

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

In Re: Westside Care Center, LLC d/b/a
 Westside Care Center, LLC
 349 Bidwell Street
 Manchester, CT 06040

CONSENT ORDER

WHEREAS, Westside Care Center, LLC (hereinafter the "Licensee") d/b/a as Westside Care Center (hereinafter the "Facility") has been issued License No.-2291C to operate a chronic and convalescent nursing home under Connecticut General Statutes Section 19a-490 by the Department of Public Health (hereinafter the "Department"); and,

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on September 6, 2006 and concluding on September 15, 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 - attached); and,

WHEREAS, the execution of this Consent Order on behalf of the Licensee does not constitute any admission of any kind regarding the violations alleged in Exhibit A; and,

WHEREAS, the Facility has provided in-service education to its employees, has revised numerous policies and procedures, and has engaged new staff and consultants subsequent to the unannounced inspections that commenced on September 6, 2006 and concluded on September 15, 2006; and,

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

1. The Licensee shall contract with an advanced practice registered nurse specializing in psychiatry (hereinafter Psychiatric APRN) who shall provide consulting services to the facility twenty (20) hours a week and shall confer with the Administrator, Director of Nursing Services, Medical Director and other staff, as the consultant deems appropriate, concerning the consultant's assessment of the services provided to patients with mental health/behavioral issues.
2. The Psychiatric APRN 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 Department will evaluate the hours of the Psychiatric APRN at the end of the three (3) month period and may, in its discretion, reduce or increase the hours and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the Psychiatric APRN shall include all pertinent provisions contained in this Consent Order. The costs incurred as a result of the contractual agreement between the Licensee and the Psychiatric APRN shall be assumed by the Licensee.
 - a. The Psychiatric APRN shall perform the following duties:
 - i. Provide oversight and guidance to the facility regarding patients identified with behavioral issues;
 - ii. Conduct weekly rounds of all patients identified with behavioral problems including patients housed on the secured unit and make recommendations regarding care plan interventions, drug regimes and therapeutic interventions. The rounds shall include the Nurse Supervisor, Director of Nursing, Medical Director and the Pharmacist Consultant;
 - iii. Audit at least ten (10) medical records per week to determine whether individualized care plans have been developed, implemented and revised in response to the residents' comprehensive assessments and identified needs.

- iv. Review protocols for the care and services provided to patients with behavioral issues and make specific recommendations as to the care of individual patients including, but not limited to, drug regimes, care plans, interventions and therapies.
3. The Psychiatric APRN shall make recommendations to the Administrator, Director of Nurses and Medical Director for improvement in the delivery of behavioral interventions and care provided by the facility. If the Psychiatric APRN and the Licensee are unable to reach an agreement regarding the implementation of the consultant's recommendation(s), the Department after meeting with the Licensee and the Psychiatric APRN shall make a final determination, which shall be binding on the Licensee and not subject to further review in any forum;
4. The Psychiatric APRN shall participate in all assessments and care planning for residents who engage in smoking activities.
5. The Psychiatric APRN shall submit reports every two (2) weeks to the Department and the Licensee addressing:
 - i. Assessments of the care and services provided to the patients;
 - ii. Recommendations made by the Psychiatric APRN and the Licensee's response to implementation of the recommendations.
6. Within fourteen (14) days of the execution of this Consent Order the Licensee shall develop and/or review and revise, as necessary, policies and procedures as follows:
 - a. Assessing, monitoring and care planning for patients with behavioral issues including, but not limited to, patients who exhibit and/or are identified to be at risk for aggressive and/or self-injurious behaviors and/or elopement from the facility;
 - b. Reporting changes in patient conditions;
 - c. Discharge planning;
 - d. Criteria for admission to the secured unit and periodic reassessment of the need to be maintained on said unit;
 - e. Programs and staff training that are specific to the secured unit;
 - f. Ensuring that recreation programs are geared to the particular needs of patients residing on the secured unit;
 - g. Consistent assignment of the same staff to the secured unit;
 - h. Safety measures for patients who are deemed a danger to themselves or others;

- i. Assessments and plans of care relevant to the needs of all patients;
 - j. Assessing and reporting changes in patient conditions; and,
 - k. Smoking policies and procedures.
7. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff inclusive of agency staff shall receive in-service education regarding the policies and procedures identified in paragraph number six (6).
8. All new employees shall be provided with a comprehensive orientation program which shall be developed with and approved by the Medical Director.
9. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure the following:
 - a. Direct care staff receive training and orientation, prior to assuming patient care duties in areas specific to the needs of the patient population;
 - b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive assessment and care plan;
 - c. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
 - d. Nurse aide assignments accurately reflect patient needs;
 - e. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to the deterioration of mental and/or physical status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
10. 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, the care provided by nursing staff and remediation of staff who do not perform according to facility policies and procedures and/or standards of care. 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.
11. Individuals appointed as a Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.
 12. 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 supervision 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 provided to patients by all caregivers is in accordance with individual comprehensive care plans.
 13. 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.
 14. The Licensee shall establish a Quality Assurance Program ("QAP") which shall identify and address quality of care issues. Membership on the QAP shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, the Medical Director and other professionals who may be necessary to address areas related to their disciplines. Meetings shall be held monthly and minutes shall be kept for a

minimum of three (3) years and made available for review upon request of the Department.

15. The Licensee shall pay a monetary payment to the Department in the amount of twelve thousand dollars (\$12,000) by money order or bank check, payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The monetary payment and any reports required by this document shall be directed to:

Barbara A. Yard
Health Program Supervisor
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12HSR
Hartford, CT 06134-0308

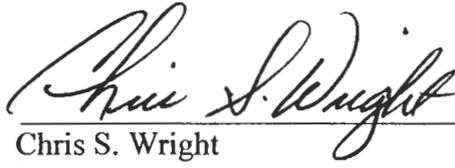
16. In accordance with Connecticut General Statutes Section 19a-494, the Department hereby reprimands Westside Care Center for failure to comply with the applicable state statutes and Regulations of Connecticut State Agencies.
17. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Consent Order or of any other statutory or regulatory requirement. The Department may petition any court with proper jurisdiction for enforcement in the event the Licensee fails to comply with its terms.
18. The provisions of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document provided that the Department is satisfied that the Licensee has maintained substantial compliance with applicable State and Federal laws and regulations and the terms of this Consent Order.
19. The Execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau of the Department of Criminal Justice's Statewide Prosecution Bureau.
20. 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.

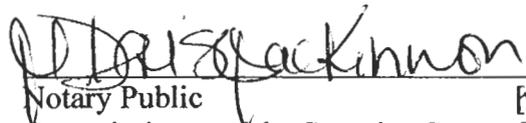
21. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below. I, Chris S. Wright, Manager, am authorized to sign this Consent Order on behalf of the Licensee and do so under my own free will.

WESTSIDE CARE CENTER, LLC - LICENSEE

By: 
Chris S. Wright
Manager

Personally appeared Chris S. Wright on this 23 day of April, 2007 and made oath to the truth of the statements contained herein.

My Commission Expires: 4/30/07 
(If Notary Public) Notary Public
M. Denise MacKinnon Commissioner of the Superior Court []
Notary Public
My Commission Exp. 4/30/2007

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

April 30, 2007

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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October 30, 2006

Ms. Colette Johnson, Acting Administrator
Westside Care Center
349 Bidwell Street
Manchester, CT 06040

Dear Ms Johnson:

Unannounced visits were made to Westside Care Center which concluded on September 15, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a certified survey and multiple investigations.

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 2:00 P.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,

Barbara Yard

Barbara A. Yard
Health Program Supervisor
Facility Licensing and Investigations Section

BAY:JDL:BSC:JCBG:lsj

c. Director of Nurses
Medical Director
President



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: Concluded on September 15, 2006

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

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

I. Based on clinical record review, observation and staff interview for three of ten sampled residents (Residents #7, #26 and #30) who exhibited aggressive and/or suicidal behavior, the facility failed to notify the physician when there was a significant change in condition and/or a need to alter treatment. The findings include:

- a. Resident #7's diagnoses included schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set (MDS) assessment dated 8/23/06 identified that the resident had short and long-term memory deficits, exhibited wandering behavior and was verbally and physically abusive. A review of the resident care plan (RCP) dated 8/28/06 identified the initiation of frequent every thirty minute monitoring of the resident. The RCP dated 8/30/06 further identified the resident's inappropriate decision-making skills related to schizophrenia and vascular dementia. Interventions included to assess and monitor the resident and record and report concerns/changes to the physician and/or conservator.

The nurses' narrative notes dated 8/24/06 through 8/30/06 identified that Resident #7 had been yelling out, shaking the side rails, was very combative, screaming and struck a nurse aide during care. On 8/30/06 at 10:15 PM the resident was transferred to the hospital emergency room. Subsequent to the resident's return to the facility, the nurses' notes dated 8/31/06 through 9/01/06 identified that Resident #7 continued to yell out, was disruptive to other residents, swearing loudly and touched staff inappropriately. Review of the psychiatry consult dated 9/05/06 identified the resident was progressively more confused, aggressive and agitated. The documentation further indicated that Resident #7 needed hospitalization and directed staff to transfer the resident to the hospital on a Physician Emergency Certificate (PEC).

Interview with the Licensed Practical Nurse on 9/07/06 at 10:30 AM identified that Resident #7 had not been sent to the emergency room because a bed was not available. Interview with Physician #1 on 9/07/06 at 10:45 AM identified he was not aware that the recommendation for a PEC was made on 9/05/06 and/or that the resident was not transferred to the emergency room. Additionally Physician #1 indicated that he would expect to be made aware if a PEC was initiated. Interview with Psychiatrist #1 on 9/07/06 at 11:45 AM identified a PEC was initiated for Resident #7 on 9/05/06 because the resident was dangerous, assaultive and his level of disturbance could not be managed properly at the skilled nursing facility, noting the incident as an emergent situation. Additionally, the physician was not made aware that a bed was not available. The interview further indicated that had he been informed he would have placed the resident

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on 1:1 supervision and contacted the clinical coordinator to find a bed for the resident.

Interview with the Licensed Practical Nurse #2 (the nurse who took the initial PEC information on 9/05/06) on 9/07/06 at 7:04 PM identified that the physician had not been informed that the PEC had been initiated or that a bed had not been located.

- b. Resident #26's diagnoses included borderline personality disorder, schizophrenia, chronic obstructive pulmonary disease (COPD) and a history of smoking. Resident #26 resided in a locked dementia unit related to non-compliance with smoking rules and for the facility to monitor the resident's smoking. The resident assessment dated 1/5/06 identified that Resident #26 was alert, oriented, experienced some difficulty with new situations and had an unpleasant mood in the morning. Additionally, the assessment identified that the resident made negative statements, was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. A Resident Care Plan (RCP) dated 2/20/06 indicated that the resident was moody, weepy and demanding. Interventions included psychiatric services, allowing the resident to vent feelings and setting limits and/or boundaries.

Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset over a change in her smoking privileges and had lacerated the right wrist with a piece of broken glass from a picture frame. Review of the Behavioral Health Program Manager's note dated 4/3/06 (Director of the facility's Behavioral Program) indicated that Resident #26 was suicidal, agitated, uncooperative with care and had made the statement "I wanted to die, let it bleed." Resident #26 was placed on one-to-one close staff observations on 4/3/06 until transferred to the emergency department at 5:00 PM. Review of a nurse's note dated 4/3/06 at 8:45 PM indicated that the resident had returned to the facility with documentation identifying that Resident #26 was no harm to self and/or others. However, on 4/4/06 a psychiatrist's note identified that Resident #26 had made a suicidal attempt. The psychiatrist identified that the resident required transfer to an acute psychiatric facility and signed a Physician Emergency Certificate (PEC). On 4/4/06 at 4:30 PM a nurse's note indicated that Resident #26 had exhibited increased agitation, slapped another resident across the face and was transferred to the emergency room. After the resident returned to the facility on 4/5/06 at 1:35 PM, there was no indication that the resident's transfer to an acute psychiatric hospital was pursued.

During an interview on 9/12/06 at 11:20 AM RN #5 stated that a PEC meant that the resident was to be rushed to an emergency facility although the nurse could not recall why the resident had not been transferred to a psychiatric hospital when Psychiatrist #1 signed the PEC. The ADNS on 9/7/06 at 1:30 PM stated that the PEC probably was not pursued because the resident had been sent out to the emergency department later that day for escalating behaviors and was cleared to return to the facility. Psychiatrist #1 on 9/8/06 at 2:30 PM stated that he had signed the PEC in the morning. Psychiatrist #1

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further identified he had not been informed that the facility had not transferred the resident to the hospital based on the PEC and would have expected the facility to pursue sending the resident to a psychiatric facility after the resident returned from the emergency room on 4/5/06.

