STATE OF CONNECTICUT
DEPARTMENT OF
FACILITY LICENSING AND **CTION**

Original

IN RE: Shelton Lakes Health Care Cente
d/b/a Apple Rehab Shelton Lakes
5 Lake Road
Shelton, CT 06484

CONSENT ORDER

WHEREAS, Shelton Lakes Health Care Center, Inc. ("Licensee"), has been issued License No.2298 to operate a Chronic and Convalescent Nursing Home known as Apple Rehab Shelton Lakes, ("Facility") under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and,

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates commencing on June 4, 2014 and concluding on June 11, 2014; and,

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated June 26, 2014 (Exhibit A – copy attached); and,

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

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, its Section Chief, and the Licensee, acting herein and through Brian Foley, its Managing Partner hereby stipulate and agree as follows:

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

2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The registered nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections or any other information that the Department deems relevant that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility sixteen (16) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its sole and absolute discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines, based upon any information it deems relevant, that the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order. The Department shall base any decision regarding a reduction in the hours of services of the INC upon onsite inspections conducted by the Department and based on all other information the Department deems relevant.
3. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
4. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the effective date of this Consent Order.
5. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
6. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct

patient care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

7. The INC shall submit written reports every other week to the Department documenting:
    a. The INC's assessment of the care and services provided to patients;
    b. Whether the Licensee is in compliance with applicable federal and state statutes and regulations; and,
    c. Any recommendations made by the INC and the Licensee's response and implementation of the recommendations.
8. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
9. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
    c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and;
    d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated June 26, 2014 (Exhibit A).
10. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet or conference call with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meeting or conference call shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

11. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
12. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and any other information the Department deems relevant.
13. Within fourteen (14) days of the execution of this Consent Order, the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to patient change of condition, physician notification, patient supervision, provision of care in accordance with the patient plan of care, nutrition, hydration and patient abuse and neglect.
14. Within twenty-one (21) days of the execution of the Consent Order all Facility nursing staff shall receive in-service education regarding the policies and procedures identified above if not previously conducted.
15. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs. Within twenty-one days of the effective date of this Consent Order, all licensed staff shall receive in-service education and training regarding the Facility's policies and procedures related to dehydration prevention if not previously conducted.
16. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the patients;
    b. Patients are maintained, clean, comfortable and well-groomed;
    c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;

e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;

f. Nurse aide assignments accurately reflect patient needs and a mechanism is implemented to ensure that each certified nurse aide has reviewed their assignment(s) prior to providing care and services to each patient in which they are assigned;

g. Each patient's nutritional and hydration needs are assessed, monitored and documented in accordance with his/her individual needs and plan of care;

h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified; and,

i. Medical Director engagement in ensuring that quality medical care is provided.

17. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating registered Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. A nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a five (5) year period.

18. Individuals appointed as Nurse Supervisors shall be employed by the Facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.

19. Nurse Supervisors shall be provided with the following:

a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;

b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;

c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant

Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and,

20. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers is in accordance with individual comprehensive care plans. The Licensee shall develop and maintain a patient acuity system, which shall identify the number and qualifications of nursing and ancillary staff necessary to meet the needs of patients housed in the facility. The Licensee shall, on a daily basis, utilize the acuity system to establish staffing ratios.

21. The Licensee shall provide a Nurse Manager on the Rehabilitation Unit for the day and evening shifts within four (4) weeks of the execution of the Consent Order. The Nurse Manager shall be a Registered Nurse with at least one year of supervisory experience. The Nurse Manager's duties and responsibilities shall include, but not be limited to:

    a. Ensure that all assessments, including, but not limited to hydration and nutritional assessments are conducted timely and accurately;
    b. Ensure that physicians and/or mid-level practitioners are notified timely when patients experience a significant change in condition; and
    c. Conduct patient rounds every 2 hours to ensure that patient needs are met

22. The Licensee shall provide minimum staffing ratios of :

    a. One (1) nurse aide to eight (8) patients between the hours of 7:00 A.M. to 3:00 P.M.;

    b. One (1) nurse aide to twelve (12) patients between the hours of 3:00 P.M. to 11:00 P.M.; and

    c. One (1) nurse aide to twenty (20) patients between the hours of 11:00 P.M. to 7:00 A.M.

    d. The staffing ratio will be risk adjusted based on the facility census and acuity.

