STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

April 6, 2010

Mr. Robert Morgan, Administrator
West Rock Health Care Center
34 Level St
New Haven, CT 06515

Dear Mr. Morgan:

Unannounced visits were made to West Rock Health Care Center on March 29, 31, 2010; April 1, 2, 3 and 4, 2010 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a monitoring visit.

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 with Ann Marie Montemerlo, Supervising Nurse Consultant, for April 20, 2010 at 12 Noon 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:

- Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
- Date corrective measure will be effected.
- 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,

Janet Williams, RN

Janet Williams, R.N
Public Health Services Manager
Facility Licensing and Investigations Section

JMW:zbj

c. Director of Nurses
Medical Director

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS #_____
P.O. Box 340308 Hartford, CT 06134

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or Section 19-13-D8u (c)(1)(5).

1. Based on medical record reviews and infection control logs, the facility failed to establish an IV Therapy Program prior to the implementation of IV therapy for residents. The findings are based on a review of a clinical record, review of available policies and procedures and staff interviews.
    a. Resident #11 (R #11) was admitted to the facility on 3/8/2010 from an acute care hospital with diagnoses which included COPD, pneumonia with bacteremia, heel wound infection and diabetes.
    Admission physician orders included Vancomycin 1 gm twice daily in 200 cc's over 1 hour via PICC line.
    Documentation on the medication administration record (MAR) reflected that the resident received five doses of this medication.
    Interview with the DNS on 3/29/2010 identified that although the facility had an IV manual which had been prepare by a pharmaceutical company, the Facility failed to develop a comprehensive IV Therapy Program to encompass any and all requirements as stated in Section 19-13-D8 u c and 19-13-D8 u (5).
    Further interview with the DNS identified that the Facility was not aware of any other residents who may have received IV therapy previously but felt that perhaps R #11 was the first. She also identified that it was her impression that LPN's were able to administer IV therapy in the Facility and was unable to decipher which staff actually provided the therapy to R #11.
    A review of the facility infection control logs identified that R #11 and R #28 also received IV Vancomycin during the months of April and May of 2009, respectively.
    b. Resident #17 had diagnoses that included a history of Cerebral Vascular Accident (CVA), left hemiplegia, and cellulites. Review of the clinical record dated 4/13/09 identified that R #17 had a central venous catheter placed through the brachial vein in order to receive intravenous (IV) antibiotics for an infection. The clinical record contained a "Central Venous Catheter/Physician order sheet dated 4/20/09 that directed staff at the facility to administer the antibiotic, Vancomycin, one gram in D5W (dextrose and water) every forty eight hours for ten days through the resident's PICC line. Interview with LPN #11 on 3/31/10 identified that he/she was aware that R #17 had received IV antibiotics while at the facility. LPN #11 stated that R #17's IV medication was scheduled to be administered at 6:00

AM, that she worked the 7:00 AM to 3:00 PM shift, and therefore had not personally administered the IV medication but knew it was being given at the facility. Facility policy directed that IV medications only be administered by a Registered Nurse (RN) or other licensed personnel who were trained to perform such a procedure.

c. An immediate action plan was presented to the Department on 3/29/2010 which identified that the facility would not provide IV therapy at the facility until such time that a comprehensive IV therapy program was developed.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (t) Infection Control (1)(2)(A)(B).

2. Based on two medical records reviewed, the facility failed to provide the necessary care and services for each resident to prevent neglect and failed to ensure that each resident received the care and services necessary to achieve or maintain their highest practicable functional status, optimal physical and mental well being and/or assess changes in condition. The findings include:

   a. Resident #26 (R #26) was admitted to the facility on 12/1/04 with a diagnosis of paranoid schizophrenia.
   The MDS of 2/19/10 did not identify any problems in the area(s) of mood and/or with behavioral symptoms however did identify that the resident required supervision in the area of hygiene/bathing.
   Psychiatric consult notes for the period of 1/09 through 12/30/09 identified a decline in the resident's hygiene, increased depression, increased isolation and apathy. New interventions were not identified.
   The current RCP did not reflect the resident's decline in the identified areas.
   Observation of the resident on 3/29/2010 at approximately 10:30 a.m. identified the resident at 10:30 a.m. sitting on his bed which was unmade and with an accumulation of soiled sheets. The resident's hair was quite greasy and unkempt. He/she was wearing an extremely soiled shirt.
   Interview with NA #11 assigned to care for the resident identified that the resident had refused all care and told her to leave the room and shut the door. Further interview identified that the NA was new to the facility, was supposed to be working with someone as part of her orientation however was given an assignment because the facility was "short". She was not familiar with the residents and did not know what any of their needs were other than what some of

the other NA's told her. When she arrived on the unit in the morning, she asked the nurses for report but they were "confused" so she did not receive one. I also asked if "I was to get an assignment sheet" and was told "no."
A review of the list of residents that she was assigned to care for simply identified a resident name, room number and shower needs. Three of the five residents on her list had refused care.
Interview with the DNS on 3/29/2010 identified that the aide was not supposed to have an assignment and was still on orientation. She could not provide a rationale for why this occurred nor could she provide a policy and procedure regarding the facility orientation process.
She did add that the facility had "flow cards" at the nursing station which the NA's were to refer to and which reflected the needs of the residents. She also added that R #26frequently refuses care.
A review of the flow card for R #26 identified that the resident was self care in the areas of hygiene and dressing, which was not reflective of the resident's current status and/or identified needs.
Further interview with NA #11 identified that no one had informed her of the flow cards.
Further review of the current RCP failed to identify interventions to address the resident's hygiene needs as well as the staff identified refusals of care.

b. Resident #10 (R #10) had diagnoses that included paraplegia and a contracted left hand that was observed to be in a clenched fist position. During an observation of R #10's morning bed bath on 3/31/10 at 10:35 AM, Nursing Assistant #11 (NA #11) failed to cleanse the resident's left hand. Upon surveyor inquiry, NA #11 stated that the Occupational Therapist (OT) was responsible for the cleaning and daily stretching of the fingers of the resident's left hand as well as placement of the carrot shaped cone inside the left hand. Interview with the Physical Therapist on 4/1/10 at 12:45 PM identified that R #10 is seen by the OT three times a week and that after speaking with the OT, the Physical Therapist learned that the nursing assistants were responsible for daily cleaning of R #10's left hand but that the OT was responsible for placement of the cone during his/her visits to the resident. Review of R #10' care card identified that R #10 had a contracted left hand but lacked documentation to reflect the nursing assistant's responsibility for daily cleaning at the contracted site.
Review of the clinical record identified that R #10 tested positive for Methicillin Staphylococcus Aureous (MRSA) of the nares on 3/13/10 and was placed on isolation precautions. Although R #10's care card was last updated on 3/30/10,

the care card lacked documentation to reflect the need for isolation precautions when providing care to the resident.
An immediate action plan was presented to the Department on March 29, 2010 and updated on March 31, 2010 which identified that all care cards in the facility would be updated related to specific residents' needs. The facility developed a system whereby the care cards would be updated with each new intervention and that a daily review via the twenty four hour reports would be utilized to ensure that all updates had been documented on the care card. In addition, facility policy would now require nursing assistant to carry the care cards of their assigned residents with them when providing care to the residents.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (s) Social Work (10).

3. For one medical record reviewed the facility failed to assist the resident with discharge planning. The findings are based on a review of the medical record and interviews with facility staff.
   a. Resident #26 was admitted to the facility on 12/1/04 with a diagnosis of paranoid schizophrenia. A review of the psychiatric consult notes for the period of 1/09 through 12/30/2010 identified that the resident had a decline in mood and expressed on several occasions a desire to leave the facility. The MDS of 2/19/2010 identified zero discharge potential. The current RCP did not address the resident's expressed desire to leave the facility.
   Interview with the DNS on 3/20/2010 identified that the facility was actually looking into increasing the resident's level of care from "ICF" to "skilled" due to the resident's increased need with hygiene and also a possibility that the resident had "epilepsy as a child." Discharge was not anticipated.
   Interview with the resident on 3/29/2010 identified that the resident was alert and oriented. The resident was easily engaged in conversation and shared an interest in science specifically organic chemistry. An interest in computers was also expressed. Although the resident had expressed outside interests which were also conveyed to the psychiatrist by stating a need "to get out of here", documentation was lacking to reflect that this information was incorporated into the RCP and/or to assist with discharge planning.

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

4. The governing body failed to oversee current practices in the facility .The findings are based on a review of policies and procedures and an interview with the DNS and include the following:
   a. A review of the facility policy and procedure manual identified that the policies and procedures had last been reviewed and revised in October of 1999. Furthermore, per the DNS, policy and procedure manuals were not available on the nursing units however one was available in the supervisor's office. The DNS reported that she was currently working on updating the policy and procedure manual however her last day of employment at the facility was scheduled to be April 2, 2010.

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

5. For one of one medical record reviewed, the facility failed to provide treatments as ordered by the physician and/or in accordance with the resident care plan. The findings are based on a review of the medical record and a grievance report and include the following:
   a. Resident #26 was admitted to the facility on 7/6/09 with diagnoses which included Deep Vein Thrombosis (DVT) and ventral Hernia.
   Physician orders dated 1/6/10 directed the application of jobst stockings on bilateral lower extremities every morning-off at bedtime (6 a.m.-8 p.m.), measure left calf once daily. Also, Desenex liquid spray, apply to 1st toenail/digit twice daily. The Treatment Record also reflected that the resident was to receive an abdominal binder to ventral hernia daily.
   A review of a grievance report dated 2/8/10 identified that the resident was not receiving treatments as ordered by the physician, e.g. application of jobst stockings, abdominal binder and fungal treatment. Documentation was lacking to reflect a resolution to the complaint and/or that the complaint form had been signed by the administrator.
   A review of the treatment record for March of 2010 reflected inconsistent application of the jobst stockings, abdominal binder and fungal treatment.
   Additionally, documentation was lacking to reflect that the resident's calf had been measured at any time.

