

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

IN RE: Tikvah, LLC of Suffield, CT
d/b/a Suffield by the River
7 Canal Road
Suffield, CT 06078

CONSENT ORDER

WHEREAS, Tikvah, LLC of Suffield, CT d/b/a Suffield by the River (hereinafter the "Licensee"), has been issued License No.AL-0036 to operate an Assisted Living Services Agency known as Suffield by the River, (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 19, 2006 and concluding on October 24, 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 November 3, 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 Celia J. Moffie, its Executive Director/Owner hereby stipulate and agree as follows:

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

2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of 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 sixteen (16) 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 three (3) weeks after the execution of this document.
6. The INC shall confer with the Licensee's Supervisor of Assisted Living Services 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 Supervisor of Assisted Living Services 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 governing authority, the quality assurance committee 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, and assisted living 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 November 3, 2006 (Exhibit A).
11. The INC, the Licensee's Executive Director and Supervisor of Assisted Living Services shall meet with the Department every four (4) weeks 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 upon the execution of this Consent Order, the Licensee, through its Governing Body and Supervisor of Assisted Living Services, shall ensure substantial compliance with the following:

- a. All clients are initially assessed in a timely and comprehensive manner and all subsequent re-assessments are comprehensive and completed as often as necessary, but no less than every one-hundred twenty (120) days, depending on the condition of the client;
 - b. Each client service program is reviewed and revised to reflect the individual client's problems, needs and goals, based upon the client assessment and in accordance with applicable federal and state laws and regulations;
 - c. The personal physician or covering physician is notified in a timely manner of any significant changes in client's condition including, but not limited to, decline in skin integrity, and deterioration of mental, physical, nutritional, and/or hydration status;
 - d. All services are provided in accordance with written physician orders. The use of restraints is inappropriate in the care of clients;
 - e. All licensed nurses shall only administer medications which they have personally prepared/poured;
 - f. Assisted living aides are provided with written instructions that are reflective of the needs of the client and which include pertinent aspects of the client's condition to observe and report to the registered nurse; and
 - g. If the client's condition is no longer chronic and stable, services of a licensed home health care agency are engaged or other appropriate arrangements are made for discharge.
15. 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.
16. The Licensee shall within twenty-one (21) days of the execution of this Consent Order, review and revise, as necessary, the service program of each client receiving assisted living services as of the date of this Consent Order, based upon the client's current and ongoing assessments of chronic and stable status, appropriateness for home health care agency services and reflective of the individual client's problems, needs and goals.
17. The Licensee shall within twenty one (21) days of the effective date of this Consent Order review and revise as necessary all policies and procedures which are pertinent to client assessment, development and implementation of the client service program ,

medication administration by licensed personnel and notification of the appropriate source of medical care of the condition of the patient.

18. The Licensee shall within thirty (30) days of the effective date of this Consent Order in-service all direct service staff on topics relevant to provisions of Sections 14, 16 and 17 of this document. The Licensee shall maintain an attendance roster of all in-service presentations which shall be available to the Department for a period of two (2) years.
19. The Licensee shall within sixty (60) days of the effective date of this Consent Order, audit the client service record of each client currently receiving services to ensure that each client's current condition is accurately and consistently documented. Within ten (10) days after the completion of the client service record audits, all direct care staff shall be provided with in-service education pursuant to deficient practices identified as a result of the client service record audits. Subject to this Consent Order, documentation of in-services shall be maintained by the Licensee for review by the Department for a period of three (3) years.
20. The Licensee shall include in its Quality Assurance Program (QAP) a mechanism to review patient care issues including those identified in the November 3, 2006 violation letter and, if applicable, implement remediation measures. 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. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand five hundred dollars (\$2,500.00), 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:

Victoria V. Carlson, RN, MBA
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

22. 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, 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.

23. 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.
24. 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.
25. 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.
26. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.
27. The execution of this Consent Order shall not constitute an admission by the licensee of any of the allegations contained herein or of any of the alleged violations contained in Exhibit A attached hereto.

*

*

*

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.

Tikvah, LLC of Suffield, CT d/b/a Suffield
by the River

February 9, 2007
Date

By: 
Celia J. Moffie, Executive Director/Owner

STATE OF Connecticut)

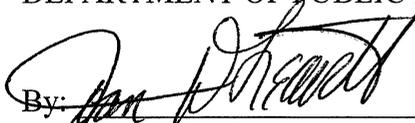
County of Hartford) ss at Suffield February 9, 2007

Personally appeared the above named Celia J. Moffie and made oath to the truth of the statements contained herein.