23. The Licensee shall provide minimum nursing licensed staffing ratios of:

    a. One (1) licensed nurse to thirty (30) patients on the 7:00 A.M. to 3:00 P.M.;

    b. One (1) licensed nurse to thirty (30) patients on the 3:00 P.M. to 11:00 P.M.; and

c. One (1) licensed nurse to sixty (60) patients on the 11:00 P.M. to 7:00 A.M. shift.

d. The staffing ratio will be risk adjusted based on the facility census and acuity.

24. The Department shall retain the authority to extend the staffing ratios, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and any other information the Department deems relevant.

25. The Licensee, within seven (7) days of the execution of this Consent Order, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

26. The Licensee shall establish a Quality Assessment and Performance Improvement Program ("QAPI") to review patient care issues including those identified in the June 26, 2014 violation letter. The members of the QAPI shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAPI meetings shall be kept for a minimum of five (5) years and made available for review upon request of the Department. The INC shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The Committee shall implement a quality assurance program that will measure, track and report on compliance with the requirements of this Consent Order. The Committee shall measure and track the implementation of any changes in the Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of quality assurance meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the facility for a minimum period of five (5) years.

27. The Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars ($5,000), by money order or bank check payable to the Treasurer of the

State of Connecticut and delivered to the Department with the signed Consent Order. The money penalty and any reports required by this document shall be directed to:

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

28. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law. The allegations and findings contained in Exhibits A shall be deemed true in any subsequent proceeding in which the licensee's compliance with the Consent Order is at issue or the licensee's compliance with Connecticut statutes and regulations and/or with Federal statutes and regulations is at issue.
29. The Licensee understands that this Consent Order will be reported consistent with federal and state law and regulations and consistent with Department policy. In addition, the Licensee understands that this Consent Order will be posted on the Department's website.
30. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
31. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this Consent Order unless otherwise specified in this Consent Order.
32. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act,

Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

33. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the June 26, 2014 violation letter referenced in this Consent Order.
34. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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

Shelton Lakes Health Care Center, Inc.

Brian Foley, Managing Partner

On this 5th day of February, 2015, before me, personally appeared Brian Foley who acknowledged himself to be the Managing Partner of Shelton Lakes Health Care Center, Inc. and that he, as such Managing Partner being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by himself as the Managing Partner.

My Commission Expires: 8/31/2017
(If Notary Public)

Notary Public [ ]
Commissioner of the Superior Court [ ]

MICHAEL R. HETSKO
Notary Public, State of Connecticut
My Commission Expires Aug. 31, 2017

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/24/15
Date

By: Barbara Cass
Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE ___ OF ___

July 15, 2014

Helen Byron, Administrator
Apple Rehabilitation at Shelton Lakes
5 Lakes Road
Shelton, CT 06484

Dear Ms. Byron:

This is an amended edition of the violation letter originally dated June 26, 2014.

Unannounced visits were made to Apple Rehabilitation at Shelton Lakes on June 4, 5, 9, 10, and 11, 2014 representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure, and a certification inspection.

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

An office conference has been scheduled for July 10, 2014 at 10:00AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by July 9, 2014 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

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

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

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Kim Hriceniak, RN, SNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

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

DATES OF VISIT: June 4, 5, 9, 10, and 11, 2014

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

KH:mb
Complaint #16477

DATES OF VISIT: June 4, 5, 9, 10, and 11, 2014

THE FOLLOWING VIOLATION(S) 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 (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1).