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

Interview with the DNS identified that the resident frequently refused said treatments. She also identified that many times the resident refused treatments and it was important that if that happened, that the staff return at a later time, however not all staff knew to do this. Documentation was lacking to reflect that interventions had been initiated in response to these refusals. Documentation was also lacking to reflect that the MDS identified the resident refusals.
A review of the resident status sheet, which served as a Nurse Aide Assignment, did not identify the resident refusals.
Observation and interview with the resident on 3/31/2010 identified that he was pleased to be wearing his abdominal binder and jobst stockings. He did not express an unwillingness to be compliant with treatment.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (t) Infection Control (1)(2)(A)(B).

6. Based on a review of facility documentation, observations, and interviews with facility staff, the facility failed to ensure an active and effective infection control program. The findings include:
   a. Resident #10 (R #10) was readmitted to the facility on 2/5/10 from the acute care hospital where the resident was treated for a Urinary Tract Infection (UTI). Physician orders dated 3/19/10 directed the use of an indwelling Foley catheter. Review of the interdisciplinary care plan dated 2/6/10 identified that R #10 would remain free of all avoidable infections with interventions that included providing incontinent care and catheter care in accordance with facility policies. During an observation of R #10's Hoyer lift transfer on 3/31/10 at 11:37 AM, Nursing Assistant #10 (NA #10) was observed to lift the resident's Foley drainage bag approximately two feet above the resident's bladder line as the resident was lifted from the bed via the Hoyer lift. The external tubing of the catheter was filled with dark yellow, thick appearing urine and the Foley drainage bag contained approximately two hundred and fifty cubic centimeters (cc.). Interview with NA #10 on 4/1/10 at 9:45 AM identified that although he was aware of the increased risk for backflow of urine and subsequent risk of infection when raising a Foley drainage bag and tubing above a resident's bladder line, he did not recall his actions on 3/31/10 during R #10's transfer. Facility policy directed that the Foley drainage bag must be held or positioned lower than the bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the bladder.
   Review of the clinical record identified that R #10 was diagnosed with MRSA in the nares on 3/13/10. Interview with the Infection Control Nurse on 3/31/10 identified

that in accordance with facility policy, staff members and visitors entering R #10's room would be required to wear a gown if anticipating direct contact with the patient and would also require a face mask if standing within three feet of the resident. On 3/31/10 at 9:15 AM, no face masks were available on the isolation cart outside R #10's doorway, At 9:36 AM, Maintenance Worker #1 was observed to enter R #10's room wearing only gloves to deliver items to the resident's room and stopped to talk with R #10 at the resident's bedside. Interview with Maintenance Worker #1 at the time of the observation identified that he had been instructed to wear a facemask when entering the resident's room but didn't see any available masks.

b. Resident #12 (R #12) was admitted to the facility on 3/27/10 with diagnoses that included MRSA in the nares and was placed on isolation precautions. The nursing admission assessment dated 3/29/10 identified R #12 as alert, oriented, and cooperative. Observation on 3/31/10 at 11:50 AM, Resident #12 (R #12) was observed in a wheelchair at the doorway of his/her room when he/she was stopped by LPN #10 and NA #12. The resident was instructed by both staff members that he/she was not able to leave his/her room without a facemask. R #12 became very upset and questioned the staff as to the rationale for the mask. R #12 stated that he/she had been at the facility for several days, that he/she had been out the room and at the nursing station multiple times, as well as in the dining room for meals and had never been told that he/she required a mask upon leaving his/her own room. Interview with the ICN on 3/31/10 at 3:55 PM identified that he/she instructed staff that a facemask must be worn if coming within three feet of a resident who had been identified with MRSA of the nares. The ICN presented a small handbook for Association of Professionals in Infection Control (APIC) that was published in 1997 that he/she stated she used to determine the type of isolation needed. The ICN was unable to explain why the resident had been allowed to leave the room without a facemask since his/her admission to the facility on 3/27/10.

c. Resident #15 (R #15) was readmitted to the facility on 3/22/10. Review of the clinical record identified that R #15 had tested positive for Methicillin Staphylococcus Aureous (MRSA) of the nares on 3/15/10 and was placed on isolation precautions. No subsequent laboratory testing was available in the resident's record. R #15's care card was last updated on 3/30/10 and identified the need for contact precautions. Observation of R #15's room identified that there was no posted precaution signage on the resident's door to identify the need for precautions upon entering the room. Review of facility policy directed that appropriate equipment and supplies be used to maintain sanitary conditions while isolation precautions are in effect. The policy directed that an orange colored sign that indicated the need for contact precautions, be placed on the door to the resident's room

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

d. Facility policy regarding infection-surveillance reflects that the infection control nurse will record the resident's name once signs/symptoms are exhibited of infection on an initial infection surveillance form. These reports are then presented at quality improvement and medical staff meetings. Documentation was lacking to reflect that these reports had not been prepared on any resident who presented with infection at any time during the previous year to date.

e. Documentation was also lacking to reflect that any discussion had occurred at medical staff meetings regarding said infections.
Additionally, the facility could not locate any record of any infection control committee meetings that may have taken place during the previous year and/or could not provide any information to identify that the facility met regularly to review infection control data, review policies and monitor the program goals and activities. Facility policy identified, in part, that the Infection Control Committee (ICC) will meet quarterly and make recommendations regarding the prevention and transmission of infection and will review reported infections and also aid in determining appropriate corrective action.

f. A review of monthly infection control logs reflected a list of resident names, onset date of infection, infection site, treatment initiated and in some cases the necessity for culture however did not always identify the resolution of the infection.
Documentation was lacking to reflect that information contained in the logs was not in any way analyzed for trends and for planning further infection control activities, need for staff education and to detect institutional outbreaks.
A review of these logs for the period of 8/0/09 through 3/10/2010 identified several residents who presented with cellulitis and/or other infections associated with skin, such as infection of the axilla. Documentation was lacking to reflect that further analysis of this data was conducted in an effort to determine any predisposing factors of the resident population which may have contributed to the development of these infections and/or any interventions which might be necessary to prevent further infection.

g. Documentation was also lacking to reflect that the facility calculated baseline rates of infection as a means of detecting an outbreak based on site specific infection.
Facility policy identified that the facility would identify a rate of infection based on a representation of infections presented during a period of time

h. A further review of the infection control logs identified that at least two residents, R #13 and R #28 both required IV Vancomycin to treat a cellulitis and a "line infection" respectively, however, the facility did not have an IV Therapy Program in place.
Documentation regarding the resolution of these two infections was not identified.

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

i. A review of infection control surveillance rounds identified that provisions for staff monitoring had not been incorporated into the monthly rounds. Facility policy, in part, directs that the infection control nurse will monitor resident –care practices to include hand washing, isolation precautions, dressing technique, and perineal/catheter care, etc.

j. Interview with the infection control nurse on 3/31/2010, identified that she had only been in the position for three weeks. She was going to begin the calculation of infection control rates however she did not have any data from her predecessor and did not know what the previous practices in the facility had been.
Interview with the Administrator and DNS on 3/31/2010 did not provide any information regarding any additional information concerning the infection control program.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (f) Administrator (3)(C) and/or (h) Medical Director (2)(A)(C)(i) and/or (l) Nurse Aide Training and Employment (4)(ii)(iii).

7. Based on a review of facility documentation, observations, interviews and the findings contained in this document, the facility failed to ensure that the active medical staff functioned in accordance with the facility's medical staff by-laws. The findings include:
   a. A review of the medical staff committee meeting minutes for the past year identified that the facility lacked an active organized medical staff as per the facility medical by-laws. The only physician present at all four meetings was the medical director. Facility by-laws identify that the facility shall have an active organized medical staff. All staff members must attend at least 50% of the meetings per year. Interview with the Administrator on 4/1/2010 identified that he was not aware that the physicians were not attending. A review of the medical director's employment agreement dated 2/21/09, identified, in part, that he would supervise the medical staff adherence to the bylaws and rules and regulations; and evaluate the Medical Staff performance and take appropriate progressive discipline as is necessary. Documentation was lacking to reflect that any action had been taken in response to lack of attendance at the medical staff meetings.

The following are violations of the Connecticut General Statutes Section 19a-555 and/or violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (h) Medical Director (2)(A) and/or (h) Medical Director (2)(B) and/or (h) Medical Director (2)(C) and/or (h) Medical Director (2)(K).

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

8. Based on medical record reviews, a review of facility policies and procedures and interviews with facility staff the facility failed to ensure that the medical director was responsible for the overall quality of care in the facility. The findings include:
   a. A review of the medical director's agreement signed by the medical director and dated 2/21/09 identified that the Medical Director supervises the quality of medical care provided and is responsible for the medical staff bylaws.
   b. A review of the medical staff committee meeting minutes for the last year identified that the facility lacked an active organized medical staff. Documentation on the attendance sheets for these meetings did not reflect that any other physician other than the medical director attended.
   c. A review of the medical director's weekly rounds book and the doctor's rounds lists, which were undated, simply identified a resident name, date of last history /physical, date of last MD orders signed, date of last MD progress note and date of MD due. Documentation was lacking to reflect that the Medical Director participated in any discussions regarding problems discussed with the staff and/or resolutions to said problems.
   d. A review of the medical records of Residents #11 and #17 as well as infection control logs for Residents #13 and #28 identified that at least four residents had received IV Vancomycin at the facility despite the fact that the facility did not have an IV Therapy Program in place. R#11 had been discharged from an acute care hospital with orders for the IV Vancomycin. Documentation was lacking to reflect that the Medical Director had consulted with the Administrator and the DNS about the ability of the Facility to address the resident's need for IV therapy despite the facility's absence of an IV Therapy Program.
   e. Documentation was lacking to reflect that the Medical Director provided any inservice education programs to facility staff within the last year. The Medical Director's employment agreement identified that he would present four in-service training programs per year.
   f. Although the Medical Director's employment agreement identified that he will work with the DNS to establish policies, documentation identified that the nursing policy and procedure manual had last been reviewed and revised in 1999.
   g. The Medical Director's Employment Agreement also identified that he would manage the Continuous Quality Improvement Team, in part, to improve the performance of medical services as an integral part of improving organization performance. A review of the CQI minutes dated 3/9/2010, failed to identify input from the medical director regarding pertinent topics regarding medical care.