- c. Resident #30's diagnoses included bipolar disorder and mood swings. An inter-agency patient referral report dated 11/10/05 identified that the resident had been hospitalized due to suicidal intent with a plan to jump in front of traffic. The Minimum Data Set assessment dated 11/17/05 identified that the resident had no short or long-term memory deficits, experienced some difficulty in making decisions, exhibited verbally abusive behaviors, was resistive to care and independent with activities of daily living. A nurse's note dated 12/22/05 identified that Resident #30 had called the public emergency number as well as the public suicide telephone line. The note further identified that the nursing supervisor and the Behavioral Health Manager were notified. A late entry nurse's narrative note dated 12/24/05 identified that Resident #30 called the public emergency telephone number requesting to go to the hospital with non-specific complaints. Further review of the clinical record identified a nurse's note dated 12/24/05 which indicated that a nurse aide found Resident #30 in his room bleeding from his right wrist. Resident #30 indicated that he was trying to kill himself because he wanted to be sent to the hospital.

Further review of the clinical record and the twenty-four hour shift to shift report failed to provide evidence the physician was notified on 12/22/05 of the resident's behavior. Further investigation regarding the incident on 12/24/05 indicated the licensed staff had reported the incident to the Behavioral Health Manager because it was the facility's practice to refer to him as a "doctor."

The following is a violation of the Connecticut General Statutes 19a-535 (b) and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (3)(D) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

2. Based on clinical record review and staff interviews for one of one sampled resident (Resident #27) identified as an elopement risk, the facility discharged the resident who eloped and refused to readmit the resident upon the resident's return to the facility less than 48 hours later. The findings include:
- a. Resident #27 had diagnoses that included delusions, schizoaffective disorder, bipolar type and was conserved. Review of a physician 's progress note dated 2/17/06 indicated that Resident #27 was admitted to the facility with aggressive behaviors secondary to being non-compliant with taking medications. A resident assessment dated 5/17/06 identified that the resident was cognitively impaired. The resident care plan dated

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5/25/06 indicated that Resident #27 was at risk for an unauthorized leave based on verbalization and an attempt to leave the facility on 4/7/06. Interventions included to provide a secured unit as needed and perform an assessment to determine the resident's ability to meet minimum basic needs. The physician's orders dated 6/25/06 directed the administration of Risperdal Consta 37.5 milligrams (mg.) intramuscularly every 2 weeks, Cogentin 0.5 mg two times daily and Risperdal (oral) 0.5mg two times daily. On 7/12/06 at 5:30 PM a nurse's narrative note identified that Resident #27 could not be found to administer the evening medications, and the facility had subsequently conducted a search of the building and common areas without success. A nurse's note dated 7/13/06 at 7:30 AM indicated that the resident's conservator had called stating that Resident #27 had spent the night in a hotel out of state.

The Acting Administrator (ADM) on 9/7/06 at 1:10 PM stated that Resident #27 had returned to the facility by taxi less than forty-eight hours after leaving the facility. The acting administrator further indicated that Resident #27 was not readmitted on 7/14/06 because of a facility policy to discharge a resident if they have not returned within twenty-four hours and had been assessed to be able to meet their minimal basic needs. The ADM stated the resident was sent to the hospital emergency room, admitted to the hospital and subsequently transferred to another extended care facility. Review of an Unknown/Unplanned Leave Capacity to Meet Minimal Basic Needs interview dated 4/7/06 indicated that Resident #27 was at risk for leaving the facility but had appropriately responded to the questions asked on the interview and had been assessed as able to meet her minimal basic need requirements should Resident #27 leave the facility. Psychiatrist #1 on 9/14/06 at 11:40 AM indicated that while Resident #27 may have been able to make some of her needs known, the resident was extremely delusional and required placement in an environment that could oversee the resident's needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (1) Administrator (3)(A) and/or (3)(D) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

3. Based on clinical record review and staff interviews for four of ten sampled residents (Residents #15, #18, #22 and #26) who smoked cigarettes and/or requested staff assistance with care, the facility transferred the residents to a secured dementia unit and/or forfeited the residents' smoking breaks because the residents were non-complaint with the facility's smoking rules and/or failed to provide the necessary assistance to the resident. The findings include:
 - a. Resident #15's diagnoses included substance abuse disorder, paranoid disorder, depression and a history of a suicidal attempt. A significant change assessment dated 6/30/06 identified that the resident had no cognitive deficits, was independent in carrying out most activities of daily living and exhibited verbally abusive behaviors toward others. A care plan dated 8/08/06 identified that the resident was non-compliant with

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the facility's smoking policy. Interventions included to encourage resident compliance, review the smoking policy with the resident and conduct room searches as needed. Review of the plan of care identified that on 8/08/06 cigarettes were found on the resident's bed. On 8/14/06 the resident was found smoking outside the facility at 1:45 AM. A nurse's note dated 8/14/06 identified that during a room search, numerous inhalers were found as well as an unopened pack of cigarettes that was hidden in a pouch of cat food. Interventions for this behavior included forfeiture of the resident's smoking privileges for three days. The plan of care also indicated the resident was offered a Nicoderm patch which was applied. A nurse's note dated 8/14/06 further identified that Resident #15 had threatened to leave the facility against medical advice and had barricaded the door to her room with a chair on two occasions. On 8/18/06 a nurse's note identified a room search had been conducted in Resident #15's room. This search yielded multiple items that were not permitted including silverware (e.g. several butter knives, two pairs of scissors, cigarettes and cigarette butts placed in a half cup of an unknown liquid). Following this incident the care plan was revised to include the denial of smoking privileges for seven days secondary to the resident's second offense of failing to comply with the facility's smoking policy. On 8/19/06 the plan of care directed fourteen days' denial of smoking privileges. Interview with the Corporate Nurse Consultant on 9/14/06 at 2:00 PM identified that residents were given the privilege to smoke but non-compliance with the smoking policy directs progressive denial of that privilege.

- b. Resident #18's diagnosis included schizophrenia. A quarterly assessment dated 2/05/06 identified that the resident was moderately cognitively impaired, had short and long-term memory deficits, wandering behaviors, was independent with most activities of daily living but required limited assistance with personal hygiene. A quarterly updated smoking risk factors assessment dated 2/4/06 identified that Resident #18 had attempted to smoke in unauthorized areas and/or at inappropriate times in the last ninety days. The plan of care dated 2/06 identified the resident's potential for an alteration in safety related to smoking, physical movements that could contribute to a safety hazard and the tendency to smoke cigarettes when the butts were too low. The interventions included supervision of outdoor smoking by nursing staff, small smoking groups and frequent fifteen minutes monitoring for non-compliance with smoking policy. A nurse's narrative note dated 2/8/06 identified that Resident #18 was observed smoking in one of the unit's shower rooms and was continued on frequent fifteen minute monitoring. The note also identified that a room search was done and no "contraband" was found. On 2/22/06 a nurse's narrative note indicated that Resident #18 was observed smoking in the bathroom in his room. A non-invasive body and room search yielded half a cigarette as well as a lighter. According to the nurse's narrative note, the resident was continued on frequent fifteen minute monitoring. On 2/24/06 an addendum nurse's note indicated that Resident #18 had been found in a unit's shower room with a lighted cigarette. The note also identified that Resident #18 was moved to another unit for

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safety. On 3/6/06 during the 3:00 PM to 11:00 PM shift a nurse's note identified that cigarette smoke had been noted and ashes had been found on the floor beside the resident's toilet. Resident #18 denied smoking in the room and a room search did not provide any further evidence. Fifteen minute frequent monitoring was initiated on 3/18/06. On 3/28/06 during the 3:00 PM to the 11:00 PM shift a nurse's note identified that matches and a cigarette lighter had been found in Resident #18's room, and the resident was unable to smoke for seventy- two hours due to non-compliance with the smoking policy. Review of the physician's orders dated 3/29/06 directed in part, the application of a Nicotine patch 7 Milligrams every day for 5 days. The patch was to be placed on the resident at 9:00 AM and removed at 9:00 PM. Review of the smoking policy identified a progressive monitoring protocol. The policy also directed in part, if a resident is found to be in possession of smoking materials, the adjustments would be made to their smoking schedules. Subsequent to the first violation, privileges would be forfeited for three days. Interview with the Corporate Nurse Consultant on 9/14/06 at 11:00 AM identified that it was the facility's practice to place residents on a locked unit whenever they were non-compliant with the smoking policy. The interview also identified the resident is given a nicotine patch for smoking cessation. Interview with the Acting Administrator on 9/14/06 at 11:30 AM identified the criteria for admission to the secured unit is a diagnosis of dementia.

- c. Resident #22 had diagnoses that included acute depression. The annual assessment dated 3/15/06 identified that the resident had no short or long-term memory deficits, experienced some difficulty in new situations regarding decision making, required total assistance from staff with activities of daily living, utilized a mechanical lift for transfers and was continent of bowel and bladder. The plan of care dated 3/22/06 identified that the resident was at risk for falls, required a mechanical lift for all transfers and had a history of making accusations regarding the care and/or services that staff provided. Interventions included for two staff members to address the resident's needs at all times. Facility documentation dated 3/28/06 identified that Nurse Aide #10 had told Resident #22 on 3/26/06 that it was difficult to place the resident on a bed pan without an air mattress on the bed. The documentation also indicated that Resident #22 was directed to have a bowel movement in the bed pad while in bed. Further review of the facility's documentation identified NA #10 refused to provide a bed pan for the resident's use and encouraged the resident to relieve himself in the bed because it was too much trouble without the air mattress being on the bed. A statement provided by NA #22 on 3/31/06 identified in part that he had directed Resident #22 to "do what he had to do and go in the pad and he would take care of him right away." The documentation also indicated that Resident #22 stated he was emotionally distressed over the incident.
- d. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, chronic obstructive pulmonary disease (COPD) and a history of smoking. The resident assessment dated 1/5/06 identified that Resident #26 was alert, oriented, experienced

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some difficulty with new situations, had an unpleasant mood in the morning, made negative statements, was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. The resident's care plan (RCP) dated February 2006 indicated that Resident #26 was moody, weepy and demanding with interventions that included psychiatric services, allowing the resident to vent feelings and setting limits and /or boundaries. The RCP dated 3/9/06 identified that R #26 was non-compliant with the facility's smoking rules on 1/12/06, 2/25/06 and 2/28/06 with interventions that including every 15 minute close observation and a psychiatric evaluation. The RCP also indicated that on 3/9/06 Resident #26 was again identified as non-compliant with smoking rules and was transferred to a secured unit. Review of a social service note dated 3/9/06 indicated that the resident's conservator of person agreed to the transfer. Facility documentation dated 3/15/06 at 10:30 PM indicated that Resident #26 had made a suicidal gesture by using a nail clipper to lacerate her right wrist and was transferred to the hospital emergency department. A nurse's note dated 3/16/06 at 10:45 AM indicated that Resident #26 returned to the facility. Review of the Psychotherapy Progress notes dated 3/16/06 indicated that Resident #26 was upset that she had been transferred to the locked unit. Review of social service notes dated 3/9/06 through 3/24/06 indicated that Resident #26's behavior escalated resulting in additional transfers to the hospital. A note dated 3/24/06 stated that the resident's transfer to the secured unit (B-Wing) had become an inappropriate intervention. Review of a social service note dated 4/10/06 indicated that Resident #26 was transferred to F-Wing (an unlocked unit).

The Admission Coordinator on 9/14/06 at 11:20 AM stated that the facility has no written criteria for the admission to the secured (dementia) unit. The Social Worker on 9/7/06 at 10:20 AM stated that a team approach, consisting of the social worker, nursing staff and the Behavioral Health Program Manager had made a team decision to transfer the resident to the secured unit. The Behavioral Health Program Manager on 9/8/06 at 9:20 AM stated that he was on vacation when the resident was transferred to the secured unit and would not have suggested the transfer.

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

4. Based on clinical record review, facility documentation and interviews for one of five sampled residents (Resident #24) who reported an allegation of abuse, the facility failed to ensure the incident was reported and /or investigated. The findings include:
 - a. Resident #24 had diagnoses that included dementia with behavioral symptoms. A quarterly assessment dated 7/27/06 identified that the resident had modified independence in decision making and verbally and physically abusive behaviors. A resident care plan dated 8/3/06 identified that the resident had the potential to be abusive

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and/or to be the victim of abuse and had experienced physical altercations with other residents. Interventions included for staff to conduct a team review to ensure the resident's safety, a psychiatric consultation as needed and the continuation of every fifteen minute checks due to altercations. Facility documentation dated 9/8/06 identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 had stated that he "was going to do bad things to him, like rape or kill him." During an interview on 9/8/06 at 12:50 PM the program manager identified that Resident #24 and Resident #20 did not like each other. The program manager further indicated that he did not file a grievance for Resident #24 and did not report the resident's concern to the administrator. Review of the facility's policy identified in part that whenever there is a witness or a report of a resident's alleged abusive action, the administrator or on-call designee and the Director of Nursing are to be notified immediately. Subsequent to the surveyor's inquiry, the facility provided documentation dated 9/8/06 regarding the event that had been reported by Resident #20 to the Behavioral Health Program Manager on 9/5/06.