My Commission Expires: 5-31-2010 Karen A. Usabille
(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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 8

November 3, 2006

Cathleen Marchesi, RN, SALSA
Suffield by the River
7 Canal Road
Suffield, CT 06078

Dear Ms. Marchesi:

Unannounced visits were made to Suffield by the River on September 19, 20, 21, 22, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through October 24, 2006.

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

An office conference has been scheduled for November 22, 2006 at 9:00 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,

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

c. D. Canalis



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

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d)(4)(A) Governing authority of an assisted living services agency and/or D105(h)(3)(D) Nursing services provided by an assisted living service agency.

1. Based on a tour of the secured dementia unit, agency protocol and staff interview, it was determined that the agency failed to ensure the safety of clients in the secured dementia unit at all times. The findings include:

- a. A tour of the secured dementia unit on 9/19/06 identified that the windows in the client's rooms were not adjusted to prevent them from being fully opened.
- b. In addition, the gate to the outside garden was not locked on 9/19/06 and 9/21/06. RN #1, assigned to the secured dementia unit stated on interview on 9/21/06, that at times the landscapers forget to lock the gate but that the door alarm will sound if residents walk into the garden area. There was no code to exit the secured unit but if the door is pushed long enough, an alarm will sound. The agency protocol is to always have an aide outside with the clients since a new waterfall area was constructed this season. The SALSA and/or RN #1 failed to ensure the safety of the clients at all times by checking the outside door daily and as indicated and/or by adjusting the windows appropriately to prevent a client from using them as an exit.

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g)(2)(A)(B)(D) Supervisor of assisted living services and/or (h)(1)(3)(B)(C)(D) Nursing services provided by an assisted living agency and/or D105(i)(5)(B) Assisted living aide services provided by an assisted living services agency.

2. Based on observations, clinical record review and staff interviews, it was determined that for six (6) of eight (8) clients, the SALSA and/or the RN failed to document a comprehensive reassessment of the client and/or to review and update the client service program as often as the clients' condition required, but not less than every 120 days and/or to update special instructions for the aides to follow including pertinent information to be observed and reported to the RN and/or failed to ensure that appropriate protocols were being followed (Client #s 2, 4, 5, 6, 7, 8). The findings include:

- a. Client #2 moved into the MRC on June 25, 1999 and was moved into River Walk (the secured unit) on 7/29/05 with diagnoses including status post CVA, mitral valve regurgitation, seizure disorder, dementia, GERD; congestive heart failure (CHF), atrial fibrillation and chronic obstructive pulmonary disease (COPD).
- i. The nursing narrative dated 1/21/05 noted that the client choked at breakfast in the main dining room. The Heimlich maneuver was performed by an ALSA aide and a large piece of pineapple was coughed up. The daughter was notified and she (the daughter) was to call and notify the physician. The client

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

service program and aide's instruction sheet was not updated to reflect this choking episode. The SALSA/RN failed to take responsibility to notify the physician of the incident and to request a speech therapy evaluation or other appropriate interventions. On 9/20/06, the SALSA stated that a speech therapy evaluation was not done.

