

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

IN RE: Hewitt Health and Rehabilitation Center of Shelton, CT d/b/a
 Hewitt Health and Rehabilitation Center of Shelton
 45 Maltby Street
 Shelton, CT 06484

CONSENT ORDER

WHEREAS, Hewitt Health and Rehabilitation Center of Shelton, CT. (hereinafter the "Licensee"), has been issued License No.2297 to operate a Chronic and Convalescent Nursing Home known as Hewitt Health and Rehabilitation Center of Shelton, (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 September 12, 2006 and concluding on September 25, 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 October 30, 2006 (Exhibit A – copy attached); and

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

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Brian Foley, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC. The INC shall be at the facility twenty (20) hours per week to conduct an initial assessment of the

Licensee's regulatory compliance. The Department will evaluate the hours of the INC after the initial assessment of the facility. Should the Department determine that the INC needs to remain at the facility, the following provisions (paragraphs #2 through #13) shall apply.

2. The INC shall function in accordance with the FLIS' INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of three (3) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility twenty (20) 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 three (3) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of this document.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

8. The INC shall submit weekly written reports to the Department documenting:
 - a. The INC's assessment of the care and services provided to patients;
 - b. The Licensee's compliance with applicable federal and state statutes and regulations; and
 - c. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
 - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week;
 - d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated October 30, 2006;
 - e. Evaluation of the facility's Infection Control Program;
 - f. Review the facility's infection control policies/procedures pursuant to infection control practices;
 - g. Evaluation of the implementation of the facility's infection control policies and procedures;
 - h. Determining compliance with the facility's policies and procedures for cohorting of patients with infections;
 - i. Evaluating of the facility's wound care program; and
 - j. Educating and remediation of staff relevant to infection control and wound care.
11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first two (2) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the

tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
14. Effective immediately upon execution of the Consent Order, the Licensee shall employ a full time Infection Control Nurse whose sole responsibility is to implement an infection prevention, surveillance and control program which shall have as its purpose the protection of patients and personnel. The Registered Nurse hired for this position must have expertise and experience specific to infection control. The Infection Control Nurse, in conjunction with the Director of Nurses, Medical Director and Administrator shall implement a mechanism to ensure that each patient with an infection is properly identified and receiving the appropriate care and services pertinent to the identified infection. The Infection Control Nurse shall ensure the following:
 - a. Maintaining an effective infection control program;
 - b. Reviewing the facility's policies/procedures pursuant to infection control prevention, with the Director of Nurses, Medical Director and Administrator and revise as necessary;
 - c. Inservicing all staff pursuant to infection control principles and practices;
 - d. Evaluating patients on admission to determine the existence of an infection;
 - e. 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
 - f. Evaluation of staff on a routine basis, on all three shifts, regarding the implementation of infection control techniques.
15. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to

- physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, and turning and repositioning of patients.
16. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number sixteen (15).
 17. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. A nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a three (3) year period.
 18. Individuals appointed as Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.
 19. Nurse Supervisors shall be provided with the following:
 - a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
 - c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
 - d. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers in accordance with individual comprehensive care plans.
 20. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order.

The name of the designated individual shall be provided to the Department within said timeframe.

21. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the October 30, 2006 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
22. The Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars (\$5,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Rosella Crowley, 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

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

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

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

HEWITT HEALTH AND REHABILITATION
CENTER OF SHELTON, CT - LICENSEE

3-22-07
Date

By: Brian Foley
Brian Foley, President

STATE OF CONNECTICUT)

County of HARTFORD) ss MARCH 22, 2007

Personally appeared the above named Brian Foley and made oath to the truth of the statements contained herein.

My Commission Expires: 10-31-2010
(If Notary Public)

Mark E. Hambley
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court
MARK E. HAMBLEY

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

March 27, 2007
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 20

October 30, 2006

Ms. Elyse Dent, Administrator
Hewitt Health & Rehabilitation Center, Inc
45 Maltby Street
Shelton, CT 06484

Dear Ms. Dent:

Unannounced visits were made to Hewitt Health & Rehabilitation Center, Inc on September 12, 13, 14, 15, 18, 19 and 25, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and licensing and certification inspections.

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 November 15, 2006 at 10:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

Respectfully,

Rosella Crowley R.N., S.N.C.

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

RAC:ET:lsI

c. Director of Nurses
Medical Director
President
CT #5702



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

DATES OF VISIT: September 12, 13, 14, 15, 18, 19 and 25, 2006

EXHIBIT A

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

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

1. Based on clinical record reviews, and interviews for 3 of 16 sampled residents (R#4, 19, 31), the facility failed to ensure that the resident's MDS assessments were accurately coded to reflect the presence of pressure sores and/or fecal impaction. The findings include:
 - a. Resident #4's diagnoses included nephrectomy, Parkinson's disease, dementia, and stroke. A quarterly assessment dated 6/5/06 failed to accurately identify the presence of a stage three pressure sore of the penis and a stage two pressure sore of the sacrum. Interview and review of the clinical record with the MDS Coordinator on 9/14/06 at 2 PM failed to provide evidence that the MDS had been accurately coded to reflect the two pressure sores.
 - b. Resident #19's diagnoses included chronic constipation. The quarterly assessment dated 5/12/06, and annual assessment dated 8/1/06 identified the resident as cognitively impaired, totally dependent on staff for all ADL's, and incontinent of bowel. The care plans from admission in September 2004 through 8/8/06 identified chronic constipation as an ongoing problem. On 4/19/06, the resident was admitted to the hospital with a fecal impaction. Review of the 5/12/06 quarterly assessment on 9/14/06 at 3:45 PM with the unit manager, failed to provide evidence that the assessment had been accurately coded to reflect the new diagnosis/history of fecal impaction.
 - c. Resident #31's diagnoses included diabetes. A quarterly assessment dated 8/17/06 identified that the resident was cognitively impaired, totally dependent on staff for all activities of daily living, and had no pressure sores. The care plan dated 8/3/06 identified an alteration in skin integrity related to a stage two pressure area of the sacrum. Interview and review of the clinical record on 9/15/06 at 10:30 AM with the MDS coordinator noted that the sacral wound was still present. Interview further noted that the quarterly assessment of 8/17/06 failed to reflect the presence of the pressure sore.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(1).