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h. Documentation was also lacking to reflect that the Medical Director reviewed information regarding facility infections and/or made recommendations to address these issues.
Interview with the Administrator in Training on 3/31/2010 identified that the Facility has recently brought on an additional medical director to serve as a "co-medical director" in an effort to improve the medical care in the building.

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

9. Review of the implementation of an immediate action plan which was submitted to the Department on both 3/29 and 3/31/2010 in response to the lack of comprehensive nurse aide assignments identified that the facility failed to ensure compliance with this plan. Documentation regarding nurse aide assignments on both dates failed to reflect that all the current needs were addressed on the assignments as specified in the action plan provided to the Department and dated March 29, 2010. On 3/31/2010, an addendum was provided to the action plan in response to the Department's continued concerns in this area however a review of the assignments on 4/1/2010, at the Department, continued to identify noncompliance. Resident care needs still not identified, in part, were issues such as infection control precautions, transfer methods, interventions for resident refusals, skin integrity, etc.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (s) Social Work (7).

10. Based on clinical record review and interview for the one resident with a change in condition (Resident #27), the facility failed to ensure the Social Worker provided care and services to promote the resident's psychosocial well being. The findings include:
    a. Resident #27's diagnoses included depression, increased agitation, history of myocardial infarction and end stage renal disease. The Minimum Data Set (MDS) dated 10/1/09 identified intact cognition, open expression of conflict with family and friends and an antidepressant received daily. The care plan dated 10/4/09 identified depression, aggressive behavior and a history of verbal and physical abusive behaviors. Interventions included the social worker assisting with the psychosocial needs of the resident. The social service progress note dated 10/15/09 identified the resident continued to exhibit inappropriate behaviors and verbalized a desire for discharge from the facility.

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The nurse's note dated 12/20/09 identified the resident was hospitalized after an episode of verbal abuse and threats of physical harm to staff and other residents. The 12/24/09 nurse's note identified the resident returned to the facility. Review of the clinical record and social service documentation on 3/28/10 at 1:45 PM with the Director of Nurses (DNS) failed to reflect Social Worker #1 conducted an assessment and/or provided psychosocial care and services after the resident's return to the facility on 12/24/09.

b. The nurse's note dated 1/12/10 identified the resident was admitted to the hospital with "renal problems". The 2/8/10 nurse's note identified the resident returned to the facility after a hospitalization for acute respiratory failure. Review of the clinical record with the Director of Nurses (DNS) on 3/28/10 at 1:45 PM failed to reflect Social Worker #1 conducted an assessment of the resident after return to the facility on 2/8/10 to provide psychosocial care and services. Furthermore, the clinical record noted the last assessment conducted by Social Worker #1 was on 10/15/09. Interview with the Director of Nurse (DNS) on 3/28/10 at 2:00 PM indicated Social Worker #1 no longer was employed at the facility and was unavailable for interview. The DNS was unable to identify why the assessments were not conducted.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

11. Based on clinical record review and interview for one resident reviewed for pain management and/or dialysis (Resident #27), the facility failed to monitor pain and/or edema per the physician's order. The findings include:
    a. Resident #27's diagnoses included end stage renal disease, chronic hypertension, diabetes mellitus, peripheral neuropathy and right eye blindness due to diabetic neuropathy. The Minimum Data Set (MDS) dated 12/30/09 identified intact cognition. The care plan dated 1/3/10 identified pain in the right eye due to glaucoma and diabetic neuropathy. Interventions included to assess the resident's pain every shift and administer pain medication as ordered. The physician's order dated 1/19/10 directed to conduct pain monitoring every shift and rate the pain with 1 for no pain, 2 for moderate pain, 3 for moderate/severe pain and 5 most severe pain. The nurse's note dated 3/4/10 identified the resident reported a van accident occurred in the parking lot of dialysis and noted pain in the right hip. The physician was notified and a right hip X-ray was obtained that was negative for injury. Documentation in the clinical record failed to identify that the severity of the resident's pain was assessed

per the physician's order on 3/4/10 for the 3-11 PM shift and/or 3/5/10 for the 11-7AM shift. Additionally, the March 2010 MAR failed to reflect that pain assessments were conducted for 20 of 57 possible shifts. The Director of Nurses (DNS) on 3/28/10 at 2:00 PM failed to reflect documentation that staff monitored the resident for pain every shift per the physician's order. The DNS was unable to explain why the monitoring was not conducted consistently.

b. The physician's order dated January 2010 directed to monitor edema every shift. The care plan dated 1/3/10 identified bilateral lower extremity edema with interventions that included monitoring both lower extremities for swelling. The March 2010 Medication Administration Record (MAR) failed to reflect lower extremity edema was monitored for 23 of 57 possible shifts. Interview with the Director of Nurses (DNS) on 3/28/10 at 2:00 PM indicated documentation of edema monitoring would be completed on the treatment kardex and/or in the nurse's notes and she was unable to explain why the monitoring was not conducted consistently per the physician's order.

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

12. Based on clinical record review, review of facility policy and interview for one resident reviewed for dialysis (Resident #27), the facility failed to maintain fluid restriction per the physician's order. The findings include:
    a. Resident #27's diagnoses included end stage renal disease, chronic hypertension, diabetes mellitus, history of myocardial infarction and peripheral neuropathy. The Minimum Data Set (MDS) dated 12/30/09 identified intact cognition and edema. The care plan dated 1/3/10 identified bilateral lower extremity edema with interventions that included monitoring of oral intake and administering medications as ordered. The physician's order dated 3/1/10 directed to decrease the resident's fluid restriction from 2500 cubic centimeters (cc) to 1500 cc per 24 hours. The Intake and Output Record dated March 2010 identified the resident exceeded the 1500cc fluid restriction on March 1, 4 and 7, failed to reflect consistent intake monitoring for each shift on March 3, 8, 9, 13, 15 and 16 and failed to reflect that any intake was monitored on March 10, 11, and 12, 2010. Review of the facility I&O Policy and interview with the Director of Nurses (DNS) on 3/28/10 at 2:15 PM identified facility policy directs the 3-11PM nurse to total the 24 hour I&O intake for a resident and document the total on the chart. The DNS indicated the 3-11 PM nurse is responsible to assess the totals and notify the Supervisor with any concerns so action can be initiated. The

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

DNS was unable to identify why the 3-11PM nurses did not identify the intake was above the prescribed fluid restriction and/or why monitoring was not conducted every day to ensure the resident's intake was per the physician's order.

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13. Based on clinical record review, review of facility policy and interview for one resident reviewed for wound monitoring (Resident #27), the facility failed to provide a treatment and/or monitor a wound in accordance with acceptable standards of practice. The findings include:
    a. Resident #27's diagnoses included end stage renal disease, chronic hypertension, diabetes mellitus, history of myocardial infarction and peripheral neuropathy. The Minimum Data Set (MDS) dated 12/30/09 identified intact cognition, edema and a history of a resolved ulcer in the past 90 days. The care plan dated 3/3/10 identified scratches on the thigh with interventions that included monitoring for resolution of the wound. The nurse's note dated 3/3/10 identified the resident scratched an area on the left thigh sustaining a 5.0 centimeter (cm) by 2.0 cm by 0.1 cm open wound. The physician's order dated 3/3/10 directed to cleanse the area on the left anterior thigh with Normal Saline followed by Xerofoam and a dry clean dressing every day for 14 days. The March 2010 treatment kardex identified the treatment to the left thigh was not provided on 3/4, 3/5, 3/6, 3/8, 3/9, and 3/10/10 (6 days). Additionally, a review of the clinical record and facility documentation failed to reflect that a subsequent measurement of the wound was conducted after 3/3/10. Interview with the Director of Nurses (DNS) on 3/28/10 at 2:15 PM indicated the facility policy directs the charge nurse to conduct an assessment of a wound weekly. The DNS indicated she was unable to locate wound documentation for the resident after 3/3/10. The facility Wound Policy identifies all wounds will be measured, at minimum, on a weekly basis. Measurement will include length, width and depth.

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

14. Based on observation and interview for one of four treatment carts, the facility failed to ensure that the treatment cart was locked when not being used. The findings include:
    a. On 3/28/2010 at 8:45 AM an observation included an unlocked treatment cart on the A Wing, positioned in the hallway by the nurses' station. Five residents were observed to pass by in close proximity of the treatment cart while no licensed staff

member was in attendance. An observation of the contents located inside the cart included the following: Nyamyc Powder, 1/3rd full, a full three ounce (oz) bottle of Dermagran Hydrol gel wound dressing and another that was 1/3rd full, a full 4 oz bottle of Ketoconazole shampoo, a full tube of Clotrimazol - beta cream 1%/0.5 %, and a tube of Lidocaine Hydrochloride Jelly. An interview on 3/28/2010 at 9:00 AM with the Licensed Practical Nurse (LPN) #11 did not identify why the cart was left unlocked, but indicated that it should have been locked while unattended and in reach of residents. A 3/28/2010 Staff Education sheet provided by the Director of Nurses (DNS) following the observation identified that three licensed staff members were inserviced on locking the medication treatment cart.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (t) Infection Control (2)(A)(B).