ii. The nursing narrative of 11/29/05 indicated that the client had a congested cough that was non-productive. The daughter called the physician; RN #1 stated on interview on 10/24/06 that she was unsure if she called the physician however, the daughter did call and she (RN #1) got new orders. The nursing narrative of 11/29/05 noted that the nurse was called to see the client who was very pale with audible expiratory wheeze as well as wheezes scattered throughout lower lobes. A nebulizer treatment was given. The client was sent to the hospital with a diagnosis of aspiration pneumonia. The client returned to the ALSA 12/7/05. The nursing narratives of 12/12/05, 12/13-26/05 described the client as complaining of weakness, fatigue, and having a weak congested cough on 12/15/05, and that the client slept in the recliner most of this evening. The narrative of 12/19/05 indicated that the client "continues to complain of fatigue, weakness, the congestive cough is less often and lungs diminished after cough." The nursing narrative of 12/22/05 indicated that oxygen continued to run at 2 liters per minute, congestive cough is rare, and client coughs with some liquids. A fax was sent to the physician on 12/22/05 to update him re: the client blood sugar values but there was no documentation that she alerted the physician about the client's physical sign and symptoms and/or respiratory status. The narrative of 12/26/05 indicated that the client was very tired, no cough was heard, lungs diminished, appetite fair and fluids were encouraged. The next nursing narrative was written nineteen days later on 01/14/06 to record that the ALSA aide's report stated that the client was sent to the Hospital #2 due to respiratory distress. The client was discharged 1/20/06, with reason for admission documented as congestive heart failure (CHF), shortness of breath for the last few days, bilateral pleural effusion, likely COPD and a UTI. The discharge summary from the hospital dated 1/20/06 stated that the client had a cough for about two weeks, which was non-productive, shortness of breath for the last, few days and increase swelling of her legs. The client was given 80mg of Lasix and Solumedral 125mg and Albuterol nebulizer treatment. Her blood pressure in the emergency room ranged from 157/103 to 147/95. Orders on the discharge summary indicated that a daily weight should be taken, low sodium diet, restriction of fluid intake and honey thick liquids, chopped diet and aspiration precautions. Review of the clinical record with RN #1 failed to provide evidence that the discharge orders were implemented and/or followed.

iii. Client #2 was on a sliding scale for insulin from 12/8/05 to 2/8/06. Blood sugars were ordered BID on a daily basis. The client was on Glyburide 5 mg BID, which was discontinued on 1/20/06. On 5/10/06 a verbal order discontinued fasting blood sugars every AM and ordered fasting blood sugars every AM Monday and Thursday; however there were no parameters recorded as to when the physician must be notified. On interview 9/21/06, the RN stated that no parameters were given, but based on the average blood sugar readings, she would call the physician when the client's readings reached 200 RN #1 failed to call the physician to clarify the orders to maintain the client's safety. The aides provide the blood sugar checks however, they had no parameters to guide them as to when to call the nurse. The RN on interview 9/21/06, stated that the aides document the blood sugar on a flow sheet, that she does check blood sugars on the flow sheets and the aides are very careful about reporting any higher than

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

average blood sugars to her. The RN failed to instruct the aides by obtaining exact parameters from the physician and providing clear directions for the aides for reporting variances that might indicate a change in the client's condition that might require prompt attention. In addition, the aide's instruction flow sheet did not include signs and or symptoms of hypo/hyperglycemia to report to the nurse.

iv. The nursing narrative dated 4/29/06 indicated that the client vomited and then had two loose stools at midnight. This narrative documented a six (6) loose stools on this date ranging from large to small in amount; Immodium was given three times. The nursing narrative dated 4/30/06 indicated that the client was listless at 11:00AM and both daughters were notified. At 2:30 PM, the client was shaky and unable to stand without the assist of two. The daughters agreed not to send mother to the emergency room at this point. Lopressor and Lasix were held this PM. At 7:15 PM, the client had one large liquid stool. The daughter continued to want the client to remain at the ALSA that evening; RN #1 stated on interview on 10/24/06, that since there was no documentation of the physician being called, she assumed that it was not done. The next narrative was not written until 5/3/06. This narrative indicated that the client was very pale, weak, more confused from baseline, skin turgor was poor, and mucous membranes were dry. The daughter agreed to transfer the client to the hospital. The client was admitted with the diagnosis of altered mental status, mild congestive heart failure and gastroenteritis. During an interview with the RN #1 on 9/21/06, she stated that the two daughters were nurses and they decided the care their mother would get. There was no documentation in the record that the client was a "DNR (do not resuscitate)/DNH (do not hospitalize). The RN failed to notify the physician of the client's change in condition and/or take appropriate action to ensure the client's safety.

v. The client was hospitalized as follows: in 9/2005 with urosepsis, 11/2005 with aspiration pneumonia, and 5/2006 with altered mental status and mild congestive heart failure. At the time of the 5/2006 hospitalization the client's medications included Digoxin.125 mg. daily and Lasix 40 mg. The nursing narrative dated 7/24/06 stated that the assisted living service aides reported that the client was in respiratory distress with increased pulse rate last evening, 7/23/06, around 10:30 PM, 911 was called and the patient was hospitalized. The discharge report dated 7/25/06 documented that the client was admitted with congestive heart failure. The hospital discharge summary dated 7/23/06 indicated that the client was diuresed of two liters of fluid. The RN instructions included on the "Result Review Report Inpatient Discharge Instructions" dated 7/24/06 recorded the client's discharge weight at 117 pounds and directions stated to call the physician with a 2 pound weight gain or more in one day or 5 lbs or more in a week. In addition, a fluid restriction of 4-5 cups per day was also requested and a 2 Gm sodium diet.

