

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

IN RE: Wintonbury Care Center, LLC of Bloomfield, CT d/b/a
Wintonbury Care Center
140 Park Avenue
Bloomfield, CT 06002

CONSENT ORDER

WHEREAS, Wintonbury Care Center, LLC of Bloomfield, CT (hereinafter the "Licensee"), has been issued License No.2221-C to operate a Chronic and Convalescent Nursing Home known as Wintonbury Care Center, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

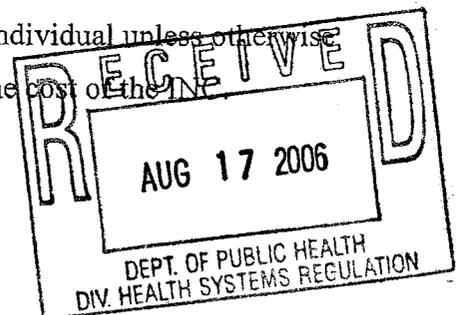
WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on November 22, 2005 and concluding on April 5, 2006; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated April 20, 2006 (Exhibit A – copy attached); and

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

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Christopher Wright, its ~~Member~~ ^{Managing} ~~Member~~ ^{Manager}, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC.



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

- c. Recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
 - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
 - d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated April 20, 2006.
11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.
12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.

14. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to the following:
 - a. Physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning and interventions pertinent to pressure ulcers;
 - b. Assessment and/or monitoring and care planning for patients at risk for dehydration and/or fecal impaction;
 - c. Assessment and/or monitoring and care planning of patients with behavioral issues;
 - d. Assessment and/or care planning of patients with pain; and
 - e. Criteria for determining admission to the locked unit.
15. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff inclusive of agency staff shall be inserviced, to the policies and procedures identified in paragraph number fourteen (14).
16. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
 - a. Sufficient nursing personnel are available to meet the needs of the patients;
 - b. Patients are maintained, clean, comfortable and well groomed;
 - c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
 - d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
 - e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
 - f. Nurse aide assignments accurately reflect patient needs;
 - g. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
 - h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does

- not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
- i. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
 - j. Necessary supervision and assistive devices are provided to prevent accidents;
 - k. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs; and
 - l. Patients with behavioral health issues will be appropriately assessed, plan of care reviewed and revised to reflect the individual patient's problem, needs and goals based upon the patient's assessment and in accordance with applicable federal and state laws and regulations.
17. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. A nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a three (3) year period.
18. Individuals appointed as Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.
19. Nurse Supervisors shall be provided with the following:
- a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said

- administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
- d. Nurse Supervisors shall be responsible for ensuring that all care is provided to reside patients by all caregivers is in accordance with individual comprehensive care plans.
20. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
21. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the April 20, 2006 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
22. The Licensee shall pay a monetary payment to the Department in the amount of five thousand five hundred dollars (\$5,500.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. ^{Said check} ~~The money penalty~~ and any reports required by this document shall be directed to:

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

23. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above,

including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

24. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
25. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
26. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
27. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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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.

WINTONBURY CARE CENTER, LLC
OF BLOOMFIELD, CT -- LICENSEE

8/16/2006
Date

By: Christopher S. Wright
Christopher Wright, Managing Member
MANAGER

STATE OF Connecticut

County of Hartford) ss 8/16 2006

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

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

M. Denise MacKinnon
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

8/21/06
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 20

April 20, 2006

Mr. Richard Demio, Administrator
Wintonbury Care Center, Llc
140 Park Ave
Bloomfield, CT 06002

Dear Mr. Demio:

Unannounced visits were made to Wintonbury Care Center, Llc on November 22, 2005, February 14, 15, 16, 17, 21, 22, 23, March 31 and April 3, 2006 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 April 5, 2006.

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

An office conference has been scheduled for May 4, 2006 at 10:00 am 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. If the meeting needs to be rescheduled, please submit the plan of correction to our office by May 4, 2006.

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,

Donna Ortelle, R.N., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

DMO:LN:PG:

c. Director of Nurses
Medical Director
President

vl

Complaint # CT4570, #4773, #5356, #4478, #4376, #5196, #4467, #4506, #4306



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: Wintonbury Care Center, Llc

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Dates of Visit: November 22, 2005, February 14, 15, 16, 17, 21, 22, 23, March 31, and April 3, 2006

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

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

1. Based on review of the clinical record and interview for one of two sampled residents (Resident #5) who had a decline in bladder function, the facility failed to notify the physician of a change in condition. The findings include:
 - a. Resident #5's diagnoses included Schizophrenia and Turner syndrome. A quarterly assessment dated 8/13/06 identified the resident had modified cognitive skills, was independent with ADL's, and continent of bladder. An annual assessment dated 11/2/06 identified the resident required limited assistance with ADL'S and was incontinent of bladder daily, a decline in bladder function. Review of the NA sheets identified the resident was continent of bladder until 10/18/05. Further review identified that from 10/19/05 to 2/14/06 the resident was incontinent of bladder daily. Interview and review of the clinical record on 2/17/06 at 1:00 PM with the ADNS failed to provide evidence that the physician was notified of the resident's decline in bladder function.

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

2. Based on review of clinical record, observation and interview for one resident (Resident # 27) assessed for self-administration of medications, the facility failed to assess the resident in a timely manner according to the facility policy. The findings include:
 - a. Resident #27 diagnoses included pneumonia, anxiety and depression. The last documented assessment for self-administration of medications dated 6/29/05 identified the resident was capable to self-administer medications. An assessment for self-administration of medication in the clinical record dated 12/12/05 was noted to be incomplete. The quarterly assessment dated 12/17/05 identified intact short and long term memory, periods of altered perception of surroundings and varying mental function. Physician orders dated 2/06 identified Duoneb 3ml Unit Dose 30 via nebulizer, four times daily. Observation on 2/15/06 at 5:50 PM identified the resident was set-up for the nebulizer treatment and the licensed nurse was observed leaving the resident's room as the resident was reminded to keep the nebulizer mask on while attempting to remove it. Interview with the MDS Coordinator on 2/25/06 at 6:00 PM identified that the expectation is that the assessment to self-administer medication be updated quarterly. Interview with the DNS on 2/16/05 at 8:00 AM identified that the resident should not be self-administering in that the resident had recently returned from the hospital and had experienced a change in condition.