15. Based on observation and interview for one resident who utilized oxygen, the facility failed to change oxygen tubing according to the facility practice. The findings include:
    a. Resident #29 had a 1/5/2010 Resident Care Plan (RCP) that identified diagnoses of asthma, chronic obstructive pulmonary disease (COPD) and oxygen dependence. Care plan approaches included maintain oxygenation daily. Physician orders dated 1/28/2010 that included oxygen 2 liters via nasal cannula and change and date the tubing on Sunday, 11:00 PM - 7:00 AM shift. Review of the treatment administration kardex (TAR) the resident's oxygen tubing was signed off as having been changed on Sunday on the 11:00 PM - 7:00 AM shifts on 3/7/2010 and 3/21/2010, and failed to be signed off as being changed on 3/14/2010 and 3/28/2010. However, an observation on 3/28/2010 at 9:05 AM identified that the resident's oxygen tubing was last changed on 3/7/2010. An interview at that time with LPN #11 identified the facility practice was to change the tubing weekly and the tubing should have been changed on 3/14, 3/21, and 3/28/2010.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (f)(3) and/or Section 19-13-B42 (3)(B).

16. Based on observation and interview, the facility failed to ensure that the dishwasher temperatures were adequate to ensure sanitary conditions. The findings include:
    a. An observation at 10:00 AM identified two dietary staff members were washing dishes in the dish room. A further observation on 3/28/10 at 10:10 AM identified that while the first two observations of the dish wash temperature met the manufacturer's specifications at 142 degrees Fahrenheit (F), the 3rd through 5th, did not and were

observed at 138 degrees F. Additionally, five observations of the rinse cycle identified that none reached the manufacturer's specifications of 180 degrees F and were record to between 156 degrees F and 158 degrees F. The observation further identified that after the third observation, the Dietary Supervisor identified that a toggle switch was in the off position and tried to switch it on. The Dietary Supervisor identified at 10:20 AM that he couldn't get the booster to turn on which would be indicated by a red light. He further identified that paper products would be used to serve lunch and until the dishwasher could be fixed. An interview on 3/28/2010 at 12:20 PM with the owner of the facility identified the company would be arriving at 2:00 PM to replace the motor of the dishwasher.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (v) Physical Plant (15)(C)(iv).

17. Based on observation and interview of residents' beds and the linen rooms, the facility failed to maintain linens in a manner that promotes residents' quality of life. The findings include:
    a. An observation of resident rooms #111 and #112 on the A unit identified that the linen on the residents' beds was worn thin and generally brown tinted. An observation of two linen closets identified that the majority of clean linens were worn, stained and brown in color. An interview of the Finance Representative on 3/28/2010 at 9:20 AM identified that "we probably need a full replacement of linen." At that time LPN #13 stated to the Finance Representative, " I know you went out and bought towels because we needed them." An interview on 3/28/2010 at approximately 3/28/10 at 1:00 PM with the Finance Representative identified a receipt from a Walmart that identified that on 3/3/10, 20 towels were purchased. At that time the Finance Representative provided a PayPal secure payment for an Internet purchase for 140 sheets and 140 pillow cases dated 3/28/10.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

18. Based on clinical record reviews, and interviews for one resident with a spinal cord injury Resident #30 (R #30) and for one resident with heel blisters Resident #10 (R #10), the facility failed to implement the plan of care. The findings include:

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a. Resident #30 had diagnoses that included a thoracic (T) 2 and 3 spinal cord injury, an infected wound with bone debridement with Methicillin-Resistant Staphylococcus aureus and right groin and hip reconstruction with a vertical rectus abdominis myocutaneous flap. The admission physician orders dated 3/16/10 identified the administration of a Fleets enema per the rectum every day at 9:00 PM. The 3/17/10 at 1:00 AM nurse's note identified that the resident refused the Fleet enema and stated it was too late for the enema because he had requested same at 6:00 PM and was not given such. The note further identified that the resident requested to see the nursing supervisor to discuss this issue. Review of the Medication Administration Record (MAR) identified that despite the physician order for a Fleets enema to be administered at 9:00 PM, the MAR reflected that on admission on 3/16/10, the licensed nurse transcribing the physician orders scheduled the enema to be administered at 12:00 AM. The MAR further identified that on 3/17/10 at 12:30 AM the resident refused the enema and that the resident stated that he had requested the same at 6:00 PM on 3/16/10 but did not receive the enema. The March 2010 MAR reflected that this order was changed on 3/17/10 to reflect a time change in the administration of the Fleets enema.

b. R #10 was admitted to the facility on 2/5/10 with diagnoses that included paraplegia, end stage liver disease, Hepatitis C, a State IV sacral decubitus and a history of heel ulcers. A 3/11/10 physician order directed off loading the heels with foam boots. A 3/15/10 physician order directed the application of skin prep to the right heel followed by a bulky dressing daily and apply skin prep to intact blisters on bilateral feet. A 3/22/10 physician order directed the application of a skin prep to the left heel twice (BID) a day. Review of the March TAR identified that the treatment was administered on 3/17/10, however, there was no evidence that the treatment was administered on 3/15 or 3/16/2010. Furthermore, the treatment was circled as not being completed on 3/16 through 3/20/10 and then was discontinued, but did not identify the reason the treatment was not completed. An interview on 3/28/10 at 10:30 AM with LPN # 14 that the resident has chronic pain and receives a Fentanyl Patch 125 micrograms/hour (mcg/h) which is applied every 48 hours and a Fentanyl o/t 200 mcg lollipop by mouth every four hours as needed for pain. LPN #14 also stated that the resident frequently refuses care, including treatments, and that he won't allow a treatment to be completed unless he gets a Fentanyl lollipop. A further interview on 3/28/10 at 1:00 PM with LPN #14 identified that she had not completed the heel dressing on 3/20/10 because there were three emergencies that day and she told the nursing supervisor that it wasn't completed.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (o) Medical Records (4).

19. Based on observation, the facility failed to ensure that the medical records were stored in a secure and organized system. The findings include:
    a. Observation during a tour of the facility with the Director of Nurses #2 on 4/3/10 at 12:50 P.M. identified that medical records were stored in large cardboard boxes on the floor in a room at the ground level of the facility. Further observation identified that although efforts had been initiated to evacuate water, the floor had pooling water and had soaked several boxes that contained medical records.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (u) Emergency Preparedness Plan (5).

20. Based on interview with facility staff, the facility failed to ensure that staff were oriented to fire safety procedures. The findings include:
    a. During an interview with Registered Nurse (RN) #12 who was the nursing supervisor on 4/3/10 at 11:50A.M, he/she stated that this was his/her third day in the facility and he/she had not received a thorough orientation to emergency procedures. Subsequent to surveyor inquiry RN #12 was unable to convey correct procedure in the event of a fire emergency stating that the overhead page was "Red Man" which was promptly corrected by Director of Nurses #2 stating that the correct page was "Code Red".

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I) and/or (t) Infection Control (1)(2)(A)(B).

21. Based on review of the clinical record, review of facility policies, observations and interview, the facility failed to provide care in a manner to promote wound healing to one of two residents, Resident #10, who had a Stage IV pressure ulcer. The findings include
    a. Resident #10 (R #10) had diagnoses that included a Stage IV pressure ulcer on the sacral area. Review of the interdisciplinary care plan dated 2/6/10 identified that R #10 had multiple pressure ulcers including the coccyx/sacral wound. The care plan identified that R #10 would remain free of all avoidable infections of the pressure ulcer with interventions that included treatments to the wounds as prescribed by the physician. During an observation of incontinent care provided to R #10 on 3/31/10 at

10:50 AM. NA #11 was observed to wipe upwards from R #10's anal area and brought the fecal smeared washcloth up and over the resident's Stage IV sacral pressure ulcer. NA #10 proceeded to wipe the resident's anal area again and brought the fecal smeared washcloth up and into the cratered area of the wound. NA #11 was stopped by the surveyor from a third attempt to wash the same area. Interview with NA #11 at the time of the observation identified that she did not have an understanding of infection control practices during incontinent care to a resident with an open area. Review of facility policy directed that when providing care, staff should cleanse from the least contaminated area to the most contaminated area.

b. During the observation of R #10's morning care on 3/31/10 at 10:35 AM, Nursing Assistant #11 (NA #11) removed a large dressing from R #10's sacral area that was saturated with serosanguinous drainage. NA #11 proceeded to discard the dressing into the trash bag at the bedside. Upon the arrival of Licensed Practical Nurse #10 (LPN #10) at 11:10 AM, NA #11 did not report the drainage on the discarded dressing to LPN #10. Interview with LPN #10 on 3/31/10 at 2:00 PM identified that NAs at the facility sometimes remove dressings before the nurse arrives for treatment, that she had noted only a small of drainage at R #10's wound site when she arrived to provide the prescribed treatment, and that NA #11 did not report the saturated dressing to her.

c. Observation of R #10's pressure ulcer treatment provided by LPN #10 on 3//31/10 identified that LPN #10 washed his/her hands, donned a pair of gloves, and cleansed the already uncovered wound bed with Normal Saline. When finished with the cleansing, LPN #10 was observed to discard the gloves and don another pair of gloves to continue with application of the prescribed dressing without the benefit of washing his/her hands. Facility policy directed that hand-washing is required between glove changes.