5. Based on clinical record review, facility documentation and interviews for two of ten sampled residents (Residents #21 and #26) who required assistance with meals and/ or requested assistance with care, the facility failed to ensure that assistance was provided in a dignified manner. The findings included:
 - a. Resident #21 had diagnoses that included dementia, paralysis and osteopenia. A quarterly assessment dated 4/17/06 identified that the resident had short and long-term memory deficits, moderately impaired cognition, required extensive assistance with eating and total assistance from staff with activities of daily living. The plan of care dated 4/21/06 identified that the resident was at nutritional risk related to dysphagia and had a self care deficit and included interventions for staff to encourage the resident's intake at meals and to feed the resident meals if necessary. Facility documentation dated 5/24/06 identified that Nurse Aide #9 was observed holding down Resident #21's hand on the wheelchair tray so that the resident could be fed. The documentation further indicated that Resident #21 was saying "no, I don't want it" while trying to hold her hand in front of her mouth. Interviews with Resident #42 and Resident #43 who were identified to be alert and oriented on 9/12/06 at 9:45 AM and 11:25 AM respectively identified that Resident #21 had said "no" and indicated through gestures that she did not want the food but NA #9 fed her anyway. Interview with NA #9 on 9/8/06 at 3:30 PM identified that the incident witnessed on 5/24/06 did not occur. Facility documentation also indicated that NA #9 had been inserviced on 5/30/06 regarding appropriate interactions with combative residents.
 - b. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, chronic obstructive pulmonary disease (COPD) and a history of smoking. The resident

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assessment dated 1/5/06 identified that Resident #26 was alert, oriented, experienced some difficulty with new situations, had an unpleasant mood in the morning, made negative statements, was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. Review of facility documentation dated 9/6/06 at 11:50 AM indicated that the resident had complained about a nurse aide who had spoken to the resident sarcastically in the residents' smoking area. The documentation identified that the nurse aide had upset the resident. During an interview on 9/8/06 at 11:05 AM Resident #26 stated that NA #5 had make a sarcastic statement to the resident on 9/6/06. Interview with the Admission Coordinator on 9/13/06 at 3:15 PM identified that while she was in the smoking area on 9/6/06, she overheard NA #5 saying to Resident #26, "Why are you being so nice to me now? Yesterday you were trying to write me up, and I was going to come and see you to make sure you wrote everything down right." The Admission Coordinator stated that NA #5's tone of voice towards the resident was antagonistic, sarcastic and mean. The DNS stated that abuse could not be substantiated but that NA #5 had been issued a disciplinary warning for an inappropriate conversation with a resident.

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

6. Based on clinical record review and staff interviews for six of six sampled residents (Resident #'s 7, #20, #24, # 26, #30 and #33) who were identified with attention-seeking behaviors and/or inappropriate behaviors, the facility failed to assess the resident for suicidal thoughts and/or dangerous behaviors. The findings include:
 - a. Resident #7's diagnoses included schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set (MDS) assessment dated 8/23/06 identified that the resident had short and long term memory deficits, moderately impaired cognition and behaviors that included wandering and verbal and physical abusiveness. Review of the resident care plan (RCP) dated 8/28/06 identified the initiation of frequent every thirty minute monitoring of the resident. The RCP dated 8/30/06 further identified the resident's inappropriate decision- making related to schizophrenia and vascular dementia. The interventions included assessing and monitoring the resident and recording and reporting concerns/changes to the Physician and/ or Conservator. The nurses' narrative notes dated 8/24/06 through 8/30/06 indicated that Resident #7 had been yelling out, shaking the side rails, very combative, screaming and struck a nurse aide during care. The decision was made to transfer Resident #7 to the hospital emergency room. The nurses' narrative notes dated 8/31/06 through 9/1/06 indicated that Resident #7 continued to be yelling out, was disruptive to other residents, swearing loudly and had touched staff inappropriately. Review of the psychiatry consult dated

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9/5/06 identified that Resident #7 was progressively more confused, aggressive and agitated. Additionally, the documentation indicated Resident #7 needed hospitalization and directed the facility to send the resident to the hospital on a Physician Emergency Certificate (PEC). Interview with the Licensed Practical Nurse on 9/7/06 at 10:30AM identified that Resident #7 was not sent to the emergency room because a bed was not available. An interview with Psychiatrist #1 on 9/7/06 at 11:45 AM identified a PEC was initiated for Resident #7 on 9/5/06 because the resident was dangerous, assaultive and his level of disturbance could not be managed properly at the skilled nursing facility. The psychiatrist stated that this was an emergent situation. However, review of facility documentation failed to identify that the resident had been assessed between 9/5/06 and 9/7/06 when the resident was transferred to the hospital.

- b. Resident #20's diagnoses included Post Traumatic Stress Disorder (PTSD). An admission assessment dated 6/1/06 identified that the resident was independent with decision making, had long and short term memory impairment, withdrawal from activities of interest, reduced social interactions and required supervision of staff for activities of daily living (ADL). Facility documentation dated 9/8/06 identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 told him that he "was going to do bad things to him, like rape or kill him". Interview with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM identified that Resident #24 and Resident #20 did not like each other. Further interview and clinical record review with the Behavioral Health Program Manager on 9/8/06 at 1:20 PM failed to provide evidence that Resident #20 was assessed in response to his homicidal ideation.
- c. Resident #24's diagnoses included dementia with behavioral symptoms. A quarterly assessment dated 7/27/06 identified that the resident had modified independence in decision making and verbally and physically abusive behaviors. The resident care plan (RCP) dated 8/3/06 identified that the resident had the potential for abuse and/or to be the victim of abuse and/or physical altercations with other residents. Interventions included a team review to ensure the resident's safety and for the Social Worker to monitor the resident for psychosocial well being. Facility documentation dated 9/8/06 identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 told him that he "was going to do bad things to him, like rape or kill him". Interview with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM identified that Resident #24 and Resident #20 did not like each other. Review of the clinical record on 9/8/06 at 1:20 PM with the Behavioral Health Program Manager identified that an assessment was not done regarding Resident #24's psychosocial well being following the incident on 9/5/06, and the most current Social Service quarterly documentation was dated 8/3/06. Interview with the Behavioral Health Program Manager on 9/8/06 at 1:20 PM identified that Resident #24 was not assessed because he had contracted for safety.

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- d. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, Chronic Obstructive Pulmonary Disease (COPD) and a history of smoking. The resident assessment dated 1/5/06 identified that Resident #26 was alert, oriented, experienced some difficulty with new situations, had an unpleasant mood in the morning, and made negative statements. Additionally, the assessment identified that the resident was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. The resident's care plan (RCP) dated 2/2006 indicated that Resident #26 was moody, weepy, and demanding. Interventions included to provide psychiatric services, allow the resident to vent her feelings, and set limits and/or boundaries.

Facility documentation dated 3/15/06 at 10:30 PM indicated that Resident #26 had made a suicidal gesture by using a nail clipper to lacerate the right wrist and was transferred to the emergency room. A nurse's note dated 3/16/06 at 10:45 AM indicated that Resident #26 returned to the facility and was placed on every fifteen minute checks.

A nurse's note dated 3/20/06 at 2:00 AM indicated that Resident #26 was transferred to the hospital for respiratory distress related to COPD, was readmitted on 4/3/06 at 11:15 AM and informed that her Conservator of Person (COP) wanted the resident to have only one cigarette per smoking break instead of two. Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset with regard to the change in the smoking privileges and had lacerated her right wrist with a piece of broken glass from a picture frame located in the resident's room. Review of the Behavioral Health Program Manager's note dated 4/3/06 indicated that the resident was suicidal, agitated, uncooperative with care and had made the statement; "I wanted to die, let it bleed." Resident #26 was placed on one to one close observations until transferred to the emergency department at 5:00 PM. Resident #26 returned to the facility on 4/3/06 at 8:45 PM and the every fifteen minute checks were resumed. Although a smoking assessment had been conducted on 4/3/06, an assessment was lacking to reflect the resident's response to the change in the smoking restriction and/or a behavioral assessment upon return to the facility.

Review of the resident's nursing notes dated 4/3/06 indicated Resident #26 returned to the facility at 8:45 PM. Resident #26 was seen by Psychiatrist #1 the following morning (4/4/06). The psychiatrist's note dated 4/4/06 indicated that Resident #26 had made a suicidal attempt, recommended that the resident be transferred to an acute psychiatric facility and signed a Physician Emergency Certificate (PEC). A nurse's note dated 4/4/06 at 4:30 PM indicated that Resident #26 had increased agitation, slapped another

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resident across the face and was transferred to the emergency room and returned to the facility on 4/5/06 at 1:35 PM. Review of the record indicated that there was no nursing behavioral assessment upon return from the hospital on 4/5/06.

A nurse's note dated 4/5/06 at 11:10 PM indicated that Resident #26 was found sitting on the side of the bed, cutting her right wrist with a piece of glass and was transferred to the emergency department. Review of the record indicated that there was no nursing behavioral assessment prior to transfer to the hospital on 4/5/06.

Facility documentation dated 4/16/06 at 10:15 PM indicated that Resident #26 was found in the bathroom cutting her left wrist with a safety pin. NA #3 on 9/7/06 at 2:00 PM stated that on 4/16/06 she was assigned to do the one to one close observations on R #26. NA #3 stated that she had taken Resident #26 out on a smoking break, and as the resident was leaving the smoking area, Resident #26 made a comment to another resident that she would not be seeing him anymore. NA #3 stated she had informed the charge nurse prior to the time that Resident #26 returned to her room from the smoking area. Although this information was provided to the nurse, the facility failed to perform a behavioral assessment of the resident at that time. NA #3 stated that after returning to her room, Resident #26 was observed to be looking through the drawers in her night stand. NA #3 stated she had asked Resident #26 what she was looking for, but the resident had told her "nothing". NA #3 further stated that Resident #26 went into the bathroom but would not leave the bathroom door open. NA #3 identified that she called for the nursing supervisor and when the supervisor arrived Resident #26 used a safety pin to cut at her wrist. Although review of facility documentation identified that the resident engaged in self injurious behaviors, further review failed to identify that a nursing behavioral assessment had been conducted by the RN prior to being transferred to the emergency room and/or after the resident returned from the hospital on 4/3/06, 4/4/06, 4/5/06, 4/16/06.

- e. Resident #30 had diagnoses that included suicidal ideation with intent, bipolar disorder and mood swings. The Minimum Data Set assessment dated 11/7/05 indicated the resident's long and short term memory were intact , and the resident experienced some difficulty in making decisions, verbally abusive behaviors, resistance to care and independence with activities of daily living. An Inter Agency Patient Referral report dated 11/10/05 identified that Resident #30 was hospitalized for suicidal intent to jump in front of traffic. A nurse's narrative note dated 12/22/05 reflected Resident #30 had called the public's emergency number and also the public's suicide telephone lines. A late entry nurse's narrative note dated 12/24/05 identified that Resident #30 had called the public's emergency telephone number requesting to be taken to the hospital with non- specific complaints. Further review of the clinical record identified a nurse's note dated 12/24/05 that indicated a nurse aide had found Resident #30 in his room bleeding from his right wrist. Resident #30 stated that the was trying to kill himself because he

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wanted to be sent to the hospital. The documentation further noted that Resident #30 sustained a small superficial cut on the right wrist. Although Resident #30 had called the suicidal hot line on 12/22/05 and the facility was aware, the facility failed to provide evidence Resident #30 was assessed for suicidal intent on 12/22/05.

- f. Resident #33 had diagnoses that included schizoaffective disorder and bipolar disease. The admission assessment dated 6/8/06 identified that the resident's long and short term memory were intact, and the resident had moderately impaired cognition, verbally abusive behavior, required supervision of activities of daily living and received antipsychotic medication. A plan of care dated 6/15/06 identified that the resident had an altered thought process related to diagnoses of schizophrenia and/or bipolar disease. The interventions included monitoring the resident for sign and symptoms of depression and any suicidal ideation and directed staff to report any changes promptly to the psychiatric consultant. A nurse's note dated 8/6/06 identified that Resident #33 had been transferred to the hospital emergency room secondary to suicidal ideation. A subsequent nurse's narrative note dated 8/10/06 at 3:00 AM identified that Resident #33 had given a note to a licensed staff member to pass on and/or fax to the psychiatrist at 1:30 AM. The nurse's note indicated the nursing supervisor was notified and Resident #33 stayed in the dayroom from 2:30 AM to 3:45 AM. Review of the note passed to staff reflected that Resident #33 was suicidal and depressed. Further review of the clinical record identified that an intervention for staff to provide every fifteen minute monitoring to Resident #33 was continued after the note was passed to staff, and a referral was made to the psychiatric consultant. On 8/11/06 Resident #33 refused to take the scheduled Depakote stating that it made him more suicidal. Another referral was placed to the psychiatric consultant. Review of the clinical record with the Director of Nursing and the Behavioral Health Consultant on 9/14/06 at 11:00 AM failed to provide evidence that Resident #33 was assessed in response to his suicidal ideation.