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

3. Based on review of the medical record, review of facility policies, observations, and

FACILITY: Wintonbury Care Center, Llc

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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interviews, the facility failed to ensure that a wrist restraint observed to be in use for one resident, (Resident #14) was assessed to be the least restrictive and/or that a physician 's order was obtained for use of the wrist restraint. The findings include:

- a. Resident #14 had diagnoses that included a Traumatic Brain Injury (TBI) dementia, and a history of aspiration pneumonia. Review of the assessment dated 7/20/05 identified that the resident required a feeding tube. Review of the Resident Care Plan (RCP) dated 7/20/05 identified a need for restraints to prevent the resident from dislodging her feeding tube with interventions that included the use of hand mitts at all times. Although a signed release by Person #1 dated 3/29/05 for the use of " limb restraints as needed during physical care only " was present in the medical record, the record lacked physician orders for the restraint. Observation of R #14 on 2/14/06 at 9:45 AM identified that R #14 was lying quietly in the bed. The resident 's left hand was covered with a hand mitt but R #14 ' s right extremity had a wrist restraint that was fastened to the bed. Intermittent observations identified that the wrist restraint remained in place until 11:12 AM when direct care was started by Nursing Assistant (NA #1). Interview with NA #1 at 11:12 AM identified that R #14 ' s wrist restraint was in place when she arrived for duty at 7:00 AM on 2/14/06. NA #1 stated that the resident usually had one arm tied and the other hand mitted. Interview with LPN #6 at 11:15 AM identified that she readmitted R #14 on 2/9/06 and that she must have come from the hospital with the restraint. Following the interview, a review of the medical record with LPN #6 lacked a physician 's order for the wrist restraint. Subsequent to surveyor inquiry, the wrist restraint was removed by LPN #6 and replaced with a hand mitt.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (g) Reportable Events (6).

4. Based on clinical record review, review of facility policy and interview for one sampled residents (Resident # 23) with injuries of unknown origin, the facility failed to investigate according to policy. The findings include:
 - a. Resident #23 diagnoses included severe depression with psychotic features. A psychiatric management note dated 4/27/05 identified the resident had dementia and questioned whether the resident would be more appropriate on a dementia unit. The MDS dated 5/26/05 identified short and long-term memory deficits, moderately impaired cognition, varying mental function, persistent anger, socially inappropriate behavior and resistance to care. Review of facility documentation identified that on 6/21/05, Resident #23 accused his roommate, Resident # 2 of hitting him. Nurses' notes dated 6/21/05 at 8 AM identified that Resident # 23 had a bruised and edematous face and stated that he had fallen, however, at 4:40 PM he stated his roommate had hit him. Interview and review of the accident injury report with DNS on 2/15/06 at 11:45AM identified that their policy for investigating injuries of unknown origin is to look back two shifts and interview everyone who worked with the resident. Further review of the accident and injury report failed to provide evidence that this had been completed.

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Dates of Visit: November 22, 2005, February 14, 15, 16, 17, 21, 22, 23, March 31, and April 3, 2006

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

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

5. Based on clinical record review and interview for one of nine sampled residents (Resident #37) who participated in the Tier Level Program, the facility failed to immediately reassess the resident's Tier status after the resident failed to follow the behavioral unit rules. The findings include:
 - a. Resident #37 was admitted to the secured behavioral unit with diagnoses that included paranoid schizophrenia. The assessment dated 11/17/05 identified that the resident was severely cognitively impaired, and did not exhibit depression, anxiousness, sad mood and/or problems with behavior. The RCP dated 11/23/05 reflected that the resident required stabilization on the behavioral unit and would demonstrate compliance with behavioral expectations associated with each level (four levels of independence on behavioral unit). The Level Compliance Checklist from 10/20/05 to 2/9/06 reflected that the resident had a level two status and maintained compliance with unit rules. Nursing narratives dated 2/21/06 indicated that the resident's room was searched and a razor was found. The resident was reeducated and the razor was removed from the resident's room. Review of the Behavior Unit Guidelines (rules) identified that sharp objects of any kind, to include razors, are not to be kept in residents' rooms. The guidelines further directed that an infraction of non-compliance with rules would result in a change to level one for at least a 2-week period. Review of the Level Compliance Checklist with the Charge Nurse on 2/22/06 at 12:20 PM identified that Resident #37 remained at a level two after the razor was found. Interview with the Director Behavioral Health on 2/23/06 at 10:50 AM reflected that Resident #37's status was probably not reduced because the resident did not have a history of this behavior and/or suicidal ideation and the razor might not have belonged to the resident. Review of the resident's clinical record and interview with the Behavior Unit Manager on 2/23/06 at 10:50 AM noted that, although a decision was made by the RN not to decrease the resident's level status, an assessment of the resident's behavior and/or reasons for maintaining the resident's level status were not documented at that time in the clinical record.

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

6. Based on review of the clinical record, observation and interview for one of five sampled residents (Resident # 3) with restraints and/or one of twelve sampled residents with a history of falls (Resident # 3), and/or one of three (Resident #4) sampled residents who needed assistance with feeding, the facility failed to correctly code the MDS. The findings include:
 - a. Resident #3's diagnoses included syncope and depression. A significant change assessment dated 11/12/05 identified that the resident had short and long-term memory loss, was moderately cognitively impaired, dependent for transfers and unable to ambulate. The assessment further identified that the resident utilized a trunk restraint and full side rails. A physician order dated 11/23/05 and 12/12/05 identified an intervention

FACILITY: Wintonbury Care Center, Llc

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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- to utilize two siderails in bed for mobility and a seat belt in a customized wheelchair to prevent unassisted ambulation due to dementia. Interview on 2/16/06 at 10:00 AM with the MDS Coordinator identified that the siderails were utilized for mobility and that the resident had utilized a customized wheelchair since June 2005, therefore the seat belt and the siderail were not a restraint although they were coded as a restraints.
- b. Resident #3's diagnoses include syncope and depression. An MDS dated 1/27/06 identified that the resident had long and short- term memory deficits and was moderately cognitively impaired. Facility documentation identified that on 1/12/06 at 7:20 PM the resident was lowered to the floor due to an attempt to get out of the chair and on 1/25/06 at 10:35AM facility documentation identified that while the NA was providing care to the resident, the resident was lowered to her knees. Interview and review of the MDS dated 1/27/06 with the MDS Coordinator on 2/16/06 at 10:20 PM identified that the assessment did not reflect the resident's falls.
 - c. Resident # 4's diagnoses include dementia, and glaucoma. The MDS dated 12/21/05 identified short and long- term memory deficits, modified independent cognition and supervision necessary for eating. Observation on 2/14/06 and 2/15/06 of the noon meal identified that the NA was feeding the resident. Interview with the Charge Nurse on 2/16/06 at 10:00 AM identified that the resident needs assistance at meals not merely supervision.

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

7. Based on clinical record review and interview for one sampled residents (Resident #17) who required dialysis treatments, the facility failed to develop a plan of care to address emergency care. The findings include:
 - a. Resident #17's diagnoses included hypokalemia, end stage renal disease, pancreatitis, hypertension and dementia with depressive features. An annual assessment dated 11/10/05 identified that the resident had long and short- term memory deficits and moderately impaired cognition. A physician's order dated 2/06 identified that the resident received dialysis three times weekly on Tuesday, Thursday and Saturday. Interview and record review on 2/16/06 at 11:00 AM with the staff nurse failed to provide a care plan to address emergency dialysis care.

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).