d. R #10's nursing care plan dated 2/6/10 identified that the resident had acquired a Stage IV pressure ulcer at the coccyx/sacral area. The care plan identified interventions to address R #10's wound that included weekly measurements of the area in accordance with facility policies. The 3/6/10 unsigned wound tracking documentation identified that R #10's pressure ulcer was incorrectly down-staged to a Stage II. In addition, review of R #10's clinical record with facility staff on 3/31/10 identified that R #10's wound had not been measured since 3/6/10. Observation of R #10's sacral wound on 3/31/10 identified that the wound bed was cratered, measured approximately five centimeters (cm.) by seven cm., had a small area of yellow slough with a mostly red, moist base, and appeared to have tunneling of an undetermined depth. Interview with the facility's Wound Nurse, LPN #13, on 4/1/10 at 9:55 AM identified that she was responsible for measuring and reassessment of pressure ulcers

and evaluation of treatment modalities in use at the facility on a weekly basis. LPN #13 stated that R #10 had refused to allow her measure the pressure ulcer the last time she approached the resident but that it would be expected in accordance with facility policy, that the nurse on the unit would do the measurements and any appropriate restaging during the resident's next scheduled wound treatment. LPN #13 stated that she had started her role as the Wound Nurse three weeks earlier, and that she performed the measurements and staging without RN supervision at the bedside. Review of the wound assessment sheet dated 4/1/10 identified that R #10's sacral wound was a Stage IV pressure ulcer that measured 6.0 cm. by 7.0 cm. and was 0.3 cm. in depth.

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22. For two residents, Resident #10, who was identified to be at risk for alteration in nutritional status and had a diagnosis of ascities, and Resident #15, who developed a small bowel obstruction, the facility failed to consistently monitor fluid intake and output and/or bowel movements in accordance with the plan of care and/or failed to document assessments of the resident's abdominal distention and/or weight discrepancies. The findings were based on review of the clinical record review of facility policies, observations, and interviews, and include the following:
    a. Resident #10 (R #10) had diagnoses that included End Stage Liver Disease and multiple pressure ulcers. Review of the care plan dated 2/8/10 identified R #10's risk for alteration in nutritional status related to the resident's multiple diagnoses with interventions to monitor that resident's fluid intake and to monitor for symptoms of dehydration. Physician orders dated 3/19/10 directed the use of an indwelling Foley catheter Review of the clinical record with facility staff on 3/31/10 lacked documentation to reflect that R #10's fluid intake was consistently monitored on nine of thirty one days (3/3, 3/8, 3/10, 3/11, 3/13, 3/14, 3/18, 3/20, and 3/22/10) or that R #10's urine output was consistently monitored on thirty of thirty one days with completed documentation of the resident's output only on 3/17/10. Review of facility policy directed that residents who required monitoring of intake and output would have the amount documented on the intake and output record.
    b. Resident #10 (R #10) also had diagnoses that included a history of alcohol abuse and cirrhosis with subsequent abdominal distention. Observation of R #10 on 3/31/10 identified that the resident's abdomen was largely distended and that the resident reported occasional difficulty breathing if in a supine position for a prolonged period.

Review of the facility's weight log dated 3/1/10 identified R #10's weight as 182.0 pounds. On 3/10/10, the resident's weight was documented as 178.0 pounds. Review of the assessment dated 3/12/10 identified R #10's weight as 165.5 pounds. Review of the clinical record lacked documentation to reflect that R #10 was reweighed as a result of the identification of a 16.5 pound weight loss in twelve days and/or that the physician was notified of the weight difference. The documentation dated 3/24/10 identified R #10's weigh as 181.0 pounds. On 3/31/10, R #10 was weighed by LPN #13 upon surveyor request. R #10's weight was reported as 168.0 pounds. Interview with LPN #10 on 4/1/10 at 10:40 AM identified that LPN #3 had not compared R #10's 3/31/10 weight with previous weights in order to evaluate the resident's fluid balance and/or nutritional status by the time of the interview. LPN #13 stated that she had little experience in caring for residents with R #10's disease process and stated that she believed that R #10's weight loss could have been from an unusually large bowel movement on 3/30/10. LPN #13 was unable to articulate the significance of R #10's abdominal distention and/or its relationship to the resident's disease process and had not provided an evaluation of R #10's abdomen and/or abdominal girth. Review of facility policy directed that any weight change of greater or less than 5.0 pounds within a thirty day period would be retaken the next day for confirmation. In addition, the policy directed that the Dietician be notified for further review.

c. Resident #15 (R #15) was admitted to the facility on 2/10/10 with diagnoses that included chronic diarrhea. Review of the clinical record identified that R #15 first complained of abdominal pain on 3/11/10. A subsequent abdominal assessment identified no distention or tenderness and positive bowel sounds in all four quadrants. On 3/16/10, R #15 vomited a moderate amount of undigested food and complained of gastrointestinal (GI) upset. An abdominal assessment provided identified no change since 3/11/10. On 3/14/10, R #15 again vomited, complained of GI upset, and abdominal pain. The abdominal assessment identified that the resident's abdomen was firm but not distended. R #15 vomited twice on 3/16/10, again complained of GI upset, and again the documentation identified that the resident's abdominal assessment showed no tenderness, distention, and that bowel sounds were present in all four quadrants. R #15 was subsequently transferred to the acute care hospital where he/she was identified to have a small bowel obstruction. Review of the clinical record with facility staff on 3/31/10 lacked documentation that R #15's bowel movements were consistently monitored each shift from 3/1/10 through 3/16/10. Review of facility policy directed that staff would identify risk factors to bowel dysfunction, monitor the resident's response to interventions and overall progress, and monitor and document the frequency and consistency of bowel movements.

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

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

23. Based on review of the clinical record review of facility policies, observations, and interviews, the facility failed to ensure that medications were administered timely to four of four residents reviewed, Residents #16, #18, #19, and #20. The findings include:
    a. During a tour of the facility on 3/31/10 at 4:35 PM, Resident #16 (R #16) approached the surveyor to report that he/she was upset as his/her 4:00 PM medications were due and that the nurse at the desk told him/her that he/she was only filling in for a short time and that he/she would have to wait until the scheduled nurse arrived. R #16 stated that medications on the 1B unit were never administered timely despite ongoing complaints. Interview with LPN #14 on 3/31/10 at 4:45 PM identified that the scheduled 3:00 PM to 11:00 PM shift nurse, LPN #15, was going to be late and that he/she was only there to cover the unit until LPN #15's arrival. Review of facility documentation identified that the 3:00 PM to 11:00 PM shift nurse did not punch in until 5:52 PM. The Medication Administration Records (MARs) of Residents #16, #18, #19, and #20 were reviewed and identified to have the individuals' 4:00 to 4:30 PM medications signed off by LPN #15 as having been given at the scheduled time (4:00 PM and/or 4:30 PM). Interview with LPN #15 on 4/1/10 at 12:15 PM identified that she arrived at the facility just before 6:00 PM on 3/31/10, that another nurse had administered some of the overdue medications to approximately four or five residents, and that she started the full 4:30 PM medication pass between 6:00 PM and 6:15 PM. LPN #15 stated that she did not document an addendum to identify that the medications were not administered timely. LPN #15 stated that it was impossible for one nurse to administer medications within the two hour acceptable window to the forty five residents on the unit and that medications on the unit were often given outside the acceptable time parameters for medication administration. Review of facility policy directed that medications be administered within one hour of their prescribed time.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (q) Dietary Services (2)(C).

24. Based on review of the clinical record review of facility policies, observations, and interviews, the dietary department failed to ensure that one resident, Resident #12, received breakfast timely on 4/1/10 and/or failed to identify that a system was in place to

ensure that residents who inadvertently did not receive a meal would be identified. The findings include:

a. Resident #12 (R #12) was admitted to the facility on 3/27/10 with diagnoses that included Insulin Dependent Diabetes Mellitus (IDDM) and was on a sliding scale for insulin administration four times daily. On 4/1/10 at 9:30 AM, R #12 was observed in bed and reported that she still had not received breakfast. The resident was visibly upset and stated that she had already reported to staff that she had not received a breakfast tray but that no one had responded. Interviews with various nursing assistants on the unit identified that R #12's assigned caregiver, Nursing Assistant #10 had not yet arrived for duty. At 9:40 AM, NA #10 arrived for work and was handed a breakfast tray by Dietary Aide #1, for R #10. Interview with LPN #10 at 9:45 AM identified that he/she noticed that R #12 did not get a breakfast tray at approximately 9:00 AM and called to the kitchen to have one delivered. Interview with Dietary Aide #1 on 4/1/10 at 10:00 AM identified that R #12's name had inadvertently been eliminated from the dietary ticket list and therefore a tray was not sent for the resident. Interview with the Food Service Supervisor (FSS) on 4/1/10 at 11:10 AM identified that it was the responsibility of the supervisory staff in the Dietary Department to ensure all residents are included on dietary ticket lists for each meal but was unable to explain why R #12's name was not on the breakfast list on 4/1/10. The FSS stated that his/her staff should have realized that a tray was missing but was unable at the time of the interview to identify the system used by dietary staff to ensure that all residents in the facility were included on the list at each meal.