2. Based on clinical record reviews, observations, and interviews for 6 of 48 sampled residents (R#3, 4, 18, 24, 28, 39), the facility failed to ensure that the resident's care plans were comprehensive and included their needs related to turning and re-positioning, toileting, incontinent care, pressure sore prevention/treatment, and/or MDR infections/colonizations. The findings include:

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EXHIBIT A

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- a. Resident #3 was admitted to the facility on 4/6/06 diagnoses that included urinary retention. Physician order's on admission directed the use of a Foley catheter. Physician orders dated 4/10/06 directed the staff to discontinue the use of the Foley. A-urology consult dated 4/13/06 identified that the resident had an extremely distended bladder, was catheterized, and 1500cc of urine was obtained. Interview and review of the clinical record on 9/14/06 at 1:55 PM, with the nursing supervisor failed to provide evidence that a care plan and/or interventions were developed after the Foley was removed to assess for bladder distention/return of function. Interview on 9/19/06 at 1:15 PM with the Urologist identified that the resident should have been assessed for bladder distention at least daily.
- b. Resident #4's diagnoses included nephrectomy, Parkinson's disease, dementia, and stroke. The quarterly assessments dated 3/13/06 and 6/5/06 identified that the resident was cognitively impaired, totally dependent on staff for all ADL's, incontinent of bowel, and had an indwelling catheter for bladder continence. The quarterly assessment dated 3/13/06 identified the presence of a stage two pressure sore, and a history of healed pressure sores. The quarterly assessment dated 6/5/06 failed to document the presence of two stage three pressure sores. The care plans dated 3/20/06 and 6/12/06 identified stage three pressure ulcers of the penis related to the Foley catheter, and suprapubic tube as of 5/17/06. The care plan lacked interventions for the prevention of skin breakdown related to the supra-pubic tube site. The care plan also failed to identify the unstageable new pressure ulcer of the penis as of 5/8/06 with interventions to aide in healing or prevent new areas from developing.
- c. Resident #18 was re-admitted to the facility on 5/11/06 with diagnoses that included failure to thrive, dementia, and Parkinson's disease. The significant change assessment dated 5/22/06 identified that the resident was cognitively impaired, required extensive to complete assistance with all ADL's, and had a stage one pressure sore. The care plans dated 5/22/06 and 8/8/06 included skin integrity as a problem. Interventions included to assist with good skin care after each incontinent episode, inspect skin for red areas, encourage food and fluids, treatments per physician order, assist with repositioning, and to provide a pressure relieving mattress. The wound record dated 5/15/06 identified the presence of eschar on the left heel measuring 3 by 2 cm, and a stage one of the sacrum. On 6/12/06, wound records identified the presence of a stage one of the right heel. The wound records further noted that all of the areas had healed by 6/26/06. On 9/6/06, wound records identified the presence of stage two pressure sores of both heels. Interview and review of the clinical record with the treatment nurse on 9/14/06 at 10:40 AM failed to provide evidence that the care plan had reflected the presence of the heel wounds, or any interventions specific to the heels to prevent further skin breakdown. The care plan also lacked specific interventions related to the frequency and level of assistance required for turning and re-positioning.
- d. Resident #24's diagnoses included altered mental status. The admission assessment dated 8/24/06 identified that the resident was cognitively impaired, totally dependent on staff for all ADL's, and was incontinent of bowel and bladder. An admission bowel and

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- bladder assessment dated 8/17/06 identified that the resident had a Foley catheter and was incontinent of bowel. Interview and review of the current care plan (dated 8/29/06) on 9/18/06 at 2:40 PM with the DNS failed to provide evidence that the resident's incontinence had been addressed on the care plan.
- e. Resident #28's diagnoses included carotid stenosis, diabetes, pain, stage 3 pressure sore of the heel, and critical aortic stenosis. The significant change assessment dated 12/30/05 identified that the resident was cognitively impaired, required extensive assistance for all activities of daily living, and was frequently incontinent of bowel and bladder. The care plan updated through 2/6/06 identified that the resident required assistance with all activities of daily living. Interventions included to offer to help resident if he can not complete tasks, assist with repositioning to prevent further skin breakdown, and to keep clean and dry. Interview and review of the care plan with the DNS on 9/14/06 at 9 AM failed to provide evidence that the care plan interventions were specific to address the resident's needs related to:
- i. frequency and level of assistance required for turning and repositioning
 - ii. frequency and level of assistance needed for toileting and/or incontinence checks.
- f. Resident #39's diagnoses included a history of C-diff and MRSA pneumonia. A quarterly assessment dated 8/17/06 identified that the resident was cognitively impaired, required assistance with ADL's and was incontinent of bowel and bladder. The care plan dated 8/24/06 identified the risk for skin breakdown due to incontinence and shingles. Interview and review of the clinical record with 9/19/06 at 12:50 PM with the MDS coordinator failed to provide evidence that the resident's history of MRSA and C-Diff had been addressed on the care plan. The nurse stated that she does not routinely include MRSA, VRE, and C-Diff infections on the care plans.
3. Based on clinical record review and staff interview for 1 of 13 sampled residents (R#25), the facility failed to update the care plan when the resident developed pressure sores. The findings include:
- a. Resident #25's diagnoses included bilateral heel ulcers. The nursing admission assessment dated 9/3/06 identified the presence of bilateral blisters under the skin with intact skin covering the blisters. The admission assessment dated 9/10/06 identified that the resident was without cognitive impairment, required extensive assistance with all ADL's, and had three stage three pressure ulcers. The admission/interim care plan dated 9/3/06 identified the presence of bilateral heel blisters. Interventions included to keep the right heel elevated and change the dressing as ordered. Interview and review of the clinical record on 9/14/06 at 12:30 PM with RN#1, failed to provide evidence that the care plan had been reviewed and revised when the intact blisters were noted to have progressed to open areas and/or necrotic areas on 9/9/06.