1. Based on clinical record review, interviews, review of facility documentation, and review of facility policy for one of three residents (Resident # 65) reviewed for hydration and/or one of four sampled residents (Resident #116) reviewed for weight loss, the facility failed to notify the physician and/or family when fluid goals were not met and/or when a significant weight loss was identified. The findings include:
    a. Resident # 65 diagnoses included dehydration and dementia. The Significant change MDS dated 4/30/14 identified severe cognitive impairment, required extensive assistance with eating and experienced a weight loss. The physician orders dated 4/30/14 directed to provide a puree thin liquid diet, Resource supplement 60ml two times a day in between meals and whole milk 180ml with chocolate syrup three times a day. The NA flow sheets dated 4/24/14 through 5/1/14 indicated Resident #65 consumed 0 % and 25 % of meals. In addition, several meal intakes were not recorded during this time frame. A nurse ' s note dated 5/1/14 for the 7:00AM-3:00PM shift identified Resident #65 was noted with a temperature of 97.3, pulse 96, respirations 22 and blood pressure 104/64. Resident #65 was lethargic, had decreased fluid intake and had not met his/her fluid goals for 9 days. The nurse's note further identified that tenting was noted to the chest area, the supervisor was notified and an order was obtained by the physician to encourage fluids. A physician's order dated 5/2/14 directed to administer Dextrose 5 1/2 normal saline at 50 cc an hour for 48 hours intravenously for dehydration. Physicians order dated 5/4/14 directed to continue the IV fluids for 24 hours. A review of the clinical record from 4/24/14 through 5/1/14 failed to provide evidence that the physician was notified that Resident #65 was not meeting the fluid goals prior to 5/1/14. Interview with LPN # 6 on 6/11/14 at 11:00 AM identified that he/she observed Resident #65 to be lethargic on 5/1/14 and then reviewed the I & O 's which identified that the resident did not meet his/her fluid needs for 9 days . LPN # 6 further identified that although he/she identified Resident #65 had not met his/her fluid goals for nine days on 5/1/14, the clinical record lacked documentation of the Intake and Output (I & O) records for the dates of 4/24/14-5/3/14 . The physician was notified by the nursing supervisor and directed to encourage fluids. LPN # 6 identified on 5/2/14 he/she asked the physician to conduct an assessment of Resident # 65 because LPN #6 was concerned about the resident's hydration status. The physician evaluated the resident and identified IV fluids were required for a diagnosis of dehydration for a total of seventy two hours. Interview with the ADNS on 6/9/14 at 2:30 PM identified that she was unable to locate the I & O's for the dates of 4/24/14-5/3/14. The ADNS further identified that it is the responsibility of the 11-7 nurse to file the I & O's in the clinical record once the sheet is completed. Interview with the Director of Nurses on 6/11/14 at 9:30 AM identified that it is the responsibility of the 11:00PM-7:00AM nurse to tally the I & O's for the past 24 hours and identify which residents are not meeting their fluid needs to pass onto the next shift. The DNS further identified that it would be her expectation that when a resident is not

meeting their fluid goals and is exhibiting signs of dehydration an assessment would be completed and reported to the physician immediately. A review of the facility hydration protocol identified that if a resident does not meet fluid goals and does show signs of dehydration the physician, dietician and family will be notified to determine any changes to the plan of care.

b. Resident #116's diagnoses included anemia, dementia with behavioral disturbances and agitation. The care plan dated 3/22/14 identified impaired cognition; his/her appetite may fluctuate, required a therapeutic restrictive diet to manage cardiac disease, and was at risk for changes in weight. Interventions directed weights as ordered, offer supplements as needed, offer to set up for meals, cut food into small pieces and provide lip plate. The monthly physician ' s order dated 3/27/14 directed to provide a no added salt, low cholesterol, regular consistency, thin liquid diet. The 14-day Minimum Data Set (MDS) assessment dated 4/3/14 identified moderately impaired cognition, short and long-term memory deficits and required limited assistance with eating. A review of weekly weight monitoring audit documentation noted the following weights: 4/3/14- 207 lbs., 4/7/14- 193 lbs., 4/14/14- 193 lbs., 4/28/14- 183 lbs., 5/5/14- 182 lbs., 5/12/14- 182 lbs. (which represents a 5% weight loss since 4/14/14). The dietary progress note dated 4/16/14 identified Resident #116 ' s weight was trending down, now 193 pounds (lbs.) and recommended weekly weights. The physician orders dated 4/16/14 directed to obtain weekly weights. A review of the clinical record from 4/14/14 through 6/11/14 failed to identify that the physician and /or family were made aware of the 5% weight loss in a timely manner. Interview and review of facility documentation with the ADNS on 6/11/14 at 12:20 PM identified that the clinical record lacked documentation that the physician and/or family were notified at the time a significant weight loss was identified on 5/12/14. Attempts to contact MD#1 were unsuccessful. A review of the facility change in resident condition policy directed all significant change in resident's condition will be reported to the physician and family. The nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or Connecticut General Statues 19a-550.

