

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

IN RE:           Haven Health Center of Waterford, LLC of Waterford, CT.  
                  Haven Health Center of Waterford  
                  171 Rope Ferry Road  
                  Waterford, CT 06385

CONSENT ORDER

WHEREAS, Haven Health Center of Waterford, LLC of Waterford, CT. (hereinafter the "Licensee"), has been issued License No. 2273 to operate a Chronic and Convalescent Nursing Home known as Haven Health Center of Waterford, (hereinafter the "Facility") under Connecticut General Statutes Section 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 9, 2006 and concluding on December 14, 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 January 2, 2007 (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 FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Anthony K. Scierka, its President, hereby stipulate and agree as follows:

1. The Medical Director shall review all prospective patients to identify care needs and make determination if patients' care and services can be met by staff.
2. 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. The terms of the contract executed with the INC shall include all provisions of this paragraphs 3-14 and Exhibit B of this Consent Order.

3. 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.
4. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility forty (40) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its 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.
5. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
6. 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.
7. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, the W/ICC, 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.
8. 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.

9. The INC shall submit weekly written reports to the Department documenting:
  - a. The INC's assessment of the care and services provided to patients;
  - b. The Licensee's compliance with applicable federal and state statutes and regulations; and
  - c. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
10. Copies of weekly INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
11. 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 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 January 2, 2007 (Exhibit A).
12. The INC, the Licensee's Administrator, the W/ICC and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first three (3) months this Consent Order is in effect 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.

13. 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.
14. The Department shall retain the authority to extend the period the INC services 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.
15. The Licensee shall at it's own expense, contract with a registered nurse credentialed in wound care and infection control and acceptable to the Department to serve as a Wound/Infection Control Consultant (W/ICC) within ten (10) days of signing this document for a minimum of twenty-four hours per week for six (6) months. The terms of the contract executed with the W/ICC shall include all provisions of this paragraph 15 and Exhibit B of this Consent Order:
  - a. The Independent Wound/Infection Control Consultant shall evaluate the Facility's infection control program. At the end of the six (6) month period, the Licensee shall no longer be obligated to contract with the W/ICC unless the Department identifies through inspections and/or the W/ICC reports identify that the continued presence of the Independent W/ICC is necessary to ensure substantial compliance with the provisions of the regulations of the Connecticut State Agencies and federal requirements. The Department may, in its discretion at any time or from time to time, reduce or increase the W/ICC'S responsibilities and hours, if, in the Department's view, the reduction is warranted;
  - b. The W/ICC shall conduct and submit to the Department an initial assessment of all patient pressure ulcers and an assessment of the Facility's regulatory compliance with regard to care and assessment of pressure ulcers and the Facility's infection control program and identify areas requiring remediation. The W/ICC shall submit a weekly written report identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and shall evaluate the overall functioning of the infection control program and wound care program and make subsequent recommendations and the Facility's response to implementation of said recommendations. Copies of said report shall be provided to the Licensee, the Medical Director and the Department.

- c. The W/ICC shall perform the following duties:
    - i. Evaluating of the facility's Infection Control Program;
    - ii. In-service, education and ongoing evaluation of all licensed nursing (inclusive of Agency staff) relevant to infection control practices assessment and care planning for individuals at risk or patients with pressure sores;
    - iii. Maintaining an effective Infection Control Program;
    - iv. Review the Facility's infection control policies/procedures pursuant to infection control practices;
    - v. Evaluation of the implementation of the Facility's infection control policies and procedures;
    - vi. Determining compliance with the Facility's policies and procedures for cohorting of patient's with infections;
    - vii. Evaluation of the facility's wound care program;
    - viii. Education, remediation and on going evaluation of nursing staff (inclusive of agency staff) relevant to assessment of pressure ulcers and/or provision of care to patients with pressure ulcers; and
    - ix. Training and oversight of nursing staff pertinent to weekly statistics, preventative pressure sores protocols and assessment of patients for risk of pressure sores or vascular areas.
  - d. The Independent W/ICC contracted to provide wound care oversight shall provide a weekly report to the INC, Licensee, Director of Nurses, Medical Director and the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity and infection control;
  - e. The Independent W/ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation;
  - f. The W/ICC shall confer with the Licensee's Administrator, Director of Nursing Services, the INC, Medical Director and other staff determined by the INC to be necessary to the performance of the duties set forth herein.
16. Effective immediately upon execution of the Consent Order, the Licensee shall employ a full time Infection Control Nurse (ICN) whose sole responsibility is to implement an

infection prevention, surveillance and control program which shall have as its purpose the protection of patients. The Registered Nurse hired for this position shall have expertise and experience specific to infection control. Should the registered nurse appointed to the position of ICN lack professional work experience in the areas of infection control. The ICN shall also be responsible for staff education in the area of infection control. The ICN, in conjunction with the Director of Nurses, Medical Director and Administrator shall implement a mechanism to ensure that each patient with an infection is properly identified and receives the appropriate care and services pertinent to the identified infection. The ICN shall ensure the following:

- a. Maintenance of an effective infection control program;
- b. Review of the facility's policies/procedures pursuant to infection control prevention, with the Director of Nurses, Medical Director and Administrator and revise as necessary;
- c. Inservicing of staff pursuant to infection control principles and practices;
- d. Evaluation of patients on admission to determine the existence of an infection;
- e. Development of policies and procedures relative to assessing for appropriate room, roommate and isolation protocols;
- f. Ensure accurate line listings of patient infections to include date of onset of infection, type of infection, site of infection, treatment, room location and any culture/lab results; and
- g. Evaluation of staff on a routine basis, on all three shifts, regarding the implementation of infection control techniques.

17. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:

- a. Sufficient nursing personnel are available to meet the needs of the patients;
- b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
- c. Patient assessments are performed in a timely manner, documented and accurately reflect the condition of the patient;
- d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;

- e. Nurse aide assignments accurately reflect patient needs;
  - f. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
  - g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
  - h. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice; and
  - i. Necessary supervision and assistive devices are provided to prevent accidents.
18. Appointment of a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any resident related issues(s) or problems(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period. Nurse Supervisors shall be provided with the following:
- a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
  - b. 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. 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 care is provided to patients by all caregivers is in accordance with individual comprehensive care plans.
19. 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 time frame.
  20. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the January 4, 2007 violation letter. The Licensee shall implement a mechanism for collection/evaluation of care issues for discussion at QAP meetings. 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.
  21. Within two (2) weeks of the effective date of this Consent Order, the facility shall develop and maintain a patient acuity system which shall identify the number and qualifications of nursing and ancillary staff necessary to meet the needs of patients housed in the facility. The facility shall, on a daily basis, utilize the acuity system to establish staffing ratios.
  22. In accordance with Connecticut General Statute Section 19a-494(a)(5), the license of Haven Health Center of Waterford, LLC of Waterford is placed on probation for a period of two (2) years. The provisions of this Consent Order constitute the conditions of probation imposed hereunder.
  23. In accordance with Connecticut General Statute Sections 19a-494 (4) and 19a-494 (7) the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a Chronic and Convalescent Nursing Home.
  24. The Licensee shall pay a monetary penalty to the Department in the amount of one hundred thousand dollars (\$100,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

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

25. 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.
26. 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.
27. 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.
28. 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.
29. 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.

HAVEN HEALTH CENTER OF WATERFORD,  
LLC OF WATERFORD, CT.

February 7, 2007  
Date

By:   
Anthony K. Scierka, President

STATE OF CONNECTICUT)

County of MIDDLESEX) ss February 7 2007

Personally appeared the above named Anthony K. Scierka and made oath to the truth of the statements contained herein.

My Commission Expires: 9/30/2010 Kelly Lynn Begley  
(If Notary Public) Notary Public [  ]  
Justice of the Peace [  ]  
Town Clerk [  ]  
Commissioner of the Superior Court [  ]

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

2/14/07  
Date

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

**KELLY LYNN BEGLEY**  
NOTARY PUBLIC  
State of Connecticut  
My Commission Expires  
September 30, 2010



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

EXHIBIT <sup>A</sup>  
PAGE 1 OF 53

January 2, 2007

Mr. Mohamed Hussain, Administrator  
Haven Health Center Of Waterford  
171 Rope Ferry Road  
Waterford, CT 06385

Dear Mr. Hussain:

Unannounced visits were made to Haven Health Center of Waterford concluding on December 14, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and an extended survey.

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 January 16, 2007 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.

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,

Judy F. McDonald  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

JFM:HC:PMG

c. Director of Nurses  
Medical Director  
President  
Complaint # CT #6040

Phone:



Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # \_\_\_\_\_

P.O. Box 340308 Hartford, CT 06134

*Affirmative Action / An Equal Opportunity Employer*

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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 (e) Governing Body (1)(B).

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

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

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

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

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

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

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

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

5. Based on review of clinical records, review of facility policies, review of facility documentation, observations, and interviews, for three of seven residents with pressure ulcers, Residents #5, #9 and #34, who experienced changes in status and/or in the

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WERE IDENTIFIED

appearance of wounds, the facility failed to promptly notify the physician of the changes in the resident's status. The findings included:

- a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments, Peripheral Vascular Disease (PVD), and Type II Diabetes. Review of the admission assessment dated 9/5/06 identified that R #9 entered the facility without a pressure ulcer, subsequently developed a blister on 9/29/06, and then subsequently developed a Stage II pressure ulcer on the left heel. Review of the Resident Care Plan (RCP) dated 10/17/06 identified the left heel pressure area with interventions that included keeping the physician updated if the area worsened. Review of the wound care documentation identified that R #9's left heel wound was last assessed on 11/12/06 and described R #9's heel wound as a Stage II pressure ulcer that measured 4.0 cm. by 4.0 cm. and was 0.2 cm. in depth. On 11/28/06 at 10:30 AM, R #9's dressing change was completed by LPN #1. Observation of R #9's left heel ulcer dressing change identified a moderate to large amount of foul smelling, serosanguineous drainage coming from the heel wound. Interview with LPN #4, the charge nurse of the unit, at 10:40 AM on 11/28/06 identified that over the previous week, she had observed that R #9's heel dressing was frequently saturated with drainage, required more than the once daily treatment as per physician orders, but that she had not notified that physician of the observation. Review of physician progress notes and facility documentation with facility staff that included the twenty four hour report sheets dated 11/14/06 through 11/28/06 failed to provide documentation to reflect that R #9's physician was notified of the need for more frequent dressing changes due to increased drainage and/or kept informed of the appearance of the wound. Subsequent to the 11/28/06 observation, R #9's left heel wound was reassessed. Review of the wound assessment dated 11/28/06 identified that R #9's left heel ulcer was now unstageable, with black eschar and measured 6.0 cm. by 6.0 cm. The physician was informed and directed that R #9's left heel ulcer be assessed at the wound clinic on 11/29/06. Review of the wound clinic documentation identified that R #9 received two grams of the antibiotic, Ancef, at the clinic and orders for the resident to be further evaluated by a surgeon. Interview with LPN #1 on 12/1/06 at 10:00 AM identified that subsequent to R #9's appointment with the surgeon on 11/30/06, R #9 was directly admitted to the hospital. Review of R #9's clinical records from the acute care hospital identified that R #9 underwent a left below the knee amputation on 12/4/06 as a result of the left heel ulcer necrosis.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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WERE IDENTIFIED

- b. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data Set assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily and was experiencing an acute episode of a recurrent problem. This assessment further identified that the resident had a stage two (2) pressure ulcer and received antipsychotic, antianxiety, antidepressant and hypnotic medications daily. Review of the physician orders, dated 8/9/06, directed the staff to administer an antibiotic medication four times a day for one week. The Resident Care Plan, dated 8/9/06 identified that the antibiotic therapy was due to an infection of the pressure ulcer and interventions included to assess for signs and symptoms of infection. Review of the nurses notes, from 8/17/06 to 8/20/06, identified that the resident had three episodes of elevated temperature ranging from 100.2 degrees Fahrenheit (F) to 101.3 degrees F, with the normal range 98.6 degrees F, and documentation was lacking that the resident's physician had been informed of the temperature elevations. Interview with MD #1, on 11/15/06, identified that the facility did not inform him of the resident's elevated temperatures for the time period identified. Interview with RN #1, on 11/20/06, identified that the physician was not informed of Resident #5's elevated temperatures. Review of facility policy and procedure, titled "Physician Notification/Family Notification", identified that the physician will be notified of changes in the resident's status.

In addition review of Resident #5's treatment kardex, from 10/2/06 to 10/20/06, identified that the staff carried out treatments that included an application of provodine followed by a dressing daily to the right hip area and to the left heel area. Interview with RN #1, on 11/20/06, identified that there was no physician order that directed the staff to complete these identified treatments and/or there was no facility protocol to direct the nurse to provide treatment as identified. Review of the nurses' notes, from 10/2/06 to 10/20/06, lacked documentation that the physician was informed of the two new "decubitus" on the right hip and left heel. Interview with MD #1, on 11/29/06, identified that he was not informed of these two areas and/or was not aware that the nursing staff were completing a treatment to the two areas. Review of facility policy and procedure, titled "Physician Notification/Family Notification", identified that the physician will be notified of changes in the resident's status.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT  
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WERE IDENTIFIED

- c. Resident #34 was readmitted to the facility on 7/12/06 with the diagnoses of cerebrovascular accident, acute renal insufficiency, anemia, deconditioning, right inguinal hernia, prostatic hypertrophy and skin ulcerations. The Minimum Data Set assessment, dated 7/24/06, identified that the resident was cognitively impaired, required extensive staff assistance for bed mobility, dressing, hygiene, bathing and toileting needs. The assessment also identified that the resident had limited range of motion on one side of the body (arm, hand, leg and foot) and had two stage two (2) pressure ulcers. Resident #34 was discharged from the facility on 8/27/06 and returned to the facility on 9/2/06 with the additional diagnosis of urosepsis and was to be treated with intravenous antibiotics followed by oral antibiotics. The Resident Care Plan, dated 9/2/06, identified that the resident had an infection with interventions to assess the resident for signs and symptoms of infection and update the physician and family as needed. While on oral antibiotic therapy for the urosepsis, the nurses notes, dated 9/8/06, identified that the resident had an elevated temperature of 101.7 degrees Fahrenheit (F), with the normal range 98.6 degrees F, and documentation was lacking that the resident was assessed by a Registered Nurse and/or that the physician was informed of the elevation in temperature. Review of facility policy and procedure, titled "Physician Notification/Family Notification", identified that the physician will be notified of changes in the resident's status.