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

7. Based on clinical record review and interview for four of ten sampled residents who had suicidal ideation (Residents #15, #16, #30, #31), the facility failed to ensure the plan of care was comprehensive. The findings include:
- a. Resident #16 had diagnoses that included schizoaffective disorder, Bipolar disorder and personality disorder. A Minimum Data Set assessment dated 12/1/05 indicated that the resident had short-term memory impairment, experienced some difficulty in new situations regarding decision making and was independent in carrying out activities of daily living. A nurse's narrative note dated 3/25/06 identified that Resident #16 had

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requested "lots of Ambien" (a sleep enhancer) and had stated that she wanted to take the Ambien and "end it all." The note indicated that Resident #16 was having command hallucinations and wanted to see two deceased children whom she missed. The documentation further identified that the resident had verbalized a plan to carry out the suicide. The decision was made to send the resident to the emergency room on 3/25/06. The resident returned from the hospital later on 3/25/06 and was placed on every fifteen minute frequent monitoring. However, the nurses' narrative notes for the period from 3/25/06 through 4/20/06 indicated that Resident #16 was monitored every fifteen minutes, thirty minutes and /or every hour. Review of the clinical record with the Minimum Data Set Coordinator and Care Plan Coordinator on 9/7/06 at 11:00 AM identified that a plan of care was not implemented in order to address the resident's suicidal ideation. Subsequent to the surveyor's inquiry, a plan of care was initiated on 9/7/06.

- b. Resident #30 had diagnoses that included suicidal ideation with intent, bipolar disorder and mood swings. The Minimum Data Set assessment dated 11/7/05 identified that the resident had no long and short term memory were intact, some difficulty in making decisions, verbally abusive behaviors, resistance to care and independence with activities of daily living. An Inter Agency Patient Referral report dated 11/10/05 identified that Resident #30 was hospitalized for suicidal intent to jump in front of traffic. A nurse's narrative note dated 12/22/05 reflected Resident #30 had called the public's emergency number as well as the public's suicide telephone lines. A late entry nurse's narrative note dated 12/24/05 identified that Resident #30 had called the public's emergency telephone number requesting to be taken to the hospital with non-specific complaints. Further review of the nurses' narrative notes identified that on 12/24/05 a nurse aide found Resident #30 in his room bleeding from the right wrist. Resident #30 stated that the was trying to kill himself because he wanted to be sent to the hospital. The documentation further indicated that Resident #30 sustained a small superficial cut on the right wrist. Review of the plan of care dated 12/17/05 identified behavioral symptoms related to the resident's depression and status post suicidal ideation with intent. The plan of care also identified that Resident #30 had continued to call the emergency number and demanded to be taken to the hospital. Although the plan of care identified that the resident had suicidal tendencies, the plan failed to include interventions to address the resident's suicidal behavior.
- c. Resident #31 had diagnoses that included chronic obstructive pulmonary disease, hypertension and a history of resolved delirium. The acute care hospital's discharge information included a psychiatric consultation dated 3/1/06 which identified "the resident was sad about his medical condition and had thought of dying." The documentation further identified the resident had described a time in his life when he had held a pistol and stated that if God were to call him he would willingly go. However, the resident denied that he was suicidal at that time.

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An admission assessment dated 3/17/06 identified that the resident had no short or long-term memory deficits, experienced some difficulty in new situations, had socially inappropriate behaviors and required limited to extensive assistance with activities of daily living. An initial psychiatric diagnostic consultation dated 3/21/06 identified that the resident was severely depressed with suicidal ideation and had expressed a desire to die. On 4/21/06 a subsequent assessment and treatment plan identified that the resident's chief complaint was "panic attacks" and indicated the resident "knew he would die soon" but denied frequent thoughts and/or fear, stating "I will be better." The documentation indicated that Resident #31's psychiatric history was unknown and the resident denied suicidal ideation. On 4/25/06 a follow-up psychiatric consultation identified that Resident #31 was very depressed and wanted to die.

On 5/18/06 a nurse's narrative note indicated that Resident #31 had been sent to the hospital emergency department during the 7:00 AM to 3:00 PM shift after a physical altercation with another resident. The resident returned to the facility at 6:00 PM on 5/18/06, and on 5/19/06 a nurse's narrative note written during the 7:00 AM to 3:00 PM shift identified that Resident #31 was in a pleasant mood and had not exhibited any anxiety, agitation or behavioral symptoms.

On 5/22/06 a nurse's narrative note identified that at approximately 3:30 PM a nurse aide had found the resident with a cable cord wrapped around his neck while the resident was attempting to exit through the window. The resident stated that he was trying to jump and kill himself. Subsequent to the incident, a psychiatric consultation dated 5/22/06 identified that a suicide attempt had been witnessed, and the resident had verbalized that he felt lonely, hopeless and helpless and wished to die. The psychiatrist identified that the resident was a danger to self and required transfer to the nearest emergency room for a psychiatric evaluation and treatment. The resident was subsequently transferred to the hospital and admitted.

Review of the resident's current plan of care with the Care Plan Coordinator on 9/12/06 at 10:30 AM identified that although the resident's anxiety and sad appearance as well as the resident's potential for altered thought processes had been identified and included an intervention to notify the charge nurse immediately of any significant changes, the care plan failed to include any specific interventions in response to the resident's expressed desire to die.

- d. Resident #15's diagnoses included substance abuse disorder, paranoid disorder, depression and a history of a suicidal attempt. A significant change in status assessment dated 6/30/06 identified that the resident had modified independence in cognitive skills for daily decision making, independence in all or most activities of daily living and exhibited verbally abusive behaviors toward others. During an interview and review of

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the clinical record on 9/15/06 at 10:45 AM the Acting Administrator identified that the resident had attempted suicide in February 2006 and a plan of care was in place at that time to address the issue. However, review of the current care plan failed to identify that Resident #15's suicidal ideation had been addressed since the resident was readmitted to the facility on 6/19/06.

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

8. Based on clinical record review, observation and staff interview for ten of ten sampled residents (Residents #7, #8, #18, #20, #24, #26, #29, #30, #33 and #40) who exhibited aggressive and/or suicidal behavior and/or expressed fear regarding the behavior of another resident and/or were identified to be at risk for elopement, the facility failed to review and/or revise the plan of care after the residents' inappropriate behaviors escalated and/or the residents engaged in self injurious behaviors and/or the resident left the facility unattended and/or the resident expressed a concern regarding the behavior of another resident. The findings include:
 - a. Resident #7 had diagnoses that included schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set assessment dated 8/23/06 identified short and long-term memory deficits, moderately impaired cognition and behaviors that included wandering and verbal and physical abusiveness. Review of the Resident Care Plan (RCP) dated 8/28/06 identified that Resident #7's monitoring status was changed from every fifteen minute monitoring to every thirty minute monitoring. The RCP dated 8/30/06 identified the resident's inappropriate decision-making related to schizophrenia and vascular dementia and included interventions for staff to assess and monitor the resident and record/report any concerns or changes to the physician and the conservator. Review of the nurses' narrative notes for the period from 8/24/06 through 8/30/06 identified that Resident #7 was yelling out, shaking the side rails, very combative, screaming and had struck a nurse aide during care. The decision was made to transfer Resident #7 to the hospital emergency room. The resident returned to the facility, and the nurses' narrative notes dated 8/31/06 through 9/1/06 indicated that Resident #7 was continuing to yell out, was disruptive to other residents, swearing loudly and touched staff inappropriately. Review of the psychiatry consult dated 9/5/06 identified that the resident was progressively more confused, aggressive and agitated. Additionally, the documentation indicated that Resident #7 required hospitalization and the psychiatrist directed that the resident be sent to the hospital on a Physician Emergency Certificate (PEC).

Interview with a Licensed Practical Nurse on 9/7/06 at 10:30 AM identified that Resident #7 had not been transferred to the hospital because a bed was not available.

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Interview with Psychiatrist #1 on 9/7/06 at 11:45 AM identified a PEC had been initiated for Resident #7 on 9/5/06 because the resident was dangerous, assaultive and his level of disturbance could not be managed properly at the skilled nursing facility. Although the psychiatrist identified that this was an emergent situation, review of the RCP failed to reflect the resident's current status and/or interventions to address the dangerous behaviors until the resident was transferred to the hospital on 9/7/06.

- b. Resident #8's diagnoses included paranoid type schizophrenia and Parkinson's disease. A quarterly assessment dated 7/20/06 identified that the resident had a short-term memory deficit and modified independence with decision-making skills. A care plan dated 7/27/06 and revised on 9/7/06 identified that the resident had impulse control disorder. The interventions included providing one to one observations upon rising at bedtime and fifteen minutes frequent monitoring checks. Review of a nurse's narrative note dated 8/8/06 at 11:45 AM identified that Resident #8 had grasped a female resident inappropriately and physically assaulted a nurse aide who was assigned to provide the one-to-one monitoring. The nurse's narrative note further identified that following the incident the resident was transferred to the hospital and returned to the facility at 9:00 PM. A physician's order dated 9/8/06 directed one to one close observation monitoring around the clock.

Interview with the Registered Nurse on 9/12/06 at 1:30 PM identified that the resident was receiving one to one close observation monitoring at all times. Interview and review of the plan of care on 9/12/06 at 1:35 PM with the Care Plan Coordinator failed to identify that the plan of care had been revised to reflect the physician's directive for the resident to receive one to one observation at all times.

- c. Resident #18 had diagnoses that included schizophrenia. The quarterly assessment dated 2/5/06 identified that the resident had short and long-term memory deficits, moderately impaired cognition, wandering behaviors and independence in most activities of daily living but required limited assistance with personal hygiene. A quarterly updated smoking risk factors document dated 2/4/06 identified that Resident #18 had attempted to smoke in unauthorized areas and/or at inappropriate times in the last ninety days. The plan of care dated February 2006 identified the resident's potential for alteration in safety related to smoking and indicated that the resident's physical movements and tendency to smoke cigarettes when the butts were too low were contributing factors. The interventions included supervision of outdoor smoking by nursing staff, a small smoking group and frequent fifteen minute monitoring for non-compliance with smoking policy.

On 2/18/06 a nurse's narrative note identified that Resident #18 had been observed smoking in one of the unit's shower rooms. The note identified that the every fifteen minute monitoring of the resident would be continued. The note also identified that a

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room search was done and no contraband was found. On 2/22/06 a nurse's narrative note indicated that Resident #18 was again observed smoking in the bathroom in his room. A non-invasive body and room search yielded half a cigarette and a lighter. According to the nurse's narrative note, the every fifteen minute monitoring of the resident was again continued. On 2/24/06 an addendum nurse's note identified another instance when the resident was found to be smoking without authorization. The note indicated that Resident #18 had been found in a shower room with a lighted cigarette and was transferred to a room on a secured unit afterward. Subsequently, on 3/18/06 cigarette smoke was noticed, and ashes were found on the floor beside the resident's toilet. The resident denied smoking in the room, and a room search did not provide evidence of any unauthorized items. On 3/18/06 the facility again implemented the intervention of every fifteen minute monitoring. On 3/28/06 during the 3:00 PM to the 11:00 PM shift a nurse's note identified that matches and a cigarette lighter had been found in Resident #18's room. After the incident the resident was not permitted to smoke for seventy- two hours because of his non-compliance with the facility's smoking policy.

On 3/29/06 the physician's orders directed staff to apply a Nicotine patch 7 Milligrams daily for 5 days. The order directed staff to apply the patch at 9:00 AM and remove it at 9:00 PM . Review of the Smoking policy identified a progressive monitoring protocol. Review of the plan of care with the Corporate Nurse Consultant on 9/15/06 at 11:00 AM failed to provide evidence that the care plan had been reviewed and/or revised to reflect the resident's non- compliance with the facility's smoking policies prior to being placed on a locked unit.

- d. Resident #20's diagnoses included Post Traumatic Stress Disorder (PTSD). An admission assessment dated 6/1/06 identified the resident as independent with decision making, long and short term memory impairment, withdrawal from activities of interest, reduced social interactions and required the supervision of staff for activities of daily living (ADL). The plan of care dated 6/15/06 identified a problem of mood deficit and included interventions for staff to encourage Resident #20 to develop positive relationships with roommates and other residents. Facility documentation dated 9/8/06 identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 told him that he "was going to do bad things to him, like rape or kill him". Interview with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM identified that Resident #24 and Resident #20 did not like each other. Clinical record review identified the plan of care dated 6/15/06 was not reviewed and/or revised regarding the incident on 9/5/06.
- e. Resident #24's diagnoses included dementia with behaviors. A quarterly assessment dated 7/27/06 identified the resident with modified independence for decision making and verbally and physically abusive behaviors. The RCP dated 8/3/06 identified the

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potential for abuse and/or to be the victim of abuse and/or physical altercations with other residents. Interventions included a team review for safety, a psychiatric consultation as needed and the continuation of checks every 15 minutes due to a history of altercations. Further review of the clinical record including a Social Service quarterly note dated 8/3/06 identified that the care plan also identified the resident's cognitive deficits, communication deficits, fluctuation in mood with persistent behaviors, verbal outbursts secondary to misinterpretation and poor impulse control.