On interview 10/24/06, RN #1 stated that the nurses and she did not see these instructions and therefore they were not followed; the physician was not communicated with to determine if these instruction were to be followed. The vital sign record indicated that on 8/8/08, 8/21/06 and 8/30/06 the RN documented that weights were unable to be taken and there was no documentation that any other weights had been obtained; there was no documentation that the physician was notified. The RN failed to call the physician to verify orders, and/or to update the client service program to reflect the change in this client's condition, and/ or to update the aides instructions based on the hospital discharge orders to assure the client's quality of care and safety.

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

- b. Client #4 was admitted to the ALSA on 12/30/03 with diagnoses that included diabetes mellitus type II, coronary artery disease, atrial fibrillation, gastro esophageal reflux disease (GERD), depression, a history of cerebral vascular accident (CVA), and hypertension. Review of the clinical record identified that the client was admitted to an acute care hospital from 6/24/06 to 7/3/06 with diagnoses of acute urinary tract infection and exacerbation of acute congestive heart failure (CHF) due to diastolic dysfunction. She was admitted to a skilled nursing facility for post hospital rehab from 7/3/06 through 9/5/06, at which time the client was readmitted to the ALSA. She was identified as alert, oriented, forgetful at times. The interdisciplinary referral form (W-10), directed that she was to have no concentrated sweets and a no added salt diet, finger stick blood sugars twice a day before breakfast and dinner, was to take an oral hypoglycemic (Starlix 120 mg TID) and a diuretic that was double the dose prior to hospitalization (Lasix 40 mg qd vs Lasix 20 mg qd.).
- i. Review of the client service program updated on 9/6/06 and the memo of understanding with Home Health Care Agency (HCA) #1 dated 9/6/06, documented that finger-stick blood sugar levels were to be done twice a day by the ALSA, before breakfast and dinner. Review of the clinical record identified that there was no documentation of results in the record nor were there any parameters given by and/or requested from the physician. During a home visit on 9/21/06, the assisted living aide stated that a log of the blood sugar level results was kept in the client's apartment. Review of the documented results identified that they were only done in the morning and ranged between 116 and 145. It was also noted that the blood sugars results were not documented until 9/16/06 and that they were only done once per day. During an interview with the SALSAs and ALSA Aide #1 on 9/21/06, they stated that they could not begin testing until 9/16/06 because they were having a problem with the strips. When asked if the physician had been notified, they felt sure that the client's daughter had notified him. The SALSAs failed to notify the physician directly that discharge orders were not followed for 10 days after discharge.
- ii. Review of the vital signs record documented that weight, blood pressure and pulse were taken every 4 months. On 2/15/06, the client weighed 195 lbs, on 6/13/06, she weighed 199 lbs. and when she returned to the ALSA, she weighed 185 lbs. HCA #1 became jointly involved with Client #4 on 9/6/06 but did not direct the ALSA to get daily weights despite the recent hospitalization for CHF exacerbation. During an interview with the SALSAs on 9/21/06, she stated that the HCA nurse who visited the previous day had heard some "crackles in the client's lungs" and the client was going to see her primary care physician (PCP) that afternoon. The next day on 9/22/06, the SALSAs stated that the PCP had increased the client's Lasix to 40 mg in the AM and 20 mg in the PM. The ALSA failed to implement appropriate nursing standards of care regarding monitoring an individual with CHF and/or did not get consistent daily weight measurements to help monitor the client's fluid retention status.
- c. Client #5 was admitted to the secured, cognitively impaired unit of the ALSA on 12/28/05 with diagnoses including dementia, normal pressure hydrocephalus, Parkinson's disease and diabetes mellitus. A cognitive exam dated 12/29/05 had a score of 11 out of 30 indicating significant impairment. A functional assessment last updated on 8/28/06 identified that the client was occasionally incontinent of bowel and bladder, and totally dependent for all activities of daily living (ADL).
- i. During lunchtime observation on 9/21/06, Client #5 was observed sitting in a wheel chair with no