The following is a violation of the Connecticut General Statutes Section 19a-550 (b)(8) and/or violations of the Regulations of Connecticut State Agencies Section 19-13-D&t (f) Administrator (3)(D) and/or (o) Medical Records (2)(H).

6. Based on review of the clinical record, review of facility policies, observations, and interviews, the facility failed to ensure for one resident, Resident # 55, that restraints were implemented in accordance with facility policies. The findings included:
  - a. Resident #55 (R #55) had diagnoses of probable vascular dementia with difficulty walking. Review of the assessment dated 9/29/06 identified that R #55 was independent in transfers and ambulation as well as most other Activities of Daily Living (ADLs) and had a history of multiple falls. Review of physician order dated 10/12/06 identified that R #55 was to be out of bed to a borrowed custom wheelchair for rest periods when agitated or anxious, lethargic, or unsteady on feet. Review of the NA care card directed the same instructions. Interview with Occupation Therapist #1 (OT #1) on 12/14/06 at 11:45 PM identified that

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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WERE IDENTIFIED

although she was aware that R #55 had been screened for a decline in functional mobility (on 10/4/06) that she had not recommend the custom wheelchair for the resident. Observation on 12/14/06 at 9:30 AM identified that R #55 was seated in a custom wheelchair with a seat belt and a lap tray. R #55 was smiling and communicating with Nursing Assistant #14 (NA #14) and did not appear to be agitated or anxious. Upon request and with the direction of NA #14, R #55 was unable to remove the seat belt. Review of the clinical record lacked documentation to reflect that the resident was assessed for the need for the seat belt and/or lap tray restraint and/or that an informed consent for the use of the restraints was obtained. Interview with NA#14 on 12/14/06 identified that R #55 had utilized the custom wheelchair daily for approximately two months and that the resident remained seated in the chair during out of bed hours except when the resident was ambulated by staff. NA #14 stated that she applied the custom wheelchair's attached seat belt and lap tray whenever the resident was seated in the chair. NA #14 stated that she understood the seat belt and the lap tray to be part of the seating process of the borrowed custom wheelchair. Interview with the facility's Care Plan Coordinator on 12/14/06 at 1:00 PM identified that the facility had identified that R #55 was no longer independent in ambulation, required more assistance in ADLs, and that R #55 was scheduled for a change in condition assessment review within the next week. The Care Plan Coordinator stated that she was unaware that R #55 was utilizing the borrowed custom wheelchair with the lap belt and lap tray daily. Review of the clinical record identified that documentation of a physician order for use of the lap belt and lap tray was lacking. Review of facility policy directed that a restraint assessment form would be completed and that documentation of failed alternatives prior to implementation of a restraint would be included. In addition, the policy directed that an explicit physician order would be in the clinical record that included the reason for the restraint, frequency and times to be used, and anticipated duration of the restraint use.

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

7. Based on review of clinical records, review of facility policies, review of facility documentation, observations, and interviews, for six of seven residents with pressure ulcers, Residents #5, #9, #10, #11, #12, and #33, the facility failed to ensure that the

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

residents received appropriate care and treatment for the pressure ulcers and did not suffer from neglect. The findings included:

- a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments, Peripheral Vascular Disease (PVD), and Type II Diabetes. Review of the admission assessment dated 9/5/06 identified that R #9 entered the facility without a pressure ulcer. Review of the Resident Care Plan dated 9/5/06 identified the potential for impaired skin integrity with interventions that included a pressure relief mattress, encouragement or assistance with repositioning every two hours, and checking the condition of the resident's skin daily. Review of the nursing note dated 9/29/06 identified that R #9 had developed a Stage II pressure area on the left heel. Review of the clinical record lacked documentation to reflect the size and/or appearance of the open area at the time of the observation through 10/3/06 when R #9 was transferred to the hospital after the resident's permacath was inadvertently dislodged. Review of the clinical record identified that R #9 was readmitted to the facility on 10/17/06. Review of the readmission assessment dated 10/17/06 identified that R #9 had a left heel ulcer, a right leg and ankle open area, and an excoriated buttocks but lacked documentation to reflect the size and/or appearance of the areas upon readmission. Physician orders dated 10/17/06 directed treatment to the left heel ulcer that included accuzyme ointment to be applied daily, however, the clinical record lacked documentation to reflect the size and/or appearance of R #9's left heel ulcer for twelve additional days. Review of the wound care documentation dated 10/28/06 identified that R #9 had an unstageable left heel ulcer that measured 4.0 centimeters (cm.) by 4.0 cm. in size with a small amount of odorifous serosanguineous exudate.

In addition, review of physician orders dated 9/30/06 directed the use of a waffle boot to the left heel when the resident was in bed. Observations on 11/28/06 from 5:00 AM until 7:30 AM, R #9 remained in bed without the benefit of the waffle boot and/or without the resident's left heel being elevated off the mattress. Interview with NA #2 at 6:35 AM identified that R #9 did not always have the waffle boot in place but did not attempt to replace the boot and/or float the resident's heels after providing care. Interview with R #9 on 11/28/06 at 8:00 AM identified that he had reported to staff that his heel was more painful, that the staff thought the area "might get better if it got some

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

air," and suggested that the waffle boot be removed. R #9 was unable to identify the staff member who suggested that the boot be removed.

In addition, intermittent observations from 5:00 AM until 10:30 AM on 11/28/06 identified that R #9's left heel remained covered with a kerlix wrapped dressing that was observed with dried appearing, reddish, brown stained material that covered the entire heel area. The bed sheets below R #9's left heel were observed at 6:20 AM to have five, dried appearing, spots of the same reddish brown material. Nursing Assistant #1 (NA #1) and NA #2 provided incontinent care to R #9 at 6:20 AM at which time a strong odor coming from the resident's left heel area was noted. Although NA #2 observed the dried dressing with the surveyor, in a subsequent interview, NA #2 stated that the resident's dressing was done by the day shift staff. R #9's left heel dressing remained in place until surveyor inquiry at 10:30 AM when R #9's dressing change was completed by LPN #1. Observation of R #9's left heel ulcer dressing change identified a moderate to large amount of foul smelling, serosanguineous drainage coming from the heel wound. Interview with LPN #4 at the time of the observation identified that over the previous week, she had observed that R #9's heel dressing was frequently saturated with drainage, required more than the once daily treatment as per physician orders, but that she had not notified that physician of the observation. Review of the clinical record identified that R #9's left heel wound had not been assessed since 11/12/06, fifteen days earlier, and was identified at that time as a Stage II pressure ulcer that measured 4.0 cm. by 4.0 cm. and was 0.2 cm. in depth. Review of the wound assessment dated 11/28/06 identified that R #9's left heel ulcer was now unstageable, with black eschar and measured 6.0 cm. by 6.0 cm. R #9's left heel ulcer was assessed at the wound clinic on 11/29/06 per physician request. Review of the wound clinic documentation identified that R #9 received two grams of the antibiotic, Ancef, at the clinic and requested that R #9 receive an evaluation of the left heel wound by a surgeon. Interview with LPN #1 on 12/1/06 at 10:00 AM identified that subsequent to R #9's appointment with the surgeon on 11/30/06, R #9 was directly admitted to the hospital. Review of R #9's clinical records from the acute care hospital identified that R #9 underwent a left below the knee amputation on 12/4/06 as a result of the left heel ulcer necrosis.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- b. Resident #10 (R #10) was admitted to the facility in May of 2006 with diagnoses of a recent right subtrochanteric fracture and a community acquired Stage IV sacral decubitus ulcer. Review of the assessment dated 8/6/06 identified that R #10 required extensive to total assistance from staff for most Activities of Daily Living (ADLs). Review of physician orders dated 11/8/06 directed wound care to R #10's sacral wound that included treatment/dressing change be performed daily and as needed if the dressing became soiled or dislodged. On 11/28/06 at 6:35 AM, Nursing Assistant #2 (NA #2) was observed to assist R #10 off the bedpan. As the NA removed the bedpan, some of the urine spilled over the end of the pan and onto the soaker pad underneath the resident. R #10's sacral wound dressing was observed to be soaked with urine. NA #2 continued to provide incontinent care to the resident washing around the urine soaked wound dressing. Interview with NA #2 during the observation identified that the nursing assistant confirmed that the dressing was soaked with urine but stated that the dressing was changed on the day shift. Interviews on 11/28/06 with LPN #3, the 11:00 PM to 7:00 AM charge nurse at 7:20 AM and LPN #4, the 7:00 AM to 3:00 PM nurse at 8:30 AM identified that the condition of R #10's dressing had not been reported to them by the nursing assistant. At 8:50 AM, R #10 reported to the surveyor that facility staff told her that they were going to change the wound dressing because the surveyor had remarked to the NA that the dressing was yellow. However, R #10's urine soaked dressing remained in place for more than three hours, from 6:35 AM until 10:15 AM when upon surveyor inquiry, observation of R #10's sacral wound dressing with the Acting Director of Nursing (DNS) identified that the urine soaked dressing remained on the sacral wound, appeared partially dried, and was foul smelling.
- c. Resident #11 (R #11) was admitted to the facility on 4/14/06 with diagnoses of presenile dementia and Type II Diabetes. Review of the admission assessment dated 4/14/06 identified that R #11 entered the facility without a pressure ulcer. Review of an undated Braden Scale assessment, used to determine a resident's risk to develop pressure ulcers, identified that R #11 was at low risk to develop pressure ulcers. Although review of the clinical record dated 4/14/06 through 6/16/06 lacked documentation to reflect that R #11 had developed any pressure areas, the nursing note dated 6/17/06 identified that "treatment to heels" was performed but lacked documentation to reflect the size or appearance of the areas. Review of physician orders dated 8/17/06 directed treatment orders to the right heel that included washing the

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

area with normal saline solution, followed by application of Panafil, followed by a dry clean dressing. The treatment orders directed that the dressing be changed daily and as needed if dislodged. Review of the clinical record lacked documentation to reflect the size or appearance of the right heel area at the time of the initiation of the treatment. Review of a readmission assessment dated 9/20/06 identified that R #11 had ulcerations on both heels. Review of the Resident Care Plan (RCP) dated 9/20/06 identified R #11's right heel wound was infected with interventions that included antibiotic therapy and treatments as ordered but was lacking documentation to reflect the size or appearance of the areas. On 11/29/06 at 9:30 AM, LPN # 5 was observed to perform the dressing change to R #11's right heel. Interview with LPN #5 during the observation identified that all wounds are measured and evaluated weekly by LPN #1. Review of the clinical record and facility documentation on 11/30/06 with LPN #1 failed to identify documentation to reflect that R #11's right heel pressure area was monitored through descriptions of the area and/or measurements of the area at any time since its development sometime in June of 2006. Subsequent to the 11/29/06 observation, R #11's right heel wound was reassessed. Review of the wound assessment dated 11/30/06 identified that R #11's right heel ulcer was assessed as a Stage II, had a small amount of exudate, and measured 3.0 cm. by 3.6 cm. and was 0.2 cm. in depth.

- d. Resident #12 (R #12) was admitted to the facility on 9/16/99 with diagnoses of lower paraplegia and ulcers of the heel and mid foot. Review of the assessment dated 5/19/06 identified that R #12 was independent for most Activities of Daily Living (ADLs) and had no pressure ulcers. Review of physician order dated 6/9/06 directed a treatment to R #12's left heel that included to wash the area with normal saline solution, followed by application of accuzyme to the darkened areas, covered with damp gauze, and followed by a Telfa dressing. Documentation was lacking in the clinical record to reflect the size or appearance of the right heel area at the time of the initiation of the treatment. Interview with LPN #6 on 11/29/06 identified that R #12 has had the area "for a long time", described the area as a callous, and that the resident frequently "picked" and reopened the area. On 11/29/06 at 10:05 AM, LPN #5 was observed to perform the treatment to R #12's left heel area. Interview with LPN #5 during the observation identified that all wounds in the facility are measured weekly by LPN #1. Review of the clinical record and facility documentation on 11/30/06 with LPN #1 failed to identify

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

documentation to reflect that R #11's left heel pressure area was monitored through descriptions of the area and/or measurements of the area at any time since the initiation of the resident's current treatment orders dated 6/9/06. Although an interview with Doctor of Osteopathy #1 (DO #1) on 11/29/06 at 11:45 AM identified that he had observed R #12's wound recently, that the wound was chronic, and that it often reopened. However, review of R #12's clinical record lacked documentation of a physician's progress note since 12/31/05. Subsequent to surveyor inquiry, R #11's left heel wound was identified as a Stage III pressure ulcer that measured 2.0 cm. by 2.0 cm. and was 0.6 cm. in depth.

- e. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem. The assessment further identified that the resident had a stage II (a partial thickness loss of skin layers) pressure ulcer- treatments included pressure relieving devices for the bed and ulcer care, and received antipsychotic, antianxiety, antidepressant and hypnotic medications daily. The Resident Care Plan, dated 8/17/06, identified that the resident had a stage II pressure ulcer on the coccyx with the intervention that included to encourage the resident to turn and reposition every two hours. Review of the weekly body audits for Resident #5, dated 10/4/06 and 10/18/06, identified that the resident had decubitus areas on the coccyx, right hip and left heel. Review of the nurses notes, from 8/4/06 to 10/20/06, identified that Resident #5 had a stage II pressure ulcer located on the coccyx, however there lacked documentation that the areas on the right hip and the right heel had been assessed and/or monitored and/or that the resident had refused to turn and reposition every two hours. The Interim Director of Nursing was unable to provide wound documentation for the identified two areas-the right hip and right heel, upon request. The resident was transferred to another nursing home. Review of the interagency patient referral report, dated 10/20/06, identified that the resident had a stage III (a full thickness loss of skin, exposing the subcutaneous tissues) ulcer on the coccyx requiring a dressing, an area the right hip that required a dressing and an area on the right heel that required a dressing. Review of the receiving facility wound documentation,

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

dated 10/20/06, identified that Resident #5 had a stage III ulcer on the coccyx, a 6.0 centimeter (cm) long by 5.5 cm wide by 0.2 cm deep black eschar area on the right hip and a 5.0 cm long by 3.0 cm wide by 0.0 cm deep eschar area on the right heel.