Facility documentation dated 9/8/06 identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 had told him that he "was going to do bad things to him, like rape or kill him". Interview with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM identified that Resident #24 and Resident #20 did not like each other. Interview and clinical record review with the Behavioral Health Program Manager on 9/8/06 at 1:20 PM failed to identify that the RCP was reviewed and/or revised subsequent to the event on 9/5/06.

- f. Resident #29 had diagnoses that included Post Traumatic Stress Disorder (PTSD), a history of depression with suicidal ideation and paraplegia. An assessment dated 2/3/05 identified that the resident had a short-term memory deficit and impaired decision-making. An undated Wander Risk Assessment indicated that Resident #29 was at moderate risk for elopement/ wandering.

On 4/26/05 a psychiatric consultation identified that Resident #29 was experiencing conflict with a roommate and appeared depressed. The documentation indicated that the roommate was upsetting Resident #29 by calling her names, and Resident #29 needed help defending herself. On 4/27/05 a care plan identified that Resident #29's room had been changed due to the conflict with the roommate. Although the care plan included an intervention for staff to encourage Resident #29 to verbalize feelings about the new room and to provide every fifteen minute checks as necessary, the clinical record failed to include any documentation regarding the resident's response to the new room.

On 4/28/05 facility documentation identified that Resident #29 had eloped from the facility. The documentation indicated that the resident had been found more than a mile from the building propelling the wheelchair down a city street and was reluctant to return, expressing dissatisfaction with the facility. Although a care plan dated 4/28/05 included an intervention for every fifteen minute checks, the care plan failed to include any further measures to protect the resident's safety and/or address the resident's response to the facility and the room change.

On 4/29/05 a psychiatric note further identified that the resident was depressed and felt

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lonely and hopeless. The documentation identified the resident had verbalized that she was experiencing difficulty with the new room and was not receiving adequate staff assistance. The note further indicated that the resident had expressed a feeling of desperation and stated she could no longer remain at the nursing home.

On 5/26/05 facility documentation again identified that Resident #29 was noted to be missing from the facility at 1:15 AM and was found outside in the rain. Afterward, on two subsequent occasions (i.e. 5/27/05 and 5/30/05) the resident was found outside on the facility's grounds without the knowledge of the staff. Despite the resident's history of elopement from the facility and expressions of sadness and desire to leave, clinical record review failed to identify that the facility had reviewed and/or revised the care plan to protect the resident's safety and/or respond to the resident's expressed needs/concerns.

- g. Resident #33 had diagnoses that included schizoaffective disorder and bipolar disease. The admission assessment dated 6/8/06 identified that the resident had no short or long-term memory deficits, moderately impaired cognition, verbally abusive behavior, required supervision of activities of daily living and received antipsychotic medication. The plan of care dated 6/15/06 identified that the resident had an altered thought process related to a diagnosis of schizophrenia and/or bipolar disease. The interventions included to monitor for sign and symptoms of depression and any suicidal ideations and to report any changes to the psychiatric consultant promptly.

A nurse's note dated 8/6/06 at 11:00 PM identified that Resident #33 had been sent to the hospital emergency room secondary to suicidal ideation. The resident returned to the facility on 8/7/06, and on 8/10/06 at 3:00 AM a nurse's narrative note identified that Resident #33 had given a note to a licensed staff member to pass on and/or fax to the psychiatrist at 1:30 AM. The nurse's note indicated that the nursing supervisor was notified, and Resident #33 stayed in the dayroom from 2:30 AM to 3:45 AM. Review of the note passed to staff reflected that Resident #33 was suicidal and depressed. Further review of the clinical record identified that after the resident passed the note to staff, the facility continued the measure to provide the resident with frequent every fifteen minute monitoring, and a psychiatric consultation was requested by placing the resident's name in the referral book. On 8/11/06 at 10:00 PM a nurse's narrative note identified that Resident #33 had refused to take the scheduled dose of the medication Depakote stating that it made him more suicidal. The nurse's note further indicated that another referral had been placed in the psychiatric consultant's book.

Review of the clinical record with the Director of Nursing and the Behavioral Health Consultant on 9/14/06 at 11:00 AM failed to provide evidence that the plan of care was revised subsequent to the events that occurred during the period from 8/6/06 through

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8/11/06.

- h. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, chronic obstructive pulmonary disease (COPD) and a history of smoking. The resident assessment dated 1/5/06 identified that Resident #26 was alert, oriented, experienced some difficulty with new situations, had an unpleasant mood in the morning, made negative statements, was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. The resident's care plan (RCP) dated 2/2006 indicated that Resident #26 was moody, weepy and demanding with interventions that included psychiatric services, allowing the resident to vent her feelings, setting limits and /or boundaries.

Facility documentation dated 3/15/06 at 10:30 PM indicated that Resident #26 had made a suicidal gesture by using a nail clipper to lacerate her right wrist and was transferred to the emergency department. A nurse's note dated 3/16/06 at 10:45 AM indicated that Resident #26 returned to the facility, and there were no new orders. Review of the resident's care plan dated 3/15/06 identified that Resident #26 had used nail clippers to slash at the right wrist, but there lacked documentation that the care plan had been revised to include new goals and/or interventions to prevent Resident #26 from causing any further harm to herself.

A nurse's note dated 3/20/06 at 2:00 AM indicated that Resident #26 was transferred to the hospital for respiratory distress related to a diagnosis of COPD. Resident #26 was readmitted to the facility on 4/3/06 at 11:15 AM and was informed that her conservator had requested that her smoking privileges be decreased from two cigarettes per smoking break to one because of the resident's respiratory symptoms. Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset about the change in the smoking privileges, broke a picture frame from her room, lacerated the right wrist and was sent to the emergency room. The resident care plan lacked documentation that revisions had been made to indicate that Resident #26 had cut her wrist for the second time and/or any interventions to prevent Resident #26 from causing any further harm to herself. Review of the smoking care plan failed to address potential problems related to the decrease in the number of cigarettes that Resident #26 was allowed to smoke at each smoke break.

Review of a nurse's note dated 4/3/06 indicated that Resident #26 returned to the facility at 8:45 PM. Resident #26 was seen by Psychiatrist #1 the following morning(4/4/06) The psychiatrist's note dated 4/4/06 indicated that Resident #26 had made a suicidal attempt and recommended that Resident #26 be transferred to an acute psychiatric facility and signed a Physician Emergency Certificate (PEC). A nurse's note dated 4/4/06 at 4:30 PM indicated that Resident #26 had increased agitation, slapped another

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resident across the face and was transferred to the hospital emergency room. The resident returned to the facility on 4/5/06 at 1:35 PM. No revisions were made to the care plans to address managing the resident's escalating behaviors.

A nurse's note dated 4/5/06 at 11:10 PM indicated that Resident #26 was found sitting on the side of her bed, cutting her right wrist with a piece of glass (third incident) and was transferred to the emergency department. The nurse's note dated 4/6/06 at 4:45 PM indicated that Resident #26 returned to the facility and was placed on one to one close observations. No revisions were made to the RCP.

Facility documentation dated 4/16/06 at 10:15 PM indicated that Resident #26 was found in the bathroom cutting her wrist with a safety pin. Resident #26 was transferred and admitted to an acute care psychiatric unit.

During an interview on 9/6/06 at 11:00 AM the Social Worker stated that she was responsible to make revisions to the care plan related to mood and behavior but could not explain why the care plans had not been revised prior to 4/16/06.

- i. Resident #30 had diagnoses that included bipolar disorder and mood swings. An Inter Agency Patient Referral Report dated 11/10/05 identified that Resident #30 was hospitalized for a suicidal intent with a plan to jump in front of traffic. The Minimum Data Set assessment dated 11/17/05 identified that the resident's long and short term memory were intact, and the resident experienced some difficulty in making decisions, verbally abusive behaviors, resistance to care and independence with activities of daily living. A nurse's narrative note dated 12/22/05 identified that Resident #30 had called the public's emergency number and also called the public's suicide telephone line. A late entry nurse's narrative note dated 12/24/05 identified that Resident #30 had called the public's emergency telephone number requesting to go to the hospital with non-specific complaints. Further review of the clinical record identified a nurse's note dated 12/24/05 which indicated a nurse aide found Resident #30 in his room bleeding from his right wrist. Resident #30 stated that he was trying to kill himself because he wanted to be sent to the hospital.

Although the clinical record included a care plan dated 8/18/05 which identified behavior deficits related to depression, the facility failed to review and revise the RCP to reflect the resident's suicidal intention and interventions to address the behaviors.

- j. Resident #40 had diagnoses that included major depression with psychotic features and/or suicidal ideations. The resident was admitted to the facility on 8/9/06 and readmitted on 9/11/06. Readmission documentation dated 9/11/06 identified a physician's order for post hospitalization care for major depression with suicidal ideations. Interview and clinical record review with the Acting Administrator on

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9/15/06 at 10:45 AM identified no evidence that the care plan had addressed the suicidal ideations since the resident's most recent readmission to the facility on 9/11/06.

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

9. Based on clinical record review, observations, staff interviews and facility policies documentation for one of one sampled resident requiring continuous tube feedings (Resident #5) and/or for one of three sampled residents with multiple episodes of suicidal gestures (Resident #26), the facility fail to follow acceptable standards of care and/or assess the resident in accordance with professional standards. The findings include:

- a. Resident #5 had diagnoses that included Dementia, Depression, Renal Failure and Alzheimer's Disease. A Significant Change in status assessment dated 5/27/06 identified that Resident #5 had short and long-term memory deficits and receiving tube feeding as a nutritional approach.

Observations on 9/7/06 at 10:27 A.M. identified that no assessment of the tube feed residual was accomplished. Interview with the LPN indicated that it was forgotten. Review of facility documentation with the Administrator identified that aspiration of gastric contents is expected.

According to Lippincott's Manual of Nursing Practice, 8th Edition 2006, the gastric residual is to be checked prior to flushing continuous tube feedings.

- b. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, Chronic Obstructive Pulmonary Disease (COPD) and a history of smoking. The resident assessment dated 1/5/06 identified Resident #26 as alert, oriented, had some difficulty with new situations, had an unpleasant mood in the morning, and made negative statements. Additionally, the assessment identified that the resident was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints. The resident's care plan (RCP) dated 2/2006 indicated that Resident #26 was moody, weepy, and demanding. Interventions included psychiatric services, allowing the resident to vent her feelings, and setting limits and /or boundaries.

Facility documentation dated 3/15/06 at 10:30 PM indicated that Resident #26 had made a suicidal gesture by using a nail clipper to lacerate the right wrist and was transferred to the emergency room. A nurse's note dated 3/16/06 at 10:45 AM indicated that R #26 returned to the facility and was placed on every fifteen-minute checks.

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A nurse's note dated 3/20/06 at 2:00 AM indicated that Resident #26 was transferred to the hospital for respiratory distress related to COPD, was readmitted on 4/3/06 at 11:15 AM and informed that her Conservator of Person (COP) wanted the resident to have one cigarette per smoking break instead of two. Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset with regard to the change in the smoking privileges and had lacerated her right wrist with a piece of broken glass from a picture frame located in the resident's room. Review of the Behavioral Health Program Manager note dated 4/3/06 indicated that R #26 was suicidal, agitated, uncooperative with care and had made the statement; " I wanted to die, let it bleed." Resident #26 was placed on one to one close observations until transferred to the hospital emergency department at 5:00 PM. Resident #26 returned to the facility on 4/3/06 at 8:45 PM and the every fifteen-minute checks were resumed. Although a smoking assessment had been conducted on 4/3/06, an assessment was lacking to reflect the resident's response to the change in the smoking restriction.

Review of the resident's nursing notes dated 4/3/06 indicated Resident #26 returned to the facility at 8:45 PM. Resident #26 was seen by Psychiatrist #1 the following morning (4/4/06). The psychiatrist note dated 4/4/06 indicated that Resident #26 had made a suicidal attempt, recommended that the resident be transferred to an acute psychiatric facility and signed a Physician Emergency Certificate (PEC). A nurse's note dated 4/4/06 at 4:30 PM indicated that R #26 had increased agitation, slapped another resident across the face and was transferred to the emergency room and returned to the facility on 4/5/06 at 1:35 PM.

A nurse's note dated 4/5/06 at 11:10 PM indicated that Resident #26 was found sitting on the side of the bed, cutting her right wrist with a piece of glass and was transferred to the emergency department. Resident #26 returned to the facility on 4/6/06 at 4:45 PM and was placed on one to one close observation.

NA #3 on 9/7/06 at 2:00 PM stated that on 4/16/06 she was assigned to do one to one close observations of Resident #26 and had taken the resident outside on a smoking break. As Resident #26 was leaving the smoking area, Resident #26 made a comment to another resident that she would not be seeing him anymore. NA #3 stated she had informed the charge nurse prior to the time that Resident #26 returned to her room. A nursing narrative note dated 4/16/06 at 2:30 PM lacked documentation related to the resident's comment. Facility documentation dated 4/16/06 at 10:15 PM indicated that Resident #26 was found in the bathroom cutting her left wrist with a safety pin.