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

4. Based on clinical record reviews, and interviews for one of two sampled residents with chronic constipation and/or bowel problems requiring ongoing physical assessment (R#27) and/or for one of two sampled residents who developed pressure wounds related to Foley catheter use (R#3), the facility failed to ensure that complete bowel assessments were done, bowel movements monitored, and/or laxatives administered when needed resulting in a fecal impaction and/or volvulus, and/or that a resident admitted with swollen genitals and a Foley catheter was monitored for changes. The findings include:
 - a. Resident #27 was admitted to the facility on 7/27/06 with diagnoses that included atonic colon with colonic distention, hypernatremia and hypokalemia. The hospital discharge summary dated 7/27/06 identified that the resident had poor intake, required a tap water enema daily, and a rectal tube as needed to decompress the bowel. An addendum to the discharge summary noted that the resident's hospital stay was extended due to increased distention when the rectal tube had been removed/discontinued, and that the distention resolved when the tube was reinserted. The admission physician orders transcribed from the hospital records to the facility orders noted that the tap water enema had been changed from daily to "as needed" with no explanation noted in the nursing notes. An x-ray of the abdomen was taken on 8/2/06 for follow up as directed by the hospital discharge summary. Nurse's notes dated 8/2/06 for the 3-11 PM shift identified that the resident was noted to be semi-comatose with a temperature of 102.4. Tylenol was given. At an unknown time between 5 PM and 9:55 PM, when the resident was transferred to the hospital, nurse's notes identified that the resident's temperature was 103.2, the left arm and hand were edematous, and the abdomen was distended. Review of the results of the abdominal x-ray taken on 8/2/06 noted that they had been faxed to the facility at 3:38 PM. The report identified that the resident's sigmoid colon was "very distended" and there was a possible sigmoid volvulus. Interview and review of the clinical record with the DNS on 9/13/06 at 3 PM failed to provide evidence that the resident's abdomen had been assessed from admission on 7/27/06 until just prior to discharge to the hospital on 8/2/06 when the nurse documented that the resident's abdomen was distended, but failed to assess bowel sounds.
 - b. Resident #3 was admitted to the facility on 4/6/06 with diagnoses that included a right ankle fracture. The nurse's notes dated 4/6/06 identified that the resident was alert and oriented, required the assistance of one for ADL's, had a Foley catheter, and had a swollen penis and scrotum. A wound tracking sheet identified that 5 days later, on 4/11/06, a 6 by 1.5 cm open area was noted on the penis that contained yellow slough. The resident was evaluated by a urologist on 4/13/06 who identified severe phimosis, with necrotic tissue resulting from the retracted foreskin with necrosis on the glans. A circumcision was performed at that time, and the resident was returned to the facility.

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Interview and review of the clinical record on 9/13/06 at 10:45 AM with the Nursing Supervisor failed to provide evidence that the resident's penis and scrotal area had been assessed and/or monitored after admission on 4/6/06 until the necrosis was noted.

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

5. Based on clinical record reviews, observations and interviews for three sampled residents (R#14, 19, 28), the facility failed to follow physician orders, and/or care plan interventions related to the administration of medications as ordered, monitoring/assessing abnormal skin conditions, and/or assessing the resident's abdomen/gastrointestinal functioning. The findings include:
 - a. Resident #14's diagnoses included rheumatoid arthritis. A quarterly assessment dated 11/21/06 identified the resident was without cognitive impairment, and required extensive assistance with all ADL's. Physician orders dated 1/11/06 directed the administration of Percocet 5/325, one tablet every four hours as needed for moderate pain, two tablets as needed for severe pain, and Ambien 5 mg at bedtime as needed for insomnia. Nurse's notes dated 1/24/06 identified that at 5 PM, the resident complained of pain and requested two tablets of Percocet. The note identified that the resident received 2 tablets of Ambien instead of the two 2 Percocet. Interview and review of the clinical record and facility documentation on 9/15/06 at 12:45 PM with the DNS noted that the medication error had occurred due to the failure of the nurse to triple check the medication against the order to ensure the correct medication was administered.
 - b. Resident #19's diagnoses included chronic constipation, Parkinson's disease, bilateral below the knee amputations, and acute renal failure. The quarterly assessment dated 5/12/06 and annual dated 8/1/06 identified the resident as cognitively impaired, totally dependent on staff for all ADL's, and incontinent of bowel. The care plans from admission in September 2004 through 8/8/06 identified chronic constipation as a problem. Interventions included to provide medications as ordered, encourage adequate fluids, monitor bowel movements daily for frequency, consistency and amount, and to monitor for headache, nausea, vomiting, abdominal distention and/or cramping as they may be signs of constipation. Physician orders for April 2006 directed that the resident receive Enulose 15 ml. daily as needed for constipation if no bowel movement for 3 days, Dulcolax suppository at bedtime if Enulose ineffective, and an enema if the Dulcolax was ineffective. Review of bowel movement worksheets for 4/5/06 through 4/10/06 noted that the resident had only one small BM on 4/9/06. Review of the medication administration records identified that neither the Enulose nor Dulcolax had been administered. On 4/11/06, the physician visited and ordered an abdominal x-ray and Fleet enema. The x-ray results revealed retained feces in the left colon with no evidence of obstruction. On 4/19/06, the resident was admitted to the hospital with a

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fecal impaction and urosepsis. Review of the medication administration records identified that from 4/11/06 through 4/19/06 the resident did not receive any laxatives. Interview and review of the clinical record with the unit nurse on 9/14/06 at 10:30 AM noted that although medium BM's had been recorded daily from 4/16-19/06, the record failed to provide evidence that the resident's abdomen had been assessed as per the care plan after he was noted to have had "retained feces" on x-ray 4/11/06 requiring enemas. Further review noted that on 4/19/06 the resident's abdomen was noted to be "grossly distended" and the resident was transferred to the hospital. Review of the hospital discharge summary dated 4/24/06 noted that upon admission the resident's abdomen was firm and distended with decreased bowel sounds. A CT scan identified the presence of a fecal impaction.

