommendations to such parties for improvement in the delivery of direct patient care in the facility.
7. Kettle Brook Care Center, LLC is ordered to contract with an Independent Nurse Consultant (INC) who is approved by the Department.
- a. 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 or clinical management requirements of the Regulations of Connecticut State Agencies or those set forth in this order.
 - b. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in ensuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not except any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
 - c. The Licensee shall incur the cost of the INC.
 - d. 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.

- e. The INC shall have the responsibility for:
 - i. 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. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - ii. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
- f. 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.
- g. The INC shall weekly written reports to the Department documenting;
 - i. The INC assessment of the care and services provided to patients;
 - ii. The Licensee compliance with applicable federal and state statutes and regulations pertinent to the facility; and
 - iii. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
- h. The INC shall be at the Facility forty (40) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends.

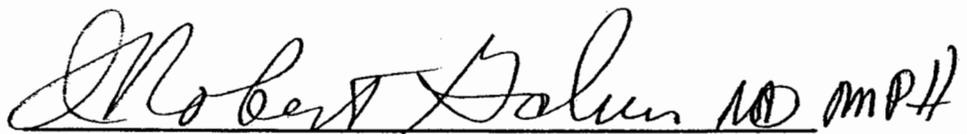
8. Within five (5) business days of this order, Kettle Brook Care Center, LLC is hereby ordered to develop and maintain a patient acuity system which shall identify the number and qualifications of nursing and ancillary staff necessary to meet the needs of patients housed in the facility. The Licensee shall, on a daily basis, utilize the acuity system to establish staffing ratios.

9. Staffing ratios shall be maintained, at a minimum, as follows:
 - a. 1st shift
12 licensed staff
25 nurse aides
 - b. 2nd shift
9 licensed staff
22 nurse aides
 - c. 3rd shift
7 licensed staff
13 nurse aides

10. Failure to comply with this Order will be cause for additional action pursuant to Connecticut General Statutes 19a-494a and 19a-534a, which actions could include summary revocation or suspension of the Facility's license.

11. This order shall remain in effect until the completion of proceedings brought pursuant to Connecticut General Statutes Section 19a-494 unless withdrawn or modified by written order of the Commissioner of Public Health.

Dated at Hartford, Connecticut this 25th day of August, 2006.



J. Robert Galvin, M.D., M.P.H., Commissioner
Department of Public Health

STATEMENT OF CHARGES

TO: Kettle Brook Care Center, LLC. Of East Windsor, CT
96 Prospect Hill Road
East Windsor, CT 06088

Pursuant to the provisions of Connecticut General Statutes §19a-494 the Connecticut Department of Public Health, Facility Licensing and Investigations Section, (hereinafter "Department") brings the following charges against Kettle Brook Care Center, LLC. of East Windsor, Connecticut (hereinafter "respondent").

COUNT ONE

1. Respondent is and has been at all times referenced in this Statement of Charges the holder of a Connecticut chronic and convalescent nursing home License No. 2219-C.
2. Between approximately March 28, 2006 and August 17, 2006, respondent failed to prevent pressure sores and/or to ensure that patients who had pressure sores received, in accordance with the patient's plan of care and/or nursing standards of practice, treatment and/or nursing services and/or anti-decubiti, devices and/or skin assessments to promote healing, prevent infections and prevent the development of additional pressure sores.
3. The above referenced conduct violates Section 19-13-D8t (f)(3); (f)(3)(F); (j)(2); (k)(1); (m)(1); (m)(2)(A); (m)(2)(B); (m)(2)(C); (o)(2)(I); (o)(2)(K); and/or (t)(2)(A) of the Public Health Code of the State of Connecticut.

COUNT TWO

4. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
5. Between approximately July 15, 2006 and August 17, 2006, respondent failed to employ qualified personnel in sufficient numbers to assess and/or meet patient needs with respect to the prevention and/or treatment of pressure sores and/or with respect to general patient care.
6. The above referenced conduct violates Section 19-13-D8t (e)(1)(B); (e)(2)(E); (f)(3); (f)(3)(F); (j)(2); (k)(1); and/or (m)(1) of the Public Health Code of the State of Connecticut.

