

**State of Connecticut
Department of Public Health
Facility Licensing and Investigations Section**

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

MODIFIED CONSENT AGREEMENT

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

WHEREAS, the Licensee has a Consent Agreement with the Department which became effective February 2, 2005, of which is attached hereto (Exhibit A); and

WHEREAS, the Department's Facility Licensing and Investigations Section ("FLIS") conducted unannounced inspections at the Facility for the purposes of conducting a complaint investigation and a survey; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in violation letter dated November 21, 2005 (Exhibit B); and

WHEREAS, an office conference regarding the November 21, 2005 violation letter was held between the Department and the Licensee on December 14, 2005; and

WHEREAS, the Licensee and the Department have agreed to modify the aforementioned Consent Agreement; and

WHEREAS, the Licensee without admitting wrongdoing is willing to enter into this Modified Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan Leavitt, its Section Chief, and the Licensee, acting herein by Larry Santilli, its President, hereby stipulate and agree as follows:

1. The Consent Agreement executed with the Department on February 2, 2005, shall be incorporated and made a part of this modified Consent Agreement, provided; however, that the provisions of this Modified Consent Agreement shall supersede any provision of the February 2, 2005, Consent Agreement that is inconsistent with the Modified Consent Agreement.
2. The Licensee shall within fourteen (14) days of the execution of the Modified Consent Agreement, review or revise, as necessary, current policies and procedures relative to physician notification, administration of medications, implementation of physician's orders, maintenance of oxygen therapy, assessing and monitoring residents for a decline and/or change in condition, administration of intravenous therapy, abuse prohibition including but not limited to reportable events, assessments and verification of nursing staff, neurological assessments, pain management, modes of transfer and bowel and bladder assessments.
3. The Licensee shall within twenty-one (21) days of the execution of the Modified Consent Agreement conduct inservice programs for all nursing staff, including agency contracted staff, which will include the facility's policies and procedures as stipulated in paragraph two (2) above.
4. The Licensee shall within forty-five (45) days of the execution of the Modified Consent Agreement institute a Quality Assurance Program to develop and

- implement a mechanism to ensure compliance as outlined in paragraphs two (2) and three (3).
5. The letter from the Administrator of the Licensee's Facility attached hereto as Exhibit C is accepted by the Department as evidence that the Licensee has complied with the requirements of paragraphs #2, #3 and #4 of this Modified Consent Agreement.
 6. The Licensee shall continue to contract at its own expense, with a registered nurse acceptable to the Department to serve as an Independent Nurse Consultant (INC) until such time as the Department identifies that the Facility is able to maintain continued compliance with the Regulations of Connecticut State Agencies and federal and state laws and regulations. The INC shall be at the facility thirty (30) hours a week. The Independent Nurse Consultant shall have fiduciary responsibility to the Department and shall perform said functions in accordance with FLIS's Independent Nurse Consultant Guidelines (Exhibit D - copy attached). The responsibilities of the INC shall include monitoring of care and services provided to residents residing in the Facility on all three (3) shifts and/or remediation of staff when potential care issues are identified. The Independent Nurse Consultant shall have the responsibility for:
 - a. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered, licensed practical nurses and ancillary staff;
 - b. Review of violation letter dated November 21, 2005 and assume responsibility for monitoring, educating and evaluating the Facility's plan of correction;
 - c. Shall submit reports on a weekly basis to the Department to address the facility's initiative to comply with applicable federal and state statutes and regulations and the assessments of the care and services provided to residents.
 7. The Department will evaluate the hours of the INC and/or responsibilities at the end of the two (2) months after the execution of this document and may, in its

- discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted.
8. Any records maintained in accordance with any state or federal law or regulation or as required by this Modified Consent Agreement shall be made available to the Independent Nurse Consultant and the Department, upon their request.
 9. The Licensee shall continue to employ a qualified Infection Control Nurse for no less than thirty-two (32) hours per week.
 10. The Licensee shall continue to contract one (1) or more individuals with credentials in wound care (e.g. APRN or RN) to consult with the facility regarding wound care, make recommendations, inservice staff, observe patient wounds and, as applicable, document in the clinical record. Said consultant(s) shall work no less than eight (8) hours per week.
 11. The Independent Nurse Consultant, the Licensee's Administrator, the Director of Nursing Services, the Licensee or a designee of the Governing Authority, and the individual assigned to oversee the implementation of the requirements of this document shall meet with the Department every four (4) weeks after the effective date of this Modified Consent Order during the tenure of the INC to discuss issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations and the assessments of the care and services provided to residents.
 12. The individual assigned to oversee the implementation of the requirements of this document shall submit monthly reports to the Department regarding the implementation of the consent Order components every month for the first six (6) months and every three (3) months thereafter for the duration of the Consent order.
 13. Reports and meetings required by this document shall be sent to:

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

14. All parties agree that this Modified Consent Agreement is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Agreement or of any statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Modified Consent Agreement 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.
15. 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 DCJ's Statewide Prosecution Bureau.
16. The terms of this Modified Consent Agreement and the Agreement executed on February 2, 2005, shall be in effect for a period of two (2) years from the effective date of this document.

*

*

*

IN WITNESS WHEREOF, the parties hereto have caused this Modified Consent Agreement to be executed by their respective officers and officials, which Modified Consent Agreement is to be effective as of the later of the two dates noted below.

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

4/25/06
Date

By [Signature]
Larry Santilli, President

State of Connecticut
County of Hartford

ss: Durham 4/25/2006

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

My Commission Expires: 3/31/10

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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

4/27/06
Date

By: [Signature]
Joan Leavitt R.N., Section Chief
Facility Licensing and Investigations Section

EXHIBIT A
PAGE 1 OF 7

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

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

CONSENT ORDER

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

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

WHEREAS, the Department during the course of the aforementioned inspections identified alleged violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated November 5, 2004 (Exhibit A - copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the DHSR of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Director, and the Licensee, acting herein through Larry Santilli, its President, hereby stipulate and agree as follows:

EXHIBIT A
PAGE 2 OF 7

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

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

EXHIBIT A
PAGE 3 OF 7Licensee: Northbridge Healthcare Center, Inc. of Bridgeport, CT.
Page 3

- with applicable federal and state statutes and regulations and the INC's assessment of the care and services provided to patients, subsequent recommendations made by the INC and the Licensee's response to implementation of said recommendations. Copies of the reports shall be provided to the Licensee. The INC's position shall be occupied and the duties of the INC shall be performed by a single individual unless otherwise approved by the Department. The INC shall confer with the Licensee's Administrator, Director of Nursing Services and other staff as the INC deems appropriate concerning the assessment of nursing services and the Facility's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and the Licensee for improvement in the delivery of assessment and Resident Care Planning. The INC shall have a fiduciary responsibility to the Department.
- d. The INC shall make recommendations as necessary to ensure the Facility's conformance with applicable federal and state statutes and regulations. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department shall make a final determination which, during the term of this Consent Order shall be binding on the Licensee.
- e. The INC shall have the responsibility for assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on resident assessment and care planning.
- f. The INC shall review the violation letter dated November 5, 2004 and assume responsibility for monitoring, educating and evaluating the Facility's plan of correction.
- g. The INC shall implement the Department's Guidelines for INCs (Exhibit C).

EXHIBIT A
PAGE 4 OF 7

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

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

EXHIBIT A
PAGE 5 OF 7

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

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

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

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

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

*

*

*

*

EXHIBIT A
PAGE 7 OF 7

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

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

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

1/27/2005
Date

By: [Signature]
Larry Santilli, President

State of Connecticut)
County of Hartford

ss Southington 1/31 2005

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

My Commission Expires: 12/31/05

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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/02/2005
Date

By: [Signature]
Marianne Horn, R.N., J.D., Director
Division of Health Systems Regulation



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B
PAGE 1 OF 30

November 21, 2005

Ms. Grace Flight, Administrator
Northbridge Health Care Center
2875 Main Street
Bridgeport, CT 06606

Dear Ms. Flight:

Unannounced visits were made to Northbridge Health Care Center on October 17, 18, 19, 20 and 21, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and a certification survey with additional information received through October 26, 2005.

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

An office conference has been scheduled for December 14, 2005 at 1 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

Respectfully,

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC:DW:

- c. Director of Nurses
Medical Director
President
vl

Complaint #4519, 4515, 4532, 4462, 4273, 4257, 4258, 4259, 4226, 4037



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

FACILITY: Northbridge Health Center

EXHIBIT **B**
Page 2 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t
(i) Director of Nurses (2)(L).