2. Based on facility documentation and interviews the facility failed to maintain an updated grievance log according to the facility policy. The findings include:
   a. A review of the grievance log on 6/10/14 identified that the first grievance available for review was dated 5/9/14. Observation and interview with the Administrator of the grievance log on 6/10/14 at 1:00PM identified that he/she began logging the grievances when he/ she began employment at the facility in March of 2014. He/she further identified that it is his/her responsibility to keep the grievance log, and he/ she had investigated any grievances that have come to his/ her attention since March 2014. Interview with the Social Worker on 6/10/14 at 2:00PM identified that she does not keep

the grievance log, it is kept with the Administrator, but he/she investigates any grievances and forwards them to the Administrator. The Social Worker further identified that he/she could not recall if any grievances had taken place prior to 5/9/14 because he/she was not involved in the grievance process when the previous Administrator was in place. A review of the Grievance policy identified that the Social Worker will keep an updated grievance book for 1 year. Subsequent to surveyor inquiry on 6/10/14 the current Administrator communicated with the prior Administrator and was informed that the grievance log was kept in a maroon binder; however the current Administrator was unable to locate the binder.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(C) and/or Connecticut General Statues 19a-550.

3. Based on clinical record review, review of facility documentation and interviews for one of three sampled residents (Resident #39) who were reviewed for reporting an allegation, the facility failed to ensure the resident received personal care that resulted in neglect. The findings include:
    a. Resident #39's diagnoses included sepsis, hypertrophy prostate, urinary retention and depression. The quarterly Minimum Data Set assessment dated 7/5/13 identified that Resident #39 had no cognitive impairments, no behavioral symptoms, mild depression, required extensive one person assistance with bed mobility, personal hygiene, and dressing, required supervision with eating after set up, was always incontinent of bowel and utilized an external urinary catheter. The resident care plan dated 7/16/13 identified that Resident #39 was incontinent of bowel and bladder. Interventions directed to offer incontinent care every two hours. Review of the Reportable Event Form dated 8/25/13 at 4:30 PM identified that Resident #39 had reported that no one took care of him/her all day. The bed linens were observed to be soiled with dry feces and urine stains. The social service progress dated 8/28/13 identified that on interview Resident #39 stated that no one came in to take care of him/her on Saturday and the only time he/she saw anyone was when the meals were served. Resident #39 indicated that he/she did put the call light on but no one responded. Review of the investigation identified that in written statements the 3-11 PM Nurse Aide (NA) #3 and Licensed Practical Nurse (LPN) #2 identified that the incontinent brief was saturated with urine and had dried feces, the bed linen had rings of dry urine and the external catheter was off. Interview with LPN #2 on 6/9/14 at 11:45 AM identified that on 8/24/13 she worked the evening shift. At the beginning of the shift the nurse aide caring for Resident #39 came to her and asked that she observe the condition Resident #39 was left in. LPN #2 indicated that she observed the resident's external catheter was off and Resident #39 was totally soaked in urine with rings of urine noted on the incontinent pad and hard, dry stool was observed. LPN #2 identified that it appeared Resident #39 had not been changed all day by the appearance of the both the urine and stool. Interview with NA #3 on 6/9/14 at 1:45 PM identified

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

that Resident #39 reported that he/she had not been seen all day. The 7-3 PM nurse aide came in once, was rude to him/her and never returned. NA #3 indicated that she had observed the resident's incontinent brief was very saturated with urine, urine rings were noted on the linen and a large amount of dried stool was. NA #3 identified that she immediately reported Resident #39's condition to the nurse before rendering care. Interview with LPN #5 on 6/9/14 at 11:55 AM identified that he/she only saw R#39 twice to administer medications and only observed the Foley bag. Review of facility policy directs that incontinent care is performed by nursing staff on all residents who are incontinent. Facility policy on abuse directs that abuse or mistreatment of any kind toward a resident is strictly prohibited. Neglect means the deprivation by any individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being.

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

4. Based on review of facility documentation and interviews for four of five employee files reviewed, the facility failed to complete screening of new hires according to the facility's abuse prohibition policy and/or one sampled resident (Resident #64), reviewed for fragile skin, the facility staff failed to report an injury of unknown origin. The findings include:
   a. Review of Dietary Aide#1's employee file identified that he/ she was referred for employment by the Housekeeping Supervisor. Further reviews of the employment application identified additional 2 references were provided. Review of the employee file failed to provide documentation of attempts to obtain references prior to the offer for employment. In addition a reference was not obtained from the Housekeeping Supervisor although he/she was listed as a reference. Interview with the Human Resources Manager on 6/5/14 at 3:25PM indicated that it was not her practice to obtain personal references because the reference will be in favor of the applicant.
   b. Review of LPN#3's application for employment identified 3 previous employers and 3 personal references. A review of the employee file however identified only one reference check was done prior to an offer of employment.
   c. Review of LPN#4's and RN#2's application for employment identified 1 previous employer and 3 personal references. Review of the employee file for LPN#4 and RN#2 identified only one reference check each was completed for LPN#4 and RN#2 prior to an offer of employment.
   Interview with the Human Resources Manager on 6/5/14 at 3:25PM indicated he/she was recently hired at the facility and has several duties and responsibilities that included payroll, human resources and accounts payable. The Human Resources Manager identified that he/she was only one person to fill all the above roles and that the reference checks were not completed due to his/her multiple responsibilities within the organization. A review of the facility abuse prevention policy identified that reference checks for all potential employees will be completed including previous employers.