COUNT THREE

7. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
8. Between approximately April 14, 2006 and August 17, 2006, respondent failed to provide its patients with accurate patient assessments and/or patient care plans which contained patients' current problems and/or needs and/or approaches.
9. The above reference conduct violates Section 19-13-D8t (j)(2); (k)(1); (o)(2)(H); and/or (o)(2)(I) of the Public Health Code of the State of Connecticut.

COUNT FOUR

10. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
11. Between approximately July 11, 2006 and August 17, 2006, respondent lacked an effective infection control program and/or plan.
12. The above referenced conduct violates Section 19-13-D8t (e)(2)(B); (f)(3); (t)(2)(A); and/or (t)(3) of the Public Health Code of the State of Connecticut.

COUNT FIVE

13. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
14. Between approximately June 5, 2006 and August 17, 2006, the respondent's Governing Body failed to ensure that respondent's nursing home was staffed with a qualified Administrator/Director of Nursing and/or Assistant Director of Nursing.
15. The above referenced conduct violates Section 19-13-D8t (e)(2)(B); and/or (e)(2)(E) of the Public Health Code of the State of Connecticut.

COUNT SIX

16. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
17. Between approximately March 28, 2006 and August 17, 2006, the Medical Director failed to ensure that quality medical care was provided in the nursing home.
18. The above referenced conduct violates Section 19-13-D8t (h)(2)(B) of the Public Health Code of the State of Connecticut.

Therefore, the Department of Public Health Services prays that: the Commissioner of Health Services, as authorized in 19a-494 of the Connecticut General Statutes revoke or take any other actions as authorized in said section against the Chronic and Convalescent Nursing Home license of Kettle Brook Care Center, LLC of East Windsor, CT as he deems appropriate and consistent with law.

Dated at Hartford, Connecticut this 28 day of August, 2006

By: Joan D. Leavitt
Joan D. Leavitt, Section Chief
Department of Public Health
Facility Licensing and Investigations Section

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

TO: Kettle Brook Care Center, LLC of East Windsor, Connecticut
Kettle Brook Care Center, LLC
96 Prospect Hill Road
East Windsor, CT 06088

AMENDED SUMMARY ORDER

WHEREAS, pursuant to Connecticut General Statutes, Section 19a-493, Kettle Brook Care Center, LLC of East Windsor, Connecticut has been issued a License No. 2219-C by the Connecticut Department of Public Health (hereinafter "Department"), to operate a "Chronic and Convalescent Nursing Home" facility known as Kettle Brook Care Center, LLC (hereinafter "Kettle Brook"); and

WHEREAS, Connecticut General Statutes § 19a-534a authorizes the Commissioner of Public Health to issue a Summary Order if the Commissioner finds that the health, safety or welfare of any patient or patients in any nursing home facility imperatively requires emergency action and incorporate findings to that effect into the order.

WHEREAS, in response to complaints received by the Department of Public Health regarding care and services provided by Kettle Brook Care Center, LLC investigations were initiated on various dates commencing on August 7, 2006 up to and including August 17, 2006 by representatives of the Department's Facility Licensing and Investigations Section; and

WHEREAS, pursuant to Connecticut General Statutes, Sections 19a-495 and 19a-496, nursing home facilities are required to comply with all pertinent regulations promulgated by the Department of Public Health; and

WHEREAS, during the course of the aforementioned inspections at Kettle Brook Care Center violations of Section 19-13-D8t (e) Governing Body (1)(B) and /or (2)(B) and/or (2)(D) and/or (2)(E); (f) Administrator (3) and/or (3)(A); and/or (h) Medical Director (2)(A) and (2)(B) and (2)(J); and/or (j) Director of Nurses (2); and/or (k) Nurse Supervisor (1); and/or (m) Nursing Staff (1) and/or (2)(A) and/or (2)(B) and/or (2)(C); and/or (o) Medical Records (2)(H) and/or (2)(I) and/or (2)(K); and/or (t) Infection Control (2)(A) and/or (3) of the Regulations of Connecticut State Agencies were identified which seriously jeopardize the health, safety and welfare of patients at Kettle Brook Care Center, LLC and have resulted in serious negative patient outcomes.

WHEREAS, the Department will issue a statement of charges seeking disciplinary action pursuant to Connecticut General Statutes Section 19a-494 to be served separately asserting the violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies (Public Health Code) set forth in the violation letter dated August 25, 2006 (attached hereto) and a Notice of Hearing.