In addition review of the nutrition assessment, dated 8/8/06, identified that the resident weighed 110 pounds (lbs), was within the ideal body range of 108-132 lbs, was provided supplements three times daily, received medication and protein supplements to enhance wound healing, had a poor appetite due to the disease of cancer and the resident's family brings the resident food at times. The Resident Care Plan, dated 8/8/06, identified that the resident had the potential for weight loss due to poor intake with the intervention to monitor the resident's weight weekly. Review of facility documentation, from 8/4/06 to 10/20/06 lacked documentation that the resident was weighed weekly and/or that any further interventions were put in place for Resident #5's documented increasing refusal of meals during this period. Review of the weekly body audits for Resident #5, dated 10/4/06 and 10/18/06, identified that the resident had decubitus areas on the coccyx, right hip and left heel. The resident was transferred to another nursing home on 10/20/06. Review of the interagency patient referral report, dated 10/20/06, identified that the resident had a stage III (a full thickness loss of skin, exposing the subcutaneous tissues) ulcer on the coccyx requiring a dressing, an area the right hip that required a dressing and an area on the right heel that required a dressing and the dietary notes identified that the resident had a poor appetite and weighed 110 pounds. Review of the receiving facility wound documentation, dated 10/20/06, identified that Resident #5 had a stage III ulcer on the coccyx, a 6.0 centimeter (cm) long by 5.5 cm wide by 0.2 cm deep black eschar area on the right hip and a 5.0 cm long by 3.0 cm wide by 0.0 cm deep eschar area on the right heel and the resident's weight was 103.6 lbs. (a weight loss of 6%). Interview with the Dietitian, on 11/20/06, identified that no further nutritional interventions were put into place for the resident, other than those identified.

- f. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. The Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. The Resident Care Plan, updated 9/20/06, identified that Resident #33 had six areas of impaired skin integrity/ulcers (left shoulder, right great toe, left upper buttock, coccyx, right shoulder, right hip) with interventions that included to monitor and document ulcer condition every week, to complete the treatment as per physician orders and to update the physician. Observation of wound care, on 11/28/06, identified that the resident had a total of ten pressure ulcers (as noted above and areas on the left hip, right outer foot, right upper hip and the left foot). Review of the weekly facility documentation/monitoring was inconsistent for Resident #33's eight pressure ulcers areas (left hip, right great toe, left shoulder, right upper hip, left upper buttock, coccyx, right shoulder and right hip). Facility documentation identified that three of the identified areas had been measured eight days ago (left hip, left upper buttock and right shoulder), that one area had been measured fifteen days ago (right upper hip) and four areas had been measured twenty-two days ago (right great toe, left shoulder, coccyx and right hip). Upon request for measurements of the identified areas on 11/29/06 it was identified that two (left upper buttock and right shoulder) of the eight identified areas had become worse as compared to the last measurements and that two areas (right outer toe and left foot) lacked documentation prior to 11/29/06.

In addition observation, on 11/28/06, identified that LPN #4 cleansed the resident's right shoulder with Dakins solution in error and the physician order, dated 11/1/06, directed the staff to cleanse this area with normal saline. Observation, on 11/28/06, identified that LPN #1 applied Aquacel-AG to the resident's left shoulder in error and the physician order, dated 11/1/06, directed the staff to cleanse with normal saline followed by Xenaderm then cover with dressing daily. An additional observation, on 11/28/06, identified that LPN #1, cleansed the resident's right upper buttock with normal saline and applied Aquacel-AG in error and the physician's order, dated 11/1/06, identified cleanse with Dakins followed by Aquacel then cover with dressing daily. It was further identified that on 11/28/06 LPN #1 cleansed the resident's right outer foot with normal saline followed by Aquacel-AG followed by a dressing, without a physician's order. According to the Nurse Practice Act Section 20-87a the scope of practice for nurses does not include prescriptive authority.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

Review of facility policy directed that the facility would promote the rights of all residents to protect the residents from harm. The policy directed that the facility would take every step possible to protect the residents from abuse, neglect, and mistreatment. Review of the facility's definition of neglect included the failure to provide goods and services to avoid physical harm. Review of facility policy directed that wound assessment documentation would be completed weekly and as changes in the wound are apparent. The policy further directed that the weekly documentation would include a description of the area, including color, size, depth, location, extent of any drainage, condition of the wound area as well as surrounding area, and any isolation procedures as needed. Review of facility documentation identified that the list of current pressure ulcers in the facility was inaccurate on 11/28 and 11/29/06 as it lacked documentation to reflect the pressure ulcers of Residents #11 and #12. In addition, review of the facility's wound care documentation for individual residents that included staging, measurements, and appearance of wound was located in one central book that is held by administrative staff, did not become part of the clinical record until the area was healed or the resident was discharged, and therefore not readily available for review by licensed staff and/or physicians on off shifts. Interview with LPN #1 on 11/30/06 identified that the facility did not currently have a wound care consultant on staff and that those residents who required more extensive treatment would be sent for evaluation at a wound clinic.

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

8. Based on reviews of clinical records, review of facility policies, observations, and interviews for five of seven residents, Residents #5, #9, #11, #12, and #33, who were reviewed for the presence of pressure ulcers, the facility failed to perform comprehensive and/or accurate assessments of the residents' skin condition and/or failed to complete assessments for nine residents, Residents #1, #3, #5, #6, #33, #34, #15, #36 and #52 that had a change in condition and/or status. The findings included:
  - a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments, Peripheral

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

Vascular Disease (PVD), and Type II Diabetes. Review of the admission assessment dated 9/5/06 identified that R #9 entered the facility without a pressure ulcer. Review of the Braden Scale assessment dated 9/5/06 was completed to determine the resident's risk for pressure ulcers and that although the assessment did not identify R #9 as at risk for pressure ulcers, a care plan was initiated for the potential for impaired skin integrity with intervention that included a pressure relief mattress, encouragement or assistance with repositioning every two hours, and checking the condition of the resident's skin daily. Review of the nursing note dated 9/29/06 identified that R #9 had developed a Stage II pressure area on the left heel. Documentation was lacking of an assessment of the left heel pressure ulcer to reflect the size and/or appearance of the area from the time of its identification on 9/29/06 through 10/3/06. On 10/3/06, R #9 was transferred to the hospital after the resident's permacath was inadvertently dislodged.

In addition, review of the clinical record identified that R #9 was readmitted to the facility on 10/17/06. The general readmission assessment dated 10/17/06 identified that R #9 had a left heel ulcer but lacked documentation to reflect that an assessment of the ulcer was performed to determine the size, staging, and/or appearance of the ulcer. The clinical record lacked documentation to reflect that assessments of R #9's left heel wound were provided until 10/28/06, eleven days later. Intermittent observations from 5:00 AM until 10:30 AM on 11/28/06 identified that R #9's left heel was covered with a kerlix wrapped dressing that was observed with dried appearing, reddish, brown stained material and that a strong odor was noted to be coming from the resident's left heel. Subsequent to surveyor intervention at 10:30 AM, R #9's dressing change was completed by LPN #1. Observation of R #9's left heel ulcer dressing change identified a moderate to large amount of foul smelling, serosanguineous drainage coming from the heel wound. During the observation of wound care to R #9's left heel pressure ulcer on 11/28/06, interview with LPN #4 identified that over the previous week, she had observed that R #9's heel dressing was often saturated with drainage and that the dressing required more frequent replacement as a result of the drainage. Documentation in the clinical record was lacking to identify the increased drainage and/or odor from the wound. Review of the clinical record identified that R #9's left heel wound was last assessed on 11/12/06, fifteen days earlier, and identified R #9's wound as a Stage II pressure ulcer that measured 4.0 cm. by 4.0 cm. and was 0.2 cm. in depth. Subsequent to the 11/28/06 observation, R #9's left heel wound was reassessed. Review of the wound assessment dated

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

11/28/06 identified that R #9's left heel ulcer was now unstageable, with black eschar and measured 6.0 cm. by 6.0 cm. Subsequent to the 11/28/06 observation and surveyor inquiry, the physician was notified, R #9 was assessed at the wound clinic on 11/29/06 and received two grams of the antibiotic, Ancef, while at the clinic. On 11/30/06, R #9 was evaluated by a surgeon and directly admitted to the hospital. Review of R #9's clinical records from the acute care hospital identified that R #9 underwent a left below the knee amputation on 12/4/06 as a result of the left heel ulcer necrosis.

In addition, review of the wound assessment dated 10/28/06 identified that R #9 had a 4.0 centimeter (cm) by 4.0 cm. unstageable pressure ulcer but documentation of the ulcer location was lacking. Although the 10/28/06 wound assessment identified R #9's pressure ulcer as community/hospital acquired, documentation in the clinical record identified that the resident acquired a Stage II pressure ulcer on the left heel at the facility on 9/29/06 prior to hospitalization.

- b. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data Set assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem. The assessment further identified that the resident had a stage II pressure ulcer and received antipsychotic, antianxiety, antidepressant and hypnotic medications daily. Review of facility documentation, from 8/4/06 to 10/20/06 identified that Resident #5 had a stage II pressure ulcer located on the coccyx. Review of the weekly body audits for Resident #5, dated 10/4/06 and 10/18/06, identified that the resident had decubitus areas on the coccyx, right hip and left heel. Review of the treatment kardex for Resident #5, from 10/2/06 to 10/20/06, identified that the staff were applying provodine to the hip and heel areas daily, however there was no documentation that the physician was notified of these hip and heel decubitus and there was no physician order for the provodine to the hip and heel. Review of the nurses notes, from 8/4/06 to 10/20/06, lacked documentation that the areas on the right hip and the right heel had been assessed and/or monitored. The Interim Director of Nursing was unable to provide wound documentation for the identified two decubitus-the right hip and right heel, upon request, although she was responsible to monitor the pressure ulcers in the facility. The resident was

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

transferred to another nursing home on 10/20/06. Review of the interagency patient referral report, dated 10/20/06, identified that the resident had a stage III ulcer on the coccyx requiring a dressing, an area the right hip that required a dressing to be completed and an area on the right heel that required a dressing to be completed.

- c. Resident #11 (R #11) was admitted to the facility on 4/14/06 with diagnoses of presenile dementia and Type II Diabetes. Review of the admission assessment dated 4/14/06 identified that R #11 entered the facility without a pressure ulcer. Review of an undated Braden Scale assessment used to determine a resident's risk to develop pressure ulcers identified that R #11 was at low risk to develop pressure ulcers. Although review of the clinical record dated 4/14/06 through 6/16/06 lacked documentation to reflect that R #11 developed any pressure areas, the nursing note dated 6/17/06 identified that "treatment to heels" was performed. Review of the clinical record identified that documentation was lacking of an assessment to reflect the size or appearance of R #11's heels. Review of physician orders dated 8/17/06 directed treatment orders to the right heel that included washing the area with normal saline solution, followed by application of Panafil, followed by a dry, clean dressing. The treatment orders directed that the dressing be changed daily and as needed if dislodged. Review of the clinical record identified that documentation of an assessment of R #11's right heel to include the size and/or appearance of the area was lacking from the time of the initiation of the 8/17/06 treatment through 9/14/06. On 9/14/06, R #11 was admitted to the hospital after experiencing an unresponsive/ hypotensive episode.

In addition, review of the readmission assessment dated 9/20/06 identified that R #11 had ulcerations on both heels. Review of the Resident Care Plan (RCP) dated 9/20/06 identified R #11's right heel pressure ulcer was infected with interventions that included antibiotic therapy and treatments as ordered. Review of the clinical record identified that documentation of an assessment to include the size and/or appearance of R #11's heel wounds was lacking through 11/29/06. On 11/29/06 at 9:30 AM, LPN # 5 was observed to perform the dressing change to R #11's right heel pressure ulcer. Interview with LPN #5 during the observation identified that she does not routinely measure the wounds of residents at the facility as wounds are measured and evaluated weekly by LPN #1. Review of the clinical record and facility documentation on 11/30/06 with LPN #1 failed to identify documentation to reflect that R #11's right heel pressure area was assessed to include descriptions of the area and/or measurements of the area at

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

any time since its development sometime in June of 2006. Subsequent to the 11/29/06 observation, R #11's right heel wound was reassessed. Review of the wound assessment dated 11/30/06 identified that R #11's right heel pressure ulcer was assessed as a Stage II, had a small amount of exudate, and measured 3.0 cm. by 3.6 cm. and was 0.2 cm. in depth. Review of physician orders directed the addition of Multivitamins, Vitamin C, Zinc, and a protein supplement to R #11's daily medication regime.

- d. Resident #12 (R #12) was admitted on 9/16/99 with diagnoses of lower paraplegia and ulcers of the heel and mid foot. Review of the assessment dated 5/19/06 identified that R #12 was independent for most Activities of Daily Living (ADLs) and had no pressure ulcers. Review of a physician order dated 6/9/06 directed a treatment to R #12's left heel that included to wash the area with normal saline solution, followed by application of accuzyme to the darkened areas, covered with damp gauze, and followed by a Telfa dressing. Review of the clinical record lacked documentation to reflect the size or appearance of the left heel area at the time of the initiation of the treatment. Interview with LPN #6 on 11/29/06 identified that R #12 has had the area "for a long time", described the area as a callous, and that the resident frequently "picked" at and reopened the area. On 11/29/06 at 10:05 AM, LPN #5 was observed to perform the treatment to R #12's left heel area. Interview with LPN #5 during the observation identified that all wounds in the facility are measured weekly by LPN #1. Review of the clinical record on 11/30/06 with LPN #1 identified that documentation of an assessment to include the size and/or appearance of R #12's left heel pressure ulcer was lacking through initiation of the 6/9/06 treatment through 11/29/06. Subsequent to surveyor inquiry, R #12's left heel wound was identified as a Stage III pressure ulcer that measured 2.0 cm. by 2.0 cm. and was 0.6 cm. in depth.
- e. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. In addition the Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. The Resident Care Plan, updated 9/20/06, identified that Resident #33 had six areas of impaired skin integrity/wounds (left shoulder, right great toe, left upper buttock, coccyx, right shoulder, right hip) with interventions that included to monitor and document wound condition every week. In addition review of the

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

weekly facility documentation/monitoring was inconsistent for Resident #33's eight pressure ulcers areas (left hip, right great toe, left shoulder, right upper hip, left upper buttock, coccyx, right shoulder and right hip). Facility documentation identified that three of the identified areas had been measured eight days ago (left hip, left upper buttock and right shoulder), that one area had been measured fifteen days ago (right upper hip) and four areas had been measured twenty-two days ago (right great toe, left shoulder, coccyx and right hip). In addition upon request for measurements of the identified areas on 11/29/06 it was identified that two (left upper buttock and right shoulder) of the eight identified areas had become worse as compared to the last measurements. Observation of wound care, on 11/28/06, identified that the resident had a total of ten pressure ulcers (as noted above and areas on the left hip, right outer foot, right upper hip and the left foot). Documentation was lacking that the wound areas on the right outer foot and/or the left foot were monitored and/or assessed until 11/29/06.