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25. Based on review of the clinical record review of facility policies, observations, and interviews, the facility failed to develop a comprehensive plan of care for one resident, Resident #15, who had a recent history of a bowel obstruction. The findings include:

a. Resident #15 (R #15) was readmitted to the facility on 3/22/10 after surgical intervention for a Small Bowel Obstruction (SOB). Review of the clinical record identified that after returning to the facility on 3/22/10, on 3/23/10, R #15 complained of constipation and was given Milk of Magnesia in accordance with physician orders with no results. Physician orders were obtained for Lactulose on 3/24/10 and was administered with large results. Three days later during the 11:00 PM to 7:00 AM shift on 3/27/10, R #15 again complained of abdominal pain and although the record

lacked documentation of any intervention on that date, the documentation identified that the resident did have a large bowel movement on 3/27/10. Review of the clinical record with facility staff on 3/31/10 lacked documentation to reflect that R #15's bowel movements were consistently monitored each shift since readmission to the facility more than a week earlier. Interview with LPN #11 on 3/31/10 at 2:30 PM identified that facility policy directed that all residents' bowel movements be tracked using the Medication Administration Record (MAR). LPN #11 stated that it appeared that when R #15 was readmitted to the facility, a new MAR was generated and that someone had failed to include a box on the MAR for documentation of the R #15's bowel movements. Review of the nursing care plan last updated on 3/16/10 lacked documentation to reflect that a plan of care was developed upon R #15's readmission to address the recent obstruction, monitoring of the resident's recent diagnosis including every shift monitoring of bowel movements, and/or interventions to prevent reoccurrence. Review of facility policy directed that staff would identify risk factors to bowel dysfunction, monitor the resident's response to interventions and overall progress. In addition, facility policy directed that an individualized, comprehensive plan of care that included measurable objectives and time tables be developed to meet the resident's medical and nursing needs.

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

26. Based on observations, clinical record review and resident and staff interviews for one sampled resident who was transported to an outside medical appointment (Resident #22), the facility failed to ensure that a system was developed and/or maintained to protect the resident from neglect. The findings include:
    a. Resident #22's diagnoses included Diabetes Mellitus, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission nursing assessment dated 3/18/10 identified that the resident was alert with some confusion, required assistance with transfers, used a wheelchair for mobility and was incontinent of bladder. A care plan dated 3/18/10 identified that the resident experienced anxiety, required a routine schedule and was to receive toileting and/or incontinent care every two hours and was to be monitored for signs or symptoms of hypoglycemia and hyperglycemia.
    A physician's order dated 3/18/10 identified that a dental consultation was to be provided as indicated. Review of an inter-agency referral sheet indicated that the

facility had scheduled the resident to be seen for a dental consultation outside the facility on 3/31/10.
Observation identified that at approximately 8:55 AM Resident #22 left the facility to be transported to the dentist. Interview with Director of Nursing #1 at approximately 11:00 AM on 3/31/10 identified that the resident had been accompanied to the appointment by a facility employee.
Subsequently, observation at 1:55 PM on 3/31/10 identified that the resident had not returned to the facility. Although RN #2 indicated at 2:00 PM that there had been a delay in the time of the resident's return and stated that Resident #22 would be at the facility before 2:30 PM, observation at 3:00 PM indicated that the Resident #22 had not yet returned to his/her room. Upon further surveyor inquiry at the time, LPN #16 indicated the resident was in the dining room receiving the noon meal which had been missed during the time that the resident was outside the facility.
Observation at 3:05 PM identified that Resident #22 was seated in a wheelchair at a table in the main dining room without food or beverage and was starting to wheel self away from the table. At 3:10 PM LPN #10 and DNS #1 indicated that although NA #17 had been asked to provide Resident #22 a meal, the nurse aide had left for the day. Subsequently, at 3:14 PM LPN #16 identified that there had been a misunderstanding regarding the resident's lunch. LPN #16 stated that the Dietary Department had not been informed of the resident's need for a meal and would prepare food for Resident #22.
Interview with Resident #22 at 3:20 PM on 3/31/10 identified that he/she had not received any food, fluids or care since leaving the facility and had not seen the dentist during the time that he/she was at the dental office. The resident identified that he/she was thirsty and hungry. After further surveyor inquiry Resident #22 was provided a beverage at 3:30 PM, and at 3:35 PM the resident was observed eating a tuna fish sandwich. Subsequently, from 4:20 PM to 4:42 PM Resident # 22 was observed seated in the corridor of his/her unit calling out intermittently. At 4:42 PM an interview with Nurse Aide #13 who was assigned to the resident during the 3:00 PM to 11:00 PM shift identified that he/she had not yet provided any care to the resident because the resident had been in the dining room at the beginning of the shift, and subsequently Nurse Aide #13 had been providing care to other residents since arriving at the facility.
Review of facility policies and procedures failed to identify a protocol for ensuring the resident's needs were met during trips to outside medical appointments and/or responding to unexpected circumstances and/or ensuring that the resident received necessary care and services upon return to the facility.

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

Interview with the Director of Nursing at approximately 4:00 PM on 3/31/10 identified that the dental consultation had not been performed because the information that was faxed to the dental office during the morning of 3/31/10 at their request had not reached the proper location. The Director of Nursing stated that multiple instances of miscommunication regarding Resident #22's care and treatment had occurred on 3/31/10.

Interview with the Assistant Administrator on 4/5/10 at 11:27 AM identified that the facility had been unable to locate any specific protocol for staff to follow when accompanying residents to medical appointments. However, the Assistant Administrator stated that the facility has developed a new procedure to prevent the reoccurrence of the situation that occurred on 3/31/10.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (g) Reportable Events (3) and/or (g) Reportable Events (6) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

27. Based on clinical record review, facility records of reportable events, documentation and staff interview for one sampled resident (Resident #21) who experienced a potentially self-injurious incident, the facility failed to prepare a written reportable event report and/or conduct an investigation regarding the event. The findings include:
    a. Resident #21's diagnoses included Multiple Sclerosis and bipolar disorder. A 14-day Minimum Data Set Assessment (MDS) assessment dated 2/22/10 identified that the resident had a short-term memory deficit, periods of restlessness, total dependence on staff for transfers and bed mobility and required supervision of eating. A care plan dated 3/8/10 identified that the resident had the potential for behavioral changes relative to his/her diagnoses and included an intervention for staff to provide emotional support.

    Review of a nurse's narrative note dated 3/11/10 at 11:15 AM identified that a night nurse and supervisor had informed the 7:00 AM to 3:00 PM nursing supervisor that the resident had been observed with a shampoo bottle at his/her mouth, and staff were unable to determine if Resident #21 had ingested any of the shampoo. The note identified that staff were instructed to secure cosmetics and toiletry items.

    Interview with the Director of Nursing on 3/31/10 at 11:00 AM failed to identify that a reportable event report had been prepared and/or the facility had conducted an investigation regarding the resident's possible ingestion of shampoo.

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

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

28. Based on clinical record review and staff interview for one sampled resident (Resident #21) who experienced a potentially self-injurious incident, the facility failed to immediately consult the physician regarding the need for further evaluation and/or treatment when the event occurred. The findings include:
    a. Resident #21's diagnoses included Multiple Sclerosis and bipolar disorder. A 14-day Minimum Data Set Assessment (MDS) assessment dated 2/22/10 identified that the resident had a short-term memory deficit, periods of restlessness, total dependence on staff for transfers and bed mobility and required supervision of eating. A care plan dated 3/8/10 identified that the resident had the potential for behavioral changes relative to his/her diagnoses and included an intervention for emotional support to be provided.
    Review of a nurse's narrative note dated 3/11/10 at 11:15 AM identified that a night nurse and supervisor had informed the 7:00 AM to 3:00 PM nursing supervisor that during the night of 3/10/10 to 3/11/10 the resident had been observed with a shampoo bottle at his/her mouth, and staff were unable to determine if Resident #21had ingested any of the shampoo. The note identified that staff were instructed to secure cosmetics and indicated the resident had expressed no complaint of discomfort. The nurse's note also identified that although the 7:00 AM to 3:00 PM shift had attempted to notify the physician, the telephone line was busy. At 3:00 PM on 3/11/10 a subsequent nurse's narrative note indicated the physician had been reached and informed of the incident that occurred during the 11:00 PM to 7:00 AM shift the previous night.
    Interview and clinical record review with the Director of Nursing on 3/31/10 at 11:00 AM identified the physician should have been consulted when the incident occurred, and there was no documentation to reflect that the facility had contacted him/her until the next day.

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) and/or (o) Medical Records (2)(I).

29. Based on clinical record review and interview for one sampled resident (Resident #21) who experienced a potentially self-injurious incident, the facility failed to ensure that the

resident was assessed and/or monitored in accordance with standards of quality. The findings include:

a. Resident #21's diagnoses included Multiple Sclerosis and bipolar disorder. A 14-day Minimum Data Set Assessment (MDS) assessment dated 2/22/10 identified that the resident had a short-term memory deficit, periods of restlessness, total dependence on staff for transfers and bed mobility and required supervision of eating. A care plan dated 3/8/10 identified that the resident had the potential for behavioral changes relative to his/her diagnoses and included an intervention for emotional support to be provided.

Review of a nurse's narrative note dated 3/11/10 at 11:15 AM identified that a night nurse and supervisor had informed the 7:00 AM to 3:00 PM nursing supervisor that the resident had been observed with a shampoo bottle at his/her mouth during the 11:00 PM to 7:00 AM shift. Although the note identified that staff were unable to determine if Resident #21had ingested any of the shampoo, there was no documentation to reflect that the resident was assessed immediately following the incident and/or monitored until the 7:00 AM to 3:00 PM shift nurse's note indicated at 11:15 AM that the resident's temperature, blood pressure, pulse and respiration rate were obtained.

Clinical record review and interview with the Director of Nursing on 3/31/10 at 11:00 AM identified no assessment or monitoring of the resident immediately following the incident and/or other immediate response to the incident.