1. Based on clinical record reviews, and staff interviews for three of eight sampled residents with a significant change in condition (R# 7, 19, 24), the facility failed to notify the physician when the resident's fluid intake failed to meet their estimated needs for 10 days resulting in a hospital admission for dehydration and/or failed to notify the physician when a resident was admitted with wounds/skin conditions requiring treatment orders and/or when a prescription wound debridement agent was not available for 4 days and/or failed to notify the physician when a lab report identified an infection resulting in a delay of treatment for 4 days. The findings include:
 - a. Resident # 7's diagnoses included dementia and congestive heart failure. The Minimum Data Set dated 5/31/05 identified short and long term memory problems, modified independence with decision making ability and the need for extensive assistance with eating. Physician orders dated 8/20/05 directed to administer Lasix 40 milligrams daily. A dietary evaluation dated 3/9/05 identified the resident's estimated fluid needs to be between 1575-1890 milliliters (ml) daily. The intake and output records from 8/14/05 through 8/24/05 (11 days), identified that the resident did not meet the estimated fluid needs on 11 of 11 days. During those 11 days the total fluid intake documentation was noted to be between 670ml - 1400ml. Physician orders dated 8/25/05 directed to obtain lab work including a Blood Urea Nitrogen (BUN) and Creatinine levels. A lab report dated 8/25/05 identified a BUN of 90mg/dl (normal 7-30mg/dl) and a Creatinine of 4.6mg/dl (normal 0.5-1.2 mg/dl). Nurses notes dated 8/25/05 at 9:30 P.M. noted the resident to be combative and have a change in mental status. Nurse's notes further identified that the resident was sent to the hospital at 10:15 P.M. and admitted with a diagnosis of dehydration and acute renal failure. On admission to the hospital, the residents Blood Urea Nitrogen (BUN) was 95mg/dl and had a Creatinine of 4.3mg/dl. Review of the clinical record failed to provide evidence that the physician had been notified of the resident's intakes not meeting the estimated fluid needs. Interview with MD#2 on 10/20/05 at 10:00AM identified that he had not been made aware that the resident did not meet the estimated fluid needs during the time frame of 8/14/05 - 8/24/05.

FACILITY: Northbridge Health Center

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- b. Resident #19's diagnoses included dehydration. The admission minimum data set dated 12/14/05, identified that the resident was without cognitive impairment and required limited assistance of staff for activities of daily living. A care plan dated 1/28/05 identified a potential for dehydration related to vomiting. Interventions included to encourage fluids, maintain input and output, and keep physician and family updated. Physician progress notes dated 1/28/05-1/29/05 identified an evaluation of the resident's hydration status, with new orders directed encouraging 120 cc of fluid intake an hour. In addition the physician's order included monitoring closely for nausea/vomiting/diarrhea and offering clear liquids. Physician instructions also included notifying him if resident had not improved. The twenty-four hour report on 1/29/05 identified that on the 3-11 PM and 11-7 shift, the resident had a poor food and fluid intake. On 1/30/05 3-11 PM and 11-7 AM shift, fluids were also documented as being taken poorly. On 1/31/05 and 2/1/05 the resident was lethargic and complained of not feeling well. The 24 hour report sheet during that time, noted the resident to be weak and lethargic. On 2/2/05 nurses notes on the 7-3 shift noted the resident to be weak and lethargic and had an episode of vomiting. The physician was called and directed that the resident be transferred to the hospital. The resident was admitted to the hospital with a diagnosis which included severe dehydration and acute renal failure. Interview and clinical record review with the unit manager on 10/20/05 at 12:30 PM. identified that she would have expected the physician to be notified of the failure of the resident to improve and/or meet the required fluid needs.
- c. Resident #24 was admitted on 9/14/05 at 10 PM with diagnoses that included heart failure, status post pacemaker insertion, nosocomial pneumonia, and anxiety.
- i. Nursing notes dated 9/14/05 during the 11 PM-7 AM shift documented the presence of a transparent dressing on the mid-back on a large abscess-like out pouching with a stage II in the center and bilateral buttocks areas with transparent dressings in place. The weekly wound / non pressure ulcer report sheet dated 9/14/05 documented a 3x2 cm yellow slough area and red rash on the buttocks. Medical doctor admission orders dated 9/16/05 directed to cleanse the upper/mid back area with normal saline followed by santyl ointment daily and as needed and to apply anti-fungal ointment extra thick to the buttock and perineum rashes. Interview and review of the clinical record on 10/19/05 at 1:45 PM with the infection control nurse

FACILITY: Northbridge Health Center

EXHIBIT B
Page 4 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- failed to provide evidence that the physician had been notified of the mid/back open area and buttock rash from 9/14/05 until 9/16/05.
- ii. R#24's physician orders dated 9/16/05 directed to cleanse the upper/mid back area with normal saline followed by Santyl ointment. Review of the treatment administration record noted that the treatment was omitted on 9/19, 20, 21, 23/05 because the medication was not available. Interview and review of the clinical record on 10/20/05 at 12:25 PM with the infection control nurse failed to provide evidence that the physician had not been notified of the Santyl treatment being omitted or to obtain other orders until it was available.
 - iii. R#24's initial assessment dated 9/21/05 identified minimal/some difficulty cognitive decision making skills, required limited to extensive assistance with activities of daily living, was continent of urine by use of a Foley catheter, and identified presence of other open lesions and rashes. Physician orders dated 9/23/05 at 7:25 PM directed to remove the Foley catheter on the 11-7 shift. Nurse's notes dated 9/23/05 documented that the Foley catheter had been removed at 11:00 PM. A laboratory report dated 9/23/05 noted a final urine culture to be positive for infection with staphylococcus aureus. The report identified that it was not faxed to the physician until 9/27/05. Physician orders dated 9/28/05 directed Macrobid 100 mg antibiotic therapy. Interview and review of the clinical record on 10/19/05 at 1:45 PM with the infection control nurse and on 10/20/05 at 8:25 AM with the corporate nurse failed to provide evidence that the physician had been notified of the lab report indicating a urinary tract infection for four days delaying the start of antibiotic therapy until the 5th day after the results were reported to the facility by the lab.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D&t
(f) Administrator (3)(A).

2. Based on clinical record review, staff and resident interviews for the only sampled resident (R#18) who reported that money was missing/taken, the facility failed to provide evidence that an investigation was conducted. The findings include:
 - a. Resident #18's diagnoses included diabetes and depression. A quarterly assessment dated 2/9/05 identified the resident to be without cognitive impairment

FACILITY: Northbridge Health Center

CAPTION B
Page 5 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

and required limited assistance from staff for activities of daily living. Nursing narrative notes dated 4/29/05 at 2 PM identified that the resident reported that a middle aged person with reddish blonde hair had entered her room and had taken \$25.00. A resident fund account form identified that the resident had withdrawn money (\$40.00) from the business office on that date. Interview with the resident on 10/19/05 at 11:00 A.M, identified that the resident had money taken, but was unable to recall the date. Interview with the administrator on 10/17/05 at 10:15 A.M. identified that the facility did not investigate the alleged theft as per facility abuse policy. According to the policy, alleged misappropriation of resident property requires an immediate investigation.

3. Based on clinical record review, staff interviews and review of facility policy, for one of four sampled residents with allegations of mistreatment by staff (R #2), the facility failed to conduct a screening with the appropriate registries to verify a nurse aide's certification in accordance with facility policy. The findings include:
 - a. Resident #2's nurse's note dated 9/10/05 at 5:00 AM indicated that R #2 had made an allegation of being pinched by NA #6 during the 11-7 shift (9/05-9/10/05). Review of NA #6's personnel file indicated that NA #6 had been hired on 7/25/05. Review of NA #6's personnel file indicated that NA #6 had received certification from another state, but lacked documentation to reflect that the facility had conducted a screening with the appropriate registries to verify NA #6's certification and/or that NA #6 had applied for certification in the state of Connecticut. Review of the facility's Abuse policy indicated that before hire, all employees must complete an application and pass: criminal background check, licensure and/or certification verification, a minimum of two reference checks and a screening for any history of abuse, neglect or mistreatment of residents.

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

4. Based on clinical record review, review of facility documentation and interviews, for one of twenty-three sampled residents who depended on staff for incontinent care (Resident # 1), the facility failed to ensure the resident was treated with dignity when requesting assistance with care needs. The findings include:

FACILITY: Northbridge Health Center

Page 6 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- a. Resident # 1's diagnoses included chronic urinary tract infection. A Minimum Data Set (MDS) dated 5/24/05 identified the resident was frequently incontinent of bowel and bladder, and required extensive assistance for toileting. The Resident Care Plan (RCP) dated 3/22/05 and/or 5/11/05 identified the resident's toileting deficit and potential for urinary tract infection. Interventions included using the call light for assistance with toileting, and monitoring the resident's signs and symptoms such as dysuria and frequency. Physician orders dated 5/11/05 indicated that Resident # 1 was being treated for a urinary tract infection with Imipenem 250 milligrams (mg) intravenously every six hours for twelve days. Review of the facility documentation, interview with Resident # 1 on 10/18/05 at 9:50 AM and interview with Nurse Aide (NA) # 2 on 10/20/05 at 1:50PM indicated that on 5/13/05 at 9PM, Resident # 1 rang the call bell to request assistance with incontinence care and was told by NA #12 to "stop ringing the call bell", and that NA #12 "was busy," which Resident #1 perceived to be rude and abusive. Social Services progress notes on 5/16/05 also indicated that after that incident, Resident # 1 was afraid to ring the call bell and remained "soaking wet" the next shift.