- f. Resident #15 was readmitted to the facility on 9/6/06 with the diagnoses of status post rectal bleeding, erosive gastritis, urinary tract infection, acute and chronic renal failure congestive heart failure, Diabetes Mellitus, dysphagia and gastric feeding tube. The Minimum Data Set assessment, dated 9/11/06, identified that the resident was cognitively impaired, required maximum staff assistance for personal hygiene, bathing, and toileting needs. Review of facility documentation, dated 12/12/06, identified that on 12/11/06 Resident #52's "left great toe nail cracked and pulled away". Review of the nurses notes, dated 12/11/06, lacked documentation that the resident was assessed by a Registered Nurse after the event. Interview with the Director of Nursing, on 12/13/06, identified that there was no assessment of Resident #15's toe.

In addition review of the physician orders, dated 12/11/06, directed the staff to cleanse the resident's left great toe and apply an antibiotic medication, and to start an antibiotic medication by mouth for one week. Review of the Resident Care Plan, dated 12/11/06, identified that the resident had a toe infection with interventions that included to assess for signs and symptoms of infection and document all findings. Review of the nurse's notes, from 12/11/06 to 12/13/06, lacked documentation that the resident's infected toe was assessed by a Registered Nurse. Interview with the Director of Nursing, on 12/13/06, identified that there was no assessment of the resident by a Registered Nurse and/or there was no documentation of any "wounds" for this resident.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- g. Resident #36 was readmitted to the facility on 12/8/06 with the diagnoses of recurrent clostridium difficile and colitis, Diabetes Mellitus, cerebrovascular accident, and urinary tract infection. Review of the physician progress notes, dated 12/11/06, identified that the resident had complaints of left lower extremity swelling and pain and the plan identified was to get an ultrasound of the left extremity in the morning to rule out deep vein thrombosis and to "monitor closely overnight". Review of the nurses notes, dated 12/11/06 to 12/12/06, lacked any documentation that Resident #36 had been assessed by a Registered Nurse for the identified complaints. Interview with the Director of Nursing, on 12/13/06, identified that the expectation for the staff, for this resident's monitoring, would be to monitor the residents extremity swelling, monitor of shortness of breath and pain. The Director further identified that the only assessment completed was monitoring of the resident's oxygen saturation, on 12/11/06 and on 12/12/06.
- h. Resident #52 was admitted to the facility on 12/11/06 with the diagnoses of syncope, bilateral coronary artery disease with right carotid endarterectomy, hypertension, esophageal reflux disease, Diabetes Mellitus, urinary incontinence, and status post alcohol withdrawal with confusion. Review of the physician orders, dated 12/11/06, directed the staff to monitor the right neck staples every shift for signs and symptoms of infection. Review of the nurses notes, from 12/11/06 to 12/13/06, lacked documentation that the resident's right neck staples had been monitored on two of the six shifts (on 12/12/06 the 11 :00 P.M. to 7:00 A.M. shift and on 12/12/06 the 3:00 P.M. to 11:00 P.M. shift). Interview with the Director of Nursing, on 12/13/06, identified that there was no monitoring of the resident's neck staples on the two identified shifts.
- i. Resident #1 was admitted to the facility on 12/16/05 with the diagnoses of end stage renal disease due to nephrosclerosis with hemodialysis treatments three times weekly, congestive heart failure, bilateral pleural effusions, dementia, degenerative joint disease and hypertension. The Minimum Data Set assessment, dated 12/16/05, identified that the resident was cognitively impaired, was experiencing an acute episode of a chronic condition, received dialysis and required monitoring of an acute medical condition. The Resident Care Plan, dated 1/24/06, identified that Resident #1 was at risk for falls due to weakness, decreased endurance and cognitive deficit with the interventions that included to assist with transfers as needed and ongoing assessment of the resident's needs. Review of the clinical record, dated 1/27/06 at 3:00 P.M., indicated that the staff nurse identified Resident #1 was getting out of bed and wandering. Review of facility documentation, dated 1/29/06 at 9:45 A.M., identified that Resident #1

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- was found on the floor, sustained a laceration on the head and had complaints of pain in the right hip and ankle areas. Resident #1 was transferred to Hospital #1 and was admitted with the diagnosis of right hip fracture. The clinical record lacked documentation that the resident was assessed after the fall on 1/29/06.
- j. Resident #3 was admitted to the facility on 10/25/05 with the diagnoses of bipolar disorder, vascular dementia, hypertension, osteoarthritis, pseudoseizures and status post bilateral total hip replacements. The Minimum Data Set assessment, dated 9/14/06, identified that the resident had some cognitive impairment, was independent in ambulation and personal hygiene needs and received antipsychotic and antidepressant medications daily. Review of facility documentation, dated 5/17/06 at 4:00 P.M., reflected that Resident #3 identified that his roommate was verbally abusive and threatening him with a knife. Review of the clinical record lacked an assessment of the resident who made the allegations. According to the facility policy and procedure, titled "Resident Abuse/Neglect Policy", if resident to resident abuse is alleged the charge nurse and supervisor assess the victim for injury/harm and that assessment is documented. Interview with the Interim Director of Nursing, on 11/13/06, identified that Resident #3 was not assessed by a Registered Nurse after the allegations were identified on 5/17/06. The outcome of the facility investigation did not substantiate that Resident #3 was verbally abused and/or threatened with a knife.

In addition review of facility documentation, dated 5/24/06 at 7:30 A.M., identified that Resident #3 fell onto his left knee and right hip while ambulating with a cane. The resident sustained ecchymotic areas on the left forearm and had complaints of left knee and right hip pain. Documentation was lacking that the resident was assessed after the identified fall. Interview with the Interim Director of Nursing, on 11/13/06, identified that Resident #3 was not assessed by a Registered Nurse after the fall on 5/24/06.

In addition review of facility documentation, dated 7/23/06, identified that Resident #3 was involved in an episode of being pushed by another resident while walking in the hallway. Documentation was lacking that Resident #3 was assessed after the identified physical event on 7/23/06. According to the facility policy and procedure, titled "Resident Abuse/Neglect Policy", if resident to resident abuse is alleged the charge nurse and supervisor assess the victim for injury/harm and that assessment is documented. Interview with the Interim Director of Nursing, on 11/13/06, identified that Resident #3 was not assessed by

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

a Registered Nurse after the allegations were identified on 7/23/06. The outcome of the facility investigation identified that Resident #3 did not sustain any injury in the event of 7/23/06 and staff were informed to keep the residents separated.

In addition review of facility documentation, dated 9/25/06 at 12:30 P.M., identified that Resident #3 sustained a skin tear to the right forearm after leaning against a bench. Review of the clinical record, dated 9/25/06, lacked documentation that Resident #3 was assessed after the identified event. Interview with the Interim Director of Nursing, on 11/13/06, identified that Resident #3 was not assessed by a Registered Nurse after the skin tear was identified on 9/25/06.

- k. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data Set assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem. The assessment further identified that the resident had a stage II pressure ulcer and received antipsychotic, antianxiety, antidepressant and hypnotic medications daily. In addition physician orders, dated 8/9/06, directed the staff to administer an antibiotic medication four times a day for one week. The Resident Care Plan, dated 8/9/06 identified that the antibiotic therapy was due to an infection of the pressure ulcer and interventions included to assess for signs and symptoms of infection. Documentation was lacking in the nurses notes, dated from 8/9/06 to 8/15/06, that the resident was assessed in regards to the antibiotic medication therapy and/or the infection at the pressure ulcer site. Interview with the Interim Director of Nursing, on 11/13/06, identified that Resident #5 was not assessed by a Registered Nurse after the initiation of antibiotic therapy on 8/9/06 through 8/15/06.

In addition review of nurses notes for Resident #5, from 8/17/06 to 8/20/06, identified that the resident had three episodes of elevated temperature ranging from 100.2 degrees Fahrenheit (F) to 101.3 degrees F, with the normal range 98.6 degrees F, and documentation was lacking that Resident #5 was assessed when the temperature elevations occurred.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

In addition further review of the nurses notes for Resident #5, dated 8/23/06, identified that the resident was found on the floor at 3:00 P.M. and documentation was lacking that the resident was assessed after the identified fall.

In addition further review of facility documentation, dated 10/15/06 at 10:30 A.M., identified that Resident #5 fell on the floor. Review of the nurses' notes, dated 10/15/06, identified that the resident was found on the floor at 10:30A.M. and documentation was lacking that the resident was assessed after the identified fall.

- i. Resident #6 was admitted to the facility on 1/6/06 with the diagnoses of altered mental status, dementia, diabetes mellitus, history of Hepatitis B, and history of glaucoma. The Minimum Data Set assessment, dated 1/18/06, identified that the resident was cognitively impaired, required staff assistance for bathing needs and required staff supervision for ambulation off the unit. In addition review of facility documentation, dated 4/11/06, identified that at 9:30 P.M. Resident #6 was hit on the head by another resident. Review of the nurses notes, dated 4/11/06, lacked documentation that the resident had been assessed after the identified event. Subsequently on 4/12/06 the resident's left eye was identified as "puffy, red and painful" and the physician prescribed antibiotic medication therapy for a left eye infection. Interview with the Interim Director of Nursing, on 11/13/06, identified that there was no assessment of Resident #6 after the identified event on 4/11/06.

In addition review of facility documentation, dated 11/3/06, identified that Resident #6 had fallen to the floor. Review of the nurses notes, dated 11/3/06, lacked documentation that the resident had been assessed after the identified fall.

- m. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. In addition the Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. Review of the nurses notes, dated 11/19/06, identified that Resident #33 had increased respiratory secretions and the physician and family were notified.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

Documentation was lacking that the resident had been assessed by a Registered Nurse.

- n. Resident #34 was readmitted to the facility on 7/12/06 with the diagnoses of cerebrovascular accident, acute renal insufficiency, anemia, deconditioning, right inguinal hernia, prostatic hypertrophy and skin ulcerations. The Minimum Data Set assessment, dated 7/24/06, identified that the resident was cognitively impaired required extensive staff assistance for bed mobility, dressing, hygiene, bathing and toileting needs. The assessment further identified that the resident had limited range of motion on one side of the body (arm, hand, leg and foot) and had two stage two (2) pressure ulcers. Review of the nurses notes, dated 8/27/06, identified that Resident #34 was febrile, had hematuria and foul smelling loose stool, although documentation was lacking that the resident was assessed by a Registered Nurse. The physician was informed and directed the staff to send the resident to Hospital #1 and the resident was admitted with the diagnoses of urosepsis.

In addition while on oral antibiotic therapy for the urosepsis, review of the nurses notes for Resident #34 dated 9/8/06, identified that the resident had an elevated temperature of 101.7 degree Fahrenheit (F), with the normal range 98.6 degrees F, and documentation was lacking that the resident was assessed by a Registered Nurse and/or that the physician was informed of the elevated temperature.

In addition review of nurses notes, dated 9/12/06, identified that Resident #34 had a fall, the physician was updated and documentation was lacking that the resident was assessed by a Registered Nurse after the fall.

In addition review of Resident #34's nurses notes, dated 9/20/06, identified that MD #3 was in to examine the resident's legs and was awaiting completion of an ultrasound. Further review of the nurses' notes, from 9/20/06 to 9/22/06, lacked documentation of the resident's status, although a nurses' note dated 9/22/06 at 4:30 P.M. identified that the resident had returned from Hospital #1 with the diagnosis of a left lower extremity Deep Vein Thrombosis (DVT).

In addition Hospital #1 identified on 9/22/06 that Resident #34 had a left lower extremity DVT and directed that the resident return the to the Emergency Department if the resident had trouble breathing, lightheadedness and/or anything unusual. Review of the nurses' notes, from 9/22/06 to 9/28/06, lacked

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

documentation that the resident was monitored and/or evaluated and/or assessed for trouble breathing, lightheadedness and/or anything unusual.

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 (o) Medical Director (2)(H).

9. Based on review of clinical records, review of facility policies, observations, and interviews, the facility failed to ensure that submitted assessments for one of six residents who had pressure ulcers, Resident #12, accurately reflected the status of the resident. The findings included:
  - a. Resident #12 (R #12) was admitted on 9/16/99 with diagnoses of lower paraplegia and ulcers of the heel and mid foot. Review of the assessment dated 5/19/06 identified that R #12 was independent for most Activities of Daily Living (ADLs) and had no pressure ulcers. Review of physician order dated 6/9/06 directed a treatment to R #12 's left heel that included to wash the area with normal saline solution, followed by application of accuzyme to the darkened areas, covered with damp gauze, and followed by a Telpha dressing. Interview with LPN #6 on 11/29/06 identified that R #12 has had the area "for a long time", described the area as a callous, and that the resident frequently "picked" at and reopened the area. Although a review of the clinical record identified that R #12's left heel treatment orders remained in effect through 11/29/06, review of the quarterly assessment dated 8/14/06 lacked documentation to reflect that the resident had ulcers due to any cause. Subsequent to surveyor inquiry on 11/30/06, R #12's left heel wound was assessed and identified as a Stage III pressure ulcer that measured 2.0 cm. by 2.0 cm. and was 0.6 cm. in depth.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Administrator (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (2)(I).