Although review of facility documentation identified that the resident engaged in self injurious behaviors, further review failed to identify that a nursing mental health assessment had been conducted by an RN prior to being transferred to the emergency room and/or after the resident returned from the hospital on 4/3/06, 4/4/06, 4/5/06 and/or

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4/16/06. According to *Mental Health And Psychiatric Nursing*, Second Edition, published by J.B. Lippincott Company, an assessment of the lethality of a patient's suicidal behavior includes establishing the intent, evaluating the suicidal plan, exploring the mental state, reviewing support systems and reviewing current stressors affecting the individual. The process would further include an analysis of the predominant mood, level of anxiety, degree of self-esteem and severity of symptoms and a determination of the patient's risk of suicide with recognition that individuals with mood disorders are at increased risk. The assessment should also include an analysis of current stressors including recent loss, chronic illness and surgery.

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

10. Based on clinical record review for one of ten sampled residents (Resident #22) who required assistance with activities of daily living, the facility failed to ensure the assistance was provided.

The findings include:

- a. Resident #22 had diagnoses that included acute depression. The annual assessment dated 3/15/06 indicated that the resident's long and short term memory were intact, and the resident experienced some difficulty in new situations regarding decision making, required total assistance from staff with activities of daily living and was continent of bowel and bladder. The plan of care dated 3/22/06 identified a problem of cognitive loss related to major depression. The interventions included allowing the resident to express his feelings/concerns, attempt to validate and offer positive feedback and encourage appropriate decision making.

Facility documentation dated 3/28/06 identified Nurse Aide #10 told Resident #22 it was difficult to place him on a bed pan. The documentation also indicated Resident #22 was directed to urinate in the bed. Further review of the facility's documentation identified NA #10 refused to provide a bed pan for the resident. NA #10 encouraged Resident #22 to relieve himself in the bed because it was too much trouble without the air mattress. In a statement provided by NA #22 on 3/31/06, the nurse aide identified that he had directed Resident #22 to "do what he had to do and go in the pad and he would take care of him right away."

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

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11. Based on clinical record review and interview for one sampled resident (Resident #29) with pressure sores, the facility failed to monitor the wounds and/or implement measures to promote healing. The findings include:
- a. Resident #29 had diagnoses that included Post Traumatic Stress Disorder, a history of depression with suicidal ideation, paraplegia and a recent fracture of the left distal femur that was secured by an immobilizer. A Minimum Data Set assessment dated 7/7/05 identified that the resident had a short-term memory deficit, resistance to care, required limited assistance with transfers, physical assistance with bathing, had a limitation in range of motion of the legs and feet and utilized a wheelchair as the primary mode of locomotion. The assessment further identified that the resident was usually continent of bladder, incontinent of bowel and had a history of a pressure ulcers.

Review of the clinical record identified that on 8/1/05 the resident was noted to have a pressure ulcer on the left heel under the immobilizer that was described as measuring seven centimeters by three centimeters. However, there was no evidence that the facility had monitored the area under the immobilizer and/or initiated a plan of care or any preventive measures until 8/4/05. On 8/15/05 the resident was further identified with an open area on the left buttock. Clinical record review with the Corporate Nurse Consultant on 9/15/06 failed to provide evidence that the facility had promptly implemented measures to promote the healing of the pressure sore on the resident's heel when it was identified on 8/1/05 and/or consistently monitored the resident's wounds during the period from 8/15/05 through 10/7/05 to ensure that appropriate measures were being implemented and/or to initiate new interventions.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D81 (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

12. Based on clinical record review, observation and staff interview for one of three sampled residents (Resident #7) who required an emergency hospital transfer, the facility failed to ensure appropriate psychiatry services were in place. The findings include:
- a. Resident #7's diagnoses included schizophrenia, dementia and impulse control disorder. The Minimum Data Set assessment dated 8/23/06 identified that the resident had short and long term memory deficits, moderately impaired cognition and behaviors that included wandering and verbal and physical abusiveness. The care plan dated 8/30/06 identified the potential for an alteration in thought process related to schizophrenia and included an intervention to notify the physician of any significant changes in the resident's condition. During the period from 8/30/06 through 9/5/06 the nurses' narrative notes described multiple occasions when the resident was aggressive, abusive and/or

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disruptive. On 8/30/06 at 10:00 PM a nurse's narrative note identified that Resident #7 was combative and hit a staff member in the chest with his fist, and on 8/31/06 at 2:45 PM a nurse's note further identified that the resident was disruptive, swearing and had inappropriately touched staff. On 9/1/06 a nurse's narrative note identified that Resident #7 had kicked at a staff member, and on 9/5/06 the resident was described as being aggressive toward staff.

A psychiatric consultation dated 9/5/06 directed the facility to send the resident to the hospital on a Physician Emergency Certificate(PEC). Observations on 9/6/06 at 9:30 AM and 9/7/06 at 10:00 AM and 12:00 Noon, identified that Resident #7 was in his room alone. Interview with Licensed Practical Nurse #1 on 9/7/06 at 10:30 AM identified the Resident was not sent to the hospital on a PEC as ordered because a bed was not available. Interview with Psychiatrist #1 on 9/7/06 at 11:45 AM identified the resident should have been sent to the hospital per the PEC. Additionally, if a bed was not available, he would have expected to be made aware and he would have initiated a plan for one-to-one monitoring. Review of the policy on PEC failed to identify specific steps that staff were to take if a bed was not available and/or who was to be contacted.

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

13. Based on observation, interview and review of facility policy documentation for one of one sampled resident (R #5) who required a continuous tube feeding, the facility failed to ensure that appropriate treatment was provided. The findings include:
 - a. Resident# 5 had diagnoses that included Dementia, Depression, Renal Failure and Alzheimer 's disease. A Significant Change in Status assessment dated 5/27/06 identified that Resident #5 was impaired in short and long-term memory and and received tube feedings as a nutritional approach. Observations on 9/7/06 at 10:27 AM identified that no assessment of the tube feed residual was accomplished. Interview with the LPN noted that it was forgotten. Review of the facility documentation with the Administrator identified aspiration of gastric contents is expected.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2)(A) and/or (k) Nurse Supervisor (1).

14. Based on clinical record review, staff interviews and observations, the facility failed to ensure that the environment was free from hazards. The finding include:

- a. Resident #25 had diagnoses that included depression and was identified to be a cigarette smoker. A resident assessment dated 7/06/06 identified that Resident #25 was alert, oriented, had severely impaired decision-making skills, made negative statements, had repetitive health and/or anxious complaints and behavioral symptoms that included wandering, verbal abusiveness, socially inappropriate behaviors and resistance to care. During a tour of the facility on 9/8/06 at 11:40 AM a fragrance was detected in the hallway near Resident #25's room. During an observation made with the Director of Nurses, the Corporate Quality Assurance Nurse and the Administrator on 9/8/06, a scented jar candle was found to be burning on a small table located next to Resident #25's bed. Two other unopened votive candles were nearby, and the privacy curtains were closed.

During an interview on 9/8/06 at 11:50 AM Resident #25 stated that her sister had given her the candles on Monday, 9/4/06. The resident noted that she had lit the scented jar candle for the first time that morning. Resident #25 stated that she had obtained the matches from a store and had brought them into the facility. NA #2 on 9/8/06 at 3:21 PM identified that she was assigned as the "Door Person" on 9/4/06. NA #2 stated that Resident #25's sister had carried a bag into the facility on 9/4/06. NA #2 stated that when she checked the bag, she did not notice any candles. NA #2 further identified that the resident did not have a pocketbook, and she did not request that the resident's sister empty her pockets. Review of the facility's policy regarding the responsibilities of the "Door Person" indicated that the resident is to empty pockets and bags in front of staff.

- b. Resident #32 had diagnoses that included anxiety, major depression and recurrent psychotic features. The significant change in condition assessment dated 7/31/06 identified the resident with modified independence with decision making, sad, pained and worried facial expression. Observation during tour of the facility on 9/6/06 at 10:00 AM identified a disposable razor on top of Resident #32's dresser. Further observation identified Resident #32 was not present. However, three other residents were observed in the room. Observation and interview with Nurse Aide #8 at that time indicated the residents were to return the razors to staff following their use and/or the razors were to be removed after they were used.
- c. Resident #12 had diagnoses that included paraplegia secondary to motor vehicle

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accident and chronic pain. The annual assessment dated 6/9/06 identified the resident with independent decision making and transfers. A plan of care dated 6/16/06 identified that the resident was at high risk for falls with an intervention to lock the wheelchair and/or bed brakes. A nurse's narrative note dated 7/27/06 identified that Resident #12 reported that he had fallen from his wheelchair while transferring to bed at 2:30 PM. The note further indicated that the resident sustained a 1 1/4 Centimeter abrasion on the right knee and a 1 1/2 Centimeter abrasion on the left knee. Interview and clinical record review with the Nursing Supervisor on 9/7/06 at 9:30 AM failed to identify that a system was in place to check the wheelchair and/or bed brakes. Further review failed to identify that Resident #12 was educated to ensure the wheelchair brakes were locked prior to transferring.

- d. During a tour of the first and second floor lounge areas with maintenance staff on 9/06/06 the batteries of two electric wheelchairs were observed being charged with two residents present. Interview with the nurse aide on 9/06/06 at 10:00 AM identified that she had forgotten to unplug the wheelchairs in the morning. Interview with the Infection Control Nurse at 11:05 AM identified that the wheelchair batteries are charged overnight, and staff had inadvertently failed to unplug them in the morning.

Further observations identified multiple items stored on the overbed lights. These included two speakers on the overbed lights in Room 115, five stuffed animals on the overbed light in Room 112, a potpourri satchel on the overbed light in Room 103, six wire clothes hangers on the overbed light in Room 219, resident clothing on wire hangers on the light above the bed in Room 223, a thermostat without a cover and a hat hanging on the light above the bed in Room 226 and a wreath and two picture frames hanging on the overbed light in Room 238.

Observations further identified fifteen garments on wire hangers on a rolling walker in Room 122. On the second floor lounge the area under the bathroom sink was observed to have an opening measuring approximately 12 inches with pipes exposed. In Room 137 the tiles were noted to be missing in the bathroom, and a hole in the wall was stuffed with toilet paper.

On 9/06/06 facility water temperatures were tested and were noted to be at 129.6 F in Room 220, 129.5F in Room 212, 127.6F in Room 201, 124.9F in Room 203 and Room 133. Review of the facility's water temperature log for the period from 7/03/06 through 9/06 identified water temperatures ranged from 108 F to 118 F but failed to provide evidence that the times were staggered throughout the day. Interview with maintenance staff on 9/06/06 at 3:30 PM identified a problem with the mixing valve and indicated the part would be replaced. Subsequent to surveyor inquiry the mixing valve was replaced.

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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)(A) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

15. Based on clinical record review, observation and staff interview for nine of nine sampled residents (Residents #7, #12, #15, #20, #24, #26, #29, #30 and #33) who exhibited and/or experienced aggressive and/or suicidal behavior and/or was identified to be at risk for elopement from the facility, the facility failed to ensure that adequate supervision was provided after multiple suicidal gestures, threatening behavior the escalation of behavioral symptoms and/or after the resident left the facility unattended. The findings include:
- a. Resident #30 had diagnoses that included suicidal ideation with intent, bipolar disorder and mood swings. The Minimum Data Set assessment dated 11/7/05 identified that the resident had no long or short-term memory deficits, some difficulty in making decisions, verbally abusive behaviors, resistance to care and independence in activities of daily living. An Inter Agency Patient Referral report dated 11/10/05 identified Resident #30 was hospitalized for suicidal intent to jump in front of traffic. A nurse's narrative note dated 12/22/05 indicated that the resident had called the public's emergency number as well as the public's suicide telephone lines. A late entry nurse's narrative note dated 12/24/05 identified Resident #30 had called the public's emergency telephone number requesting to be taken to the hospital with non-specific complaints. Further review of the clinical record identified a nurse's note dated 12/24/05 that indicated a nurse aide had found Resident #30 in his room bleeding from his right wrist. Resident #30 stated that he was trying to kill himself because he wanted to be sent to the hospital. The documentation further indicated that Resident #30 sustained a small superficial cut on the right wrist. Although Resident #30 had called the suicidal hot line on 12/22/05 and the facility was aware, the facility failed to provide evidence that adequate supervision was afforded to the resident to prevent the suicidal attempt that occurred on 12/24/05.
 - b. Resident #15's diagnoses included substance abuse disorder, paranoid disorder, depression and a history of a suicidal attempt. A significant change assessment dated 6/30/06 identified the resident with modified independence for cognitive skills in daily decision making, independence for all or most activities of daily living and verbally abusive behaviors toward others. A nurse's note dated 7/26/06 on the 11:00 PM to 7:00 AM shift identified that at 1:00 AM Resident #15 received Ambien CR 12.5 Milligrams for insomnia and Percocet 5/325 (two tablets) for complaints of pain to her abdomen and feet. The note further indicated that Resident #15 became anxious and fearful that the supply of percocet would run out and asked to sit outside. The note also identified that a nurse aide escorted the resident to a bench outside at 2:15 AM, and after returning to the unit, the resident was still anxious about whether there was adequate Percocet available. The charge nurse subsequently noticed that the resident had an odor of

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alcohol.