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

5. Based on clinical record review and staff interviews, for the only sampled resident who did not want to go to bed (R #28), the facility failed to allow the resident to stay up on the 11 PM- 7 AM shift and removed her wheelchair so that she could not get out of the room/bed. The findings include:
 - a. Resident #28's diagnoses included Alzheimer's disease, anxiety and congestive heart failure. The resident was non-English speaking. The resident assessment dated 6/27/05 identified that R #28 had impaired cognition, was independent for transfers and required limited assistance with ambulation. The resident care plan dated 7/5/05 indicated that the resident had a diagnosis of anxiety. Interventions included to assess for signs and symptoms of insomnia, anxiety, and encourage diversional activities of choice. Facility documentation dated 8/4/05 at 7:00 AM indicated that R #28 was very agitated and complained about rude behavior from NA #9. The facility investigation dated 8/4/05 indicated that R #28 kept getting out of bed. NA #9's hand written statement indicated that she had taken R #28's

FACILITY: Northbridge Health Center

Page 7 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

wheel chair away because the resident kept getting out of bed. NA #9 on 10/25/05 at 3:50 PM stated that she had taken the resident's wheelchair away from the resident, because that resident kept getting out of bed, into the wheelchair and that she (NA #9) was afraid that the resident was going to fall.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

6. Based on clinical record reviews, review of facility policy and staff interviews, for two of nine residents in the survey sample with a diagnosis of depression (R #6, 27), the facility failed to ensure that the social worker assisted/assessed the resident's needs related to the allegations of mistreatment by staff that were unfounded and/or failed to assess a resident after a questionable suicide attempt. The findings include:
 - a. Resident #6's diagnoses included dementia with depression, Alzheimer's disease with behavior disturbances, anxiety, degenerative arthritis and osteoporosis. A quarterly assessment dated 8/10/04 identified the resident was cognitively impaired, required limited assistance for bed mobility, locomotion on unit, needed total staff assistance for transfer/personal care, had crying and tearfulness as mood indicators and received antianxiety and antidepressant drugs. A nurse's note dated 11/8/05 at 7:30 AM noted that the resident was observed in bed with the call light and television cord wrapped around her chest. Staff were unable to remove the cords as the resident was combative, hitting and attempting to bite staff. The resident was transferred to the emergency department for evaluation. Facility investigation documentation dated 11/9/04 noted that the resident had 3 cords wrapped around her. Review of social service notes documented that on 11/8/04 the resident was transferred to the hospital for increased combativeness and increased agitation but failed to address the incidence of the 3 cords wrapped around her. The note dated 11/9/05 again mentioned the increased combativeness and agitation but failed to document an assessment of the resident following the incident as to physical, mental, psychosocial needs/affect after the event. There were no further notes assessing the resident's well-being following the incident. Interview and review of the clinical record with the facility social worker on 10/20/05 at 10:45 AM and 11:30 AM noted that the incident had not been addressed and their expectation/practice would be to go back to assess the resident

FACILITY: Northbridge Health Center

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

for distress, consult with the family and follow the resident for three days if no ill effects and longer if needed.

- b. Resident #27's diagnoses included depression, peripheral vascular disease, and deep vein thrombosis on anticoagulants. The resident's quarterly assessment dated 3/21/05 identified that the resident was alert, oriented, had some difficulty with new situations and required minimal assistance with transfers and ambulation. A care plan dated 4/7/05 indicated that R #27 had a 5 x 3cm bruise to the left upper arm. A nurse's note dated 4/13/05 indicated that the bruise to R #27's left upper arm had increased in size and that R #25 had made an allegation that "one night, a nurse or nurse aide had thrown her into bed and she had hit her arm on the side rail". A nurse's note dated 4/13/05 at 5:45 PM, indicated that R #25 had informed a family member that the bruise on the upper left arm was caused by the johnny being too tight. LPN #5 on 10/20/05 at 9:50 AM stated that R #27 has been known to accuse staff if the resident's needs are not attended to immediately. A review of the social service notes dated 4/13/05 to 4/30/05, lacked documentation that the resident had been counseled and/or provided support by the social worker after the allegation was made in accordance with the facility's policy. The Social Worker on 10/21/05 at 11:00 AM stated that she is new to her position and the Social Worker that was overseeing R #27 at that time, is no longer with the facility. Review of the facility's policy on Resident Abuse indicated that the facility Social Worker is to provide counseling and support to the resident involved. Documentation of Psychosocial interventions must be in the clinical record. Social Services will document in the Medical Record every day for one week or more if appropriate.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D&t
(i) Director of Nurses (2) and/or (o) Medical Records (2)(H).

7. Based on staff interview and clinical record review for one of eight residents who had a significant change in condition (Resident #12), the facility failed to complete a comprehensive assessment within 14 days of identifying the changes. The findings include:
- a. Resident #12's diagnoses included Alzheimer's dementia and syncope. The admission assessment dated 1/2/05 identified that the resident was cognitively impaired, was independent with bed mobility and transfers, ate and ambulated

FACILITY: Northbridge Health Center

LATEL D
Page 9 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

with supervision, and required limited assistance with dressing, toilet use, personal hygiene, and bathing. The resident was identified as continent of bowel and occasionally incontinent of bladder. A quarterly review assessment dated 8/29/05 identified that the resident was severely cognitively impaired, required extensive to total assistance from facility staff with all activities of daily living (ADL), was totally incontinent of bowel and bladder and utilized devices and/or restraints that prevented independent rising from a chair. Interview and review of the resident's clinical record with the Director of nurses on 10/19/05 at 2:30 PM failed to provide evidence that a significant change assessment had been completed within 14 days of the quarterly assessment that identified significant declines in the resident's functioning.

8. Based on clinical record reviews and staff interviews for three sampled residents (Resident # 10, 15, 22), the facility failed to code the Minimum Data Set (MDS) accurately related to the presence of a fracture and/or the diagnosis of hypovolemia/dehydration. The findings include:
- Resident #22's diagnoses included dementia. Nurse's notes dated 4/17/05 identified that the resident's left leg was noted to be internally rotated and the resident was admitted to the hospital with a fractured left leg. The assessment dated 7/12/05 failed to identify the fracture. Interview with Licensed Practical Nurse (LPN#1) on 10/19/05 identified the fracture should have been on the assessment of 7/12/05.
 - Resident #10's diagnoses included dehydration. A quarterly assessment dated 8/2/05 identified that the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living, and had a current diagnosis of hypovolemia. Interview with the minimum data set coordinator on 10/10/05 at 12:35 PM identified the resident had a prior history of dehydration, but did not have a current diagnosis of hypovolemia and therefore the assessment was coded inaccurately.
 - Resident #15's diagnoses included dehydration. Review of the clinical record identified that the resident was transferred to the hospital on 12/6/04, 1/2, 2/14 and 2/27/05 and returned with diagnoses that included dehydration. Review of the MDS assessments dated 12/19/04, 1/11, 1/17, 2/4, 2/10 and 2/27/05 failed to provide evidence that the diagnoses of dehydration had ever been entered onto any of the assessments. Interview with the MDS Coordinator on 10/20/05 at 12:45

FACILITY: Northbridge Health Center

Page 10 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

PM identified that she did not know the resident and that the MDS Coordinator that was responsible for that unit no longer is employed at the facility.

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)(D).

9. Based on clinical record reviews and staff interviews for four sampled residents (#2, 6, 15, 31) the facility failed to develop comprehensive care plans that addressed fragile skin / multiple bruises, and/or incontinence, and/or the potential for falls, and/or a behaviors having the potential for self harm. The finding include:
 - a. Resident #2's diagnoses included cerebral vascular accident and anemia. The resident's annual assessment dated 2/2/05 identified that the resident was alert, oriented and required limited assistance with bed mobility. The resident's care plan dated 5/11/05 indicated that R #2 had a potential for skin breakdown related to limited mobility. Interventions included a pressure relieving device to the bed and chair; encourage turning and repositioning every two hours and to monitor for redness, reporting changes to the charge nurse. Nurse's notes dated 5/21/05 to 7/22/05 indicated that R #2 had a bruise on the left hip area on 5/21/05; a bruise to the left forearm on 7/19/05, and a bruise to the left lower leg on 7/22/05. Review of a nurse's note dated 9/10/05 at 5:00 AM indicated that R #2 had bruises to the right and left upper arms. LPN #4 on 10/19/05 at 12:20 PM stated that R #2 has fragile skin, bruises easily and is to be handled and transferred carefully. Interview and review of the care plan with the ADNS on 10/20/05 at 11:00 AM identified that although R #2's skin is fragile, bruises easily and she is to be turned carefully, the care plan failed to address the problem and identify interventions to prevent further injuries to the resident.
 - b. Resident # 31's diagnoses included cerebrovascular accident and Alzheimer's dementia. A Minimum Data Set (MDS) dated 07/19/05 identified the resident's frequent incontinence of bowel and bladder. Bowel and bladder retraining assessments dated 11/26/04 indicated that the resident was incontinent of bladder and that during the night, the resident was incontinent of bowel. Interview with and review of the resident care plans with Licensed Practical Nurse (LPN) # 1 on 10/20/05 at 11AM failed to provide evidence that a comprehensive care plan addressing the resident's incontinence had been developed and/or implemented.