8. Based on clinical record review, review of facility documentation and interview for one of eight sampled residents with a history of falls (Resident #3), and one sampled resident (Resident #38) admitted for short term placement, the facility failed to review and revise the RCP to address the resident's needs. The findings include:
 - a. Resident #3's diagnoses included syncope, status post lacunar infarct, chronic depression and hypertension. A significant change assessment dated 11/12/05 identified that the

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resident was moderately cognitively impaired, sometimes responded adequately to direct communication, required set-up only for eating, was totally dependent for ADL's, totally dependent for transfers with assistance of two, had not ambulated in the room or corridor in the last seven days, was unable to test balance while standing without physical help and a test for balance while in a sitting position- trunk control identified partial physical support required and/or stands/sits, but does not follow the directions for test. Review of the RCP dated 11/18/05 identified that the resident was at risk for falls secondary to medication use, dementia, poor vision and hearing. Approaches included out of bed to the wheelchair with an assistance of one and the use of a seatbelt and ambulate short distances in the room with the assistance of one. However, review of the RCP dated 11/18/05 that identified the resident had an alteration in mobility related to osteoarthritis, dementia, decreased vision and decreased hearing identified approaches that included to transfer the resident with a hooyer lift and assistance of two to the wheelchair and the use of a velcro seatbelt, use of a walker for short distances in the room, but failed to identify the amount of assistance needed, and that the resident required incontinent care and toileting required an assistance of one. A physical therapy referral dated 12/14/05 identified the resident has had a decline in function with an increase in pain in the knees. A physical therapy requisition dated 12/15/05 identified the need for a physical therapy evaluation and treatment as indicated. Review of nurse's notes dated 1/12/06 identified the NA reported that the resident had attempted to get out of the chair and the NA lowered the resident to the floor. A physician order dated 1/2/06 identified moist heat and massage to bilateral knees, transfer training, mobility exercises and balance retraining. Nurse's notes dated 1/25/06 identified that the resident was ambulating to the bathroom with the assistance of a NA and was lowered to the floor with the assistance of two NAs and sustained an abrasion to the left knee, but failed to address whether the resident had any pain. Nurse's notes dated 1/25/06 at 11:00 PM identified the resident had no complaints of pain. Nurse's notes dated 1/26/06 at 4:00 AM through 1/26/06 at 4:00 PM identified the resident displayed some agitation and did not get out of bed until late in the AM at her request and had refused to get out of bed twice previously on the shift. Nurse's notes dated 1/27/06 at 6:00 AM identified the resident became agitated when care was given, complained of pain in the leg and knee and refused Tylenol when offered and eventually took Tylenol at 6:30AM. Nurse's notes dated 1/28/06 on the 11 PM-7 AM shift identified that at 6:00 AM the resident complained of left ankle pain and received Tylenol with positive effect, and that at 10:00 AM on the 7 AM-3 PM shift the resident complained of left ankle pain. The nurse's note further identified the resident's left ankle was painful to touch and was identified to have slight swelling present. The physician was notified at that time and an order was obtained for an x-ray. The nurse's notes from 1/25/06 at the time of the fall through 1/28/06 on the 11 PM-7 AM shift failed to identify an assessment was conducted to identify, despite evidence of pain and/or change in behavior until 1/28/06 at 10:00 AM, at which time the physician was notified and an order for an x-ray was obtained. An x-ray report dated 1/28/06 identified a non-displaced fracture involving the left distal fibula. Interview on 2/15/06 at 3:30 PM with RN # 6 identified that, the resident had opened the seatbelt at the time the NA had gone into the

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bathroom to get a washcloth, or something to give the resident care, when she was coming out she saw the resident standing, so she lowered her to the floor. She further identified the resident usually opens the seatbelt, but did not usually try to stand up frequently. Interview on 2/15/06 at 11:40 AM with NA # 6 identified the NA took her to the bathroom by herself, she had the walker in front of her and the wheelchair behind the resident when the resident grabbed onto the walker and started to go down. The NA further identified that it was her understanding that she needed two people to transfer the resident from bed to chair, but could take her to the bathroom by herself. Interview and record review with the staff nurse on 2/16/06 at 10:15 AM failed to identify that the resident had been assessed on 1/25/06 through 1/28/06. According to Clinical Nursing Skills, Fifth Edition, 2000, assessment requires skilled observation, reasoning, and a theoretical knowledge base to gather and differentiate, verify, and organize data, and document the findings. Assessment is a critical phase because all the other steps in the process depend on the accuracy and reliability of the assessment.

- b. Resident #38 was admitted to the secured behavioral unit on 6/28/05 with diagnoses that included major depression and recurrent personality disorder. The assessment dated 1/4/06 identified that the resident was independent for cognition, and did not exhibit behavioral problems. The care plan dated 1/11/06 reflected that the resident was admitted for short-term placement and a goal to discharge to home/community. Approaches included adjusting all psychosocial issues and personal requests. Social service notes dated 1/26/06 indicated that the resident was transferred off of the behavioral unit to a more independent unit. Social service notes dated 2/7/06 and/or 2/9/06 identified that the resident was on a list for five years for housing at a local housing unit and was denied residency. Interview with the Social Worker on 2/23/06 at 11:50 AM noted that she was investigating the reason for the resident's denial and would work on other placement options. Further interview and review of the resident's clinical record with the Social Worker and the Director of Social Services at this time failed to identify that the resident's plan of care had been updated to include approaches for community discharge.

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

9. Based on review of the medical record, review of facility documentation, and interviews, the facility failed to ensure that one nurse, LPN #1, provided appropriate intervention in accordance with professional standards when one resident (Resident 25) reported feelings of suicidal ideation. The findings included:
- a. Resident #25 had diagnoses that included Major Depression and Borderline Personality Disorder and a history of multiple suicide attempts. Interview with LPN #1 on 11/22/05 identified that on 11/20/05 at approximately 8:45 PM, she observed R #25 crying in her room and that the resident reported that she wanted to kill herself. LPN #1 stated that she offered anti-anxiety medication to R #25 who refused the medication, and subsequently assigned a nursing assistant to sit with the resident. LPN #1 stated that approximately ten minutes later she observed R #25 run into the community room, that she heard banging

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and glass breaking. LPN #1 stated that she then notified the supervisor. LPN #1 stated that at that point, staff could not get near the resident and that R #1 used the glass shard from a broken window to cut herself. Interview with RN #1 on 12/30/05 identified that he was the supervisor on 11/20/05 and that although he immediately responded when paged, R #25 had already broken the window. RN #1 stated that he was never notified by LPN #1 prior to the urgent overhead page, of R #25's comments about wanting to kill herself or of any agitated behavior. Section 20-87a of the Nurse Practice Act, directs the practice of a of nursing by a Licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a Registered nurse or an advanced practice Registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician of dentist. In addition, during the 11/22/05 interview, LPN #1 stated that she did not question R #25 as to why she was having thoughts of suicide or ask if the resident had a plan. Interview with MD #3, the resident's current psychiatrist, on 11/22/05 identified that if a resident were to report that they wanted to kill themselves, he would expect the nurse to talk with the patient and ask, "tell me more" types of questions. MD #3 stated that when a patient reports feelings of suicidal ideation, the nurse must always assess if the patient has a plan and that a summary of the details of that assessment need to be documented in the nursing notes. MD #3 stated that "the nurse should never let it go" and that the nurse must always get the patient to contract for safety. According to the Scope and Standards of Psychiatric-Mental Health Nursing Practice manual, the nurse's assessment is a synthesis of information obtained from interviews, behavioral observations, and other available data from which a diagnosis is derived and validated with the patient if appropriate. The nurse then selects and implements interventions directed toward a patient's response to an actual or potential health problems.