10. Based on review of clinical records, review of facility policies, review of facility documentation, and interviews, the facility failed to ensure that a comprehensive plan of care was developed for five of eight residents, Residents #1, #2, #6, #9, and #33, to address care and/or services for a resident with hemodialysis and/or the level of staff assistance and/or the potential for wandering for a resident identified as at risk for elopement and/or potential emergency measures to be instituted related to a dialysis

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

access catheter for a resident whose catheter was accidentally dislodged during the provision of care and/or actual impaired skin integrity. The findings included:

- a. Resident #1 was admitted to the facility on 12/16/05 with the diagnoses of end stage renal disease due to nephrosclerosis with hemodialysis treatments three times weekly, congestive heart failure, bilateral pleural effusions, dementia and hypertension. The Minimum Data Set assessment, dated 12/16/05, identified that the resident was cognitively impaired, was experiencing an acute episode of a chronic condition, received dialysis treatments and required monitoring of an acute medical condition. Review of the clinical record identified that there were no Resident Care Plans' that identified and/or addressed the resident's unique care needs related to the hemodialysis treatments. The Interim Director of Nursing, identified on 11/13/06, there were no other care plans for Resident #1. Review of the facility policy, titled "Care Planning", identified that a comprehensive, interdisciplinary plan of care would be developed for each resident. The policy directed that an assessment would include review of the resident's medical status that included limitations and precautions. In addition, the policy directed that a collaborative, coordinated approach would be utilized to identify, integrate, and prioritize the resident's care needs based on assessment/reassessment data.
- b. Resident #2 was admitted to the facility on 9/16/06 with the diagnoses of status post internal fixation of a left intertrochanteric fracture, high cholesterol, hypertension and history of a single kidney. The Minimum Data Set assessment, dated 9/19/06, identified that the resident was cognitively intact, required staff assistance for bed mobility, transfer and toilet needs, was experiencing an acute episode of a recurrent condition and required monitoring of an acute medical condition. Review of the clinical record identified the that the care plan failed to identify the nursing interventions related to the level of staff assistance with care (MDS identified that the resident required staff assistance for mobility, transfers and toileting). The Interim Director of Nursing, identified on 11/13/06, there were no other care plans for Resident #2. Review of the facility policy, titled "Care Planning", identified that a comprehensive, interdisciplinary plan of care would be developed for each resident. The policy directed that an assessment would include review of the resident's medical status that included limitations and precautions. In addition, the policy directed that a collaborative, coordinated approach would be utilized to identify, integrate, and prioritize the resident's care needs based on assessment/reassessment data.
- c. Resident #6 was admitted to the facility on 1/6/06 with the diagnoses of altered mental status, dementia, diabetes mellitus, history of Hepatitis B, and history of

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- glaucoma. The Minimum Data Set assessment, dated 7/12/06, identified that the resident was cognitively impaired, required staff supervision for ambulation off of the unit and staff assistance for bathing needs. Review of the elopement risk assessment, completed on 7/12/06, identified that the resident was at risk for elopement. Review of the clinical record identified that there was no care plan that identified and/or addressed Resident #6's identified issue of elopement/wandering. Review of the facility policy, titled "Wandering Resident/Elopement Risk Assessment", identified that if the resident is identified at risk for wandering this problem is addressed in their care plan and interventions are initiated to decrease the potential for harm to the resident
- d. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments. Review of the clinical record identified that R #9 had a double lumen central line (Perma-cath) at the right chest that served as an access for dialysis treatments. Review of the assessment dated 9/13/06 identified that R #9 required extensive assistance for bed mobility, personal hygiene, and dressing. Review of the Resident Care Plan (RCP) dated 9/7/06 lacked documentation to reflect that a comprehensive plan of care was developed to address R #9's double lumen catheter and/or the potential for emergent incidents related to the catheter. Review of the nursing notes dated 10/3/06 at 9:30 PM identified that R #9's Perma-cath had pulled out and that R #9 was bleeding profusely from the site of the Perma-cath. The documentation identified that pressure was applied to the site, 911 was called, and R #9 was transferred to the hospital. Interview with Nursing Assistant #9 (NA #9) on 11/29/06 at 3:00 PM identified that she was assigned to provide care to R #9 on the evening of 10/3/06. NA #9 stated that the catheter usually was "taped down" but that it was not taped that evening, and that when she removed R #9's undershirt, he suddenly began bleeding. NA #9 stated that she ran out of the room to call for the nurse. Interview with LPN #7 on 11/29/06 at 2:45 PM identified that she was in the corridor outside R #9's room when NA #9 came out of the room and yelled for help. LPN #7 stated that upon entering the room, she immediately applied pressure to the site of the catheter and sent NA #9 to call the supervisor. Review of the hospital operative record dated 10/4/06 identified that the resident's Permacath had been inadvertently pulled out and that R #9 required replacement of the catheter with a left internal jugular Perma-cath. R #9 was readmitted to the facility on 10/17/06. Review of the clinical record identified that a plan of care to address observation and the potential for infection at the access site was not developed until 11/3/06. Review of the RCP with facility staff

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

lacked documentation to reflect that the care plan addressed the potential for dislodgement and/or emergent measures to be instituted if dislodgement occurred.

Review of facility policies identified that the facility lacked a policy to direct staff response to the emergency of a dislodged Permacath. Review of the facility policy, titled "Care Planning", identified that a comprehensive, interdisciplinary plan of care would be developed for each resident. The policy directed that an assessment would include review of the resident's medical status that included limitations and precautions. In addition, the policy directed that a collaborative, coordinated approach would be utilized to identify, integrate, and prioritize the resident's care needs based on assessment/reassessment data.

- e. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. In addition the Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. The Resident Care Plan, updated 9/20/06, identified that Resident #33 had six areas of impaired skin integrity/wounds (left shoulder, right great toe, left upper buttock, coccyx, right shoulder, right hip) with interventions that included to monitor and document wound condition every week. The care plan failed to identify the pressure ulcers on the left hip and the right upper hip. Observation of wound care, on 11/28/06, identified that the resident had a total of ten pressure ulcers (as noted above and areas on the left hip, right outer foot, right upper hip and the left foot) and the care plan, updated 9/20/06, also lacked documentation of these two areas. Review of the facility policy, titled "Care Planning", identified that a comprehensive, interdisciplinary plan of care would be developed for each resident. The policy directed that an assessment would include review of the resident's medical status that included limitations and precautions. In addition, the policy directed that a collaborative, coordinated approach would be utilized to identify, integrate, and prioritize the resident's care needs based on assessment/reassessment data.

11. Based on review of the clinical record and review of facility policy and procedures for one of two residents reviewed, Resident #34, for actual and/or suspected Deep Vein Thrombosis the facility failed to complete a comprehensive plan of care to address the diagnosis. The findings include:

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- a. Resident #34 was readmitted to the facility on 7/12/06 with the diagnoses of cerebrovascular accident, acute renal insufficiency, anemia, deconditioning, right inguinal hernia, prostatic hypertrophy and skin ulcerations. The Minimum Data Set assessment, dated 7/24/06, identified that the resident was cognitively impaired required extensive staff assistance for bed mobility, dressing, hygiene, bathing and toileting needs. The assessment also identified that the resident had limited range of motion on one side of the body (arm, hand, leg and foot) and had two stage two (2) pressure ulcers. Review of the nurse's note, dated 9/22/06 at 4:30 P.M, identified that the resident returned from Hospital #1 with the diagnosis of a left lower extremity Deep Vein Thrombosis (DVT). Review of the clinical record lacked documentation that this problem was identified and/or addressed on the plan of care for Resident #34's readmission. Review of the facility policy, titled "Care Planning", identified that a comprehensive, interdisciplinary plan of care would be developed for each resident. The policy directed that an assessment would include review of the resident's medical status that included limitations and precautions. In addition, the policy directed that a collaborative, coordinated approach would be utilized to identify, integrate, and prioritize the resident's care needs based on assessment/reassessment data.

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

12. Based on reviews of clinical records, observations, and interview, the facility failed to ensure that a topical pain relief patch was intermittently removed and/or reapplied and/or that barrier cream was provided after incontinent care in accordance with physician orders to one resident, Resident #9, who had a history of back pain and experienced frequent, loose stools. The findings included:
  - a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of degenerative changes in the lumbar spine. Review of physician orders dated 10/17/06 directed the use of a Lidoderm patch 5% to be applied to the resident's mid back area daily. The physician order directed that the Lidoderm patch be applied daily at 9:00 AM and to be removed at 9:00 PM. Observation of R #9's mid back area in the presence of LPN #1 on 11/28/06 at 9:40 AM identified that a Lidoderm patch dated 11/27/06 remained in place on the resident's back.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

Interview with LPN #1 at the time of the observation identified that the patch observed on the morning of 11/29/06 should have been removed by the evening staff on 11/28/06.

In addition, an assessment dated 11/3/06 identified that R #9 required extensive assistance for bed mobility and personal hygiene and was incontinent of bowel and bladder. Review of the Resident Care Plan (RCP) dated 11/3/06 identified alterations in elimination related to the resident's incontinence with interventions that included incontinent care every two hours as needed and to utilize barrier cream as needed. On 11/28/06 at 6:20 AM, Nursing Assistant #1 (NA #1) and NA #2 were observed to provide incontinent care to R #9 who had been incontinent of loose stool. R #9's sacral area, perineal floor, and bilateral groin areas were observed to be bright red. Upon request by the surveyor, NA #2 lightly pressed two fingers to the area of redness at the resident's sacral area. No blanching of the area was observed. The NAs failed to apply barrier cream in accordance with the resident's plan of care. Interview with LPN #3 on 11/28/06 at 7:20 AM identified that she would have expected barrier cream to be applied to R #9's reddened area as part of incontinent care but that after the incontinent care to R #9, the NAs had reported to her that the resident's bottom looked better. Review of the facility's protocol for incontinent care directed that a thin layer of barrier cream would be gently applied to the skin after each incontinent episode.

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

13. Based on review of the clinical record, facility policies and procedures, observations and interviews for one of one record reviewed, Resident #33, that had a urinary infection and a leaking urinary catheter, the facility failed to provide incontinent care to the resident after the catheter had leakage onto the residents skin. The findings include:
  - a. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. In addition the Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

ulcers. The Resident Care Plan, updated 9/20/06, identified that the resident had impaired skin integrity with interventions that included to provide incontinent care every two hours and as needed. Other care plans for Resident #33, dated 9/20/06 and 10/17/06, identified that the resident had urinary tract infections. In addition the Resident Care Plan, dated, 11/8/06, identified that Resident #33 had another urinary tract infection with the organism Methicillin Resistant Staphylococcus Aureus (MRSA). Observation, on 11/28/06, from 11:55 A.M. to 12:00 Noon, identified that the cloth pad under the resident's coccyx was saturated with urine and NA #3 and NA #4 removed the soiled cloth pad and replaced it with a dry cloth pad without washing the resident. Upon interview, with NA #3 and NA #4 on 11/29/06, the two staff members could not identify why the resident was not washed, although they were aware that the resident was lying on the cloth pad that was soaked with urine. Review of facility policy, titled "Incontinent care", identified that incontinent care is provided to all residents to maintain skin integrity and prevent infection.

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

14. Based on review of clinical records, review of facility policies, review of facility documentation, observations, and interviews, the facility failed to ensure that preventive measures and/or monitoring systems of pressure ulcers were consistently implemented for six of seven residents, Residents #5, #9, #10, #11, #12, and #33. The findings included:
- a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments, Peripheral Vascular Disease (PVD), and Type II Diabetes. Review of the admission assessment dated 9/5/06 identified that R #9 entered the facility without a pressure ulcer. Review of the Braden Scale assessment dated 9/5/06 was completed to determine the resident's risk for pressure ulcers and although the assessment did not identify R #9 as at risk for pressure ulcers, a care plan was initiated for the potential for impaired skin integrity with intervention that included a pressure relief mattress, encouragement or assistance with repositioning every two hours, and checking the condition of the resident's skin daily. Review of the nursing note dated 9/29/06 identified that R #9 had developed a Stage II pressure area on the left heel. Review of the clinical record lacked documentation to reflect the size

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

and/or appearance of the open area at the time of the observation through 10/3/06 when R #9 was transferred to the hospital after the resident's permacath was inadvertently dislodged.

In addition, review of the clinical record identified that R #9 was readmitted to the facility on 10/17/06. Review of the readmission assessment dated 10/17/06 identified that R #9 had a left heel ulcer, a right leg and ankle open area, and an excoriated buttocks. Although physician orders dated 10/17/06 directed treatment to the left heel ulcer that included accuzyme ointment to be applied daily, the clinical record lacked documentation to reflect the size and/or appearance of R #9's left heel ulcer at the time of readmission or for twelve additional days. Documentation was lacking in the dietary progress notes dated through 11/30/06 to address R #9's potential nutritional needs related to the presence of a pressure ulcer. Review of the wound care documentation dated 10/28/06 identified that R #9 had an unstageable left heel ulcer that measured 4.0 centimeters (cm.) by 4.0 cm. in size with a small amount of odoriferous serosanguineous exudate. Documentation was lacking in the physician progress notes dated 9/6/06 through 11/8/06, to reflect that the physician had observed R #'s left heel pressure ulcer.

In addition, review of the Resident Care Plan (RCP) dated 9/30/06 identified that R #9 had left heel wound with interventions that included the use of a waffle boot on the left foot when the resident was in bed. Observation on 11/28/06 at 5:00 AM identified that R #9's waffle boot was observed on the floor of the room under a chair. R #9 remained in bed without the benefit of the waffle boot until 7:30 AM when the resident was assisted out of bed to a wheelchair. Interview with NA #2 at 6:35 AM identified that R #9 did not always have the waffle boot in place. Interview with R #9 on 11/28/06 at 8:00 AM identified that he had reported to staff that his heel was more painful, that the staff thought the area "might get better if it got some air," and suggested that the waffle boot be removed. R #9 was unable to identify the staff member who suggested that the boot be removed.