FACILITY: Northbridge Health Center

Page 11 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- c. Resident #15 was admitted to the facility 9/04. Fall assessments dated 11/27/04 and 12/8/04 identified that the resident was at moderate risk for falls. Review of the Resident Care Plan with the Care Plan Coordinator on 10/20/05 12:45 PM failed to provide evidence that a care plan to address the potential for falls had been developed until after the resident had a fall on 12/27/04.
 - d. Resident #6's diagnoses included dementia with depression, Alzheimer's disease with behavior disturbances, anxiety, degenerative arthritis and osteoporosis. A quarterly assessment dated 8/10/04 identified the resident was cognitively impaired, required limited assistance for bed mobility and locomotion on the unit, was totally dependent on staff for transfer/personal care, had crying and tearfulness as mood indicators and received antianxiety and antidepressant drugs. A nurse's note dated 11/8/05 at 7:30 AM noted that the resident was observed in bed with the call light and television cord wrapped around her chest. Staff were unable to remove the cords as the resident became combative, hitting and attempting to bite staff. The resident was transferred to the emergency department for evaluation. Facility investigation documentation dated 11/9/04 noted that the resident had 3 cords wrapped around her. Interview and review of the clinical record with the care plan coordinator on 10/20/05 at 10:30 AM failed to provide evidence that the incident/resident's behaviors, had been addressed on the resident's care plan.
10. Based on clinical record review and staff interviews for one of six sampled residents (R#15) who had a potential for dehydration, the facility failed to develop a plan of care to prevent a recurrence. The findings include:
- a. Resident #15's diagnoses included a gastrointestinal bleed, epistaxis (nosebleeds), and chronic renal insufficiency. The clinical record identified that the resident was transferred to the hospital on 12/6/04, 1/2/05, and 1/26/05 with admitting diagnoses that included dehydration. The Resident Care Plan was reviewed by the interdisciplinary team on 12/27/04 and 1/27/05. Interview and review of the care plan with the Care Plan Coordinator on 10/20/05 at 12:45 PM failed to provide evidence that the care plan had been reviewed and/or revised to address prevention of further episodes of dehydration until 2/1/05.

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

FACILITY: Northbridge Health Center

Page 12 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

11. Based on clinical record reviews, review of facility policies and staff interviews for one of three residents with an injury of unknown origin (R#25), and/or one of six residents with allegations of mistreatment (R#28), and/or one of nine residents with a history of skin breakdown, the facility failed to ensure that resident's were assessed to determine potential injury/need to alter treatment, etc in accordance with professional standards of practice. The findings include:

- a. Resident #14's admission assessment dated 8/22/05 identified the resident as cognitively impaired, aphasic and totally dependent on staff for all activities of daily living. A hospital consultation note prior to admission to the facility dated 8/6/05, identified that the resident had a large hematoma in the right pelvic brim area sustained after a traumatic fall. She was also at that time assessed to have ecchymosis of her right flank and right hip area.
 - i. A body audit on admission dated 8/22/05, identified the resident's buttocks to be reddened, a scabbed area with steristrips on the left hand, and ecchymosis on the left upper arm. There was no mention of a hematoma or bruising of the right hip. A nursing narrative note dated 8/24/05 (two days after admission) at 9:20 P.M., identified that the charge nurse observed an ecchymotic area on the right hip measuring 12 by 8 centimeters and a 6 by 6 centimeter area on the right flank. The physician was notified and directed the resident to be transferred to the hospital for an x-ray of the right hip which was negative. Although an interview with the corporate clinical supervisor on 9/21/05 at 1:15 P.M. identified that the ecchymosis on the hip and flank was noted on admission, the body audit failed to identify that it was present at that time. Interview with the infection control nurse on 10/26/05 at 11 A.M. identified that the policy of the facility is to provide a complete assessment at the time of admission which would include identification of ecchymosis and palpation of the area for pain and tenderness. According to the facility policy, on admission a head to toe skin assessment must be performed and documented in the nurses notes.
 - ii. A wound care record dated 9/14/05 identified that the resident had a hematoma on the right hip. Nursing narrative notes dated 9/15/05 identified that the resident had a large hematoma on the right hip. On 9/17/05 nursing narrative notes on the 11-7 shift identified that there was

FACILITY: Northbridge Health Center

Page 13 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

a dressing on the right hip which was saturated with blood. The nursing narrative notes on 9/17/05 7A.M-7P.M shift, further identified that the right hip had an open area which measured 9 centimeters by 8 centimeters with serosanguinous drainage present. The physician was notified and ordered that the right hip be cleansed with normal saline and a dressing applied. On 9/20/05 the resident was transferred to the hospital and a biopsy of the right hip was obtained which identified acute inflammation and necrotic debris consistent with a decubitus. Interview with the infection control nurse on 10/26/05 at 11:00 A.M. and review of the clinical record failed to provide evidence that an assessment of the right hip area had been consistently performed from the time of admission on 8/22/05 until 9/17/05, when the hematoma was noted to be opened and draining. According to the infection control nurse, assessment of the area should have included observation of the hematoma, measurement of the area, and palpation for pain and/or tenderness with documentation into the clinical record. According to Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition, 2001, wounds are assessed by inspection (sight and smell) and palpation for appearance, drainage, and pain.

- b. Resident #25's diagnoses included Parkinson's disease, osteopenia, and osteoporosis. The quarterly assessment dated 4/14/05 identified that the resident was cognitively impaired, totally dependent on staff for bed mobility and transfers and was non-ambulatory. The resident care plan dated 4/21/05 indicated that R #25 had impaired physical mobility. Interventions included to turn and position the resident every two hours when in bed, and transfer the resident out of bed with the assistance of two staff members. Review of facility documentation dated 6/8/05 at 4:30 PM indicated that R #25 had a 1 x 1.5cm reddened area to the right top side of the head of an unknown origin. Review of the nurse's note dated 6/8/05 (3-11 shift) indicated that R#25 denied dizziness, blurred vision and that the resident's vital signs and a neurological check had been conducted. Review of a nurse's note dated 6/9/05 at 5:05 AM indicated that the resident's neurological checks were at baseline with no changes in mental status. Although the nurse's notes dated 6/8/05 and 6/9/05 indicated that R #25's neurological checks had been conducted, there lacked documentation to reflect that the resident's neurological checks had been conducted every fifteen minutes times four, then every thirty

FACILITY: Northbridge Health Center

EXHIBIT B
Page 14 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

minutes times four, then every hour times four, then every eight hours times forty-eight hour as required by facility policy. According to the Rapid Response to Everyday Emergencies, A Nurse's Guide, 2006, a neurologic assessment includes level of consciousness, pupil size and reaction, vital signs and motor and sensory function, and should be performed at least every hour, with any changes reported to the physician.

- c. Resident #28's diagnoses included Alzheimer's disease, anxiety and congestive heart failure. The resident assessment dated 6/27/05 identified that R #28 had impaired cognition, was independent for transfers and required limited assistance with ambulation. The resident care plan dated 7/5/05 indicated that the resident had a diagnosis of anxiety with interventions that included to assess for signs and symptoms of insomnia, anxiety, and encourage diversional activities of choice. Review of facility documentation dated 8/4/05 at 7:00 AM, indicated that R #28 was very agitated, and complained about rough treatment including having her hair pulled and rude behavior from NA #9. The facility investigation dated 8/4/05 indicated that R #28 kept getting in and out of bed and that NA #9 had taken R #28's wheel chair away. The ADNS on 10/20/05 at 2:55 PM stated that the resident does have some confusion but does not complain about the staff. The ADNS stated that R #28 was really agitated and crying and continued to repeat the same complaint. Although the facility documentation dated 8/4/05 indicated that R #28 had no apparent injuries, a review of the nurse's notes dated 8/4/05 to 8/5/05 lacked documentation to reflect that the resident had been assessed for injuries after the allegation of abuse was made. According to Nursing Diagnoses Reference Manual, 5th Edition 2001. Assessment related to elder abuse includes: Evidence of physical, abuse, including malnutrition, imprint of the hand or fingers, marks from restraint, unexplained bruises, burns, welts, cuts, dislocations and abrasions.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D&t
(j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

12. Based on clinical record review and interview for one of 24 sampled residents (R#10), the facility failed to follow their care plan related to monitoring intake and output to prevent dehydration. The findings include:

FACILITY: Northbridge Health Center

EXHIBIT B
Page 15 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- a. Resident #10's had diagnoses that included dehydration. A quarterly assessment dated 8/2/05 identified the resident as severely cognitively impaired, totally dependent on staff for all activities of daily living, and had a current diagnoses of hypovolemia. A care plan dated 8/10/05 identified the resident had potential for dehydration related to the inability to request fluids and drink independently. Interventions included to maintain intake and output monitoring every shift. Interview and review of the clinical record with the minimum data set coordinator on 10/19/05 at 12:35 PM failed to provide evidence that intake and output had been monitored according to the care plan.
13. Based on clinical record reviews, review of facility documentation, review of acute care hospital records, and interviews with staff, for three of thirty-six sampled residents (Resident #6, 15, 16), the facility failed to ensure that medications were administered as ordered and/or that a humidifier ordered to prevent nose bleeds was implemented in accordance with physician orders and/or that resident's with pain were assessed in accordance with their comprehensive plan of care. The findings include:
- a. Resident #16's diagnoses included Alzheimer's dementia and agitation. A Minimum Data Set (MDS) dated 8/29/05 identified that the resident was cognitively impaired. A Resident Care Plan (RCP) dated 8/22/05 identified anxiety, restlessness and combative behavior as problems. Interventions included the administration of medications as prescribed. Physician orders dated 8/22/05 directed to administer Exelon (for Alzheimer's dementia) 1.5 milligrams (mg) two tablets by mouth in the morning and 1.5mg two tablets by mouth every evening. Physician orders dated 8/29/05 directed to start the resident on Depakote ER (for agitation) 1000 mg by mouth at bedtime and to obtain a blood level of Depakote one week from the start date. Review of Medication Administration Record (MAR) and facility documentation identified that Resident #16 did not receive the Depakote as ordered by the physician on 9/05/05, 9/06/05, 9/07/05 and 9/08/05, and did not receive a 9 PM dose of Exelon on 9/10/05 and a 9AM dose of Exelon on 9/11/05. Blood levels of Depakote on 09/06/05 indicated 12.5 micrograms per liter (mcg/L), with the reference/therapeutic range being 50 to 100mcg. The physician was notified of the omitted doses of Depakote and administration of Depakote to the resident was resumed on 9/9/05. Nurse's notes and interview with facility Administrator on 10/19/05 at 1PM indicated that on 9/11/05, Resident #16 was found unresponsive, with rapid respirations and foaming at the mouth. The

FACILITY: Northbridge Health Center

Page 16 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

resident was transferred to the emergency room for evaluation and admitted to the acute care hospital with the diagnosis of new onset seizure. Blood levels of Depakote upon admission to the hospital on 9/11/05 remained at 12.5mcg/L (below the therapeutic range). Interview with Physician #5 on 10/20/05 at 09:50 AM indicated that omission of Depakote for four days could have induced seizures in the resident. Interview with Pharmacist #1 on 10/26/05 at 4:15 PM noted that abrupt discontinuation of Depakote without titration could lead to seizures in a person with no previous history of seizures.

- b. Resident #15's diagnoses included epistaxis (nose bleeds). An admission Minimum Data Set (MDS) assessment dated 10/3/05 identified that the resident had a short term memory deficit, was independent in decision making and was independent and/or required supervision in some activities of daily living. Review of the physician orders dated 10/29/04 directed a humidifier in the resident's room. Review of the consult notes dated 11/2/04 identified "needs humidifier for the room" and again on 12/23/04 the physician directed the use of a humidifier. Although the physician orders for October, November, December 2004 and January 2005 and the medication kardexes for November and December 2004 identified a physician order for a humidifier in the resident's room, there was no documentation that the humidifier was ever utilized and/or in place. Interview with the Assistant Director of Nursing on 10/19/05 at 1:45 PM identified that the humidifier was never put in the resident's room because there were infection control issues and that the humidifier was ordered because the resident had frequent nose bleeds. Interview with RN#2 (Infection Control Nurse) on 10/20/05 at 9:15 AM identified that she was unaware of any infection control issues with the humidifier nor was she aware that the resident needed one. Interview with MD#6 on 10/20/05 at 9:30 AM identified that he had ordered the humidifier to treat the resident's dry mucosa and for the recurrent nosebleeds.
- c. Resident #6's diagnoses included dementia with depression, Alzheimer's disease with behavior disturbances, degenerative arthritis, and osteoporosis. A quarterly assessment dated 10/3/05 identified the resident was moderately cognitively impaired, required total staff assistance for transfer, dressing, personal hygiene, and was without pain. A recent care plan dated 10/11/05 identified potential for pain/altered comfort related to arthritis (degenerative) of the spine, knee, an old fracture of the coccyx, and osteoporosis. Interventions included to assess the characteristics of the pain including the location, duration, quality,

FACILITY: Northbridge Health Center

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

aggravating/alleviating factors, radiation intensity and documentation should it occur, and to provide pain meds whenever necessary. Physician orders dated 9/30/05 directed Darvocet-N 100 to be given as needed for pain. Observation on 10/18/05 at 8:41 AM and 9:30 AM noted the resident lying in bed complaining of pain at the coccyx area while rubbing the hip, coccyx, stomach. The nurse aides observed at 8:41 AM providing personal care, attempted to ease the pain. When the resident continued to complain, one nurse aide notified the charge nurse. At 9:25 AM the nurse aide reaffirmed, upon surveyor inquiry, that she had told the charge nurse the resident was in pain. The resident was noted to intermittently cry and moan until 10:27 AM when the charge nurse gave the resident her medications including the Darvocet for pain. Although interview with the charge nurse on 10/18/05 at 1:30 PM noted that she gave the pain medication at 10 AM as soon as she was notified, interview with the nurse aide on 10/18/05 at 2:30 PM and 10/19/05 at 3:00 PM noted that she had reported the pain to the nurse at 9 AM. Interview with the corporate nurse on 10/18/05 at 8:05 AM noted that timely administration of medication for pain should be in about a half hour after request. In addition, although the nurse's note for 10/18/05 identified that the resident received the pain medication at 10AM and 2:30 PM, the note failed to contain a complete assessment of the pain in accordance with the care plan interventions.

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

14. Based on observations, staff interviews and clinical record reviews for two of 15 sampled residents who required assistance for transfers (Resident #12, 13) the facility failed to appropriately transfer the resident in accordance with the plan of care and/or failed to re-assess the resident after a decline in mobility. The findings include:
 - a. Resident #12's diagnoses included Alzheimer's dementia and syncope. A quarterly assessment dated 8/28/05 identified that the resident was severely cognitively impaired, required extensive to total assistance from facility staff with activities of daily living (ADL) including bed mobility and transfers. The resident care plan (RCP) dated 9/6/05 identified a problem with decreased ability to perform ADL's secondary to dementia. Interventions included providing total assistance with ADL's (grooming, bathing and dressing), provide assistance with

FACILITY: Northbridge Health Center

Page 18 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

toileting and transfers, to walk the resident to the bathroom every two hours and as needed and to ambulate every shift with contact guard and a gait belt.

- i. Physician orders dated 10/10/05 directed that the resident was to ambulate with staff every shift, and to utilize a wheelchair with lap-buddy for rest periods. Physical therapy (PT) notes dated 5/9/05 indicated that the resident was ambulating to and from the bathroom with a rolling walker. Review of facility documentation dated 6/5/05 through 10/18/05 noted that the resident care record failed to indicate the number of feet ambulated during that time period. During that time period, two hundred twenty six shifts (opportunities) lacked indication of having ambulated the resident. During an interview on 10/19/05 at 2:55 PM with a nurse aide (NA), she stated that the resident had not ambulated and/or was not able to bear weight for the past two to three months. Subsequent to surveyor inquiry a rehabilitation screen was performed secondary to a decline in ambulation that identified that the resident's prior level of function included ambulation with the assist of one. It further identified that the resident's current status was transfer with the assist of two. During an interview on 10/19/05 at 1:30 PM with the PT/Rehabilitation manager she stated that when a resident experiences a decline and/or change in their mobility ability, nursing should notify PT for reassessment.
 - ii. Observations on 10/18/05 at 10:00 AM noted two nurse aides (NA) transfer the resident from bed to wheel chair. The NA's were noted to place a gait belt around the resident's waist, then each NA placed their arms under the resident's axilla and lifted the resident to transfer. The resident's feet/toes were noted to barely touch the floor with the resident not bearing weight and staff not supporting the lower extremities. During an additional observation of the resident transfer and interview on 10/18/05 at 12:55 PM with the physical therapist, she stated that lifting the resident by the axilla to transfer was unsafe because it put the resident at risk for injuries such as shoulder tears.
- b. Resident #13's diagnoses included dementia and osteoarthritis of multiple joints. A quarterly assessment dated 5/15/05 identified that the resident was severely cognitively impaired, required total assistance from facility staff with activities of daily living (ADL), including bed mobility and transfers. The care plan dated 8/23/05 identified a problem with impaired physical mobility. Interventions

FACILITY: Northbridge Health Center

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

included transferring the resident with the assistance of two. Physician orders dated 9/24/05 directed the resident's activity as out of bed with hand hold assistance of two to custom wheel chair with lap-tray and seatbelt for pelvic positioning. Observations of morning care on 10/18/05 at 11:15 AM noted a single NA, transferred the resident from bed to wheelchair. During an interview and review of resident care card with the nurse aide on 10/18/05 at 11:50 AM he stated that although the care card directed to transfer the resident with assist of two, he was unaware of the transfer directions and had been transferring the resident this way for sometime because he had not read the care card. During an interview and clinical record review with the care plan coordinator on 10/19/05 at 12:15 she stated that the resident was to be provided assistance of two, as physician directed and that an inappropriate transfer puts the resident at risk of injury.