According to Medline Plus, a service of the US National Library of Medicine and the National Institutes of Health dated 7/2/09, in an instance of swallowing a liquid shampoo, either the National Poison Control Center or the local emergency number should be called. Although a visit to the Emergency Room may not be necessary, a health care provider would monitor and measure the patient's vital signs including temperature, breathing rate and blood pressure. Blood and urine tests may be performed.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

30. Based on observation, clinical record review and staff interview for two sampled residents (Residents #21 and #22), the facility failed to ensure that a system was maintained to ensure residents received meals in accordance with their needs and/or preferences. The findings include:

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

a. Resident #21's diagnoses included Multiple Sclerosis, bipolar disorder and Diabetes Mellitus. An admission nursing assessment dated 3/15/10 identified that the resident was alert, cooperative and forgetful, required supervision and set-up for eating and required aspiration precautions. A care plan dated 3/15/10 identified that the resident was at risk for alteration in nutrition relative to a history of weight loss and difficulty swallowing and would receive a diet of no concentrated sweets with a mechanical soft consistency.
Observation on 3/29/10 at 12:00 noon identified Resident #21 seated at a table in a small dining area with a tray in front of the resident that included an entree containing pieces of chicken on mashed potatoes. Further observation at 12:25 PM identified that Resident #21 had not eaten the meal. At 12:28 PM the resident requested that an alternative entree be provided. However, subsequent observation at 12:40 PM identified that the room where approximately nine residents had been seated during the meal was vacant, and Resident #21 was seated in an adjacent corridor without a meal. Interview with Resident #21 at the time indicated that he/she had not yet eaten and would like a meal.
Upon inquiry, LPN # 14 stated that the resident might not have eaten because he/she had refused. Subsequent to surveyor inquiry the resident was given two peanut butter sandwiches on a small plate and a container of milk.

b. Resident #22's diagnoses included Diabetes Mellitus, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission nursing assessment dated 3/18/10 identified that the resident was alert with some confusion and used a wheelchair for mobility. A physician's order dated 3/18/10 identified that the resident was to receive a low-cholesterol, diabetic, renal diet with no concentrated sweets and no added salt. A care plan dated 3/18/10 identified that the resident was to receive a diet in accordance with the physician's orders and was to be monitored for signs or symptoms of hypoglycemia and hyperglycemia. A resident status sheet dated 3/18/10 indicated that the resident required assistance with meals and identified that staff were to inform Resident #22 the location of food on the tray.
Intermittent observations from 12:00 noon to 12:20 PM on 3/29/10 identified that Resident #22 was seated in a small dining area at a table waiting to eat the noon meal with three other residents seated at the table. Approximately nine residents were seated in the room with one nurse aide (NA #17) observed to be providing assistance to the residents. During this period Resident #24 who was seated in a seat adjacent to Resident #22 was observed to call out constantly.
At 12:25 PM on 3/29/10 the nurse aide (NA #17) approached Resident #22 and while standing began to feed the resident a meal that included meat loaf, mashed potatoes and corn and returned again at 12:27 PM to feed the resident another bite of the meal

while continuing to stand before leaving the immediate area. The nurse aide failed to identify the food or beverage items that were on the tray or to offer the resident a beverage. At 12:30 PM the resident called out to request that a beverage on the tray be provided. Although the tray contained a hot beverage as well as a container of milk, the nurse aide did not offer a choice and gave the resident a few ounces of milk which he/she consumed independently. At 12:40 PM Resident #22 was observed to have been transported from the dining area. Observation of the resident's tray at 12:42 PM identified that more than seventy-five per cent of the food and beverages remained on the tray.

Interview with Resident #22 indicated that he/she would have consumed more of the fluids on the tray if they had been offered. Interview with the Admissions Coordinator on 3/29/10 at 3:45 PM identified that the resident was not comfortable being in noisy areas and needed explanations in order to promote his/her psychosocial well-being and reduce any anxiety.

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

31. Based on observation, clinical record review and resident and staff interview, the facility failed to accommodate the needs of two sampled residents (Residents #21 and #22) for an environment that promoted the residents' psychosocial well-being. The findings include:
    a. Resident #21's diagnoses included Multiple Sclerosis and bipolar disorder. A 14-day Minimum Data Set Assessment (MDS) assessment dated 2/22/10 identified that the resident had a short-term memory deficit, periods of restlessness, total dependence on staff for transfers and bed mobility and had experienced a fall in the previous 31 to 180 days. A care plan dated 3/15/10 identified that the resident had a history of falls as well as attempting to transfer self from bed and had previously shut off a bed alarm. The care plan included an intervention for the continued use of a bed alarm. Observations on 3/31/10 from 2:20 PM to 2:25 PM and 2:30 PM to 2:40 PM identified Resident #21 in his/her bed with the bed alarm sounding every few seconds when the resident moved slightly. Interview with the resident at the time identified that the alarm had been sounding frequently with little movement and created an unsettling environment. Interview with Nurse Aides #14 and #15 at 2:35 PM on 3/31/10 indicated that the alarm should not be sounding when the resident moved so slightly and needed to be replaced.
    b. Resident #22's diagnoses included legal blindness, Diabetes Mellitus, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission nursing

assessment dated 3/18/10 identified that the resident was alert with some confusion and used a wheelchair for mobility. A resident status sheet indicated that the resident required assistance with meals and identified that staff were to tell Resident #22 the location of food on the tray.
Intermittent observations from 12:00 noon to 12:20 PM on 3/29/10 identified that Resident #22 was seated in a small dining area at a table waiting to eat the noon meal with three other residents seated at the table. During this period Resident #24 who was seated adjacent to Resident #22 was observed to call out constantly.
Further observation identified that the resident subsequently received intermittent assistance with the meal while Resident #24 continued to call out. Interview with the Admissions Coordinator on 3/29/10 at 3:45 PM identified that the resident was not comfortable being in noisy areas.

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

32. Based on observation, clinical record review and staff and resident interview for one sampled resident (Resident #22) who used a waist restraint, the facility failed to ensure that an assessment was conducted to determine the least restrictive device. The findings include:
    a. Resident # 22 had diagnoses that included legal blindness, bipolar disorder, anxiety, Diabetes Mellitus, neuropathy and End Stage Renal Disease. An admission nursing assessment dated 3/18/10 identified that the resident was alert with confusion, required assistance for transfers and total care and used a wheelchair for mobility. A fall risk assessment dated 3/18/10 identified that the resident was at high risk for falls. A care plan dated 3/18/10 included an intervention for the facility to provide a safe environment. On 3/20/10 a physician's order directed the facility to provide the resident with a self-releasing seat belt and an alarm when the resident was seated in the wheelchair.
    Observations on 3/29/10 at 11:10 AM and 12:55 PM identified the resident seated in his/her room with a seat belt with a buckle secured on the resident's right side. Upon interview at 12:55 PM Resident #22 indicated that he/she was unable to remove the seat belt but noted having inadvertently undone the buckle previously.
    Clinical record review failed to identify that the facility had conducted an assessment to determine the least restrictive device. Further clinical record review and interview with the Director of Nursing on 3/29/10 at approximately 3:45 PM identified no assessment for the use of the restraint. Subsequent interview with the Director of

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

Nursing on 3/31/10 at 11:06 AM indicated the facility had determined that the buckle would be moved to the middle of the resident's waist so that he/she could release it.

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

33. Based on clinical record review and physician and staff interview for one sampled resident (Resident #22) who was transported to a dental appointment, the facility failed to consult the physician regarding the facility's failure to implement the physician's orders and/or the need to alter treatment subsequent to the resident's unexpected absence from the facility for more than five hours and/or inform the physician that a scheduled dental consultation was not performed. The findings include:
    a. Resident #22's diagnoses included Diabetes Mellitus, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission nursing assessment dated 3/18/10 identified that the resident was alert with some confusion, required assistance with transfers, used a wheelchair for mobility and was incontinent of bladder. A resident status sheet dated 3/18/10 also identified that the resident required assistance with meals. A care plan dated 3/18/10 identified that the resident experienced anxiety, required a routine schedule, was to receive toileting and/or incontinent care every two hours and was to be monitored for signs or symptoms of hypoglycemia or hyperglycemia.
    A physician's order dated 3/18/10 identified that a dental consultation was to be provided as indicated. Review of an inter-agency referral sheet indicated that the facility had scheduled the resident to be been for a dental consultation outside the facility on 3/31/10.
    Observation identified that at approximately 8:55 AM Resident #22 left the facility to be transported to the dentist. Subsequently, observation at 1:55 PM on 3/31/10 identified that the resident had not returned to the facility. Although RN #2 indicated at 2:00 PM that the resident would be returning to the facility before 2:30 PM, observation at 3:00 PM indicated that the Resident #22 had not yet returned to his/her room. Upon further surveyor inquiry at the time, LPN #16 indicated the resident was in the dining room receiving the noon meal which had been missed during the time that the resident was outside the facility. Observation at 3:05 PM identified that Resident #22 was seated in a wheelchair at a table in the main dining room without food or beverage and was starting to wheel self away from the table.
    Interview with Resident #22 at 3:20 PM on 3/31/10 identified that he/she had not received any food, fluids or care since leaving the facility and had not seen the dentist during the time that he/she was at the dental office. The resident identified that

he/she was thirsty and hungry. After further surveyor inquiry Resident #22 was provided a beverage at 3:30 PM, and at 3:35 PM the resident was observed eating a tuna fish sandwich. Subsequently, from 4:20 PM to 4:42 PM Resident # 22 was observed seated in the corridor of his/her unit calling out intermittently. At 4:42 PM an interview with Nurse Aide #13 who was assigned to the resident during the 3:00 PM to 11:00 PM shift identified that he/she had not yet provided any care to the resident.