In addition, intermittent observations from 5:00 AM until 10:30 AM on 11/28/06 identified that R #9's left heel remained covered with a kerlix wrapped dressing that was observed with dried appearing, reddish, brown stained material that covered the entire heel area. The bed sheets below R #9's left heel were observed at 6:20 AM to have five, dried appearing, spots of the same reddish brown

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

material. Nursing Assistant #1 (NA #1) and NA #2 provided incontinent care to R #9 at 6:20 AM at which time a strong odor coming from the resident's left heel area was noted. Interview with NA #2 at the time of the first observation of the heel dressing identified that although the NA looked at the dried dressing, she identified that the resident's dressing was done by the day shift staff. Subsequent to surveyor intervention at 10:30 AM, R #9's dressing change was completed by LPN #1. Observation of R #9's left heel ulcer dressing change identified a moderate to large amount of foul smelling, serosanguineous drainage coming from the heel wound. Interview with LPN #4 at the time of the observation identified that over the previous week, she had observed that R #9's heel dressing was frequently saturated with drainage, required more than the once daily treatment as per physician orders, but that she had not notified that physician of the observation. Review of the clinical record identified that R #9's left heel wound was last assessed on 11/12/06, fifteen days earlier, and identified that R #9's wound as a Stage II pressure ulcer that measured 4.0 cm. by 4.0 cm. and was 0.2 cm. in depth. Subsequent to the 11/28/06 observation, R #9's left heel wound was reassessed. Review of the wound assessment dated 11/28/06 identified that R #9's left heel ulcer was now unstageable, with black eschar and measured 6.0 cm. by 6.0 cm. Review of physician orders dated 11/28/06 directed that R #9's left heel ulcer be assessed at the wound clinic on 11/29/06. Review of the wound clinic documentation identified that R #9 received two grams of the antibiotic, Ancef, at the clinic and orders for the resident to be further evaluated by a surgeon. Interview with LPN #1 on 12/1/06 at 10:00 AM identified that subsequent to R #9's appointment with the surgeon on 11/30/06, R #9 was directly admitted to the hospital. Review of R #9's clinical records from the acute care hospital identified that R #9 underwent a left below the knee amputation on 12/4/06 as a result of the left heel ulcer necrosis.

- b. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem. The assessment further identified that the resident had a Stage II (a partial thickness loss of skin layers) pressure ulcer- treatments included pressure relieving devices for the bed and ulcer care, and received antipsychotic, antianxiety, antidepressant

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

and hypnotic medications daily. The Resident Care Plan, dated 8/17/06, identified that the resident had a Stage II pressure ulcer on the coccyx with the intervention that included to encourage the resident to turn and reposition every two hours. Review of the weekly body audits for Resident #5, dated 10/4/06 and 10/18/06, identified that the resident had decubitus areas on the coccyx, right hip and left heel. Review of the treatment kardex for Resident #5, from 10/2/06 to 10/20/06, identified that the staff were applying provodine to the hip and heel areas daily, however there was no documentation that the physician was notified of these new pressure ulcers and there was no physician order for the provodine to the hip and heel. Review of the nurses notes, from 8/4/06 to 10/20/06, lacked documentation that the areas on the right hip and/or the heel had been assessed and/or monitored.

The Acting Director of Nursing was unable to provide wound documentation for the identified two areas-the right hip and heel, upon request, although she was responsible to monitor the pressure ulcers in the facility. The resident was transferred to another nursing home on 10/20/06. Review of the interagency patient referral report, dated 10/20/06, identified that the resident had a stage III (a full thickness loss of skin, exposing the subcutaneous tissues) ulcer on the coccyx requiring a dressing, an area the right hip that required a dressing and an area on the right heel that required a dressing. Review of the receiving facility wound documentation, dated 10/20/06, identified that Resident #5 had a stage III ulcer on the coccyx, a 6.0 centimeter (cm) long by 5.5 cm wide by 0.2 cm deep black eschar area on the right hip and a 5.0 cm long by 3.0 cm wide by 0 cm deep eschar area on the right heel. According to The Guideline for Prevention and Management of Pressure Ulcers, 2003 edition, pressure ulcers are to be assessed and monitored at each dressing change, reassessed and measured at least weekly, including description of location, tissue type, size tunneling, exudates (amount, type, character, and odor), presence/absence of infection., wound edges, stage, perineal-wound skin, pain, and adherence to prevention and treatment.

In addition review of Resident #5's treatment kardex, from 10-2-06 to 10-20-06, identified that the staff carried out treatments that included an application of provodine followed by a dressing daily to the right hip area and to the left heel area. Interview with RN #1, on 11/20/06, identified that there was no physician order that directed the staff to complete these identified treatments and/or there was no facility protocol to direct the nurse to provide treatment as identified and could not identify why the treatment was being completed. Interview with MD #1, on 11/29/06, identified that he was not informed of these two areas and/or was

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

not aware that the nursing staff were completing a treatment to the two areas. According to the Nurse Practice Act Section 20-87a the scope of practice for nurses does not include prescriptive authority.

- c. Resident #10 (R #10) was admitted to the facility in May of 2006 with diagnoses of a recent right subtrochanteric fracture and a community acquired Stage IV sacral decubitus ulcer. Review of the assessment dated 8/6/06 identified that R #10 required extensive to total assistance from staff for most Activities of Daily Living (ADLs). Review of physician orders dated 11/8/06 directed treatment changes to R #10's sacral wound that included to cleanse the sacral pressure area with normal saline solution, followed by Aquacel/Ag packed into the wound, followed by gauze dressing, and application of a Telfa Island dressing. The order directed that R #10's dressing change be performed daily and as needed if the dressing became soiled or dislodged. On 11/28/06 at 6:35 AM, Nursing Assistant #2 (NA #2) was observed to assist R #10 off the bedpan. As the NA removed the bedpan, some of the urine spilled over the end of the pan and onto the soaker pad underneath the resident. R #10's sacral wound dressing was observed to be soaked with urine. NA #2 continued to provide incontinent care to the resident washing around the urine soaked wound dressing. Interview with NA #2 during the observation identified that the nursing assistant confirmed that the dressing was soaked with urine but stated that the dressing was changed on the day shift. Interviews on 11/28/06 with LPN #3, the 11:00 PM to 7:00 AM charge nurse at 7:20 AM and LPN #4, the 7:00 AM to 3:00 PM nurse at 8:30 AM identified that the condition of R #10's dressing had not been reported to them by the nursing assistant. At 8:50 AM, R #10 reported to the surveyor that facility staff told her that they were going to change the wound dressing. However, at 10:15 AM, observation of R #10's sacral wound dressing with the Acting Director of Nursing (DNS) identified that the urine soaked dressing remained on the sacral wound, appeared partially dried, and was foul smelling. Subsequent to surveyor inquiry, R #10's sacral wound dressing was changed.
- d. Resident #11 (R #11) was admitted to the facility on 4/14/06 with diagnoses of presenile dementia and Type II Diabetes. Review of the admission assessment dated 4/14/06 identified that R #11 entered the facility without a pressure ulcer. Review of an undated Braden Scale assessment used to determine a resident's risk to develop pressure ulcers identified that R #11 was at low risk to develop pressure ulcers. Although review of the clinical record dated 4/14/06 through 6/16/06 lacked documentation to reflect that R #11 developed any pressure areas, the nursing note dated 6/17/06 identified that "treatment to heels" was performed

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

but lacked documentation to reflect the size or appearance of the areas. Review of physician orders dated 8/17/06 directed treatment orders to the right heel that included washing the area with normal saline solution, followed by application of Panafil, followed by a dry, clean dressing. The treatment orders directed that the dressing be changed daily and as needed if dislodged. Documentation was lacking in the clinical record to reflect the size or appearance of the right heel area from the time of initiation of the treatment through 9/14/06 when the resident was admitted to the hospital for an unresponsive/hypotensive episode. Review of the readmission assessment dated 9/20/06 identified that R #11 had ulcerations on both heels but lacked documentation to reflect the size or appearance of the areas. Review of the Resident Care Plan (RCP) dated 9/20/06 identified R #11's right heel wound was infected with interventions that included antibiotic therapy and treatments as ordered. On 11/29/06 at 9:30 AM, LPN # 5 was observed to perform the dressing change to R #11's right heel. Interview with LPN #5 during the observation identified that she does not routinely measure the wounds of residents at the facility as wounds are measured and evaluated weekly by LPN #1. Review of the clinical record and facility documentation on 11/30/06 with LPN #1 failed to identify documentation to reflect that R #11's right heel pressure area was monitored through descriptions of the area and/or measurements of the area at any time since its development sometime in June of 2006. In addition, documentation was lacking in the dietary progress notes dated through 11/30/06 to address R #11's potential nutritional needs related to the presence of a pressure ulcer. Subsequent to the 11/29/06 observation, R #11's right heel wound was reassessed. Review of the wound assessment dated 11/30/06 identified that R #11's right heel ulcer was assessed as a Stage II, had a small amount of exudate, and measured 3.0 cm. by 3.6 cm. and was 0.2 cm. in depth. Review of physician orders directed the addition of Multivitamins, Vitamin C, Zinc, and a protein supplement to R #11's daily medication regime.

- e. Resident #12 (R #12) was admitted on 9/16/99 with diagnoses of lower paraplegia and ulcers of the heel and mid foot. Review of the assessment dated 5/19/06 identified that R #12 was independent for most Activities of Daily Living (ADLs) and had no pressure ulcers. Review of a physician order dated 6/9/06 directed a treatment to R #12's left heel that included to wash the area with normal saline solution, followed by application of accuzyme to the darkened areas, covered with damp gauze, and followed by a Telfa dressing. Review of the clinical record lacked documentation to reflect the size or appearance of the right heel area at the time of the initiation of the treatment. Interview with LPN #6 on 11/29/06

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

identified that R #12 has had the area "for a long time", described the area as a callous, and that the resident frequently "picked" at and reopened the area. On 11/29/06 at 10:05 AM, LPN #5 was observed to perform the treatment to R #12's left heel area. Interview with LPN #5 during the observation identified that all wounds in the facility are measured weekly by LPN #1. Review of the clinical record and facility documentation on 11/30/06 with LPN #1 failed to identify documentation to reflect that R #12's left heel pressure area was monitored through descriptions of the area and/or measurements of the area at any time since 6/9/06, a total of five months. In addition, documentation was lacking in the dietary progress notes dated 11/30/05 through 11/30/06 to address R #12's potential nutritional needs related to the presence of a pressure ulcer. Although an interview with Doctor of Osteopathy #1 (DO #1) on 11/29/06 at 11:45 AM identified that he had observed R #12's wound recently, that the wound was chronic, and often reopened, the clinical record lacked documentation of a physician's progress note since 12/31/05. Subsequent to surveyor inquiry, R #12's left heel wound was identified as a Stage III pressure ulcer that measured 2.0 cm. by 2.0 cm. and was 0.6 cm. in depth.

- f. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the right shoulder and hypothyroidism. The Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. The Resident Care Plan, updated 9/20/06, identified that Resident #33 had six areas of impaired skin integrity/wounds (left shoulder, right great toe, left upper buttock, coccyx, right shoulder, right hip) with interventions that included to monitor and document wound condition every week, to complete the treatment as per physician orders and to update the physician. Review of a Braden scale for Resident #33, dated 6/20/06 and 9/20/06, although signed by facility staff, documentation was lacking that the scale was completed on the identified dates. Observation of wound care, on 11/28/06, identified that the resident had a total of ten pressure ulcers (as noted above and areas on the left hip, right outer foot, right upper hip and left foot). Review of the weekly facility documentation/monitoring was lacking for Resident #33's eight pressure ulcers areas (left hip, right great toe, left shoulder, right upper hip, left upper buttock, coccyx, right shoulder and right hip). Facility documentation identified that three of the identified areas had been

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

measured eight days ago (left hip, left upper buttock and right shoulder), that one area had been measured fifteen days ago (right upper hip) and four areas had been measured twenty-two days ago (right great toe, left shoulder, coccyx and right hip). Upon request for measurements of the identified areas on 11/29/06 it was identified that two (left upper buttock and right shoulder) of the eight identified areas had become worse as compared to the last measurements. According to The Guideline for Prevention and Management of Pressure Ulcers, 2003 edition, pressure ulcers are to be assessed and monitored at each dressing change, reassessed and measured at least weekly, including description of location, tissue type, size tunneling, exudates (amount, type, character, and odor), presence/absence of infection., wound edges, stage, perineal-wound skin, pain, and adherence to prevention and treatment.

Observation, on 11/28/06, identified that LPN #4 cleansed the resident's right shoulder with Dakins solution in error and the physician order, dated 11/1/06, directed the staff to cleanse this area with normal saline. Observation, on 11/28/06, identified that LPN #1 applied Aquacel-AG to the resident's left shoulder in error and the physician order, dated 11/1/06, directed the staff to cleanse with normal saline followed by Xenaderm then cover with dressing daily. In addition observation, on 11/28/06, identified that LPN #1 and cleansed the resident's right upper buttock with normal saline and applied Aquacel-AG in error and the physician's order, dated 11/1/06, identified cleanse with Dakins followed by Aquacel then cover with dressing daily. It was further identified that on 11/28/06 LPN #1 cleansed the resident's right outer foot with normal saline followed by Aquacel-AG followed by a dressing, without a physician's order. According to the Nurse Practice Act Section 20-87a the scope of practice for nurses does not include prescriptive authority.

Review of facility policy directed that wound assessment documentation would be completed weekly and as changes in the wound are apparent. The policy further directed that the weekly documentation would include a description of the area, including color, size, depth, location, extent of any drainage, condition of the wound area as well as surrounding area, and any isolation procedures as needed. Interview with the Acting Director of Nursing on 11/30/06 identified that she and LPN #1 discussed wound care at the facility during daily morning reports but was unable to identify any additional participation in direct monitoring of wound care at the facility. Review of facility documentation identified that the list of current

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

pressure ulcers in the facility requested on 11/28 and again on 11/29/06 lacked documentation to reflect the pressure ulcers of Residents #11 and #12. Review of the facility's wound care documentation for individual residents that included staging, measurements, and appearance of wounds was located in one central book that is held by administrative staff, did not become part of the clinical record until the area was healed or the resident was discharged, and therefore not readily available for review by licensed staff and/or physicians on off shifts. Interview with LPN #1 on 11/30/06 identified that she monitors wound care in the facility in conjunction with the Director of Nursing and/or the day shift supervisor, RN #1. In addition, interview with LPN #1 on 11/30/06 identified that the facility did not currently have a wound care consultant on staff and that residents who required more extensive treatment would be sent for evaluation at a wound clinic.