WHEREAS, in light of the above violations the patients of Kettle Brook Care Center, LLC are in jeopardy and it is imperative that the Department of Public Health summarily impose the following actions:

1. Kettle Brook Care Center, LLC is hereby prohibited from admitting new patients except as provided in paragraph 10 below.
2. Kettle Brook Care Center, LLC is hereby summarily ordered to comply with Section as above 19-13-D8t (e) Governing Body (1)(B) and/or (2)(B) and/or (2)(D) and/or (2)(E); (f) Administrator (3) and/or (3)(A); and/or (h) Medical Director (2)(A) and (2)(B) and (2)(J); and/or (j) Director of Nurses (2); and/or (k) Nurse Supervisor (1); and/or (m) Nursing Staff (1) and/or (2)(A) and/or (2)(B) and/or (2)(C); and/or (o) Medical Records (2)(H) and/or (2)(I) and/or (2)(K); and/or (t) Infection Control (2)(A) and/or (3) of the (Public Health Code).
3. Kettle Brook Care Center, LLC is hereby ordered to contract with a physician consultant, who will function separate and distinct from the Licensee and the current medical director, who shall have the responsibility assessing the quality of

medical direction and/or care provided at the facility. The physician consultant shall confer with Kettle Brook's Administrator, Director of Nursing Services, Medical Director and other staff, as the consultant deems appropriate concerning the consultant's assessment of medical services.

- a. The Medical Consultant shall perform the following duties:
 - i. Provide oversight and guidance to the Medical Director;
 - ii. Accompany the Medical Director on rounds;
 - iii. Audit at least 10 medical records per week;
 - iv. Review, analyze and offer recommendations regarding facility data, to include but not be limited to, pressure sore and infection control rates; and
 - v. Review protocols for care and make specific recommendations as to the care of individual patients.
- b. The Medical Consultant shall confer with the Licensee, Administrator, Director of Nursing Services, Medical Director and other staff determined by the Medical Consultant to be necessary to the assessment of the medical care.
- c. The Medical Consultant shall make recommendations to the Licensee's Administrator, Director of Nurses and Medical Director for improvement in the delivery of medical care in the facility. If the Medical Consultant and the Licensee are unable to reach an agreement regarding the implementation of the Medical Consultant's recommendation(s), the Department after meeting with the Licensee and the Medical Consultant shall make a final determination which shall be binding on the Licensee.
- d. The Medical Consultant shall submit weekly reports to the Department documenting:
 - i. Assessments of the care and services provided to the patients;
 - ii. The Licensee's compliance with applicable federal and state statutes and regulations pertinent to the facility; and
 - iii. Recommendations made by the Medical Consultant and the Licensee's response to implementation of the recommendations.

- e. The Medical Consultant shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
4. Kettle Brook Care Center, LLC is hereby ordered to contract with/and employ one individual who is licensed in the State of Connecticut as an Administrator and who will serve at Kettle Brook Care Center, LLC in that capacity on a full time basis in accordance with state law within 5 business days of this order and identity of this individual needs to be reported to the Department upon retention.
5. Kettle Brook Care Center, LLC is ordered to ensure that the positions of Director of Nursing Services, Assistant Director of Nurses and Infection Control Nurse are filled and that the individuals who are in these positions are serving in that capacity on a full time basis.
6. Upon receipt of this order, Kettle Brook Care Center, LLC is to contract in 5 business days with a Registered Nurse, pre approved by the Department of Public Health, who is not an employee of the nursing home facility or it's parent corporation. Said Registered Nurse will function separately and distinct from the Licensee and will serve as Wound/Infection Control Consultant (W/ICC) forty hours per week. Prior to formally contracting with said consultant the facility shall submit to the Facility Licensing and Investigations Section of the Department of Public Health the curriculum vitae of the potential consultant for review and approval or disapproval by the Facility Licensing and Investigations staff.
- a. The W/ICC shall evaluate the facility's infection control and wound care program.
- b. The W/ICC shall perform the following duties:
- i. Evaluation of the facility's Infection Control Program;
 - ii. Maintaining an effective Infection Control Program;