Interview with Registered Nurse #7 on 9/15/06 at 9:50 AM regarding the event on 7/26/06 identified that Nurse Aide #11 escorted Resident #35 outside after she was medicated with Ambien. However, the nurse did not know whether the nurse aide had remained with the resident. Interview with Nurse Aide #11 on 9/15/06 at 11:15 AM identified that at about 1:45 AM she escorted Resident #15 outside where the resident sat on a bench and was given a cigarette. Nurse Aide #11 also stated that she went back into the building and the resident was left unattended for about twenty minutes to a half hour. Registered Nurse #7 further indicated that the resident was subsequently sent to the emergency room because of the scent of alcohol on her breath. Interview with the Acting Administrator on 9/15/06 at 10:45 AM failed to provide evidence the resident was provided with adequate supervision on 7/26/06 between 1:45 AM and 2:15 AM.

- c. Resident #12 had diagnoses that included paraplegia secondary to a motor vehicle accident and chronic pain. The annual assessment dated 6/9/06 identified that the resident was independent in decision making and transfers. The plan of care dated 6/16/06 identified that the resident was at high risk for falls with interventions to lock the wheelchair and/or bed brakes. A nurse's narrative note dated 7/27/06 identified Resident #12 reported that he had fallen from his wheelchair while transferring to bed at 2:30 PM. The note further indicated Resident #12 sustained a 1 1/4 Centimeter abrasion on the right knee and a 1 1/2 Centimeter abrasion on the left knee. The nurse's narrative note dated 7/27/06 also identified the Maintenance Department was notified that the wheelchair brake was broken. Review of facility documentation dated 7/27/06 identified Resident #12 fell while transferring from the wheelchair to the bed. Interview and clinical record review on 9/7/06 at 9:30 AM with the Registered Nursing supervisor failed to provide evidence that a system was in place to monitor wheelchair and/or bed brakes to ensure they were in good repair.
- d. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, chronic obstructive lung disease (COPD) and a history of smoking. Resident #26 resided in a locked dementia unit related to non-compliance with smoking rules and for monitoring of the resident's smoking. A resident assessment dated 1/5/06 identified that the resident was alert, oriented, had some difficulty with new situations, an unpleasant mood in the morning, negative statements, was depressed (sad, crying daily and/or almost daily), anxious and had repetitive health complaints.

A resident care plan (RCP) dated February 2006 indicated that the resident was moody, weepy and demanding with interventions that included psychiatric services, allowing the resident to vent her feelings and to set limits and /or boundaries. Facility documentation dated 3/15/06 at 10:30 PM indicated that Resident #26 had made a suicidal gesture by using a nail clipper to lacerate the right wrist and was transferred to the acute care

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hospital emergency department. Review of a nurse's note dated 3/16/06 at 10:45 AM indicated that the resident had returned to the facility after the hospital determined that the resident would not harm self and/or others, and there were no new orders. Although a care plan dated 3/15/06 identified that the resident had lacerated the wrist, the care plan failed to include any further revisions following the incident.

On 3/20/06 at 2:00 AM a nurse's note indicated that Resident #26 had been transferred to the hospital for respiratory distress related to the diagnosis of COPD. Upon return to the facility on 4/3/06, the resident was informed of a change in smoking privileges agreed to by her conservator because of the resident's respiratory disease (one cigarette per smoking break instead of two) and was placed on every fifteen minute close observation. Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset about the change in her smoking privileges and had broken the glass from a picture frame in her room and lacerated the right wrist with a piece of the broken glass because the resident's conservator wanted the resident to have only one cigarette per smoke break instead of two. Review of a note dated 4/3/06 written by the Behavioral Health Program Manager indicated that Resident #26 was suicidal, agitated, uncooperative with care and had made the statement that " I wanted to die, let it bleed." Resident #26 was placed on one- to-one close observations until transferred to the emergency department at 5:00 PM. Review of a nurse's narrative note dated 4/3/06 at 8:45 PM identified that the resident had returned to the facility with a letter indicating that Resident #26 was not a danger to self and/or others.

Subsequent to the resident's return, the facility resumed every fifteen minute close observation of the resident. On 4/4/06 the psychiatrist wrote a note which indicated that Resident #26 had made a suicidal attempt and recommended that Resident #26 be transferred to an acute psychiatric facility. The psychiatrist further signed a Physician Emergency Certificate (PEC) which identified that the resident was dangerous to self or others. However, the facility failed to implement any new measures, and at 4:30 PM on 4/4/06 a nurse's note indicated that the resident had exhibited increased agitation, slapped another resident across the face and was subsequently transferred to the emergency room. The resident returned to the facility on 4/5/06 at 1:35 PM and remained on every fifteen minute close observation. No revisions were made to the care plans to indicate that Resident #26 had cut her wrist for the second time and/or to identify any interventions that would be implemented to prevent the resident from additional self-harm.

There was no indication that the facility had initiated the transfer to the acute psychiatric facility after the PEC was signed by Psychiatrist #1, and the psychiatrist was not informed that the facility had failed to transfer the Resident #26 to an acute psychiatric facility. Although the nurse's note indicated the resident was being monitored on every fifteen-minute checks, the facility was unable to provide documentation that the

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fifteen-minute checks were conducted. A nurse's note dated 4/5/06 at 11:10 PM indicated that Resident #26 was found sitting on the side of the bed, cutting her right wrist with a piece of glass and was transferred to the emergency department (third attempt). Resident #26 was sent to the acute care hospital emergency department for treatment and upon return was placed on one to one (1:1) close observation. No other revisions were made to the care plan. The Director of Nurses and the Assistant Director of Nurses on 9/7/06 both stated that they did not know how the resident had obtained another piece of broken glass on 4/5/06.

Facility documentation further identified that on 4/16/06 at 10:15 PM Resident #26 was been found in the bathroom by her 1:1 nursing assistant cutting her left wrist with a safety pin (fourth attempt). Resident #26 was transferred to the acute care hospital and admitted. During an interview on 9/7/06 at 2:00 PM NA #3 stated that on 4/16/06 she was assigned to do the one to one close observations of Resident #26. NA #3 stated that she had taken the resident out on a smoke break, and as Resident #26 was leaving the smoking area, Resident #26 made a comment to another resident that she would not be seeing him anymore. NA #3 stated she had informed the charge nurse of the incident prior to the time that Resident #26 returned to the room. NA #3 stated that after Resident #26 returned to her room, the resident was observed to be looking through the drawers in the night stand before going to the bathroom. NA #3 stated she had asked the resident what she was looking for, but the resident had told her "nothing." NA #3 stated that when Resident #26 went into the bathroom, she refused to leave the bathroom door open. NA #3 stated she called for the nursing supervisor and when the supervisor arrived, the resident was observed to be using a safety pin to cut her wrist. On 4/16/06 the resident was admitted to an acute psychiatric unit at the hospital for three days. Upon return the resident was kept on 1:1 close observation and medication changes were initiated. On 9/8/06 the facility had discontinued the close observation of the resident since no further suicidal behavior had been identified

- e. Resident #24 had diagnoses that included dementia with behavioral symptoms. A quarterly assessment dated 7/27/06 identified that the resident had modified independence in decision making and verbally and physically abusive behaviors. The resident care plan dated 8/3/06 identified that the resident had the potential for abuse and/or to be the victim of abuse and had a history of physical altercations with other residents. Interventions included a team review to ensure the resident's safety, psychiatric consultations as needed and the continuation of every 15 minute checks due to the resident's altercations. Resident #20 had diagnoses that included Post Traumatic Stress Disorder (PTSD). An admission assessment dated 6/1/06 identified that the resident had short and long- term memory deficits, independence in cognitive skills for daily decision making, withdrawal from activities of interest, reduced social interactions and required the supervision of staff for activities of daily living (ADL).

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Review of facility documentation identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 had told him that he "was going to do bad things to him, like rape or kill him." Although the clinical record failed to include any documentation regarding the concerns that had been expressed by Resident #24, the two residents were roommates, and facility documentation dated 9/5/06 at 11:30 AM identified that Resident #20 was granted a room change to another location on the same floor.

During an observation of a smoking group on 9/7/06 at 6:40 PM Resident #24 identified that Resident #20 had threatened to kill him. Interview and clinical record review with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM and 1:20 PM identified that there was no evidence of the facility's monitoring and supervision of Residents #24 and #20 who continued to reside on the same floor. The program manager stated that the situation was unclear, and Residents #24 and #20 did not like each other.

- f. Resident #7 had diagnoses that included Schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set assessment dated 8/23/06 identified that the resident had short and long- term memory deficits, moderately impaired cognition, wandered and exhibited verbally and physically abusive behaviors. Review of the plan of care dated 8/28/06 identified that the facility had decreased the monitoring of the resident from every fifteen minute monitoring to every thirty minutes. On 8/30/06 a revised plan of care identified that the resident had impaired decision-making related to schizophrenia and vascular dementia. The care plan included interventions for staff to assess and monitor the resident and record and report concerns/changes to the physician and/or conservator. During the period from 8/24/06 through 8/30/06 the nurses' narrative notes identified that Resident #7 was frequently calling out/ yelling, shaking the side rails, very combative and hit a nurse aide during care. On 8/30/06 a physician's order directed the facility to transfer the resident to the emergency department for an evaluation of the behavior, and the resident was sent to the hospital at approximately 10:15 PM.

Subsequent to the resident's return to the facility, the nurses' narrative notes for the period from 8/31/06 through 9/1/06 indicated that Resident #7 was yelling out, disruptive to other residents, swearing loudly and touching staff inappropriately. Review of a psychiatric consultation dated 9/5/06 identified that Resident #7 had become progressively more confused, aggressive and agitated. The documentation further indicated that Resident #7 required hospitalization and directed the facility to send the resident to the hospital on a Physician Emergency Certificate.(PEC). Observations on 9/6/06 at 9:30 AM and on 9/7/06 at 10:00 AM and 12:00 PM identified that Resident #7 was seated alone in his room in a customized wheelchair.

Interview with Licensed Practical Nurse #1(LPN #1) on 9/7/06 at 10:30 AM identified

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that Resident #7 had not been sent to the hospital because a bed was not available. Interview with Psychiatrist #1 on 9/7/06 at 11:45 AM identified a PEC was initiated for Resident #7 on 9/5/06 because the resident was dangerous and assaultive. The psychiatrist stated that the resident's level of disturbance could not be managed properly at the skilled nursing facility, and this was an emergent situation. Interview with LPN #2 on 9/7/06 at 7:04 PM identified that after the facility was unable to find a bed for the resident, the facility assigned two to three staff members to assist the resident with activities of daily living. However, the facility failed to provide evidence and or documentation that the measures were in effect.

- g. Resident #33 had diagnoses that included schizoaffective disorder and bipolar disease. The admission assessment dated 6/8/06 identified that the resident had no long or short-term memory deficits, moderately impaired cognition, verbally abusive behavior, required supervision with activities of daily living and received antipsychotic medication. The plan of care dated 6/15/06 identified that the resident had an altered thought process related to diagnosis of schizophrenia and/or bipolar disease. Interventions directed staff to monitor the resident for sign and symptoms of depression and any suicidal ideations and to report to the psychiatric consultant promptly. A nurse's narrative note dated 8/10/06 at 3:00 AM identified Resident #33 had given a note to a licensed nurse to pass on and/or fax to the psychiatrist at 1:30 AM. The nurse's note indicated the nursing supervisor was notified and Resident #33 stayed in the dayroom from 2:30 to 3:45 AM. Review of the note passed to staff identified that Resident #33 was suicidal and depressed. Further review of the clinical record identified Resident #33 the frequent fifteen minute monitoring of the resident was continued after the note was passed to staff. A referral was made to the psychiatric consultant. On 8/11/06 Resident #33 refused to take a scheduled medication, Depakote, stating that it made him more suicidal, and another referral was made to the psychiatric consultant. During an interview and review of the clinical record on 9/14/06 at 11:00 AM, the Behavioral Health Program Manager stated that an intervention was not necessary because the resident was maintained on every fifteen minute monitoring and the licensed staff had made referrals to the psychiatric consultant.
- h. Resident #29 had diagnoses that included Post Traumatic Stress Disorder (PTSD), a history of depression with suicidal ideation and paraplegia. An assessment dated 2/3/05 identified that the resident had a short-term memory deficit and impaired decision-making. An undated Wander Risk Assessment indicated that Resident #29 was at moderate risk for elopement/ wandering. A care plan dated 4/27/05 included an intervention for every fifteen minute checks as necessary.