- c. Resident #28's diagnoses included carotid stenosis, diabetes, pain, and critical aortic stenosis. The significant change assessment dated 12/30/05 identified that the resident was cognitively impaired, required extensive assistance for all activities of daily living, and was frequently incontinent of bowel and bladder. The care plan updated through 2/6/06 identified a cognitive decline possibly due to pain and pain medications. Interventions included that the pain medication and decreased mobility could cause constipation and to follow facility bowel protocol. An interim care plan dated 3/30/06 identified the risk for constipation/impaction. Interventions included to monitor color, consistency and quantity of bowel movements, and to monitor for signs and symptoms of constipation including distention, nausea, vomiting, et.al. The resident was readmitted to the facility on 3/29/06 from the hospital. Admission physician orders dated 3/29/06 directed the administration of milk of magnesia (MOM) if the resident failed to have a bowel movement (BM) in 6-8 shifts. Physician orders dated 3/30/06 directed that the resident receive a Dulcolax suppository if no BM in two days, followed by a Fleet enema if no results from the Dulcolax. The nursing admission assessment dated 3/29/06 and the hospital documentation included that the resident's last BM was on 3/26/06. The nurse aide flow records identified that the resident did not have a BM until 4/2/06. The bowel movement work sheets noted that the resident had a medium BM on 3/30 and a small BM on 3/31/06. Review of the medication administration kardex noted that the resident did not receive any laxatives until 4/2/06 at 9 AM when MOM was administered because the resident complained of constipation. The kardex identified that the resident was later given a Dulcolax suppository at 6 PM for constipation. Nurse's notes dated 4/2/06 from 7 AM through 7 PM noted that the resident's abdomen was distended, and bowel sounds decreased. The nurse administered the milk of magnesia in the morning, and Dulcolax at 6 PM with medium results twice. At 8:30 PM a note identified that a Fleet enema was given and the resident had large results, but was still "visibly impacted, uncomfortable. Rectal bleeding noted". The physician was notified and ordered the resident transferred to the hospital for evaluation. The resident returned from the emergency department after having been disimpacted. Interview and review of the clinical record with the DNS on 9/14/06 at 9:15 AM failed to provide evidence that the laxative orders were initiated when the resident was

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admitted on 3/29/06 and had not had a BM for the 3 days prior to admission. Further review failed to provide evidence that the resident's BM's were monitored for consistency, etc. in accordance with the care plan, or that the Dulcolax suppository/Fleet enema orders had been initiated when the resident only had only one "small" BM from 3/30/06 through 4/2/06.

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

6. Based on clinical record reviews, observations, and interviews for ten of thirteen sampled residents with pressure sores (R# 1, 2, 3, 4, 18, 20, 25, 27, 29, 30), the facility failed to ensure that resident's at risk for skin breakdown were provided with appropriate preventive measures and/or that treatments were conducted in a manner that prevents infection and aides in healing, and/or that assessments/interventions were implemented when the resident's skin broke down. The findings include:
 - a. Resident #1 was admitted on 1/5/06 with diagnoses that included a pressure ulcer. The admission assessment dated 1/15/06 identified that the resident was cognitively impaired, required extensive to complete assistance with all ADL's, and had two stage two pressure sores, and one stage three pressure sore. The quarterly assessment dated 9/5/06 identified the presence of one stage four pressure sore. The care plan dated 9/12/06 identified the presence of a stage four pressure sore of the coccyx. Interventions included to utilize a Foley catheter, monitor the wound weekly, provide a pressure reducing mattress, and to assist with turning and positioning. Physician orders dated 9/8/06 directed to irrigate the wound with normal saline utilizing a red catheter, pack undermining and tunneled areas with Kling soaked with Panafil, apply dimethicone around the area, and cover with Allevyn every shift. Observation of the treatment on 9/12/06 at 10 AM noted that the nurse used scissors from out of her pocket that were attached to a key ring with 3 keys to cut the piece of Kling used for the packing. She proceeded to contaminate the red catheter by touching the tip to the treatment cart (which was used in the resident's room as a work surface), and the bed. The nurse packed the wound with the Kling and proceeded to use the contaminated scissors to cut the excess packing away from the wound. The scissors were then placed on top of the cart. Old dressings and supplies were observed being discarded into a hole in the back of the cart without being bagged first. Observation of wound care on 9/13/06 at 9:10 AM noted that the same nurse utilized an irrigation kit that was at the bedside. After irrigating and drying the wound, the nurse changed gloves, and used the scissors from the top of the cart to cut a 6 inch piece of Kling for the packing. After the wound was covered, she applied the dimethicone with the same gloves on, and then proceeded to re-cap the Panafil and replace it in a zip-lock bag with other topical treatments for the

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- resident without the benefit of changing gloves and/or washing hands. The scissors on both occasions were observed to be placed back into her pocket without decontamination. On 9/13/06 at 11 AM, subsequent to surveyor inquiry, the nurse was interviewed with the corporate nurse and surveyor. The scissors that were in her pocket were noted to still contain evidence of the green Panafil residue, and the soiled dressings were still present in an open plastic bag in the treatment cart. The cart was observed to have residue from discarded dressings along the sides of the cart.
- b. Resident #3's diagnoses included a right ankle fracture. A nursing admission assessment dated 4/6/06 identified the resident had a dry, thickened, macerated right heel. The initial MDS dated 4/13/06 identified that the resident was without cognitive impairment, totally dependent on staff for ADL's, including bed mobility, and had no pressure ulcers.
- i. Physician's order dated 4/19/06 directed the use of a multipodus boot on the right foot at all times. Nurse's notes dated 4/22/06 identified the resident had a 2 cm blackened area on the right heel. Wound tracking notes dated 7/10/06 described the right heel as unstageable, containing slough, with drainage that had a foul odor. On 7/31/06, the heel was described as a stage III ulcer. Interview and review of the clinical record on 9/14/06 at 1:50 PM, with the Nursing Supervisor identified that although the resident was identified at risk for pressure ulcers, and had evidence of the beginning of heel breakdown on admission, the care plan and clinical record lacked evidence of interventions for the prevention of the heel breakdown prior to the development of the heel ulcer on 4/19/06.
- ii. Wound notes dated 7/31/06 identified a stage I on the dorsal area of the right heel measuring 4.5cm by 2.2cm, that was black and blue. Further review of the wound notes identified that on 8/7/06 the area had worsened and was now noted as a stage II area that measured 3cm by 2.5cm. Observation of the wound treatment on 9/13/06 at 10:30 AM with the charge nurse identified a small open area on the dorsum of the right foot. Interview at that time with the charge nurse identified that the open area was caused by the multipodus boot. Interview and review of the clinical record on 9/14/06 at 1:50 PM with the nursing supervisor failed to provide evidence that the resident's skin under the multipodus boot had been monitored.
- c. Resident #4's diagnoses included nephrectomy, Parkinson's disease, dementia, and stroke. The quarterly assessment dated 3/13/06 identified that the resident was cognitively impaired, totally dependent on staff for all ADL's, was incontinent of bowel, had an indwelling catheter for bladder continence, had a stage two pressure sore, and a history of healed pressure sores. The care plan dated 3/20/06 identified a stage three pressure ulcer of the penis related to the Foley catheter. Interventions included treatments as ordered. The APRN wound note dated 5/8/06 identified a stage three pressure sore measuring 1.5 by 1 cm of the penis, an unstageable area on the penis tip measuring 2.5 by 1.0 by 2 cm, and a new 0.3 by 0.3 cm stage two pressure sore of the sacrum. On 5/17/06, the care plan identified that a suprapubic tube had been inserted. Nursing notes dated 5/17/06 identified that the resident returned from the hospital with a