- iii. Review facilities infection control policies/procedures pursuant to infection control practices;
 - iv. Evaluation of the implementation of the facility's infection control policies and procedures;
 - v. Determining compliance with the facility's policies and procedures for cohorting of patient's with infections;
 - vi. Evaluation of the facility's wound care program;
 - vii. Education and remediation of staff relevant to infection control and wound care; and
 - viii. Conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, preventative protocols and assess patients at risk for pressure sores or vascular areas.
- c. Independent W/ICC contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
- d. The Independent W/ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not except any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
- e. The Independent W/ICC shall prepare and submit to the Department weekly written reports concerning Kettle Brook's continued compliance with the applicable statutes and regulations of the Department of Health and the performance of the duties set forth in this order. Copies of said reports shall be provided to the Licensee. The Independent W/ICC shall be present at the facility forty (40) hours per week. The Independent W/ICC shall arrange his/her schedule in order to be present at various times on all three shifts.

- f. The Independent W/ICC shall confer with Kettle Brook's Administrator, Director of Nursing Services and other staff as the Consultant deems appropriate concerning the Consultant's assessment of nursing services and Kettle Brooks' continued compliance with the Public Health Code and applicable statutes. Said Consultant shall conduct meetings at the Department's request with the Department, the facility's Administrator, its Director of Nursing Services and its Licensee and make recommendations to such parties for improvement in the delivery of direct patient care in the facility.
7. Kettle Brook Care Center, LLC is ordered to contract with an Independent Nurse Consultant (INC) who is approved by the Department.
- a. 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 or clinical management requirements of the Regulations of Connecticut State Agencies or those set forth in this order.
 - b. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in ensuring the safety, welfare and well being of the patients and to secure compliance with applicable federal and state law and shall not except any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
 - c. The Licensee shall incur the cost of the INC.
 - d. 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.
 - e. The INC shall have the responsibility for:
 - i. 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. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
- ii. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
- f. 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.
- g. The INC shall weekly written reports to the Department documenting;
- i. The INC assessment of the care and services provided to patients;
 - ii. The Licensee compliance with applicable federal and state statutes and regulations pertinent to the facility; and
 - iii. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
- h. The INC shall be at the Facility forty (40) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends.
8. Within five (5) business days of this order, Kettle Brook Care Center, LLC is hereby ordered to develop and maintain a patient acuity system which shall identify the number and qualifications of nursing and ancillary staff necessary to meet the needs of patients housed in the facility. The Licensee shall, on a daily basis, utilize the acuity system to establish staffing ratios.

9. Staffing ratios shall be maintained, at a minimum, as follows:
- a. 1st shift 7:00 a.m. to 3:00 p.m.

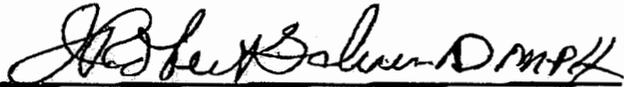
9 licensed staff – to include two (2) free floating registered nurse supervisors and one (1) treatment nurse.
20 nurse aides.
 - b. 2nd shift 3:00 p.m. to 11:00 p.m.

8 licensed staff – to include one (1) free floating registered nurse supervisor and one (1) treatment nurse.
18 nurse aides.
 - c. 3rd shift 11:00 p.m. to 7:00 a.m.

7 licensed staff – to include one (1) free floating registered nurse supervisor.
12 nurse aides.
10. Effective September 25, 2006, the facility may begin the admission of new residents in accordance with the schedule listed below. New admissions shall not exceed a total of eight (8) residents at the rate of a maximum of two (2) new admissions for each time period identified below:
- a. September 25, 2006 through October 1, 2006;
 - b. October 2, 2006 through October 8, 2006;
 - c. October 9, 2006 through October 15, 2006; and
 - d. October 16, 2006 through October 22, 2006.
- At no time shall the number of new admissions exceed two (2) per week. Subsequent admissions shall be at the discretion of the Department.
11. Failure to comply with this Order will be cause for additional action pursuant to Connecticut General Statutes 19a-494a and 19a-534a, which actions could include summary revocation or suspension of the Facility's license.
12. This order shall remain in effect until the completion of proceedings brought pursuant to Connecticut General Statutes Section 19a-494 unless withdrawn or modified by written order of the Commissioner of Public Health.

EXHIBIT E
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Dated at Hartford, Connecticut this 21st day of September, 2006.



J. Robert Galvin, M.D., M.P.H., Commissioner
Connecticut Department of Public Health