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

foot rests. She was leaning forward slightly and had a seat belt around her waist in the front that was buckled behind the back of the wheelchair; there was no slack between the client's body and the belt. When spoken to, the client responded stating that she did not like the seat belt and could not remove it. During a visit to the client's apartment on that day, it was observed that the client had a hospital bed with full-length side rails. The back side-rail was up and RN #1 stated that the client used both side rails at night for safety. Review of the nursing notes dated 12/30/05 identified that the client was attempting to stand and was becoming resistant to care. RN #1 spoke to the family "who agreed" to a wheel chair seat belt although there was no documentation of this. The next note dated 1/9/06 noted that the seat belt was a good reminder for the client not to stand-alone. Review of the clinical record failed to provide evidence that the physician ordered and/or was made aware that the client was in a seat-belt she could not remove, and/or the use of full side-rails at night, and/or that the client was assessed for other alternatives and/or the least restrictive device and/or that a consent was signed by the family and/or that the client was assessed to see if she still met ALSA guidelines of chronic and stable intermittent care.

ii. Blood glucose finger stick results were ordered by the physician and documented on the aide's instruction sheets to be done each Monday and Thursday at 7:30 AM and 4:30 PM. There were no parameters ordered and/or requested regarding levels requiring physician notification. Review of the results identified that on Thursday 6/29/06 at 4:30 PM the client's blood sugar was 322. On Thursday 8/10/06, the clients blood sugar was 220 in the AM and 183 in the PM. Other results ranged from 128 to 199 in the AM and 101 to 311 in the PM. Nursing notes between these dates did not document that the physician was notified of these variations. Review of the record on 9/21/06 identified that the last documented reading was 9/14/06 in the AM; review of the same record on 9/22/06, identified that subsequent dates were recorded. Interview with RN #1 on 9/22/06 identified that she had filled in the levels from the glucometers memory and stated she would have to get after the aides to record the readings on a timely basis. She further stated that she had not notified the physician about the elevated levels because there were no instructions to do so. The SALSA failed to obtain, and/or to document blood glucose reading parameters for physician notification and/or to notify the physician when significantly abnormal blood glucose levels were obtained, and/or to supervise the aides to assure that the aides were documenting the results on the day they were done.

d. Client #6 was admitted to the ALSA on 4/7/01 with diagnosis of depression and a history of a traumatic brain injury (TBI). Interview with the SALSA on 9/22/06 identified that the client was sent to the hospital on 9/5/06 because he was vomiting dark colored material and they thought he was having a gastro-intestinal bleed but he was better and they were waiting for him to return. Review of the functional assessment last updated on 7/10/06 identified that the client was totally dependent, required a puree diet with nectar thick liquids, was incontinent of bowel and bladder and required a toileting schedule, was dependent in the wheelchair and could walk short distances with a walker and assistance. Goals included: "shall have no falls; shall have no signs and symptoms of aspiration".

i. Review of the monthly aides activity sheets from April 2006 to present identified that the aides were to release the client's seat belt every two hours and check the seat belt every ½ hour. During an interview with RN #1 on 9/22/06, she stated that the client was still in the hospital, had never been

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

tested to see if he could release his seat belt but that he was totally dependent on staff for all his needs. She further stated that she was unaware that a physician's order was needed for a restrictive device. Review of the clinical record failed to provide evidence that the physician ordered and/or was made aware that the client was in a seat-belt, and/or that the client was assessed for other alternatives and/or the least restrictive device and/or that a consent was signed by the family and/or that the client was assessed to see if he met ALSA guidelines of chronic and stable intermittent care.

ii. Review of Client #6's record identified that on 11/10/04 the physician wrote an order for the nurse to administer medications crushed in applesauce. The service record of the care plan last updated on 7/10/06 identified that the client's son pre-poured the medications. The record contained a medication pour record that documented that the nurse pre-poured the medications weekly. Additionally there were completed "PCA (patient care associate) supervision of medications" which were to be given at 8 AM and 8 PM and were being signed by the nurses. The licensed ALSA staff did not document their medications on a medication administration record and/or if meds were pre-poured a week at a time, some nurses were crushing and administering meds poured by another nurse. During an interview with RN #1 on 9/26/06 at 1:45 PM, she stated that certain clients including Client #s 2, 6, 7, required a nurse administration because their medications were to be crushed and they did not have a pre-packaged pharmacy system. Consequently, the ALSA's method was to have a nurse pre-pour all medications once a week, into a weekly planner, and the nurse on duty would crush the medication and administer it to the client.