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).

10. Based on clinical record review, observation and interview for one sampled resident with dialysis (Resident #17) and/or one of nine sampled residents residing on the locked Behavioral Unit (Resident #36 and/or one of eleven residents observed receiving medication during a medication pass (Resident #26) and for one of one sampled residents with a fecal impaction (Resident #11), and/or for one of one sampled resident (Resident #14) who required an abdominal binder to prevent the resident from accidentally dislodging a feeding tube, and/or for one of two sampled residents with a significant weight loss (Resident #5) the facility failed to consistently implement the plan of care. The findings include:
 - a. Resident #17's diagnoses include ESRD, pancreatitis and non-insulin diabetes mellitus. An annual assessment dated 11/10/06 identified that the resident was moderately cognitively impaired. The RCP dated 8/17/05 through 2/15/06 included approaches to weigh the resident daily, auscultate for bruit every shift, and monitor intake and output.

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- Review of the clinical record identified monthly weights, inconsistent intakes and failed to identify documentation for bruit checks. Interview with the licensed staff nurse on 2/16/06 at 11:00 AM identified that daily weights, consistent intake and every shift auscultation were not accomplished.
- b. Resident # 36 diagnoses include schizoaffective disorder. The MDS dated 10/27/05 identified long and short term memory deficits, moderately impaired cognition, verbally abusive behavior and resistive to care. The Level Compliance Check List identified that on 12/5/05 the resident's Tier Level was changed from a 3 to a 1 for buying rings. Facility policy stated that Tier 1 residents are to remain on the unit and will not have Leave of Absence (LOA) for a period of two weeks. The LOA sign out sheet indicated that Resident #36 went out on pass 12/6/05 while on level One. Interview with the Behavioral Unit Manager on 2/23/05 at 11:00 AM identified that the resident should not have been permitted to go out on the LOA as a Tier 1.
- c. Resident #11's diagnoses include Alzheimer's dementia with delusions and diverticulitis. A quarterly assessment dated 11/9/05 identified the resident was moderately cognitively impaired, required extensive assistance with ADL's and was incontinent of bowel at least once a week. Physician orders dated 11/05 and 12/14/05 directed the administration of MOM 30 ml, once daily as needed for constipation. If MOM was ineffective the physician orders directed the administration of a Bisacodyl 10 mg suppository daily as needed for constipation. If Bisacodyl suppository was ineffective the orders directed the administration of a fleet enema, once daily as need for constipation. Review of the facility bowel movement book, the resident flow sheets and the nurse's notes from 12/6/05 to 12/14/05 identified that the resident had not had a bowel movement from 12/06/05 on the 11:00 PM to 7:00 AM shift, until 12/14/05 on the 3:00 PM to the 11:00 PM shift, a total of 7 days without a bowel movement. The Medication Administration Record for 12/05 lacked documentation that the resident had received the MOM, Bisacodyl suppository and/or Fleets enema for constipation. Further review of the nurse's notes identified that on 12/14/05 at 9:00 PM, the resident had a large amount of rectal bleeding and was transferred to the emergency room for an evaluation. A hospital discharge summary dated 12/21/05 identified the resident was admitted with a diagnoses of a lower gastrointestinal bleed and a fecal impaction. Interview and review of the clinical record on 2/17/06 at 1:30 PM with the ADNS identified that the bowel regimen should be implemented after 3 days without a bowel movement and an assessment of the resident's abdomen and bowel sounds should have been obtained if the bowel regimen was ineffective.
- d. Resident #14 had diagnoses that included a Traumatic Brain Injury (TBI) dementia, and a history of aspiration pneumonia. Review of the assessment dated 7/20/05 identified that the resident required a feeding tube. Physician orders dated 10/6/05 identified that the resident was to have an abdominal binder on to maintain the placement of the feeding tube. Observation of R #14 on 2/14/06 at 9:45 AM, and again at 11:15 AM identified the resident had a left hand mitt and a right wrist restraint on, but that the ordered abdominal binder was not in place. Interview with LPN #6 on 2/14/06 at 11:30 AM identified that LPN #6 was unsure why the abdominal binder was not in place despite physician orders

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- for the binder.
- e. An assessment dated 11/23/05 identified Resident # 26 was moderately cognitively impaired and required total assistance with ADLs. Physician orders dated 1/26/06 directed the administration of Lasix 20 mg every day. Observation during a medication pass on 12/15/06 at 9:00 AM identified that the resident did not receive Lasix as ordered. Interview and review of the physician orders and medication administration record on 2/15/06 at 10:00 AM with Registered Nurse #3 identified the resident was scheduled to receive Lasix 20 mg at 9:00AM everyday. It further identified that she "missed it" this morning. Subsequent to surveyor inquiry Lasix 20mg was given at 10:30AM.
 - f. Resident 35's diagnoses include Schizophrenia, Turner's syndrome and CHF. A quarterly assessment dated 1/31/06 identified the resident had modified cognitive skills and required extensive assistance with ADL's Review of the monthly weight record identified that on 1/06 the resident's weight was recorded at 155.6 pounds. Further review identified that on 2/06 the resident's weight was recorded at 138.4 pounds, a 17.2 pound weight loss. Interview and review of the clinical record on 2/16/06 at 11:00 AM with Registered Nurse #7 identified that monthly weights are done the first five days of the month. It further identified that when there is a five pound weight gain or loss, the resident should be re-weighed to determine if the weight loss is accurate. Subsequent to surveyor's inquiry the resident's weight on 2/17/06 was identified to be 160 pounds and the resident did not have a weight loss. Interview on 2/17/06 at 1:00 PM with the ADNS identified that the resident should have been re-weighed as soon as the loss was identified.

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

- 11. Based on review of the clinical record and interview for one of two sampled residents with a decline in bladder function (Resident #5), and/or for three of four sampled residents who required fluid monitoring (Resident #s 11, 14, and 39), the facility failed to attempt to restore the resident's bladder function and/or failed to assess and/or monitor the resident's food and/or fluid intake and/or assess for signs and symptoms of dehydration. The findings include:
 - a. Resident #5's diagnoses included Schizophrenia, Turner's syndrome and hypertension. A quarterly assessment dated 8/13/05 identified the resident had modified cognitive skills, was independent with ADL's and continent of bladder. An annual assessment dated 11/2/05 identified the resident required limited assistance with ADL's and was incontinent of bladder daily, a noted decline in bladder function. Review of the NA flow sheets identified that the resident was continent of bladder until 10/18/05. Further review identified that from 10/19/05 to 2/14/06 the resident was incontinent of bladder daily. A bladder retraining assessment dated 11/4/05 identified the resident voids correctly without incontinence at least once daily and is usually aware of toileting needs. It further identified the resident was a candidate for a toileting schedule. Although the resident care plan dated 11/2/05 identified occasional urinary incontinence when not toileted on time and that a toileting schedule was needed, there was no evidence of a toileting schedule in place. Interview and review of the clinical record on 2/17/06 at 1:00 PM with the ADNS