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

15. Based on clinical record reviews and interviews for eight of twenty-three sampled residents (Residents # 3, # 30, # 31, # 32, # 33, # 34, # 35 and # 36) who were incontinent of bowel and/or bladder, the facility failed to provide personal hygiene for the residents in accordance with their plans of care and/or standards of practice resulting in lack of incontinent care. The findings include:
- a. Resident # 3's diagnoses included metastatic cancer of the prostate. Physician orders dated 5/21/05 directed the administration of Lasix 20 milligrams (mg) by mouth daily. A Minimum Data Set (MDS) dated 4/25/05 identified the resident's bowel and bladder incontinence and the need for limited assistance with toileting. A Resident Care Plan (RCP) dated 3/02/05 addressed the resident's toileting deficit, with interventions including the provision of incontinent care every two hours.
 - b. Resident # 30's diagnoses included renal failure, cerebrovascular accident and organic brain syndrome. An MDS dated 06/07/05 identified the resident's bowel and bladder incontinence, and total dependence on staff for toileting. A RCP dated 6/03/05 addressed the resident's dementia and inability to use the call bell with interventions including the assessment of needs every two hours and as needed.

FACILITY: Northbridge Health Center

MEDI D
Page 20 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- c. Resident # 31's diagnoses included cerebrovascular accident and Parkinson's. An MDS dated 4/26/05 identified the resident's frequent bowel and bladder incontinence and the need for limited assistance with toileting.
- d. Resident # 32's diagnoses included benign prostatic hypertrophy and obstructive uropathy. Physician orders dated 5/21/05 directed the administration of Lactulose 15 milliliters (10gm) by mouth twice a day. An MDS dated 6/21/05 identified the resident's occasional incontinence of bladder, and total dependence on staff for toileting. A RCP dated 11/01/04 addressed the resident's toileting deficit with interventions including the provision of incontinent care every two hours and as needed.
- e. Resident # 33's diagnoses included organic brain disease. An MDS dated 04/05/05 identified the resident's bowel and bladder incontinence and total dependence on staff for toileting. A RCP dated 4/13/05 addressed the resident's incontinence with interventions including thorough perineal care after each incontinence episode.
- f. Resident # 34's diagnoses included congestive heart failure treated with Lasix 80 mg by mouth daily. An MDS dated 4/12/05 identified the resident's bowel and bladder incontinence and total dependence on the staff for toileting. A RCP dated 11/03/04 addressed the resident's incontinence with interventions including the provision of incontinent care every two hours and as needed.
- g. Resident # 35's diagnoses included spinal stenosis and hypertension, for which the resident received Hydrochlorothiazide 12.5mg by mouth once daily. An MDS dated 6/21/05 identified the resident's incontinence of bowel and bladder, and total dependence on the staff for toileting. A RCP dated 04/06/05 addressed the resident's incontinence with interventions including the provision of incontinent care every two hours and as needed.
- h. Resident # 36's diagnoses included Alzheimer's dementia. An MDS dated 5/24/05 identified the resident's incontinence of bowel and bladder and the need for extensive assistance with toileting. A RCP dated 6/01/05 addressed the resident's incontinence with interventions including perineal care after each incontinence episode. Review of clinical records and facility investigation, and interviews with NA # 10 on 10/24/05 at 9AM, with NA #11 on 10/25/05 at 1:50PM and with Registered Nurse (RN) #6 on 10/25/05 at 3:05PM, indicated that on 6/11/05, Nurse Aide (NA) #10 failed to provide incontinent care to the eight residents on her assignment during the 3 PM-11 PM shift, leading staff on the following shift

FACILITY: Northbridge Health Center

EXHIBIT B
Page 21 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

to find Residents # 3, # 33, # 34, # 35 and # 36 stained with dried feces and
Residents # 30, # 31, # 32, # 33 and # 36 soaked with urine.

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

16. Based on clinical record reviews, observations and interviews for four of twelve sampled residents with pressure sores or at risk for pressure sores (R#5, 11, 15, 24), the facility failed to ensure that residents at risk were assisted to reposition at least every two hours and/or that physicians were informed of the need for treatments / need to alter treatments that were not available and/or that wounds were assessed accurately in accordance with professional standards of practice and/or that wounds were treated. The findings include:
- a. Resident #24 was admitted on 9/14/05 at 10 PM with diagnoses that included heart failure, status post pacemaker insertion, nosocomial pneumonia, and anxiety. Nursing notes dated 9/14/05 during the 11 PM-7 AM shift documented the presence of a transparent dressing on the mid-back on a large abscess-like out pouching with a stage II in the center and bilateral buttocks areas with transparent dressings in place. The weekly wound report sheet dated 9/14/05 documented a pressure area measuring 3x2 cm with yellow slough present on the upper mid-back. Physician admission orders dated 9/14/05 failed to provide any treatment orders to the area. Physician orders dated 9/16/05 directed to cleanse the upper/mid back area with normal saline followed by Santyl ointment daily and as needed. Interview and review of the clinical record on 10/19/05 at 1:45 PM with the infection control nurse failed to provide evidence that the physician had been notified or treatment initiated to the mid/back open area from 9/14/05 until 9/16/05 when Santyl was ordered. Review of the treatment administration record noted that the treatment (Santyl) was omitted on 9/19, 20, 21, 23/05 because the medication was not available. Interview and review of the clinical record on 10/20/05 at 12:25 PM with the infection control nurse failed to provide evidence that the physician had been notified of the Santyl treatment being omitted or to obtain other orders to treat the wound until it was available. Further review noted that the back area pressure sore increased in sized and depth from admission through 9/28/05, and that wound assessments were lacking descriptions of the color, drainage, odor and/or wound bed/periphery on multiple occasions.

FACILITY: Northbridge Health Center

Page 22 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- b. Resident #5's diagnoses included dementia, renal failure, diabetes, and stroke with left hemiplegia. An annual assessment dated 7/25/05 identified that the resident was moderately cognitively impaired and totally dependent on staff for all activities of daily living. The care plan dated 8/2/05 identified the potential for skin breakdown. Interventions included to turn and reposition the resident every two hours. Observations on 10/17/05 from 6:30 AM until 9:32 AM noted the resident lying supine in the bed without the benefit of a change in position off of the back/buttocks. Interview with the nurse aide on 10/17/05 at 9:37AM noted that she was aware that the resident needed repositioning, but thought that the other nurse aide had done so when the breakfast tray was picked up.
- c. Resident #11's diagnoses included neurological complications of multiple sclerosis (MS). A quarterly assessment dated 8/1/05 identified that the resident was without cognitive impairment, was totally dependent on facility staff for all activities of daily living (ADL), including bed mobility, and had a stage four (4) Pressure ulcer. The care plan dated 8/9/05 identified a problem with actual skin breakdown. Interventions included providing the resident with turning and positioning every two hours and if the resident refuses, leave room and try again. Continuous observations on 10/17/05 from 5:48 AM through 9:30 AM (3 hours 42 minutes) noted the resident in bed on his back without the benefit of repositioning. Although the care plan directed to reapproach if the resident refuses repositioning, observation noted that staff failed to reapproach and encourage the resident to reposition. During an interview with the nurse aide on 10/17/05 at 9:35 AM she stated that although it was facility policy to turn and reposition every two hours, the resident only liked to stay on his back.
- d. Resident #15's admission Minimum Data Set (MDS) dated 10/03/04 identified that the resident had a short term memory deficit, was continent of bowel and bladder and did not have any pressure sores. Pressure sore risk assessments dated 11/28/04, 12/08/04 and 1/4/05 identified the resident was a high risk for development of pressure sores. A pressure sore report dated 1/17/05 identified that the resident had a stage 2 open area on the coccyx. Physician orders dated 1/17 and 1/18/05 directed an Allevyn dressing to the coccyx for 3 days. The resident was admitted to the hospital on 1/26/05 and the interagency referral form dated 1/28/05 identified that MD#6 (a wound consultant) directed the application of a thin Duoderm dressing or a film dressing like Tegisorb. The admission nurse's notes dated 1/28/05 identified an open area on the coccyx measuring one

FACILITY: Northbridge Health Center

Page 23 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

centimeter by one centimeter. Physician re-admission orders dated 1/28/05 failed to identify any treatment orders for the open area. Review of the treatment karex for the month of January 2005 failed to provide evidence that the treatment identified on the interagency referral form had been implemented.