Review of the physician's orders dated 3/18/10 directed the facility to check the resident's blood sugar level four times a day at 6:00 AM, 11:00 AM, 4:00 PM and 9:00 PM. The physician directed the facility to administer Novolog Insulin according to a sliding scale that included 2 units if the resident's blood sugar level was from 200 to 250 and 4 units if the level was from 250 to 300.

Review of the Medication Administration Record (MAR) identified that on 3/31/10 no blood sugar check was performed at 11:00 AM and/or when the resident subsequently returned to the facility. The MAR Record indicated that at 4:00 PM on 3/31/10 the resident's blood sugar level was 224 with no insulin administered. At 9:00 PM the resident's blood sugar level was documented as 258, and again no insulin was identified to be administered.

Interview with Physician #2 on 4/1/10 at 11:45 am indicated he had not been informed on 3/31/10 that the resident's dental consultation had not been performed and/or of the events that occurred on 3/31/10 and/or that the resident had not received insulin in accordance with the physician's orders. Physician #2 indicated that Resident #22's condition necessitated a dental evaluation. The physician further stated that because the resident had just eaten a meal when the blood sugar level was checked at 4:00 PM on 3/31/10, no insulin would have been necessary at that time. However, the physician indicated that the facility should have contacted him to discuss the resident's blood sugar levels subsequent to the time that the resident was out of the facility and to provide an update regarding the status of the dental appointment.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H) and/or (o) Medical Records (2)(I).

34. Based on clinical record review and interview for two sampled residents (Resident #22 and #23) who required a podiatry consultation, the facility failed to ensure that the podiatry assessment and/or treatment were promptly performed in accordance with the residents' needs. The findings include:

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

a. Resident #22's diagnoses included Diabetes Mellitus, neuropathy, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission nursing assessment dated 3/18/10 identified that the resident was alert with some confusion, required assistance with transfers and used a wheelchair for mobility. An admission nurse's narrative note dated 3/18/10 identified that the resident's great toenails were hard and callus. On 3/20/10 a physician's order identified that the left second toe had a scrape due to the toenail of the great toe. The physician directed the facility to arrange for a podiatry consultation and in the meantime to treat the toe with Bacitracin daily following a saline wash and to apply a band aid and 2 inch by 2 inch gauze pad or lamb's wool between the resident's toes. The Treatment Administration Record (TAR) further identified that the podiatry consultation was to be scheduled as soon as possible.
Interview with the Director of Nursing on 3/31/10 identified that although a podiatry consultation had been scheduled for 4/13/10, the facility would be attempting to arrange for Resident #22 to see a podiatrist at an earlier time to ensure that the resident's podiatry needs were met. Interview with Physician #2 on 4/1/10 at 11:45 AM identified that the resident's discharge from the facility was scheduled for 4/2/10, and Resident #22 would be moving to another state soon after being discharged.

b. Resident #23's diagnoses included Diabetes Mellitus, hypertension and right above the knee leg amputation. An admission nurse's narrative note dated 3/19/10 identified that the resident was alert, required a mechanical lift for transfers and was observed to have bloody drainage from the left great toe. A podiatry assessment dated 3/22/10 also identified that the hospital had reported some bleeding discharge from the left great toe. A physician's order dated 3/22/10 directed the facility to arrange a podiatry consultation as soon as possible, and in the meantime to cleanse the wound on the left great toe and apply Bacitracin ointment each day until the resident was seen by the podiatrist. Interview with LPN #10 on 3/31/10 at 2:10 PM identified that although a podiatry consultation was not scheduled to be performed until April 13, 2010, the facility would attempt to arrange for an appointment at an earlier time.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (s) Social Work (7).

35. Based on observation, clinical record review and resident and staff interview for one sampled resident (Resident #22) observed to wear facility nightwear during the day, the facility failed to promote the dignity of the resident.

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

a. Resident #22's diagnoses included legal blindness, Diabetes Mellitus, bipolar disorder and End Stage Renal Disease. An admission nurse's narrative note dated 3/18/10 at 2:00 PM identified that the resident required total care. An initial care plan dated 3/18/10 identified that the resident's requests would be respected and honored throughout the resident's stay.
Intermittent observations on 3/29/10 from 11:10 AM to 2:30 PM identified that Resident #22 was observed seated in various locations that included his/her room, a dining area and an area adjacent to the nurses' station dressed in facility nightwear. Interview with the resident on 3/29/10 identified that he/she was upset to be wearing the nightwear and would prefer to wear clothing that was appropriate for the daytime. Interview with the Director of Nursing on 3/29/10 identified that the resident did not have adequate clothes at the facility. Subsequent observation identified the social worker locating clothes for the resident to wear.

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

36. Based on clinical record review and interview for three sampled residents (Residents #21, #22 and #23), the facility failed to implement measures in accordance with the overall plan of care (e.g. monitoring oxygen saturation levels, intake and output, weights) and/or the resident's identified needs. The findings include:
    a. Resident #21's diagnoses included Multiple Sclerosis, bipolar disorder and Diabetes Mellitus. An admission nursing assessment dated 3/15/10 identified that the resident was alert, cooperative and forgetful, was being readmitted following hospitalization for a urinary tract infection and had recently been hospitalized with pneumonia. A care plan dated 3/15/10 identified that the resident had a urinary tract infection and included an intervention for intake and output to be monitored. A physician's order dated 3/15/10 directed the facility to monitor the resident's oxygen saturation level each shift.
    Review of clinical record documentation of the resident's intake and output for the period from 3/15/10 through 3/30/10 identified that the documentation failed to reflect a complete record of the resident's total daily intake on eleven of the sixteen days and failed to identify the amount of fluid that the resident required. The documentation further failed to identify the resident's output on any of the sixteen days although on two days (i.e. 3/17/10 and 3/18/10) the record indicated the number of times that the resident had been incontinent during the 3:00 PM to 11:00 PM shift.

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

Review of clinical record documentation identified that during the period from 3/16/10 through 3/29/10 the resident's oxygen saturation level was recorded on only eight of forty-two shifts. Interview with the MDS Coordinator on 3/31/10 at 12:55 PM identified that the documentation would be included in the nurses' narrative notes.

b. Resident #22's diagnoses included Diabetes Mellitus, neuropathy, end stage renal disease, legal blindness, bipolar disorder and anxiety. An admission physician's progress note dated 3/20/10 identified that the resident's weight during a recent hospitalization was 201.5 lbs. A physician's order dated 3/20/10 directed the facility to weigh the resident on 3/21/10 and 3/22/10 followed by once a week. Although review of the clinical record and treatment record identified no documentation that the resident's weight was obtained on 3/21/10 or 3/29/10, a dietary assessment dated 3/22/10 identified the resident's weight to be 210 lbs.

c. Resident #23's diagnoses included Diabetes Mellitus, hypertension and status post above the knee right leg amputation. An admission nursing assessment dated 3/19/10 identified that the resident required extensive assistance with care. Review of a nurse's narrative note dated 3/23/10 on the 7:00 AM to 3:00 PM shift identified that the resident to be coughing with bilateral wheezing. At 12:10 PM on 3/23/10 a nurse's note identified that the resident's oxygen saturation level was 90 per cent to 92 per cent on room air and wheezing was noted throughout the resident's lung field. Subsequently, at 2:45 PM the resident was identified to complain of shortness of breath and was noted to have an oxygen saturation level of 91% on room air. The facility initiated oxygen at 2 liters per minute which increased the resident's oxygen saturation level to 95 per cent. At 5:20 PM on 3/23/10 a nurse's narrative note identified that the physician had provided an order for a nebulizer treatment to help the resident's breathing and to continue monitoring the resident.
Review of the nurses' narrative notes for the period from 3/24/10 through 3/28/10 on the 3:00 PM to 11:00 PM shift failed to identify that the facility consistently monitored the resident's oxygen saturation level and/or performed respiratory assessments subsequent to the change in the resident's' respiratory status that was identified on 3/23/10.
Interview with Director of Nursing #1 on 3/31/10 identified that the resident's respiratory status should have been monitored and the oxygen saturation level should have been obtained on each shift.

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

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

37. Based on observations, review of posted information and staff and resident interviews, the facility failed to ensure that the lobby of the building was accessible for the residents' use. The findings include:
    a. Intermittent observations of the lobby area on 3/29/10, 3/31/10 and 4/1/10 identified that the door used to enter the lobby area from the resident units was secured by a keypad that required an access code. No residents were observed utilizing the area during the course of the three days.
    Interview with Resident #25 on 3/29/10 at 4:00 PM identified that the only time the residents were permitted to spend time in the lobby during the day was from 2:00 PM to 3:00 PM. Interview with the Assistant Administrator on 3/29/10 identified that the facility planned to change the policy that was in effect.
    Review of information posted on a bulletin board identified that the residents were permitted to use the lobby only from 2:00 PM to 3:00 PM each day.

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

38. Based on review of the clinical record review of facility policies, and interviews, the facility failed to ensure that physician orders were implemented for one resident, Resident #12, who required blood sugar monitoring three times daily with insulin coverage in accordance with the results. The findings include:
    a. Resident #12 (R #12) was admitted to the facility on 3/27/10 with diagnoses that included Insulin Dependent Diabetes Mellitus (IDDM) and was on a sliding scale for insulin administration three times daily. The Medication Administration Record (MAR) for April 2010 lacked documentation to reflect that R #12's blood sugar was obtained at 6:30 AM on 4/1/10. Subsequently, no insulin coverage was given based on the lack of information obtained related to the resident's blood sugar. Interview with Director of Nursing #2 on 4/5/10 at 3:40 PM identified that he/she reviewed the clinical record and facility documentation and was unable to identify that R #12's blood sugar was obtained. Facility policy directed that physician orders be implemented as prescribed.