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- suprapubic tube in place that was inserted for urethral erosion. Nursing notes dated 5/17/06 through 5/22/06 noted that the suprapubic tube was leaking and the dressing was frequently wet. On 5/22/06 the tube site was noted to have a moderate amount of purulent drainage. The resident was sent to the hospital and treated with antibiotics. The APRN wound assessment note dated 6/6/06 identified that the resident had a stage two pressure ulcer measuring 2 cm at the suprapubic tube site. On 8/7/06, the APRN documented that the area had become a stage three area. Interview and review of the clinical record on 9/18/06 at 12:20 PM with the MDS coordinator failed to provide evidence that the care plan reflected the presence of the pressure areas of the suprapubic tube site or sacrum, or that interventions to prevent further breakdown of the tube sites (Foley and Suprapubic), or other pressure areas had been developed and/or implemented.
- d. Resident #18 was re-admitted to the facility on 5/11/06 with diagnoses that included failure to thrive, dementia, and Parkinson's disease. The significant change assessment dated 5/22/06 identified that the resident was cognitively impaired, required extensive to complete assistance with all ADL's and had a stage one pressure sore. The care plans dated 5/22/06 and 8/8/06 included skin integrity as a problem. Interventions included to assist with good skin care after each incontinent episode, inspect skin for red areas, encourage food and fluids, treatments per physician order, assist with repositioning, and to provide a pressure relieving mattress.
- i. The wound record dated 5/15/06 identified the presence of eschar on the left heel measuring 3 by 2 cm, and a stage one of the sacrum. On 6/12/06, wound records identified the presence of a stage one of the right heel. The wound records further noted that all of the areas had healed by 6/26/06. On 9/6/06, wound records identified the presence of stage two pressure sores of both heels, the left measuring 1 by 1 cm and the right measuring 1 by 0.6 cm. Interview and review of the clinical record with the treatment nurse on 9/14/06 at 10:40 AM failed to provide evidence that the care plan had reflected the presence of the heel wounds, or that any interventions specific to the heels to prevent further skin breakdown had been developed and/or implemented.
- ii. Observation of wound care on 9/13/06 at 8:55 AM noted the treatment nurse utilizing scissors out of her pocket to remove the old dressings from both feet without cleansing the scissors first. She then dropped the old dressings onto the bed, cleansed the wounds, and applied clean dressings without the benefit of washing hands and/or changing gloves. The nurse was observed to reach into a community pack of 4 by 4's with the contaminated gloves on that she used to remove the old dressings. Although the resident was observed to have a pillow under the knees, after the wound care the resident was left with both heels resting on the mattress without the benefit of elevation and/or protection to alleviate pressure.
- e. Resident #25 was admitted on 9/3/06 with diagnoses that included diabetes, status post right knee fusion with external fixator placement that was positive for MRSA, peripheral

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vascular disease, and bilateral heel ulcers. The nursing admission assessment dated 9/3/06 identified the presence of bilateral heel blisters under the skin with the skin intact. The admission/interim care plan identified a problem with skin. Interventions included to keep the (right) leg and heel elevated due to a blister, and to change the dressing as ordered. The care plan dated 9/8/06 noted that the right heel had opened and was bleeding. No new interventions were noted except the physician's treatment order. Nurse's notes dated 9/9/06 noted that the right heel was open and draining greenish/yellow drainage. New treatment orders were not obtained until 9/12/06 when the wound APRN assessed the resident, and noted that the area had gotten worse and was now unstageable. The resident was assessed by the orthopedist on 9/13/06 who documented that the right heel pressure ulcer was significantly worse with purulent drainage. Antibiotic therapy was ordered to be continued as well as a recommendation for "more aggressive wound care". Observations of the resident on 9/14/06 from 8:45 AM to 12 noon noted the resident in bed on the back without the benefit of re-positioning. Interview and review of the clinical record on 9/19/06 at 2:40 PM with the unit nurse (LPN) failed to provide evidence that the resident's wound had been fully assessed at least weekly (including measurements, peri-wound description, etc.), or that interventions had been developed and implemented upon the resident's admission to prevent the heel blisters from getting worse.

- f. Resident #27 was admitted to the facility on 7/27/06 with diagnoses that included atonic colon with colonic distention, hypernatremia and hypokalemia. The hospital discharge summary dated 7/27/06 identified that the resident had poor intake, was totally dependent for all activities of daily living, required a Hoyer lift for transfers, and had several superficial open areas on the coccyx measuring less than 1 cm. The physician's admission history and physical dated 7/28/06 identified a small pressure sore on the left gluteal area. Physician admission orders dated 7/27/06 were lacking a treatment order to the pressure sore of the left gluteal area. A treatment order was obtained on 7/28/06 for the use of wound gel and Allevyn every three days. The nursing admission assessment form and nursing note dated 7/27/06 failed to provide any assessment of the pressure sore other than the presence of a stage two on the left buttock. An assessment by the APRN on 7/31/06 identified that the pressure sore of the coccyx/left buttock was now unstageable, 100% slough and measured 3.4 by 0.8 cm. Interview and review of the clinical record with the DNS on 9/13/06 at 3 PM failed to provide evidence that the wound was assessed upon admission. Interview with the RN supervisor who was on duty the evening of the resident's admission on 9/13/06 at 3PM, noted that she had measured the wound that evening and left it on a piece of paper for the nurse to add to the admission assessment. Review of the admission assessment form noted that it was incomplete, not signed and lacking measurements of the wound.
- g. Resident #30 was admitted on 9/6/06 with diagnoses that included hip fracture with surgical repair on 9/3/06. The admission nursing assessment dated 9/6/06 identified that the resident had bilateral dry heels. The interim admission care plan dated 9/6/06 failed to address the resident's heels or risk for breakdown after hip surgery. Physician orders