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- failed to provide evidence that the course of the resident's incontinence had been identified that a thorough assessment had been completed to determine voiding patterns and that an individualized toileting plan had been implemented to attempt restoration of bladder function.
- b. Resident #11's diagnoses include Alzheimer's dementia with delusions. Review of the resident's lab work dated 6/16/05 identified the resident's baseline BUN to be 21mg/dl (7-17mg/dl normal) and a Creatinine of 1.1mg/dl (0.7-1.2mg/dl normal). The Registered Dietician's quarterly review identified that the resident's weight was recorded at 135.4 pounds in August 2005 and 126.6 pounds in November 2005, a 8.8 pound weight loss in a three month period. The note further identified the resident is able to feed herself at supper, seems to need help during the day, her appetite fluctuates, will need a supplement and that the Remeron had been increased in June, but had not had an effect on the resident's PO intake. A physician order dated 11/8/05 identified an order for Novasource 2.0, 120 ml by mouth two times a day. Review of a dietary assessment dated 11/9/05 identified the resident's fluid needs to be 1800cc per day. A quarterly assessment dated 11/9/05 identified the resident was moderately cognitively impaired, required extensive assistance with ADL's, and required limited assistance with eating. The RCP dated 11/9/05 identified a problem with nutrition. The interventions included to encourage the resident to eat 75% of meals. Review of the ADL flow sheet identified that from 12/1/05 to 12/10/05 the resident's meal intake was recorded at 50% to 75%. The medication record dated 12/10/05 failed to identify the amount of Novasource consumed by the resident for the 10 AM and 5 PM scheduled dose. Nurse's notes dated 12/12/05 at 9:00 PM identified the resident was lethargic. The nurse's notes from 12/12/05 to 12/14/05 identified that there was no documentation of the resident's meal intake for five of nine meals. It further identified the resident ate only 25% and/or refused to eat during the evening meals on 12/12/05. The documentation dated 12/14/05 identified that the resident consumed only 25% of breakfast, 0% during the noon meal and only 25% of the evening meal. Review of the medication record identified that on 12/12 and 12/13/05 there was no documented intake of the Novasource for the 5:00 PM scheduled dose. Further review of the nurse's notes dated 12/14/05 at 9:00 PM identified the resident had a large amount of rectal bleeding and was transported to the emergency room for an evaluation. A hospital discharge summary dated 12/21/05 identified that on admission the resident's BUN was 137 and the Creatinine was 2.2, "suggesting a strong element of dehydration." Interview and review of the clinical record with the ADNS on 2/17/06 at 1:30 PM failed to provide evidence that the resident's intake had been consistently monitored.
- c. Resident #14 had diagnoses that included a history of aspiration pneumonia, Urinary Tract Infections (UTI), dehydration, and fevers of unknown origin (FUO). Review of RCP dated 8/13/04 identified that R #14 had previously had a feeding tube in place and was at risk for dehydration with goals that included ensuring that R #14 was well hydrated as evidenced by no sternal tenting, no dry mucous membranes, and no concentrated urine. Interventions included monitoring of fluid intake and urine output. Review of the dietary assessment last updated on 4/7/05 identified R #14 's fluid intake recommended by the

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dietician to be 1860 cubic centimeters (cc.) daily. Review of nursing notes dated 5/13/05 through 5/31/05 identified that R #14 was extremely combative and resistive to care and was spitting out medications on a near daily basis. Although review of the medical record from the resident's readmission from the hospital to the nursing facility on 5/14/05 through readmission to the hospital on 5/31/05 identified consistent monitoring of the resident's intake and output with the exception of two shifts on 5/17 and 5/22/05, the resident's intake was documented to be below the necessary requirements on all seventeen days. Interview with the Assistant Director of Nursing on 3/24/06 identified that it was not possible to administer IV fluids due to R #14's extreme combative behavior during this time period. Review of the nursing notes during the same time period lacked documentation to reflect that assessments of hydration status in accordance with the plan of care were performed or that revisions to the plan of care were made to address that the resident's fluid intake was consistently below the dietician's recommendations. R #14 was admitted to the hospital on 5/31/05 and subsequently had a feeding tube reinserted. Review of the discharge summary dated 6/9/05 identified that R #14 had been intermittently refusing oral intake in the nursing home and had behavioral issues that included alternating periods of agitation with periods of somnolence. The discharge summary identified that R #14 had been admitted to the hospital with diagnoses that included dehydration and acute renal failure secondary to dehydration. Review of facility policy directed that ongoing assessment of a resident's ability to drink and signs of dehydration.

- d. Resident # 39's diagnoses include severe senile dementia and a history of dehydration, Urinary Tract Infection (UTI) and sepsis. The quarterly nutritional risk assessment dated 9/13/05 identified that the resident required 1636 cubic centimeters (cc) of fluid per day and noted the resident had consumed 1500-2000cc daily during the quarterly assessment review. Review of the resident's lab work dated 11/17/05 indicated the resident's baseline BUN was 17mg/dl (7-17mg/dl normal), a Creatinine of 1.2mg/dl (0.7-1.2mg/dl normal) and sodium of 141 (135-145meq/l normal). A quarterly assessment dated 11/30/05 identified the resident was moderately cognitively impaired, required extensive assistance with ADL and with eating. The RCP dated 12/6/05 identified a problem with nutrition with approaches that included to encourage good fluid/food intake. Physician order dated 11/30/05 directed Novasource 2.0, 120 milliliters (ml) by mouth two times a day and document the amount taken. ADL flow sheets from 12/21/05 to 12/26/05 identified the resident's meal intake was 100% for two meals (breakfast on 12/22/05 and 12/23/05) and other meals were recorded at 50% to 75%. Documentation of meal intake was lacking for 8 out of 18 meal times. The Medication Administration Record from 12/22/05 to 12/26/05 failed to document the amount of Novasource consumed by the resident for the 10 AM and 6 PM scheduled dose. Intake and output records from 12/22/05 to 12/26/05 reflected inconsistent documentation of fluid intake and/or intake ranging from 880cc to 1020cc (616cc to 756cc below dietary requirements). Nursing narratives from 12/22/05 to 12/26/05 failed to indicate that a dehydration assessment had been documented. Nursing narratives dated 12/27/05 noted that the resident had a low-grade temperature (99- 100.1 degrees Fahrenheit), was semi-lethargic and was sent to the emergency room per

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physician orders. Resident #39 's acute care record identified that the resident was admitted to the hospital with altered mental status and severe dehydration reflected in part by an elevated sodium level of 175meq/l. Hospital admission blood work dated 12/27/05 further indicated that the resident's BUN was 76 and the Creatinine was 2.6. Interview with NA #3 on 3/10/06 at 2:30 PM noted that toward the end of the resident's stay at the facility, the resident did not eat and/or drink as well as she had been, nursing was aware and administered supplements. Interview with the ADNS on 3/10/06 at 2:35 PM identified that a resident's meal intake should be documented on the flow sheet by the nurse aide each day and before the end of the shift. Review of facility policy and further interview with the ADNS at this time noted that intake and output records were to be completed daily and on each shift by the nurses.