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

15. Based on review of the clinical records, review of facility documentation, and interviews, the facility failed to ensure that the nutritional status for two of eight residents, Residents #5 and #56, who were identified with a potential for decreased intake and/or the potential for weight loss, were consistently monitored in accordance with the plan of care. The findings included:
  - a. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data Set assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem, had a stage two (2) (a partial thickness loss of skin layers) pressure ulcer and received antipsychotic, anti-anxiety, antidepressant and hypnotic medications daily. Review of the nutrition assessment dated 8/8/06, identified that the resident weighed 110 pounds (lbs), was within the ideal body range of 108- 132 lbs, was provided supplements three times daily, received medication and protein supplements to enhance wound healing, had a poor appetite due to cancer and the resident's family brought the resident food at times. The Resident Care Plan, dated 8/8/06, identified that the resident had the potential for weight loss due to poor intake with the intervention to monitor the resident's weight weekly. Review

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

of facility documentation, from 8/4/06 to 10/20/06 lacked documentation that the resident was weighed weekly and/or that any further interventions were put in place for Resident #5's documented increasing refusal of meals during this period.

The resident was transferred to another nursing home on 10/20/06. Review of the interagency patient referral report, dated 10/20/06, identified that the resident had a stage III (a full thickness loss of skin, exposing the subcutaneous tissues) ulcer on the coccyx requiring a dressing, an area the right hip that required a dressing and an area on the right heel that required a dressing and the dietary notes identified that the resident had a poor appetite and weighed 110 pounds. Review of the receiving facility documentation, dated 10/20/06, identified that Resident #5 had a stage three (3) ulcer on the coccyx, a 6.0 centimeter (cm) long by 5.5 cm wide by 0.2 cm deep black eschar area on the right hip and a 5.0 cm long by 3.0 cm wide by 0.0 cm deep eschar area on the right heel and the resident's weight was 103.6 lbs.(a weight loss of 6%). Interview with the Dietitian, on 11/20/06, identified that no further nutritional interventions were put into place for the resident, other than those identified.

- b. Resident # 56 (R #56) was admitted to the facility on 10/16/06 after Coronary Artery Bypass Graft (CABG) surgery on 9/26/06. Review of the assessment dated 11/5/06 identified that R #56 weighed one hundred and fifty pounds. Review of the clinical record identified that R #56 frequently complained that he did not like the food at the facility and that he often refused meals. Review of the Resident Care Plan (RCP) dated 10/31/06 identified the resident's potential for weight loss due to poor appetite with interventions that included weekly weights and house supplements three times daily. Review of the clinical record and facility documentation (the weight book) identified that R #56 was weighed once in November 2006 and once in December 2006 but lacked documentation to reflect that R #56 was weighed weekly in accordance with the plan of care. In addition, review of the facility's weight book with facility staff identified lacked documentation to reflect that date in the month that the weights were obtained. In addition, the clinical record and Medication Administration Record (MAR) lacked consistent documentation to reflect that R #56 accepted the supplements and/or how much of the supplements R #56 accepted at each offering. Review of the documentation in the facility weight book identified R #56's December 2006 weight was 129 pounds, a twenty one pound weight loss since admission. In addition, the clinical record lacked documentation to reflect that the Dietician was notified of the resident's twenty-one pound weight loss. Interview with the Dietician on 12/14/06 at 10:45 AM identified that she was aware that weekly

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

weights in the facility were not being obtained consistently and that she communicated the issue to the nursing staff both verbally and through written request to individual units. The Dietician stated that she is in the facility for only four hours weekly and dependent on nursing staff to communicate with her regarding residents with nutritional needs/concerns.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Administrator (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(H) and/or (2)(K).

16. Based on review of clinical record and interviews for one of three records reviewed, Resident #5, that required monitoring for side effects of medication therapy the facility failed to monitor the side effects of the medications. The findings include:
- a. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. Physician order, dated 8/15/06, directed the staff to administer Seroquel 50 milligrams (mg) twice a day and Seroquel 200 mg at bedtime. The Resident Care Plan, dated 8/17/06, identified that the resident required psychotropic medications and approaches included to complete the AIMS (Abnormal Involuntary Movement Scale) every six months, to monitor for significant side effects of medication therapy. Interview and chart review with the Interim Director of Nursing, on 11/13/06, identified that the AIMS had not been completed for Resident #5.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (h) Medical Director (2)(B) and/or (n) Medical and Professional Services (5).

17. Based on review of clinical record, review of facility policies, and interviews, the facility failed to ensure for twenty of thirty eight residents reviewed who received care and services at the facility from a Doctor of Osteopathy, Residents #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #34, #35, #40, #44, #46, #47, and #49 that history and physical examinations were completed timely and/or that the physician provided ongoing documentation of each residents' progress. The findings included:
- a. A review of the clinical records, on 11/29/06, of all residents in the facility who currently received physician care and services from Doctor of Osteopathy #1 (DO #1) was conducted. The records were reviewed for the timeliness of monthly

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- visits, timely history and physician examinations, and for routine documentation of residents' progress.
- b. The record reviews of DO #1's residents identified that twelve of thirty-eight residents (Residents #3, 18, #20, #22, #23, #24, #25, #26, #29, #31, #44, and #49) were overdue for their yearly history and physician examinations by one to two years.
  - c. The record reviews of DO #1's residents identified that thirteen of thirty eight residents (Residents #3, #18, #19, #20, #22, #23, #24, #25, #26, #28, #30, #31, and #47) did not had a physician progress note documented in the clinical record for nine months or longer.
  - d. The record reviews of DO #1's twenty four remaining residents identified that five of the twenty four residents (Residents # 21, #27, #32, #35, and #49,) did not had a physician progress note documented in the clinical record for six months to nine months.

In addition, review of the monthly order sheets signed by DO #1 identified that although DO #1 signed the preprinted order sheets (that include documentation of a preprinted month) for the thirty eight residents, the DO did not document the date he visited the residents and signed the orders.

During a telephone interview with DO #1 on 11/29/06 at 11:45 AM in the presence of LPN #1, DO #1 stated that although he regularly visits the facility, sees residents, and signs monthly orders, due to reimbursement issues, he does not document progress notes consistently. Interview with the Medical Director on 11/29/06 identified that he was not aware that DO #1 was routinely not documenting the progress of residents under his care when the DO signed residents' monthly orders. Interview with the Acting Director of Nursing and RN #1 on 11/30/06 initially failed to identify that the facility had a system in place to monitor physician visits and/or when history and physical examinations were due for individual residents. However, the Acting Director of Nursing was able to locate documentation that the Director of Nursing did maintain a log to monitor timely physician visits and/or timely history and physical examinations, but was unable to explain the number of residents affected by the lack of timely yearly examinations and/or lack of documentation of progress by DO #1. Review of the facility's Medical Staff Bylaws directed that each resident would receive a comprehensive physical examination annually and that medical staff would adhere to acceptable medical standards of practice.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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 (f) Administrator (3)(F) and/or (j) Director of Nurses (2) and/or (t) Infection Control (2)(A).

18. Based on clinical record reviews, observations and interviews for one of three residents reviewed, Resident #33, the facility lacked an effective infection control program that ensured the safety and sanitary environment for the residents. The findings include:
- a. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers on the coccyx and the shoulder and hypothyroidism. The Minimum Data Set assessment, dated 9/14/06, identified that the resident was cognitively impaired, was dependent on staff for repositioning in bed, dressing, bathing, personal hygiene and toileting needs and had three stage II (partial thickness loss of skin layers) pressure sores and five stage III (full thickness skin loss exposing the subcutaneous tissues) pressure ulcers. Review of the clinical record, dated 11/8/06, identified that Resident #33 had a Methicillin Resistant Staphylococcus Aureus (MRSA) infection in the urine. The Resident Care Plan, dated 11/8/06, identified that Resident #33 had MRSA in the urine with interventions that included to identify precautions needed and set up an isolation cart in hallway, place an "alert" sign on door and review/teach precautions needed to patient and staff. Observations, on 11/28/06 from 5:00 A.M. to 12:00 Noon and on 11/29/06 from 8:30 A.M. to 11:00 A.M., identified that there was no isolation cart outside and/or an "alert" sign on the door to Resident #33 's room. Additional observations identified that there was urine leakage from the indwelling urinary catheter. Interview with NA #3 and NA #4, on 11/29/06, who were observed providing care for Resident #33 on 11/28/06 identified that Resident #33 was not on any type of isolation. Review of the care card, which directed the nursing assistant, lacked identification that Resident #33 had MRSA in the urine. Interview with the Infection Control Nurse (ICN), Licensed Practical Nurse (LPN) #2 on 11/29/06, identified that Resident #33 was started on contact precautions on 11/8/06 and she thought another staff member put out the isolation cart for the resident and/or put up the "alert" sign on the resident 's door. The ICN further identified that she informs the charge nurse only regarding a resident 's isolation needs. Facility policy identified that a resident that is displaying active infection with MRSA, the resident will be placed on contact precautions, if the MRSA infection may result in soiling of the environment with body substances. Further review of facility policies identified a

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

policy, titled "CNA Daily Assignment", which directed that the CNA assignment have complete instructions for the resident's care including any information that is required to provide individualized care.

- b. Interview with the Medical Director, on 11/29/06, identified that the role of the Infection Control Nurse (ICN) had been assumed by the Director of Nursing, prior to her medical leave on 10/13/06, and is not aware of who is in the position as of today. The Medical Director also identified that he was not aware that the ICN position cannot be filled by a Licensed Practical Nurse, but must be a Registered Nurse. Review of the Infection Control Program, on 11/29/06, with the ICN-LPN #2 (with the interim Director of Nursing (DNS) present), identified that she had been in the role of ICN since March 2006. Further interview identified that communication regarding infection control issues and/or concerns were addressed by the interim DNS and communication with the Medical Director about infection control issues and/or concerns took place at the monthly medical staff meetings. LPN #2 also identified that she does not perform formal surveillance rounds to identify infections and/or clusters of infections, and/or complete formal environmental rounds and/or does not identify and/or trend the organisms causing the infections at the facility. LPN #2 further identified that she communicates the resident's isolation needs only to the charge nurse of the unit. Although written guidelines are available at each nursing station that direct all staff on precautions for residents infected with the organisms MRSA and Vancomycin Resistant Enterococcus (VRE), risk assessments for roommates of residents with the diagnoses of MRSA infection and/or VRE infection had not been completed. LPN #2 added that she was not involved in the wound monitoring of any residents in the facility. Further LPN #2 added that she was not involved in education for any non-clinical personnel and she watched the clinical personnel performance intermittently (from daily for the unlicensed staff to monthly for the licensed staff), although she did not document this monitoring. LPN #2 identified that did not put any measures into place for residents that had either high risk and/or high volume of infections in order to prevent further infections. Interview with the interim DNS, on 11/30/06, identified that the only monitoring of the infection control program she was involved in was ensuring that the resident's admission infection control needs were provided.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (2)(E) and/or (f) Administrator (3) and/or (3)(F) and/or (j) Director of Nurses (2).

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

19. Based on clinical records review, review of facility policies, review of facility documentation, observations, and interviews, the facility lacked adequate administration and/or resources to ensure the health and safety of its residents. The findings include:
- a. During the period of 6/9/06 to 11/30/06 six residents, #5, #9, #10, #11, #12 and #33, had community and/or facility acquired pressure ulcers that were not consistently assessed and/or monitored and/or did not receive the necessary care to promote healing and/or prevent infections. Review of the Infection Control Program, on 11/29/06, with the ICN-LPN #2 (with the interim Director of Nursing (DNS) present), identified that she had been in the role of ICN since March 2006. Interview with the Medical Director, on 11/29/06, identified that the role of the Infection Control Nurse (ICN) had been assumed by the Director of Nursing, prior to her medical leave on 10/13/06, and is not aware of who is in the position as of today. The Medical Director also identified that he was not aware that the ICN position cannot be filled by a Licensed Practical Nurse, but must be a Registered Nurse.

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

20. Based on review of the clinical record, review of facility policy, review of facility documentation, and interviews, the facility failed to report events in accordance with the Public Health Code of Connecticut and/or failed to provide services according to state laws and/or acceptable professional standards, when two resident's (Resident #9 and #15) dialysis access was inadvertently dislodged during care and required subsequent emergent transfer to the hospital and surgical intervention to replace the access and/or the resident had an injury and/or for nine records reviewed (Resident #1, #2, #3, #5, #6, #11, #33, #34 and #52) for residents that required assessments to be completed.
- a. Resident #9 (R #9) was admitted to the facility on 9/5/06 with diagnoses of End Stage Renal Disease (ESRD) that required regular dialysis treatments. Review of the clinical record identified that R #9 had a double lumen central line (Permacath) at the right chest that served as an access for dialysis treatments. Review of the nursing notes dated 10/3/06 at 9:30 PM identified that R #9's Permacath had pulled out and that R #9 was bleeding profusely from the site of the Permacath. The documentation identified that pressure was applied to the site, 911 was called, and R #9 was transferred to the hospital. Review of the hospital

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

operative record dated 10/4/06 identified that the resident's Permacath had been inadvertently pulled out and that R #9 required replacement of the catheter. Interview with Nursing Assistant #9 (NA #9) on 11/29/06 at 3:00 PM identified that she was assigned to provide care to R #9 on the evening of 10/3/06. NA #9 stated that she had previously cared for R #9 and was aware that the resident had a Permacath. NA #9 stated that the catheter usually was "taped down" but that it was not taped that evening. NA #9 stated that when she removed R #9's undershirt, he suddenly began bleeding, and that she ran out of R #9's room and yelled for the nurse to come into the room. Interview with LPN #7 on 11/29/06 at 2:45 PM identified that she was in the corridor outside R #9's room when NA #9 came out of the room and yelled for help. LPN #7 stated that she immediately applied pressure to the site of the catheter and told NA #9 to call the supervisor "stat". LPN #7 stated that R #9 was very angry at the time and was yelling at her because the NA had inadvertently pulled out the catheter as she was removing the resident's shirt. Interview with R #9 on 11/29/06 identified that although he was upset at the time of the incident, he felt that it was an accident. Review of the hospital discharge summary identified that a left internal jugular Permacath was inserted. Review of facility documentation identified that no facility report or investigation was conducted as a result of the incident. Interview with LPN #1 on 11/29/06 identified that all that was reported by staff the following day was that R #9's catheter had come out, that there was bleeding and that the resident was sent out 911. Interview with the Administrator on 12/14/06 identified that although he reviews all incident reports, he does not really review the reports for the issues but rather reviews to make sure that all appropriate parties have been notified. The Administrator stated that prior to surveyor inquiry, he was unaware of the circumstances surrounding R #9's Permacath dislodgement.