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- dated 9/6/06 failed to address any treatments or preventive measures for prevention of heel breakdown. Observations of the resident's heels on 9/15/06 at 1:30 PM with the charge nurse identified a spongy area on the left heel. Further observation noted the resident was in bed at the time with both heels resting on the mattress. Subsequent to surveyor inquiry, a pressure ulcer tracking form dated 9/15/06 identified a stage two fluid filled blister/pressure sore on the left heel measuring 4.2 by 4 cm. Interview with the charge nurse at that time noted that he was not aware of the pressure area prior to the observation with the surveyor on 9/15/06.
- h. Resident #29 was admitted on 9/2/06 with diagnoses that included diabetes, gangrene of the right above the knee amputation site, and a stage two pressure sore of the left buttock. Physician orders dated 9/2/06 directed to cleanse the left buttock wound with normal saline, followed by Solosite, and an Allevyn dressing daily for seven days and then re-evaluate. Review of the treatment kardex for September 2006 noted that although the treatment to the left buttock was done daily for seven days, the wound was not re-evaluated on 9/8/06 as directed for further orders. It further noted that a new treatment was not initiated until 9/11/06 resulting in no treatment to the pressure sore for two days.
- i. Resident #2's diagnoses included diabetes, dementia, chronic cellulitis and a history of a recent pressure sore. A quarterly assessment dated 2/2/06 identified the resident was severely cognitively impaired, totally dependent on staff for all ADL's including transfer and bed mobility and had no pressure sores. The care plans dated 2/9/06, 5/4/06 and 7/27/06 identified the resident was at risk for skin breakdown related to incontinence, a decline in mobility and PVD. Interventions included the utilization of a custom wheelchair when out of bed, reposition every two hours while awake, and incontinent care after each incontinent episode. Wound records identified that from 2/5/06-2/20/06 the resident had a stage two of the left buttock. From 4/14/06-5/30/06, the resident developed a second stage two of the left buttock. From 7/4/06 through 9/13/06 the resident had a pressure sore of the left buttock that became unstageable with a yellow center. A low air loss bed was obtained for the resident on 8/31/06. Interview and review of the clinical record and the custom wheelchair positioning plan on 9/19/06 at 11:00 AM with the Director of Rehab identified the plan lacked specifics regarding timing of position changes, and degree of tilt as well as the length of time the resident could safely sit in the chair. Interview and review of the clinical record on 9/14/06 at 2:05 PM with the nursing supervisor failed to provide evidence that the origin of the repeated pressure sores were assessed, and/or that new interventions had been attempted when the resident continued to develop pressure sores of the same area.
- j. Resident #20's diagnosis included diabetes, stroke and congestive heart failure. A quarterly assessment dated 5/18/06 identified the resident was moderately cognitively impaired, totally dependent of staff for ADL's, and incontinent of bowel and bladder. The care plan dated 5/18/06 identified the resident was at risk for skin breakdown related to impaired mobility and incontinence. Interventions included to reposition the resident every two hours. Nurse's notes dated 5/16/06 identified superficial skin

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irritations on the buttocks. On 6/13/06 the wound tracking sheet noted a stage II open area on the sacrum which healed on 6/19/06. Wound tracking dated 8/29/06 identified a stage II open area on the buttocks, measuring 0.8cm by 0.5cm. Physicians order dated 8/29/06 directed the application of a topical ointment followed by a dry clean dressing at all times. Observation on 9/14/06 at 12:00PM identified the resident seated in a custom wheelchair. Observation of incontinent care at 1:15 PM identified that the resident had been incontinent of a large amount of stool. Two small open areas were noted on the buttocks that were not covered by a dressing. Observation of the treatment by the charge nurse at that time identified the two stage II pressure ulcers measured 2cm by 1.5cm and 0.75cm by 0.6cm. Interview and review of the clinical record at that time with the charge nurse identified that documentation on 9/12/06 identified only one open area that measured 0.1cm by 0.1cm. Interview with the NA who provided incontinent care identified that the resident was without a dressing on the buttocks wound since 11:00 AM, but it had not been reported to the charge nurse.

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

7. Based on clinical record review, and observations for one of four sampled residents with a Foley catheter (R#24), the facility failed to ensure that incontinent care was provided in a manner that aided in prevention of bladder infections/contamination of the indwelling catheter. The findings include:
 - a. Resident #24's diagnoses included altered mental status and MRSA in the urine. The admission assessment dated 8/24/06 identified the resident as cognitively impaired, totally dependent on staff for all ADL's, was incontinent of bowel and had a Foley catheter. The care plan dated 8/29/06 identified that the resident had an indwelling catheter with a MRSA infection of the urine. Observations on 9/14/06 at 11:35 AM noted that the resident had been incontinent of stool. NA#1 was observed to provide incontinent care by washing from the back to the front, contaminating the indwelling catheter with stool.

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

8. Based on observation and interview, the facility failed to maintain a safe environment during the transfilling of oxygen and/or recharging of electric wheelchair batteries in a safe location. The findings include:
 - a. On 9/14/06 at 7:53 AM, a maintenance worker was observed filling the portable oxygen containers from a large liquid tank in the oxygen storage room on unit 2B with the door open. Interview with the worker at that time noted that he was not aware that the door needed to be closed. The door of the room clearly noted that the door was to be kept closed.
 - b. Observations in room 306 on 9/14/06 at 10:40 AM and 9/15/06 at 2:15 PM noted an electric wheelchair battery was plugged into a wall outlet and charging on the window sill. Interview on 9/15/06 at 2:00 pm identified that the battery should not be charged in the resident's room.