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

17. Based on clinical record reviews and interviews with staff, for three of six sampled residents (Resident # 1, 12, 24) who exhibited a decline in bowel and bladder functions, the facility failed to complete bowel and bladder assessments and to conduct a bladder retraining assessment. The findings include:
- a. Resident # 1's diagnoses included chronic urinary tract infection. Physician orders dated 5/11/05 directed the administration of Nitrofurantoin 50 milligrams (mg) by mouth three times a day, and Detrol LA 4 mg at bedtime. Minimum Data Sets (MDS's) dated 5/24/05 and 8/01/05 indicated that the resident was frequently incontinent of bowel and bladder. Urinary incontinence assessment, bowel incontinence assessment, and bowel and bladder retraining assessments dated 12/21/04 indicated that the resident was continent of bowel and bladder at that time. Interview with and review of the resident's clinical record with Clinical Coordinator #1 on 10/18/05 at 10:40AM failed to provide evidence that assessments or retraining were completed/attempted after the resident's continence declined.
 - b. Resident #12's diagnoses included Alzheimer's dementia and syncope. A quarterly assessment dated 1/28/05 identified that the resident was severely cognitively impaired, required extensive to total assistance from facility staff with activities of daily living (ADL's) including bed mobility and transfers. The resident care plan (RCP) dated 9/6/05 identified a problem with decreased ability to perform ADL's secondary to dementia. Interventions included to walk the resident to the bathroom every two hours and as needed. Physician orders dated 10/10/05 directed that the resident was to ambulate with staff every shift, wheelchair with lap-buddy for rest periods. A bowel and bladder assessment dated 5/27/05 noted that the resident was continent of bowel and bladder. Observations during morning care on 10/18/05 at 9:20 AM noted that the resident had been incontinent of bowel and bladder. During interview with the nurse aide (NA) on 10/18/05 at

FACILITY: Northbridge Health Center

EXHIBIT B
Page 24 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

10:05 AM she stated that the resident was incontinent of bowel and bladder. Interview and review of clinical record on 10/19/05 at 11:00 AM with the resident care plan (RCP) coordinator failed to provide evidence that a bowel and bladder assessment had been completed after the resident's change/decline in condition./continence.

- c. Resident #24 was admitted to the facility on 9/14/05 with diagnoses that included congestive heart failure and pacemaker insertion. A Foley catheter was in place upon admission that was discontinued 9/23/05. The admission bladder assessment dated 9/16/05 identified that due to the Foley catheter, the resident was continent. Subsequent to the catheter removal, the resident's record/flow sheets identified that the resident was incontinent of bowel and bladder. Interview and review of the clinical record on 10/19/05 at 1:45 PM with the infection control nurse failed to provide evidence that an assessment for the potential for bladder retraining had been completed when the catheter was discontinued and the resident was found to be incontinent.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

18. Based on observations for 2 of 3 clean utility rooms, the facility failed to ensure that hazardous materials were stored securely. The findings include:
- A tour of the facility on 10/19/05 at 9:45am noted that the clean utility room on the fourth floor was unlocked and contained an open and unlocked drawer with eight packages of razors exposed. The third floor utility room was unlocked and contained an unlocked drawer of razors and an unlocked and open cabinet with three bottles of hydrogen peroxide and ten bottles of alcohol exposed.

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

19. Based on clinical record reviews and staff interviews for two of nineteen residents in the survey sample totally dependent on staff for transfers (R# 15, 25), the facility failed to ensure that resident's with risk factors for injury such as osteoporosis and joint rigidity, were assessed and care plans developed/implemented to ensure safe handling for

FACILITY: Northbridge Health Center

EXHIBIT B
Page 25 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

prevention of injuries and/or that care plans were implemented related to side rail use to prevent accidents. The findings include:

- a. Resident #25's diagnoses included Parkinson's disease, osteopenia, and (1987), pelvis (1991), and both arms (1995). A Transfer Summary report dated 10/25/03 indicated that R #25 had mild rigidity of the joints. The resident's quarterly assessment dated 4/14/05 identified that R #25 was cognitively impaired, totally dependent on staff for bed mobility and transfers, and was non-ambulatory with no range of motions problems identified. The resident care plan dated 4/21/05 indicated that R #25 had impaired physical mobility. Interventions included to turn and position the resident every two hours when in bed, and transfer the resident out of bed with the assistance of two staff members. An x-ray report dated 5/24/05 indicated that R #25 had diffuse osteopenia of the left hand. The nurse aide assignment indicated two staff members were required for transfers. Facility documentation dated 6/8/05 at 4:30 PM indicated that R #25 had a 1 x 1.5cm reddened area to the right topside of the head of an unknown origin. The assistant director of nursing (ADNS) on 10/20/05 at 2:35 PM noted that although her investigation was inconclusive as to how the resident had sustained a bruise to the top of the head, two nurse aides had each admitted to transferring the resident independently/without assistance on 6/8/05. Interview with one nurse aide (NA#7), a Hospice NA, on 10/21/05 at 12:01 PM noted that he had cared for the resident on 6/8/05 from 10:00 AM to 12:00 Noon. NA #7 stated that he was aware that R #25 required the assistance of two staff members to transfer but he had transferred R #25 out of bed on his own just before 12:00 Noon because he needed to leave for the day. NA #7 stated that he had asked another nurse aide for assistance but the nurse aide never showed up. NA #7 stated he gently transferred the resident out of bed to the wheelchair and denied hitting the resident's head against anything during the transfer.
- b. Resident #25's Weekly Skin Assessment sheet dated 7/5/05 indicated that there was no bruising to the left upper arm, but that R #25 had resolving ecchymotic areas to the legs and scalp. A nurse's note dated 7/8/05 at 11:30 AM indicated that R #25 had an ecchymotic area to the left upper arm and that the left upper arm was firm and edematous. The physician was notified and ordered an ultrasound and x-ray. The nurse's note at 2:00 PM indicated that the ultrasound technician

FACILITY: Northbridge Health Center

EXHIBIT B
Page 26 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- was unable to check the left brachial artery due to the resident's limited range of motion to the shoulder. The nurse's note dated 7/8/05 at 2:00 PM indicated that the ultrasound was negative for clots and the portable x-ray indicated that R#5 had a healing fracture in the left proximal humerus. R #25 was transferred to the hospital for treatment and returned at 7:30 PM with an immobilizer in place to the left arm, pain medication as needed, and orders to follow up with an Orthopedic physician. Review of the orthopedic consultation report dated 8/2/05 indicated that R #25 had severe post-traumatic arthritis of the left shoulder. The ADNS on 10/20/05 at 2:35 PM stated that the facility had concluded, that the resident's left shoulder bruising had been spontaneous and not caused by staff. Interview with LPN #3 on 10/21/05 at 10:35 AM noted that R #25 was totally dependent on staff for bed mobility and was incapable of moving on her own. NA #5 on 10/21/05 at 10:45 PM stated that R #25 was unable to move in bed without the assistance of one staff person and required two staff members to transfer. MD #1 on 10/26/05 at 10:36 AM stated that the injury could have happened spontaneously due to R #25's contractures and trying to manage R #25's hygiene. Review of the care plans dated from 4/21/05 to 10/7/05 failed to provide evidence that problems, goals and interventions were developed and implemented to prevent injury related to the resident's diagnoses of osteoporosis and joint rigidity.
- c. Resident # 15's diagnoses included epistaxis (nosebleeds), gastrointestinal bleed, chronic renal failure and transient ischemic attacks (TIA). An admission Minimum Data Set (MDS) dated 12/19/04 identified that the resident had a short term memory deficit, ambulated independently in the room, required supervision when ambulating in the hallway and utilized two (2) half side rails for bed mobility and transfers. The Restraint Reduction/Elimination forms dated 8/11/04 and 9/20/04 identified that the resident required two (2) half side rails up to enable turning, repositioning and transfers and was not a candidate for reduction/elimination. On 12/28/04 at 8 PM nurse's notes identified that the resident had rolled out of bed and was found lying on her back on the floor. An assessment was conducted and no injuries were identified. Although interview with Licensed Practical Nurse (LPN) #7 on 10/26/05 at 11:30 AM identified that she could not recall the fall whether or not the resident's side rails were up as ordered, the facility investigation at the time of the fall identified that one side rail had been left down.