On 4/28/05 facility documentation identified that Resident #29 had eloped from the facility. The documentation indicated that the resident was found more than a mile from the facility propelling the wheelchair down a city street, expressed dissatisfaction with

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the facility when found and was reluctant to return. Although a care plan dated 4/28/05 identified an intervention for every fifteen minute checks, the care plan failed to include any further measures to protect the resident's safety and/or to address the resident's dissatisfaction with the facility and/or response to a recent room change.

On 4/29/05 a psychiatric note further identified that the resident was depressed and felt lonely and hopeless. The documentation identified that the resident had verbalized that she was experiencing difficulty with the new room, was not receiving adequate staff assistance, had expressed a feeling of desperation and indicated she could no longer remain at the nursing home.

On 5/26/05 facility documentation again identified that Resident #29 was noted to be missing from the facility at 1:15 AM and was found outside in the rain. Afterward, on two subsequent occasions (i.e. 5/27/05 and 5/30/05) the resident was found outside on the facility's grounds without the knowledge of the staff. Despite the resident's history of elopement, expressions of sadness and desire to leave, clinical record review failed to identify that the facility had implemented measures to protect the resident's safety.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Events (3).

16. Based on clinical record review, facility policy and staff interviews for four of twelve sampled residents (Residents #26, #27, #30 and #31) who were involved in an accident/incident the facility failed to notify the Department. The findings include:
 - a. Resident #30 had diagnoses that included suicidal ideation with intent, bipolar disorder and mood swings. The Minimum Data Set assessment dated 11/7/05 identified that the resident had no long or short term memory deficits, some difficulty in making decisions, verbally abusive behaviors, resistance to care and independence with activities of daily living. An Inter Agency Patient Referral report dated 11/10/05 identified that Resident #30 was hospitalized for suicidal intent to jump in front of traffic. A nurse's narrative note dated 2/22/05 indicated that Resident #30 had called the public's emergency number as well as the public's suicide telephone lines. A late entry nurse's narrative note dated 12/24/05 identified Resident #30 had called the public's emergency telephone number requesting to be taken to the hospital with non-specific complaints. Further review of the clinical record identified a nurse's note dated 12/24/05 which indicated a nurse aide had found Resident #30 in his room bleeding from his right wrist. Resident #30 stated that he was trying to kill himself because he wanted to be sent to the hospital. The incident was not reported to the Department.

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- b. Resident #26 had diagnoses that included borderline personality disorder, schizophrenia, Chronic Obstructive Pulmonary Disease (COPD) and a history of smoking. Facility documentation dated 3/15/06 at 10:30 PM indicated that R #26 had made a suicidal gesture by using a nail clipper to lacerate the right wrist and was transferred to the emergency room. Review of facility documentation dated 4/3/06 at 4:30 PM indicated that Resident #26 was upset with regard to the change in the smoking privileges and had lacerated her right wrist with a piece of broken glass from a picture frame located in the resident's room. A nurse's note dated 4/5/06 at 11:10 PM indicated that Resident #26 was found sitting on the side of the bed, cutting her right wrist with a piece of glass and was transferred to the emergency department. Facility documentation dated 4/16/06 at 10:15 PM indicated that Resident #26 was found in the bathroom cutting her left wrist with a safety pin. Although each event was documented, the facility did not report the events to state agency. The Acting Administrator on 9/7/06 at 3:15 PM stated that the events should have been reported and the former Director of Nurses would have been responsible to submit the reports to the Department.
- c. Resident #27 had diagnoses that included delusions, schizoaffective disorder, bipolar type and was conserved. Review of a physician 's progress note dated 2/17/06 indicated that R #27 was admitted to the facility with aggressive behaviors secondary to being non-compliance with medications. Review of the Unknown/Unplanned Leave Capacity to Meet Minimal Basic Needs assessment conducted on 4/7/06 indicated that Resident #27 was at risk for leaving the facility Against Medical Advice (AMA) and/or an unauthorized leave. Review of a social service note dated 4/7/06 and 4/10/06 indicated that Resident #27 was delusional and refusing care and treatment. The resident assessment dated 5/17/06 indicated that R #27 was cognitively impaired. A nurse's note dated 7/12/06 at 5:30 PM indicated that the resident could not be found for her PM medications and a search of the building and common areas had been conducted. Although the event was documented, the facility did not report it to the state agency. The Administrator on 9/7/06 at 1:10 PM that the event was never reported to the Department because the event was not considered an elopement by the facility.

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

17. Based on personnel record review and staff interview, the facility failed to conduct a yearly evaluation of one nurse aide (NA #5) who had received a disciplinary warning. The findings include:
- a. Review of facility documentation dated 9/6/06 at 11:50 AM indicated that Resident #26

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had complained about a nurse aide identified as NA #5, who had spoken to the resident sarcastically in the smoking area and hurt the resident's feelings. The DNS stated that abuse could not be substantiated but that NA #5 had been issued a disciplinary warning. Review of the personnel file of NA #5 on 9/12/06 indicated that NA #5 had been employed at the facility since 1/10/1985. Further review of NA #5's personnel file indicated that a yearly performance evaluation dated January 2005 had been completed but lacked the signatures of the individual who had conducted the evaluation and/or NA #5. Upon further review, NA #5's personnel file failed to identify that the facility had conducted a subsequent evaluation which was due in January 2006.

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

18. Based on clinical record review, observation and staff interview for two of twenty-nine sampled residents (Residents #7 and #28), the facility failed to ensure the clinical record included the MI/MR screening information and/or complete documentation regarding the resident's personal property. The findings included:
- a. Resident #7 had diagnoses that included Schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set assessment dated 8/23/06 identified short and long term memory deficits, moderately impaired cognition and behaviors that included wandering and verbal and physical abusiveness. Review of the plan of care dated 8/28/06 identified the initiation of frequent thirty minute monitoring of the resident. The plan of care dated 8/30/06 further identified a problem of inappropriate decision making related to schizophrenia and vascular dementia. The interventions included assessing and monitoring the resident and recording and reporting concerns/changes to the physician and/ or conservator. The nurses' narrative notes dated 8/24/06 through 8/30/06 indicated Resident #7 was yelling out, shaking the side rails, very combative and hit a nurse aide during care. The decision was made to transfer Resident #7 to the emergency room. The nurses' narrative notes dated 8/31/06 through 9/1/06 reflected that Resident #7 was continuing to yell out, was disruptive to other residents, swearing loudly and touching staff inappropriately. Review of the psychiatric consultation dated 9/5/06 indicated Resident #7 was progressively more confused, aggressive and agitated. The documentation further indicated that Resident #7 needed hospitalization and directed the facility to send the resident to the hospital on a Physician Emergency Certificate. Review of the clinical record failed to provide evidence that the facility had obtained an MI/MR screen. Subsequent to surveyor inquiry, the information was obtained from another long- term care facility.
 - b. Resident #28 had diagnoses that included schizoaffective disorder bipolar type. An

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assessment dated 10/4/05 identified that the resident had a long- term memory deficit, moderately impaired cognition and independence with activities of daily living. A nurse's narrative note dated 10/24/05 identified Resident #28 had been discharged from the facility on 10/24/05. Subsequently, Resident #28 wrote a letter to the facility dated 4/20/06 in which she indicated that personal items belonging to her (e.g. items contained in a package) remained at the facility.

Clinical record review and interview with the social worker on 9/12/06 identified no evidence of a written response to the resident's correspondence dated 4/20/06. Further interview with the social worker identified that although the clinical record included an inventory of the resident's property, there was no documentation regarding the specific items that the facility had provided to a family member following the resident's discharge. Review of the facility's policy regarding personal items identified that the facility did not accept any responsibility for items that were left at the facility for more than thirty days after the resident was discharged.

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

19. Based on clinical record review and staff interview for three of twenty-nine sampled residents (Residents #7, #20 and #26) who exhibited behaviors, the facility failed to ensure that the Quality Assurance Committee had evaluated and/or addressed the facility's response to the residents' behaviors. The findings included:
- a. Review of facility documentation dated 4/3/06 at 4:30 PM identified that Resident #26 was upset about the change in her smoking privileges, had broken the glass from a picture frame in her room and lacerated the right wrist with a piece of the broken glass because the resident's conservator wanted the resident to have only one cigarette per smoke break instead of two. Review of a note dated 4/3/06 written by the Behavioral Health Program Manager indicated that Resident #26 was suicidal, agitated, uncooperative with care and had made the statement that " I wanted to die, let it bleed." Resident #26 was placed on one- to-one close observations until transferred to the emergency department at 5:00 PM. Facility documentation further identified that on 4/16/06 at 10:15 PM Resident #26 was been found in the bathroom by her 1:1 nursing assistant cutting her left wrist with a safety pin (fourth attempt). Resident #26 was transferred to the acute care hospital and admitted. During an interview on 9/7/06 at 2:00 PM NA #3 stated that on 4/16/06 she was assigned to do the one to one close observations of Resident #26. NA #3 stated that she had taken the resident out on a smoke break, and as Resident #26 was leaving the smoking area, Resident #26 made a

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comment to another resident that she would not be seeing him again. NA #3 stated she had informed the charge nurse of the incident prior to the time that Resident #26 returned to her room. NA #3 stated that after Resident #26 returned to her room, the resident was observed to be looking through the drawers in the night stand before going to the bathroom. NA #3 stated she had asked the resident what she was looking for, but the resident had told her "nothing." NA #3 stated that when Resident #26 went into the bathroom, she refused to leave the bathroom door open. NA #3 stated she called for the nursing supervisor and when the supervisor arrived, the resident was observed to be using a safety pin to cut her wrist. On 4/16/06 the resident was admitted to an acute psychiatric unit at the hospital for three days.

- b. Resident #20 had diagnoses that included Post Traumatic Stress Disorder (PTSD). An admission assessment dated 6/1/06 identified that the resident had short and long-term memory deficits, independence in cognitive skills for daily decision making, withdrawal from activities of interest, reduced social interactions and required the supervision of staff for activities of daily living (ADL).

Review of facility documentation identified that on 9/5/06 Resident #24 informed the Behavioral Health Program Manager that Resident #20 had told him that he "was going to do bad things to him, like rape or kill him." Although the clinical record failed to include any documentation regarding the concerns that had been expressed by Resident #24, the two residents were roommates, and facility documentation dated 9/5/06 at 11:30 AM identified that Resident #20 was granted a room change to another location on the same floor. During an observation of a smoking group on 9/7/06 at 6:40 PM Resident #24 identified that Resident #20 had threatened to kill him. Interview and clinical record review with the Behavioral Health Program Manager on 9/8/06 at 12:50 PM and 1:20 PM identified that there was no evidence of the facility's monitoring and supervision of Residents #24 and #20 who continued to reside on the same floor. The program manager stated that the situation was unclear, and Residents #24 and #20 did not like each other.

- c. Resident #7 had diagnoses that included Schizophrenia, vascular dementia and impulse control disorder. A Minimum Data Set assessment dated 8/23/06 identified that the resident had short and long-term memory deficits, moderately impaired cognition, wandered and exhibited verbally and physically abusive behaviors. Review of the plan of care dated 8/28/06 identified that the facility had decreased the monitoring of the resident from every fifteen minute monitoring to every thirty minutes. On 8/30/06 a revised plan of care identified that the resident had impaired decision-making related to schizophrenia and vascular dementia. The care plan included interventions for staff to assess and monitor the resident and record and report concerns/changes to the physician and/or conservator. During the period from 8/24/06 through 8/30/06 the nurses' narrative notes identified that Resident #7 was frequently calling out/ yelling, shaking

DATES OF VISIT: Concluded on September 15, 2006

EXHIBIT

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

the side rails, very combative and hit a nurse aide during care. On 8/30/06 a physician's order directed the facility to transfer the resident to the emergency department for an evaluation of the behavior, and the resident was sent to the hospital at approximately 10:15 PM.

Subsequent to the resident's return to the facility, the nurses' narrative notes for the period from 8/31/06 through 9/1/06 indicated that Resident #7 was yelling out, disruptive to other residents, swearing loudly and touching staff inappropriately. Review of a psychiatric consultation dated 9/5/06 identified that Resident #7 had become progressively more confused, aggressive and agitated. The documentation further indicated that Resident #7 required hospitalization and directed the facility to send the resident to the hospital on a Physician Emergency Certificate.(PEC). Observations on 9/6/06 at 9:30 AM and on 9/7/06 at 10:00 AM and 12:00 PM identified that Resident #7 was seated alone in his room in a customized wheelchair. Interview with Licensed Practical Nurse #1(LPN #1) on 9/7/06 at 10:30AM identified that Resident #7 had not been sent to the hospital because a bed was not available.

Interview with the Medical Director on 9/13/06 at 11:15 AM identified that the facility had not identified behaviors as a quality assurance concern. As a result, measures were not implemented by the quality assurance team to address and /or deal with residents' inappropriate behaviors.