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

12. Based on review observation and interview, the facility failed to ensure that infection control practices were implemented in the storage of one resident 's (Resident # 14) suction machine and catheter set up. The findings include:
 - a. Resident #14 had diagnoses that included a history of aspiration pneumonia and was experiencing recent episodes of vomiting. Physician orders directed that the resident be suctioned on an as needed basis. Observation of the suction machine and suction catheter in R #14's room on 2/14/06 at 9:45 AM identified that the machine was not in use, was uncovered, and that the suction catheter was lying across the machine, its tip resident on the cart, and was uncovered. Interview with LPN #6 at 10:55 AM on 2/14/06 identified that facility policy directed suction catheters to remain covered within the paper cover sleeve when not in use.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (c) I.V. Therapy (5) and/or (f) Administrator (3)(A) and/or (j) Director of Nurses (2)(K).

13. Based on review of facility documentation, review of facility policy, review of personnel files, and interview, the facility failed to maintain the intravenous log as directed by the Public Health Code of the State of Connecticut and/or failed to ensure that performance evaluations were completed in accordance with facility policies and/or that regular ongoing performance evaluations for one licensed nurse, LPN # 7, who displayed problems with communication to residents were completed. The findings include:
 - a. Review of the personnel file of NA #4 identified that NA #4's last performance evaluation was completed in November of 2004. During an interview with NA #4 on 2/16/06, the NA was asked to demonstrate how a resident's pulse was taken. NA #4 placed then pressed her thumb into the middle of the surveyor's wrist. Interview with the Director of Nursing (DNS) on 2/17/06 identified that nursing assistants in the facility were responsible for obtaining the vital signs of residents in the facility and reporting their findings to the charge nurse.

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- b. Review of the personnel file of LPN #6 identified that LPN #6's last performance evaluation was completed in March of 2000.
- c. Review of the personnel file of LPN #7 identified that LPN #7's last performance evaluation was completed in February of 2001. The 2/01 evaluation identified areas of concern that included that the LPN was "sometimes tactless" and was occasionally unwilling to follow orders without argument. The evaluation identified objectives for LPN #7 to "improve courtesy toward staff, residents, and families and to take responsibility toward ensuring that residents receive the care they request.
- d. In addition, LPN #7's personnel file included a written warning to the LPN dated 3/19/03. The warning identified that several family members and staff verbalized that LPN #7's general attitude and approach toward them was very poor. The documentation also identified that LPN #7 was reported to be rude toward family members. Interview with the night shift RN supervisor, RN #1, on 2/17/06 identified that although she had not been directed to monitor LPN #7's behavior, that she had needed to speak with the LPN on occasion about her attitude. RN #1 stated that she had received reports in the past that some residents didn't like the way LPN #7 spoke to them but that she had not received any since LPN #7 was moved from the secured unit to the regular nursing unit. RN #1 stated that although LPN #7's remarks did not always come through as appropriate, she did not consider LPN to be abusive in her attitude. Interview with the DNS on 2/17/06 identified that she was unable to recall if any new complaints related to LPN #7 had arisen since the 3/19/03 warning. The DNS was unable to supply and written documentation of monitoring of LPN #7's general attitude and/or poor approach to families and/or residents since 3/03. Interview with the DNS on 2/17/06 identified that she was aware that performance evaluations had not been completed in a timely manner. Review of facility policy directed that a yearly performance evaluation would be completed for each nursing employee.

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

14. Based on review of the medical record, review of facility policies, and interviews, the facility failed to ensure the accuracy of the medical records of three of three residents. The findings included:
 - a. Resident #13 had diagnoses that included schizoaffective disorder and was a resident in the facility's secured behavioral unit. Review of the resident Care Plan (RCP) dated 7/29/05 identified the resident was at risk for suicidal ideations with interventions that included every fifteen minute checks. The assessment dated 8/3/05 identified R #13 with no long or short-term memory problems but with impaired cognitive skills for daily decision making. Review of the documentation of the fifteen-minute checks provided by facility staff identified that one document in the record had been altered. Whiteout had been used to cover over the name of another resident as well as the date on the document. The name of R #13 was added over the whiteout though no new date was added. The document was reviewed with the Medical Records Director on 2/15/06 and with the

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- Director of Nursing (DNS) on 2/17/06. Interview with the DNS on 2/17/06 identified that facility policy prohibited the use of whiteout to correct entries in the medical record.
- b. Resident #14 had diagnoses that included a history of Urinary Tract Infections (UTI), dehydration, and fevers of unknown origin (FUO). Review of RCP dated 6/28/05 identified the resident's risk for dehydration and the need for a feeding tube due to dysphasia with interventions that included monitoring of intake and output. R #14 experienced multiple hospitalizations between 7/05 and 2/05 for elevations in temperature that ranged from 102 degrees to more than 104 degrees (Normal 98.6). Review of the multiple discharge summaries from the hospital identified that R #14 was identified as "clinically dehydrated" on more than one occasion. Laboratory results used to identify the resident's level of hydration upon admission to the hospital included Blood Urea Nitrogen (BUN) and creatinine levels. R #14's BUN levels were reported to be between 30 and 32 (Normal 8-25) and her creatinine levels were reported to be between 1.1 and 1.3 (Normal 0.5 to 1.1) at the time of these hospitalizations. Interview with LPN #6 on 2/15/06 identified that intake and output was monitored closely due to R #14's fluid requirements and use of a feeding tube. Review of the medical record lacked documentation to reflect that intake and output was consistently documented in the medical record.
 - c. Resident #24 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). The medical record of R #24 was selected for review by the survey team. Interview with the Medical Records Director on 2/17/06 identified that she was unable to locate R #24's Medication Administration Record (MAR) despite requests on 2/15, 2/16, and 2/17/06.

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

15. Based on review of clinical records, facility documentation, observations and interviews with facility staff, the facility failed to honor the access and visitation rights for 30 of 146 residents for a period of approximately seventy-seven hours. The findings include:
 - a. Review of records and facility documentation indicated that on 03/23/06, Residents # 27, # 35, # 42 and # 45 were involved in possessing contraband, and after investigation, were transferred from an open access unit to a secured unit at 11PM on 03/23/06. Interviews with the Director of Nursing Services (DNS) and the Assistant Director of Nurses (ADNS) on 04/03/06 at 1:20 PM indicated that prior to this transfer, all visitors to the secured unit were consistently searched and were required to open all packages brought in to the residents with permission, for inspection by the facility staff. A visit to the secured unit on 03/31/06 at 8:45 AM identified numbered key pads on both sides of the closed doors, two glass windows approximately ten by twelve inches at eye level in each door, and posted signs on the wall about denying entry to visitors who did not comply with the search prior to entering the unit. Interview with the DNS on 04/03/06 at 1:20 PM indicated that in the past, one visitor declined to be searched, and remained behind the locked doors, communicating through the window with the visited resident. According to the DNS, in an attempt to prevent contraband in the secured unit, in the early morning

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hours of 03/24/06, after the transfer of the four residents to the secured unit, the facility staff posted a sign on the doors of the secured unit, closing the unit to all visitors until 03/27/06 at 1PM, for a total of approximately seventy-seven hours. Visitors were allowed to communicate with the residents through the glass windows only. Although no grievance was filed regarding the temporary visitation rules, the facility staff still failed to honor the access and visitation rights of all thirty residents during those hours.