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

9. Based on clinical record reviews, interviews and review of the facility investigations for two of six sampled residents who had a history of falls (R#5, 15), the facility failed to develop and implement interventions on admission to prevent falls from occurring resulting in an injury, and/or failed to ensure that an alarm was in place and functional. The findings include:
 - a. Resident #15 was admitted on 3/16/06 at 5:35 PM from the hospital. The diagnoses included fall at home with neck fracture, right eye laceration, and advanced Parkinson's disease. The nursing admission assessment dated 3/16/06 at 5:35 PM identified that the resident required 2 staff for transfer assistance, personal hygiene and grooming, and was incontinent.
 - i. The fall risk assessment dated 3/16/06 identified that the resident was at risk for falls. The interim admission care plan was noted to be completed on 3/17/06. The care plan failed to identify the risk for falling or any interventions to keep the resident safe. Nursing notes dated 3/17/06 at 3:40 AM identified that the resident was found on the floor between the beds. A large amount of bleeding was noted coming from the left side of the head, a skin tear was noted on the elbow, and the resident complained of right shoulder pain. The resident was transferred to the hospital and returned with staples in place to the head laceration. Interview and review of the clinical record on 9/14/06 at 6:22 AM with the nurse who found the resident on the floor, failed to provide evidence that interventions to prevent fall injuries had been put in place when the resident

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was determined to be at risk for falls. Interviews with the RN supervisor, ADNS and corporate nurse on 9/14/06 noted that residents at risk are monitored every two hours, and the call bell is put in place, but interventions such as alarms, mats, low beds, etc. are not routinely put in place upon admission.

- ii. The care plan dated 3/28/06 identified a problem of a fall at home with a cervical fracture and another fall after admission with a head laceration. Interventions included the use of a bed and chair alarm. Nursing notes dated 4/29/06 at 7:30 PM noted that the resident was found sitting on the floor between the foot of the bed and the wall. The resident noted that she had struck her head on the wall. The resident was sent to the hospital for evaluation of possible changes to the cervical fracture. Although the nursing note identified that the alarm was in place and functioning, the facility investigation noted that the resident was found on the floor by a visitor who was passing by, and there was no evidence that the alarm was on or sounded. Further review noted that the nurse aide had assisted the resident's family to get the resident out of bed, and then left the resident with the family without applying the alarm. Interview and review of the medication administration record and treatment kardexes for March and April 2006 with the DNS and corporate nurse on 9/14/06 at 11:05 AM failed to provide evidence that the alarm was on and functioning.
- b. Resident #5's diagnoses included stroke, osteoporosis, and dementia. A quarterly assessment dated 5/4/06 identified that the resident was moderately cognitively impaired, required extensive assistance with all ADL's and had a history of falls. The resident care plan dated 5/11/06 identified the resident was at risk for falls related to poor safety awareness and impaired mobility related to a stroke. Interventions included utilizing a self release seat belt in the wheelchair. Physician orders dated 6/26/06 directed the use of a self release seat belt when in the wheelchair. Nurse's notes dated 7/9/06 at 11:20 AM identified that the resident was found lying on the floor in front of her wheelchair. Interview and review of the facility investigation with the DNS on 9/18/06 at 11:15 AM identified that the chair the resident fell from did not have a self releasing seat belt applied. It was noted that the resident's chair had been removed for cleaning the week prior and not returned.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2).

10. Based on observations and interviews, the facility failed to transport and/or served food items that were covered/maintained in a sanitary manner. The findings include:
 - a. Observation on 9/12/06 at 11:30 AM of the noon meal identified the lower shelf of a coffee cart contained slices of cake on plates that were not covered. The lower shelf was approximately 10 inches from the floor. The dietary assistant was observed pushing the

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coffee cart from the one unit to another unit while the nurse was serving the uncovered cake to the residents. Subsequent to surveyor inquiry, the uncovered sliced cake was removed. Interview with the dietary aide on 9/12/06 at 11:45 AM identified that the cake should be covered.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D&t (j) Director of Nurses (2) and/or (t) Infection Control (2).

11. Based on review of the facility infection control records, policies, observations and interviews, the facility failed to ensure that an infection control program was in place that monitored, investigated, and analyzed all infections, kept records of multi-drug resistant (MDR) bacterial colonizations, and/or infections, reviewed cohorting of residents with MDR organisms, monitored the environment via surveillance rounds, and/or presented infection data to the medical director and/or board for review. The findings include:
 - a. Upon requests to review the line listings for all residents who had current and/or histories of MDR infections and/or colonizations, the facility presented the surveyors with a list containing incomplete information for residents with Clostridium Difficile (C-Diff), Methicillin Resistant Staphylococcus Aureus (MRSA), and/or Vancomycin Resistant Enterococcus (VRE). Subsequent to surveyor inquiry, all records in the facility were reviewed and new line listings developed for each bacteria. Comparison of the original list provided to the surveyors with the list developed after review of all records noted that there were actually 21 residents with MRSA or a history of MRSA compared to 12 originally reported; two with VRE where 0 were originally reported and 3 with C-diff where 1 was originally reported.
 - b. Interview and review of the facility line listings, monthly statistics and quarterly statistics for all infections in the facility from June 2006 through August 2006 with the DNS and corporate nurse on 9/14/06 at 2 PM noted that the line listings lacked the origin of the infection, the bacteria responsible for the infection and/or the resolution of the infection and/or if the infection was community or facility acquired. The quarterly statistics were incomplete, unsigned and inaccurate when compared to the monthly listings, for example, total of all monthly skin infections was 19 and only 7 were documented on the quarterly report. Line listings and statistics were not available for October 2005 through May 2006. Interview at that time noted that the lack of monitoring infections and keeping statistics had been identified by the facility management several months prior to the survey and they thought that the problems had been corrected.
 - c. Review of facility policies identified that environmental rounds were to be made quarterly and acted upon by the department heads. Review of facility environmental rounds records noted that no rounds had been completed from 10/05 through 6/06.
 - d. Review of nurse aide assignments/care cards for the residents known to have a history of

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- MRSA, VRE or C-diff noted that for Residents # 1, 15, 19, 23, 40, 41, 42, 43, 44, 45, 46, 47, 48, 39, and 37, the assignments lacked notification to staff of the history and/or the site of the colonization/history.
- e. Review of facility policies noted that the Infection Control Committee was to meet quarterly at the medical staff meeting and should review the number and type of infections, the infection rate and the resolution rate, surveillance rounds, the policies and procedures (annually), adherence to policies and procedures by staff, and areas that needed training. Repeated requests to see evidence of the infection control meetings were unable to be accommodated by staff.
 - f. Review of the facility Infection Control Manual noted that the facility lacked policies and procedures to address monitoring and caring for residents with MRSA and VRE.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control (2).