FACILITY: Northbridge Health Center

Page 27 of 30

DATE(S) OF VISIT: October 7, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

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

20. Based on clinical record reviews and staff interviews for three of six sampled resident's (R# 7, 15, 19) with a history of dehydration, the facility failed to ensure that resident's at risk for dehydration had care plans in place to prevent dehydration and/or failed to ensure that interventions were initiated and/or assessments completed to prevent/detect dehydration. The findings include:
- a. Resident # 7's diagnosis included dementia and congestive heart failure. The Minimum Data Set dated 5/31/05 identified short and long term memory problems, modified independence with decision making ability and the need for extensive assistance with eating. Physician monthly orders for 8/2005 directed to administer Lasix 40 milligrams daily. A dietary evaluation dated 3/9/05 identified the resident's estimated fluid needs to be between 1575-1890 milliliters (ml) daily. The intake and output records from 8/14/05 through 8/24/05 (11 days), identified that the resident did not meet the estimated fluid needs on 11 of 11 days. During those 11 days the total fluid intake documentation was noted to be between 670ml - 1400ml. Physician orders dated 8/25/05 directed to obtain lab work including a Blood Urea Nitrogen (BUN) and a Creatinine. A lab report dated 8/25/05 identified a BUN of 90mg/dl and a Creatinine of 4.6mg/dl. Nurse's notes dated 8/25/05 identified that the resident was sent to the hospital emergency room for an evaluation. The hospital discharge summary dated 8/30/05 identified that the resident was admitted to the hospital on 8/26/05 with diagnoses that included dehydration and acute renal failure. On admission to the hospital, the residents Blood Urea Nitrogen (BUN) was 95mg/dl (normal 7-30mg/dl) and Creatinine was 4.1 mg/dl (normal 0.5-1.2 mg/dl). After receiving hydration in the hospital, the BUN was 33mg/dl and the Creatinine was 1.8mg/dl. Although dehydration assessments were conducted on 8/15, 17, 18, 19, 20, 21, 22 and 23/05 with no signs or symptoms of dehydration documented, review of the care plan dated 6/8/05 (in place during 8/2005) failed to provide evidence that additional interventions were implemented when the resident did not meet the estimated fluid needs during that time frame. Review of the facility policy on hydration identified that if the average intake is below the recommended fluid needs for 72 hours, the physician and dietician are notified. Interview with the physician on 10/20/05 at 10 AM noted that he was not aware of the poor fluid intakes until he

EXHIBIT B

FACILITY: Northbridge Health Center

Page 28 of 30

DATE(S) OF VISIT: October 7, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

- came in and ordered the lab work. He further stated that the renal failure was due to the dehydration.
- b. Resident #19's diagnoses included dehydration. An admission assessment dated 12/14/04 identified the resident as requiring staff assistance with activities of daily living, and a current diagnosis of hypovolemia. The care plan dated 1/28/05 identified a potential for dehydration related to vomiting. Interventions included to encourage fluids, monitor intake and output, and to keep the physician and family updated. Nurse's notes dated 1/28/05 that the resident's lips were dry, the physician was notified and intravenous (IV) hydration was initiated. A progress note dated 1/28/05 at 2 PM by the APRN noted that the resident had pulled out the IV. New orders directed to leave the IV out, monitor closely for nausea, vomiting, and diarrhea, encourage 120 cc's fluid by mouth every one hour as tolerated for three days and quantify all outputs. On 1/29/05 the physician evaluated the resident and new orders directed for clear fluids 24-48 hours and call back if the resident was not better.
- c. Nurse's notes dated 1/30/05-2/2/05 identified poor appetite, fluids were taken poorly, the resident was not feeling well and/or was lethargic. On 2/2/05 the physician was notified of the resident's condition and transferred the resident to the hospital. A hospital transfer summary dated 2/9/05 identified the resident had been admitted on 1/2/05 extremely dehydrated and hyponatremic with a sodium of 172 (normal range 136-145), BUN of 93 (normal range 6-20), and a creatinine of 6.2 (normal range 0.6-1.1). The resident was in acute renal failure, was started on intravenous fluids. After five days of treatment, the sodium was 145, BUN was 29, and creatinine was 1.7. Interview and review of the clinical record on 1/20/05 at 1:30 PM with the unit manager failed to provide evidence that the physician was notified when the resident's intakes averaged 913 cc (fluid needs were estimated as 1068-1290) from 1/28-2/2/05. Further review failed to provide evidence that the resident was assessed for signs and symptoms of dehydration or that the physician orders to provide 120 cc of fluid every hour had been initiated/documentated.
- d. Resident #15's diagnoses included gastro-intestinal bleed, frequent nose bleeds and dehydration. An admission Minimum Data Set (MDS) dated 10/3/04 identified that the resident had a short term memory deficit, required staff assistance for most activities of daily living (ADL's), weighed 112 pounds and left more than 25% of food uneaten at most meals. Nurse's notes dated 12/4/04

FACILITY: Northbridge Health Center

EXHIBIT B
Page 29 of 30

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

through 12/06/04 identified that the resident was on a clear liquid diet and had had some episodes of vomiting. The physician was notified and the resident was transferred to the hospital. The hospital admission assessment identified that the resident's nausea and vomiting were due to the Duragesic patch, and that the resident was dehydrated with a critical potassium level of 2.2 upon admission. The re-admission assessment (MDS) dated 12/19/04 identified that the resident had experienced a significant weight loss with a new weight of 99 pounds and the assessment failed to identify the recent diagnosis of dehydration. The resident's condition declined and she was transferred to the hospital again on 1/2/05 and admitted with diagnoses that included dehydration. Intake and output records were not available in the record to provide evidence of monitoring for December 2004. Interview and review of the clinical record with the infection control nurse on 10/20/05 at 1:15 PM failed to provide evidence that although the resident was known to be at risk for dehydration, that a care plan had been developed until 1/11/05. Further review identified that the care plan lacked specific interventions other than "I&O as required" to prevent further episodes of dehydration or how to monitor for early signs of dehydration. The resident was transferred to the hospital and/or admitted again on 1/26/05, 2/14/05 and 2/27/05 with admitting diagnoses that included dehydration. Review of the hospital admission assessments identified that the resident was emaciated and looked extremely dehydrated with dry oral mucosa, poor skin turgor, lethargy and that the potassium level was critical on more than one admission.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (v) Physical Plant (2)(C).

21. Based on observation and staff interview, the facility failed to ensure a safe environment during portable oxygen filling. The findings include:
 - a. Observation on 10/17/05 at 11:15AM identified that Registered Nurse (RN#1), with the door to the oxygen room open, was noted to fill a portable oxygen tank. Additionally, the oxygen room door was noted to be propped open by a liquid oxygen tank at that time. Interview with RN#1 on 10/17/05 at 11:15AM identified that he was unaware that the door should remain closed when portable oxygen tanks are filled. Additionally, RN#1 stated that he had left the door open

FACILITY: Northbridge Health Center

DATE(S) OF VISIT: October 17, 18, 19 and 20, 2005 with additional information on October 20, 2005

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

because he didn't know how to turn the light in the oxygen room. Subsequent to surveyor inquiry, the oxygen room door was closed.

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

22. Based on review of personnel files, for two of two nurse aides hired in the previous four months, the facility failed to receive registry verification prior to hiring the nurse aides.

The findings include:

- a. Routine review of personnel files of new hires noted that for two of two nurse aides hired in the previous 4 months the facility lacked registry verification that there were no abuse findings against them. Subsequent to surveyor inquiry, verifications were obtained.

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

23. Based on clinical record review for one of four discharged residents (R#15), the facility failed to have the clinical record systematically organized and complete. The findings include:

- a. On 10/17/05 the clinical record of Resident #15 was requested for a review. Upon receipt of the record it was identified that the record was in total disarray. Further review identified that there was documentation missing from the record such as medication kardexes and none of the disciplines could be viewed in their entirety by section. The resident had been discharged from the facility on 3/17/05, seven months earlier.



Health Care Center

your bridge to health

2875 Main Street

Bridgeport, CT 06606

phone: (203) 336-0232

fax: (203) 384-6304

EXHIBIT C

April 14, 2006

Janet M. Williams, R.N.

Dear Janet Williams,

In response to the Modified Consent Agreement please note that the areas listed in Sections 2, 3, and 4, which had been cited during the survey of October 25, 2005, were addressed during the "Follow-up Revisit" on January 5, 2006 and Northbridge Health Care Center was found in full compliance.

In response to sections 2, 3, and 4:

Section 2: The facility is presently in compliance with all items listed.

Section 3: The facility is presently in compliance with this section with the exception of in-servicing "agency contracted staff". The facility will be in compliance with this item per consent order stipulation, 14 days for development of policies and procedures and no later than 21 days thereafter to complete in-servicing.

Section 4: The facility is presently in compliance with instituting a Quality Assurance Program to address areas listed in Sections 2 and 3.

If you should have any further questions please feel free to call me @ 203-336-0232.

Very Truly Yours,

Grace Flight
R.N., M.B.A., C.N.H.A.
Northbridge Health Care Center

EXHIBIT "D"

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
 - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
 - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
 - Assessing administration's ability to manage and the care/services being provided by staff.
 - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.