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) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(I).

16. Based on review of clinical records, facility documentation and interviews with facility staff, for one of one sampled resident (Resident # 46) who did not adhere to the smoking policy, the facility failed to develop and implement interventions that would not affect / limit the resident's rights. The findings include:
 - a. Resident # 46's diagnoses included dementia. A Minimum Data Set (MDS) dated 02/28/06 identified problems with short-term memory and modified independence in daily decision-making. Evaluations of the resident's ability to smoke dated 09/08/05, 12/12/05 and 03/05/06 identified a history of non-compliance. Resident Care Plans (RCPs) dated 09/22/04, 4/11/05 and 06/08/06 identified a potential for fluctuation in mood, and incidences of non-compliance with the facility smoking policy on 09/27/04, 10/03/04, 10/11/04 and 06/08/05. A psychiatric evaluation dated 01/31/06 identified Resident # 46's depression, along with the resident's complaints of receiving "little respect, dignity or freedom." On 03/24/06, Resident # 46's room underwent a random room search during which the facility staff found two and a half cigarettes. The Resident Care Plan (RCP) was updated, the resident was placed on fifteen-minutes checks, with smoking privileges with-held for twenty-four hours. On 03/25/06, Resident # 46 handed the Nurse Aide (NA) an unopened pack of cigarettes marked with the resident's first and last name. Fifteen-minutes checks were extended, as well as the suspension of smoking privileges "until further notice". On 03/26/06, Resident # 46's room search revealed three matchbooks, three lighters, two opened and labeled packs of cigarettes, and an empty 50 centicubes (cc) bottle of gin liquor. Interview with the Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS) on 04/03/06 at 1:20 PM indicated that on 03/23/06, Resident # 46's was maintained on fifteen-minutes checks, with smoking privileges revoked through 04/01/06 and reinstated on 04/02/06. Review of the facility policy and of Resident # 46's clinical records indicated that although the policy directed to address smoking violations with interventions including smoking evaluations, offering smoking cessation programs, psychiatric assessments and behavioral plans, the above were not documented or considered prior to with-holding smoking privileges. Further review of the facility smoking policy identified a "progressive modification of the smoking schedule" leading to limiting disciplinary measures such as elimination of the smoking breaks and suspension of the smoking privileges, as well as restriction of leave of absence privileges.

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

17. Based on review of clinical records, facility documentation and interviews with facility staff, for one of one sampled residents (Resident # 42) who exhibited pressure ulcers, the facility failed to provide appropriate treatments and monitoring to promote healing. The findings include:
 - a. Resident # 42 was admitted to this facility on 03/07/06 from an acute care hospital with diagnoses including paraplegia, sacral decubitus, and right heel decubitus ulcer. Resident Care Plans (RCPs) dated 03/22/06 identified skin breakdown, immobility from paraplegia, and bowel incontinence with interventions including observation of skin integrity during incontinent care, and weekly skin checks per policy. An admission nursing flow sheet dated 03/07/06 identified a stage IV decubitus ulcer on the right heel measuring 5 centimeters (cm) by 5 cm, and a stage III decubitus ulcer on the left coccyx measuring 2cm by 0.5cm. Physician orders dated 03/09/06 directed to irrigate the right heel with Normal Saline, apply Hydrogel, and wrap with Kerlix twice a day; the orders also directed to apply Zinc Oxide to periwound (area surrounding wound) every shift; and finally to apply Tegaserb dressing to sacral wound, change it every third day or as needed. The physician orders or the physician notes did not indicate to allow the resident to perform own dressing changes. Review of Resident # 42's treatment kardex indicated that right heel dressing change was signed off by 7AM-3PM and 3PM-11PM nurses from 03/08/06 through 03/23/06, with the exception of 03/13/06 on 3PM-11PM shift where the treatment was signed off as "self". The Kardex also indicated that the coccyx dressing change was signed off by 3PM-11PM nurses from 03/07/06 through 03/19/06, with "self" marked on 03/13/06 and 03/20/06. The facility wound care policy directed the observation of wounds at each dressing change for signs of infection, reporting the signs of infection to physician, recording of weekly wound assessment in the resident's records, including wound site, stage, size, appearance of wound bed, tunneling, surrounding skin, drainage, effectiveness of interventions and resident's response to therapy. Interviews with Licensed Practical Nurse (LPN) # 6 on 03/31/06 at 1:30PM, with LPN # 10 on 04/03/06 at 12:20 PM, with the Director of Nursing Services (DNS) and the Assistant Director of Nursing Services (ADNS) on 04/03/06 at 1:15PM indicated that Resident # 42 performed own dressing changes on right heel and left coccyx throughout the nursing home stay. Interviews with ADNs on 04/03/06 at 1:15PM and 04/05/06 at 10:52AM indicated that although ADNS was designated to coordinate the weekly pressure ulcer review and documentation on the pressure area flow record, ADNS did not examine Resident # 42's left coccyx because the resident did not allow her to; furthermore, the ADNS assumed that left coccyx was "all healed" and the right heel was "healing well" based on Resident # 24's own report. Upon inquiry, ADNS was not sure how Resident # 42 could visualize own coccyx for healing assessment or perform a dressing change on own coccyx. Review of the records failed to indicate that Resident # 42's resistance to dressing changes and to

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nursing assessments for effectiveness of therapy was reported to the physician and / or addressed in nurses notes and care plans. Interview with the ADNS on 04/05/06 at 10:52AM failed to provide evidence that weekly wound tracking was available upon inquiry. On 03/25/06, after sustaining injuries requiring surgery, Resident # 42 was transferred to an acute care hospital where the coccyx and right heel ulcers were identified in the Emergency Department; after surgery, on 03/28/06, Resident # 42 was seen by a wound care specialist in the hospital who identified necrotic tissue to the right heel and prescribed Accuzyme (an enzymatic debriding ointment).

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

18. Based on review of clinical records and interviews with facility staff , for one of one sampled resident (Resident #18) who verbalized suicidal ideation, the facility failed to provide timely services to address mental or psychosocial adjustment difficulties. The findings include:
- a. Resident #18 was admitted to this facility on 01/25/06 with the diagnosis of major depression. A Minimum Data Set (MDS) dated 03/07/06 identified modified independence in daily decision-making, mental functions varying over the course of the day, repetitive health complaints, and reduced social interactions. Resident Care Plans (RCP's) dated 01/25/06 identified a history of suicide attempts and the risk for suicidal ideation related to the loss of the resident's family member in November 2005. Psychiatric consultations dated 01/27/06 , 01/31/06, 02/16/06, 03/03/06 and 03/14/06 indicated that Resident #18 was not a danger to self or others, but identified worsening depression, over anxiety, sleepiness and sedation. Facility documentation indicated that on 03/24/06, Resident #18 was overheard by facility staff verbalizing depression and thoughts about hurting self. Resident #18's RCP was updated to address resident's feelings with interventions including logging the resident's name in the scheduling book for psychiatric follow-up. Interviews with the Director of Nursing Services (DNS) and the Assistant Director of Nurses (ADNS) on 04/03/06 at 1:20 PM indicated that after a resident's name is logged in the psychiatric evaluation book, the resident should be seen on the following week by either the psychiatrist or the psychiatric Advance Practice Registered Nurse (APRN) who each come in once a week on separate days. Interviews and review of Resident #18's clinical records on 04/03/06 with the DNS and the ADNS indicated that although Resident #18's name was logged in the psychiatric consult book on 3/24/05, the resident was not evaluated by the psychiatrist or psychiatric APRN for an entire week following verbalization of the resident's self destructive intentions.