- 12. Based on clinical record reviews, observations and interviews for two of three sampled residents that required isolation/contact precautions related to MRSA infections (R#24, 25), the facility failed to ensure that facility policy regarding communication of the infections to staff via signage was carried out, and/or that utilization of appropriate personal protective equipment and/or appropriate handwashing took place for residents on isolation. The findings include:
 - a. Resident #24's diagnoses included MRSA in the urine. Nurse's notes dated 9/3/06 identified that the results of a urine culture were back and noted that the resident had a urinary tract infection with MRSA. The note indicated that the resident was started on antibiotics and placed on contact precautions. Observation on 9/14/06 at 1 PM with the unit supervisor, RN#1, noted the resident to be without a sign on the door to indicate to staff that the resident required contact precautions. Interview at that time noted that facility policy directs that a sign was to be posted for all infections requiring contact or other precautions.
 - b. Resident #25's diagnoses included fusion of the knee with external fixator secondary to infection with MRSA. The admission assessment dated 9/10/06 identified that the resident required assistance with ADL's, had no cognitive impairment, and had a drug resistant organism. The admission interim care plan identified a problem related to infection with MRSA. Physician orders dated 9/3/06 directed that contact precautions be maintained for MRSA in the wound. Observations on 9/14/06 at 8:30 AM noted a sign outside the resident's door identifying the need for contact precautions, and to wear gloves when entering the room and a gown if any contact was expected with the resident or environment. NA#1 was then observed to enter the room at 9:16 AM and provide re-positioning of the resident's leg, without the benefit of donning a gown or gloves or washing hands. Review of the clinical record and interview with RN#1 on 9/14/06 at 1:14 PM noted that staff is expected to gown and glove when entering the resident's

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room/providing care.

13. Based on clinical record reviews, observations and interviews for three of sixteen sampled residents for whom care was observed during the survey (R#18, 24, 39), the facility failed to ensure that appropriate handwashing was carried out to prevent the spread of infection. The findings include:
- a. Resident #18 was re-admitted to the facility on 5/11/06 with diagnoses that included failure to thrive, dementia, and Parkinson's disease. The significant change assessment dated 5/22/06 identified that the resident was cognitively impaired, required extensive to complete assistance with all ADL's and had a stage one pressure sore. The care plans dated 5/22/06 and 8/8/06 included skin integrity as a problem. Observation of wound care on 9/13/06 at 8:55 AM noted the treatment nurse utilizing scissors that she took out of her pocket to remove the old dressings from both feet without cleansing the scissors first. She then dropped the old dressings onto the bed, cleansed the wounds, and applied clean dressings without the benefit of washing hands and/or changing gloves. The nurse was observed to reach into a community pack of 4 by 4's with the contaminated gloves on that she used to remove the old dressings.
 - b. Resident #24's diagnoses included MRSA of the urine. The admission assessment dated 8/24/06 identified that the resident was cognitively impaired, totally dependent on staff for all ADL's, had a Foley catheter and was incontinent of bowel. Observation of incontinent care on 9/14/06 at 11:35 AM noted that nurse aide #2 provided incontinent care, disposed of the soiled linen, and exited the resident's room without the benefit of handwashing. Review of the clinical record and interview with the Director of Nurses on 9/18/06 at 2:40 PM noted that anytime gloves are removed, handwashing should be done.
 - c. Resident #39's diagnoses included a history of C-diff and MRSA pneumonia. The quarterly assessment dated 8/17/06 identified that the resident was cognitively impaired, required assistance with ADL's, and was incontinent of bowel and bladder. Observations on 9/19/06 at 9:04 AM noted that a nurse aide exited the resident's room holding a used brief with one gloved hand. She proceeded to take the brief down the hall into the soiled utility room. She then removed the glove, exited the soiled utility room, went to the clean linen cart to retrieve a new disposable brief and wash cloths, and re-entered the resident's room without the benefit of washing her hands. Interview with the NA at that time noted that she had not washed her hands because she had not yet finished caring for the resident.

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14. Based on observations and interviews, the facility failed to ensure that soiled linen was handled in a manner that prevents the spread of infections. The findings include:
- a. During observations on 9/14/06 at 9:35 AM, 9:45 AM, and 10:34 AM, it was noted that nurse aide # 1 carried soiled linen from residents' rooms into the hallway, and placed them in the soiled linen barrels without the benefit of gloves and/or bagging prior to leaving the rooms. Interview with the DNS on 9/18/06 at 2:40 PM noted that linen should be bagged before being brought into the hallway and gloves worn while handling soiled linen.

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

15. Based on review of employee files, facility documentation, and interview for one of two Licensed Practical Nurses employed at the the facility for which the surveyor reviewed credentials (LPN#1), the facility failed to ensure the nurse was licensed in the state of Connecticut prior to allowing her to perform resident care. The findings include;
- a. LPN#1 was hired on 1/13/06 for part time employment in the facility, as a Licensed Practical Nurse. A Termination Report dated 2/2/06 identified that the last day the LPN worked was 1/31/06. Interview and review of the employee file and facility documentation on 9/15/06 at 12:45 PM with the DNS identified that on 1/24/06 LPN#1 made a medication error. In the process of investigating the medication error, it was determined that LPN#1 did not have a current Connecticut license. Further review of the employee file identified that although the nurse was licensed in New York, there was no evidence that LPN#1 had been granted and/or applied for a license in Connecticut.

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

16. Based on survey results and interviews, the facility failed to ensure that the medical director was actively involved in the infection control program/committee, and/or reviewed other physician's negative resident outcomes. The findings include:
- a. Review of the facility infection control program noted that facility policies were incomplete and/or lacking medical director approval, tracking of infections had not been done for eight months (October 2005 through June 2006), the facility lacked an accurate listing of residents known to have histories of MDR infections/colonizations, the facility lacked current infection control policies and procedures related to MRSA and VRE, and staff failed to follow appropriate isolation and handwashing techniques. In addition, a pattern of avoidable pressure sores in the facility was not recognized and/or

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interventions to prevent further skin breakdowns initiated. Interview with the medical director on 9/19/06 at 9:45 AM noted that he was not aware of the lack of infection control monitoring, had not reviewed the negative outcomes related to pressure sore development at the facility, and/or had not reviewed records of residents who may not have had appropriate medical care by other physicians on staff at the facility.

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.