- b. Resident #15 was readmitted to the facility on 9/6/06 with the diagnoses of status post rectal bleeding, erosive gastritis, urinary tract infection, acute and chronic renal failure congestive heart failure, Diabetes Mellitus, dysphagia and gastric feeding tube. The Minimum Data Set assessment, dated 9/11/06, identified that the resident was cognitively impaired, required maximum staff assistance for personal hygiene, bathing, and toileting needs. Review of facility documentation, dated 12/12/06, identified that on 12/11/06 Resident #52's "left great toe nail cracked and pulled away". Interview with the Director of Nursing, on 12/13/06, identified that a Reportable event form had not been completed for this resident regarding this event.

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- c. Resident #1 was admitted to the facility on 12/16/05 with the diagnoses of end stage renal disease due to nephrosclerosis with hemodialysis treatments three times weekly, congestive heart failure, bilateral pleural effusions, dementia, degenerative joint disease and hypertension. The Minimum Data Set assessment, dated 12/16/05, identified that the resident was cognitively impaired, was experiencing an acute episode of a chronic condition, received dialysis and required monitoring of an acute medical condition. Review of the clinical record identified that six assessments, dated 12/16/05 (bladder, bowel, fall risk, pain, skin and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.

In addition Resident #1 was readmitted to the facility on 1/21/06 with the same diagnoses although the resident no longer received hemodialysis treatment and participated in a hospice program. The Minimum Data Set assessment, dated 1/21/06, identified that the resident was cognitively impaired, required staff assistance for bed mobility and bathing needs, was experiencing an acute episode of a chronic condition and required monitoring of an acute medical condition. Review of the clinical record identified that nine assessments, dated 1/21/06 (admission, bladder, bowel, dehydration, fall risk, pain, side rail, skin and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.

- d. Resident #2 was admitted to the facility on 9/16/06 with the diagnoses of status post internal fixation of left intertrochanteric fracture, high cholesterol, hypertension and history of a single kidney. The Minimum Data Set assessment, dated 9/19/06, identified that the resident was cognitively intact, required staff assistance for bed mobility, transfer and toilet needs, was experiencing an acute episode of a recurrent condition and required monitoring of an acute medical condition. Review of the clinical record identified that seven assessments, dated 9/16/06 (admission, fall risk, oral, pain, side rail, skin, and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.
- e. Resident #3 was admitted to the facility on 10/25/05 with the diagnoses of bipolar disorder, vascular dementia, hypertension, osteoarthritis, pseudoseizures and status post bilateral total hip replacements. The Minimum Data Set assessment, dated 9/14/06, identified that the resident had some cognitive impairment, was independent in ambulation and personal hygiene needs and received antipsychotic and antidepressant medications daily. Review of the clinical record identified that eight assessments, dated from 10/25/05 to 9/13/06 (admission, educational needs, fall risk, oral, pain, side rail, skin, and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.
- f. Resident #5 was admitted to the facility on 8/4/06 with the diagnoses of non-small cell lung cancer with metastatic disease, sacral decubitus ulcer, anxiety, and depression. The Minimum Data Set assessment, dated 8/16/06, identified that the resident was cognitively intact, had sad expressions and episodes of crying, was independent with ambulation and personal hygiene needs, experienced severe pain daily, was experiencing an acute episode of a recurrent problem. The assessment further identified that the resident had a stage II pressure ulcer and received antipsychotic, antianxiety, antidepressant and hypnotic medications daily. Review of the clinical record identified that ten assessments, dated 8/4/06, 8/5/06 and 8/15/06 (admission, bladder, bowel, dehydration, fall risk, oral, pain, skin, side rail and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.
- g. Resident #6 was admitted to the facility on 1/6/06 with the diagnoses of altered mental status, dementia, diabetes mellitus, history of Hepatitis B, and history of glaucoma. The Minimum Data Set assessment, dated 1/18/06, identified that the resident was cognitively impaired, required staff assistance for bathing needs and required staff supervision for ambulation off the unit. Review of the clinical

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

record identified that eleven assessments, dated 1/6/06 to 10/9/06 (admission, bladder, bowel, dehydration, educational needs, fall risk, oral, pain, side rail, skin and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.

- h. Resident #33 was admitted to the facility on 3/24/06 with the diagnoses of blindness, deafness, decubitus ulcers-on the coccyx and the shoulder and hypothyroidism. Review of the clinical record identified that eight assessments, dated 3/24/06 (admission, bladder, bowel, fall risk, pain, skin, side rail and wandering) and updated 6/20/06 and 9/20/06-except for the skin were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.
- i. Resident #11 (R #11) was admitted to the facility on 4/14/06 with diagnoses of presenile dementia and Type II Diabetes. Review of the clinical record dated 4/14/06 identified that R #11's admission assessments that included the Braden Scale assessment to identify the resident's risk to develop pressure ulcers, were completed by an LPN and lacked documentation to reflect oversight by an RN.
- j. Resident #34 was readmitted to the facility on 7/12/06 with the diagnoses of cerebrovascular accident, acute renal insufficiency, anemia, deconditioning, right inguinal hernia, prostatic hypertrophy and skin ulcerations. Review of the clinical records identified that nine assessments, dated 7/12/06 (admission, bladder, bowel, dehydration, fall risk, pain, side rail, skin, and wandering), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.

In addition Resident #34 was discharged to the hospital on 8/27/06 and readmitted to the facility on 9/2/06 with the same diagnoses and urosepsis. Review of the clinical record identified that three assessments, dated 9/2/06 (admission, bladder and bowel), were completed by a Licensed Practical Nurse (LPN) and lacked

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection.

- k. Resident #52 was admitted to the facility 12/11/06 with the diagnoses of syncope, bilateral coronary artery disease with right carotid endarterectomy, hypertension, esophageal reflux disease, Diabetes Mellitus, urinary incontinence, and status post alcohol withdrawal with confusion. Review of the clinical record identified that five assessments (fall risk, self administration of medications, wandering, side rail and educational needs), were completed by a Licensed Practical Nurse (LPN) and lacked documentation to reflect oversight by a Registered Nurse. According to the General Statutes of Connecticut, the role of the LPN is defined as performing selected tasks under the direction of the Registered Nurse and may contribute to the nursing assessment via data collection. Interview with the Director of Nursing, on 12/13/06, identified that there was no documentation the Registered Nurse provided oversight for the identified assessments.

The following is a violation of the Connecticut General Statutes Section 19a-555(b) and/or Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (2)(E) and or (f) Administrator (3)(F) and or (h) Medical Director (2)(A) and/or (2)(B) and/or (i) Medical Staff (4)(B).

21. Based on clinical records review, review of facility policies, review of facility documentation, observations, and interviews, the facility's Medical Director (MD #1) failed to coordinate the medical care of residents by lack of providing oversight and supervision of care to residents within the facility with regards to pressure ulcers and/or by ensuring that physician visits were timely and/or ensuring that the facility staff were qualified for their position and/or did not adhere to the Medical Staff By-Laws. The findings include:
  - a. During the period of 6/9/06 to 11/30/06 six residents, #5, #9, #10, #11, #12 and #33, had community and/or facility acquired pressure ulcers that were not consistently assessed and/or monitored and/or did not receive the necessary care to promote healing and/or prevent infections. Review of facility policy directed that wound assessment documentation would be completed weekly and as changes in the wound are apparent. The policy further directed that the weekly documentation would include a description of the area, including color, size,

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- depth, location, extent of any drainage, condition of the wound area as well as surrounding area, and any isolation procedures as needed. Interview with the Interim Director of Nursing on 11/30/06 identified that she and LPN #1 discussed wound care at the facility during daily morning reports but was unable to identify any additional participation in direct monitoring of wound care at the facility. Review of facility documentation identified that the list of current pressure ulcers in the facility requested on 11/28 and again on 11/29/06 lacked documentation to reflect the pressure ulcers of Residents #11 and #12. Review of the facility's wound care documentation for individual residents that included staging, measurements, and appearance of wounds was located in one central book that is held by administrative staff, did not become part of the clinical record until the area was healed or the resident was discharged, and therefore not readily available for review by licensed staff and/or physicians on off shifts. Interview with LPN #1 on 11/30/06 identified that she monitors wound care in the facility in conjunction with the Director of Nursing and/or the day shift supervisor, RN #1. In addition, interview with LPN #1 on 11/30/06 identified that the facility did not currently have a wound care consultant on staff and that residents who required more extensive treatment would be sent for evaluation at a wound clinic.
- b. The facility's Medical Director failed to coordinate the medical care of residents by lack of providing oversight and supervision of care to residents within the facility by ensuring that physician visits, for D.O.#1, were timely and/or that the physician dated the orders for twenty nine and thirty-eight residents respectively. During a telephone interview with DO #1 on 11/29/06 at 11:45 AM in the presence of LPN #1, DO #1 stated that although he regularly visits the facility, sees residents, and signs monthly orders, due to reimbursement issues, he does not document progress notes consistently. Interview with the Medical Director on 11/29/06 identified that he was not aware that DO #1 was routinely not documenting the progress of residents under his care when the DO signed residents' monthly orders. Interview with the Interim Director of Nursing and RN #1 on 11/30/06 initially failed to identify that the facility had a system in place to monitor physician visits and/or when history and physical examinations were due for individual residents. However, the Interim Director of Nursing was able to locate documentation that the Director of Nursing did maintain a log to monitor timely physician visits and/or timely history and physical examinations, but was unable to explain the number of residents affected by the lack of timely yearly examinations and/or lack of documentation of progress by DO #1. Review of the facility's Medical Staff Bylaws directed that each resident would receive a

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

- comprehensive physical examination annually and that medical staff would adhere to acceptable medical standards of practice.
- c. The facility's Medical Director failed to coordinate the medical care of residents by lack of providing oversight and supervision of care to residents within the facility by ensuring that the facility staff were qualified for their position. Interview with the Medical Director, on 11/29/06, identified that the role of the Infection Control Nurse (ICN) had been filled by the Director of Nursing, prior to her medical leave on 10/13/06, and is not aware of who is in the position as of today. The Medical Director also identified that he was not aware that the ICN position cannot be filled by a Licensed Practical Nurse, but must be a Registered Nurse.
- d. The facility's Medical Director failed to coordinate the medical care of residents by lack of providing oversight and supervision of care to residents within the facility by ensuring that the Medical Staff By-Laws were followed. Review of the Medical Staff Bylaws, revised 1/21/03, identified that the by-laws will be reviewed on annual basis. Interview with the facility Administrator, on 11/30/06, identified that there was no documentation that the Medical Staff By-Laws were reviewed annually.

In addition repeated requests to the facility, on 11/30/06, for a facility communication book for the Medical Director, identified that there was a book, titled "Medical Director's Round Book", that was maintained from 1/13/06 to 6/7/06. The book included the following: date, time in and time out, Review of: new admissions, discharge, death, accident, seriously ill, routine patient care, policy, pharmacy issues, standard of care and other, and medical record audits completed and signature of the Medical Director. Interview with RN #1 (Nursing Supervisor), on 11/30/06, identified that the identified book had not been utilized due to the lack of issues/concerns. Interview with the Medical Director, on 11/29/06, identified that he is at the facility every Wednesday and as needed, communicates with the Administrator regarding any issues and/or concerns on the weekly visit and the Medical Director's associate, MD #3, is available to the facility as acting Medical Director.

In addition review of the Medical Staff Meetings, on 3/15/06, 6/15/06 and 9/13/06, lacked documentation that members of the active medical staff had attended the medical staff meetings for 2006 and/or that the Medical Director had attended at least 50% of the medical staff meetings for 2006. Review of the

DATES OF VISIT: November 9, 13, 28, 29, 30, December 13 and 14, 2006

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

3/15/06 medical staff meeting identified that the meeting attendees did sign, including the Medical Director, although there were no other active medical staff members present. Review of the 6/15/06 and the 9/13/06 medical staff meetings lacked documentation of the attendees. Interview with the Administrator, on 11/30/06, identified that there is no attendance for the medical staff meetings, although the Medical Director has attended all of the meetings since the Administrator has been at the facility (April 2006). Interview with the Medical Director, on 11/29/06, identified that there is no sign-in attendance for the medical staff meetings but that he attended all the medical staff meetings in 2006.

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

22. Based on review of the clinical record and observation for one of seven resident reviewed, Resident #34, that had pressure ulcers/sores the facility failed to maintain accurate clinical records. The findings include:
- a. Resident #34 was readmitted to the facility on 7/12/06 with the diagnoses of cerebrovascular accident, acute renal insufficiency, anemia, deconditioning, right inguinal hernia, prostatic hypertrophy and skin ulcerations. The Minimum Data Set assessment, dated 7/24/06, identified that the resident was cognitively impaired required staff extensive assistance for bed mobility, dressing, hygiene, bathing and toileting needs. The assessment also identified that the resident had limited range of motion on one side of his body in the arm, hand, leg and foot and had two stage II pressure ulcers. Review of the physician orders, dated 11/1/06, identified that the staff was directed to complete a dressing to the resident's left heel daily and a telephone order, dated 11/1/06, identified that the staff apply a dressing to the left heel daily. Review of the November treatment kardex identified that the staff was to perform a treatment to the resident's left heel daily. Observation, on 11/28/06 from 11:05 A.M. to 11:20 A.M., of LPN #1 completing skin treatments for Resident #34 identified that the resident had a pressure ulcer on the right heel and the resident's left heel skin was observed intact.

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.