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)(C).

19. Based on review of facility records and acute care hospital records, interview with facility staff and review of facility documentation for 2 of 2 sampled residents with a history of self inflicted wounds and depression (Residents #25, #42), the facility failed to ensure adequate supervision and immediate appropriate interventions to prevent the resident from

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subsequent self inflicted injuries and/or failed to ensure that the resident had no access to sharp items, in accordance with the facility notification of contraband policy to prevent an accident. The findings include:

- a. Resident #25 was admitted to the facility from Facility #4 on 9/9/05 with diagnoses that included Major Depression and Borderline Personality Disorder with a history of multiple suicide attempts and multiple inpatient psychiatric hospitalizations. Review of the medical record identified that at 11:30 PM on 9/17/05, R #25 complained of auditory hallucinations and used a ballpoint pen to puncture her arm. On 9/18/05 at 1:00 AM, R #25 suddenly became aggressive, removed a fire extinguisher from the wall, threatened staff with the extinguisher, and used the extinguisher to break the glass of its case. R #1 then used the broken glass to repeatedly slash her wrists. R #25 was subsequently transferred to the Emergency Department (ED) at Acute Care Facility #1 at 1:25 AM on 9/18/05 where she received multiple sutures to six deep, self inflicted lacerations on the left forearm and returned to the facility. On 9/19/05, a Physician's Emergency Certificate (PEC) was completed, and R #25 was sent to Acute Care Facility #2 for inpatient psychiatric treatment until 10/17/05. The Resident Care Plan (RCP) dated 10/17/05 identified that R #25 was at risk for suicidal ideation and had a history of cutting herself but lacked specific direction for staff on how to recognize and/or respond to the resident's sudden onset of aggressive behaviors. On 11/1/05, R #25 again used a ballpoint pen to stab herself in the right lower arm and sustained a 0.5 centimeters (cm.) long and 0.1 cm. deep wound. Review of the RCP with the RCP Coordinator on 11/22/05 identified that the RCP was a preprinted generic plan of care and failed to address the resident's problems with auditory hallucinations. The RCP lacked individualization of interventions and/or specific direction for staff response to the resident's history of threatening staff members, quickly escalating aggressive, violent behaviors, or R #25's history of using glass or other items as a weapon. Subsequently, during the evening shift on 11/20/05 at approximately 8:45 PM, R #25 reported to LPN #1 that she wanted to kill herself. LPN #1 stated that approximately ten minutes later, R #25 came down the hallway, banged on the locked doors of the unit, and proceeded into the community room. Interview with NA #1 on 11/22/05 identified she observed R #25 repeatedly bang on the double paned window in the community room, broke the glass, and used the glass shard to cut her right wrist and left index finger. R #25 was transferred to the ED of Acute Care Facility #3. Interview with the facility's Administrator on 12/2/05 identified that R #25 had been transferred from Acute Care Facility #3 to a chronic psychiatric facility and would not be returning to the facility.
- b. Resident #42 was admitted to the facility from an acute care hospital on 03/07/06 with diagnoses of depression treated with electroconvulsive therapy, paraplegia, sacral decubitus ulcer, right heel pressure ulcer, and a history of self-inflicted wounds. The resident's records at the facility included documentation from previous admissions to an acute inpatient psychiatric facility (07/22/05 and 11/21/05) following two incidences of self-inflicted wounds (left wrist lacerations) requiring sutures. A Minimum Data Set (MDS) dated 03/16/06 identified no problem with short-term or long-term memory, and independence in daily decision-making. Interview with the Director of Nursing Services

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(DNS) on 04/03/06 at 1:15 PM indicated that Resident #42 repeatedly expressed the wish to leave the facility and find own apartment. Interview with the resident's former roommate (Resident #43) on 04/03/06 at 1:25 PM indicated that Resident #42 frequently verbalized feelings of depression. A discharge summary from the acute care hospital dated 03/06/05 indicated that the resident was to change a dressing daily to the right heel. Interview with Licensed Practical Nurse (LPN) #6 on 03/31/06 at 1:40 PM indicated that a few days after Resident #42's admission to the facility, LPN #6 observed Resident #42 changing own dressing to the right heel, using a small pair of sharp scissors with pointed tips, reportedly given to the resident by acute care hospital staff upon discharge from the hospital. Although LPN #6 was aware of the facility policy prohibiting the possession of sharp scissors by residents, LPN #6 failed to report this finding to administration and failed to substitute a pair of blunt-tip bandage scissors. According to interviews with the DNS and the Assistant Director of Nurses (ADNS) on 03/31/06 at 1:30 PM, Resident #42 was involved with illicit drug use on 03/23/06 and was transferred to the secured unit on 03/24/06 at 11 PM. The resident was placed on one-to-one observation from 11 PM on 03/23/06 through 3 PM on 03/24/06, after which the resident was started on a fifteen-minute check schedule. Interview with LPN #6 on 03/31/06 at 1:40 PM further indicated that after Resident #42 was transferred to the secured unit, LPN #6 sorted the resident's belongings on 03/24/06 during the 7AM-3 PM shift and found "between seven to ten pairs of sharp scissors, all with pointed tips", left in Resident #42's former room, and reported it to administration. Interview with the DNS on 04/03/06 at 2:30 PM indicated that the facility staff failed to update the resident care plan (RCP) to address the possession of prohibited items, with interventions directed toward protecting the resident and others. Interviews with Nurse Aide (NA) #13 on 04/03/06 at 11:15 AM, with NA #12 on 04/03/06 at 11:40 AM and with LPN # 10 on 04/03/06 at 12:20 PM indicated that the nursing staff on the secured unit were not alerted to the resident's possession of prohibited sharp items outside of the secured unit. Facility documentation indicated that on 03/25/06 at 4:15 AM, the nursing staff found Resident #42 "lying in a large pool of blood" from multiple self-inflicted wounds to the legs and lower abdomen; Resident #42 reportedly stabbed self with a pair of scissors in an attempt to "get out of the facility." The facility staff was unable to locate the scissors utilized by Resident #42, and the resident declined to comment on how he obtained the scissors. Resident #42 was transferred to the emergency department for evaluation and treatment of forty-two wounds to the right leg, approximately fifty wounds to the left leg, and forty wounds to the lower abdomen. The resident was taken to the operating room for an exploratory laparotomy, repair of three sigmoid colon perforations and repair of bilateral leg lacerations.

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.