e. Client #7 was admitted to the cognitively impaired, secured unit of the ALSA on 11/3/01 with diagnoses that included Parkinson's disease, confusion, basal cell cancer, and a history of dehydration and pneumonia. A functional assessment and client service program updated on 6/16/06 identified that the client was incontinent of bowel and bladder, dependent in a wheel chair but could be transferred with the assist of two staff, had dysphagia secondary to Parkinson's requiring a puree diet, nectar thick liquids and crushed meds and was totally dependent for all ADLs.

i. The record contained a medication pour record that documented that the nurse pre-poured the medications weekly. Additionally there were completed "PCA (patient care associate) supervision of medications" which were designated for 8 AM and 8 PM which were being signed by the nurses. The licensed ALSA staff did not document their medications on a medication administration record and/or if meds were pre-poured a week at a time, some nurses were crushing and administering meds poured by another nurse. During an interview with RN #1 on 9/26/06 at 1:45 PM, she stated that certain clients including Client #s 2, 6, 7, required a nurse administration because their medications were to be crushed and they did not have a pre-packaged pharmacy system. Consequently, the ALSA's method was to have a nurse pre-pour all medications weekly, into a weekly planner, and the nurse on duty would crush the medication and administer it to the client.

f. Client #8 was admitted to the secured cognitively impaired unit on 2/15/05 with diagnoses that included Alzheimer' disease, hypothyroidism, a history of a right femur fracture and urinary tract infections.

i. Review of the nursing notes identified that on 7/21/05 at 7:00 PM, the client was admitted to Hospital #2's emergency department and returned at 8:30 PM on 7/22/05 with changes of his psychotropic

DATE(S) OF VISIT: September 19, 20, 21, 22, 2006 with additional information received through
October 24, 2006

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

medications. A note on the following day, 7/23/05, identified that the client was self-mobile in a wheel chair and had a lap buddy. The next note written on 8/4/05 identified that Duoderm was "applied to a 1 by 1" (did not identify whether cm. or inches and/or exact location and/or whether it was open or closed) on the client's spine. There were no further notations in the clinical record regarding this area. A note dated 3/12/06 identified that the client had a large reddened area and open area 0.75 by 0.25 (did not identify whether cm. or inches) on the left hip that was cleaned with normal saline and Duoderm was applied. There were no further notes related to this area in the record. There was no notation and/or indication that the physician had been notified, that treatment orders had been obtained and/or documentation of ongoing size, treatment and/or status of the wound.

ii. Review of the vital signs and weight record identified that on 2/21/05 the client weighed 175 lbs. The next documented weight was dated 11/8/05 and the client's weight was recorded as 130 lbs. (loss of 45 lbs. in nine months - loss could have occurred in less time but there were no documented weights to compare). The next entry was dated 3/8/06 and it noted: "scale broken". The following entry was dated 7/11/06 and noted the weight to be "approximately" 130 lbs. There was no documentation in the clinical record that the physician had been notified of the weight loss and/or that interventions had been developed and implemented to monitor weight and/or prevent further weight loss and/or to promote therapeutic weight gain.

iii. During observation of the client on 9/21/06, he was sitting in a wheel chair that had rear anti-tippers and no footrests. He had a "lap buddy" that he was unable to remove when asked. The client was rocking forward and then backward to approximately a 135-degree angle. During a review of the record and interview with RN #1 on 9/21/06, no evidence could be found that the physician had ordered the "lap buddy", and/or that the client had been assessed and/or that the restraint statute had been followed. Additionally, the care plan/ aide activity instructions had not been updated to identify that the client required anti-tippers on his wheel chair because of his significant rocking.

During an interview with the RN #1 and the SALSA on 9/22/06 regarding Client #8, they could not recall if the physician was notified of the open area and/or the significant weight loss and were not able to identify why the weight on 7/11/06 was noted as "approximately". Regarding the rocking and need for wheelchair anti-tippers, RN #1 stated that the client had them on his wheelchair before she started her employment and did not realize that the information should be on the resident service program.

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.