Interview with the Administrator on 6/5/14 at 4:00PM and review of the employee files indicated that two references were required prior to offer of employment and that a checklist will be developed to highlight the tasks in the hiring process.

d. Resident #64 diagnoses included dementia with behaviors and Alzheimer 's disease. The quarterly MDS assessment dated 5/19/14 identified severe impaired cognition, required limited to extensive assistance with ADLs and the application of ointment to areas of the body other than the feet. The care plan dated 5/23/14 indicated the resident could self-propel in the wheelchair, required two nurse aides for care, transferred via mechanical lift, and was prone to self-inflicted skin tears due to frequent scratching and fragile skin. Interventions included the encouragement to wear long sleeves, trim fingernails and protection of the extremities during transfers. Observation on 6/5/14 at 10:42 AM identified Resident #64 with several bruises on his/her bilateral hands. Observations on 6/5/14, 6/9/14 and 6/10/14 identified the resident without the benefit of long sleeves to protect the upper extremities. Interview with the LPN #7 on 6/10/14 at 10:11 AM identified that the resident frequently sustains purpura. LPN#7 further identified that he/she did not report the new bruises to administrative staff. Observation and interview with RN#4 on 6/10/14 at 2:23 PM identified Resident #64 with multiple bruises on both arms and hands. Interview with the ADNS on 6/10/14 at 3:00PM indicated LPN #7 was responsible to report the incidence of new bruises and initiate an investigation. Subsequent to surveyor inquiry, an investigation was initiated on 6/10/14 which identified a discoloration to the right forearm that measured 3cmX2.1cm; and 1.2cmX1.4cm; and the left hand measured 2.1cmX3cm. The investigation identified that the bruises were likely caused as a result of striking walls in the facility while self propelling in the wheelchair.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or Connecticut General Statues 19a-550.

5. Based on clinical record review, observation and staff interview for one of two residents (Resident #40) reviewed for dignity, the facility failed to provide care in a dignified manner. The findings include:
   a. Resident #40's diagnoses included arthritis and spinal stenosis. The quarterly MDS assessment dated 12/15/13 identified intact cognition, required extensive assistance with bed mobility, transfers, toilet use, personal hygiene and bathing and was frequently incontinent of bladder/bowel. The care plan dated 12/27/13 identified the resident needed extensive assistance with ADL'S with interventions that included to toilet or provide incontinent care/repositioning every two hours and as needed. Physician orders dated 2/19/14 directed to transfer the resident out of bed via Hoyer lift. Interview with NA#2 on 6/10/14 at 10:15AM identified that the resident is usually continent of bladder. Interview with NA#4 on 6/10/14 at 1:40PM identified that the majority of the time the resident is continent and is aware when he/she has to go to the bathroom. Additionally, NA#4 identified when the resident has to go to the bathroom; he/she will ring for

assistance. Interview with Resident #40 on 6/10/14 at 1:45PM identified that at times, there is not enough staff to assist him/her onto the bedpan and he/she has accidents. Although Resident # 40 was unable to provide dates and times he/she indicated it was within the last six months. Additionally, at times staff has told the resident to finish urinating in the diaper. The resident stated that at times he/she has been left in a wet diaper for several hours because they don't have enough staff to provide care. Interview with the ADNS on 6/10/14 at 2:00PM identified he/she was not aware of the allegation and an investigation would be initiated. The ADNS further identified that telling a resident to finish urinating in their diaper is unacceptable.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

6. Based on clinical record review, interviews and observation for two of two sampled residents (R#40 and R#72) reviewed for roommate change, the facility failed to ensure that the resident and/or legal representative was informed of a roommate change. The findings included:
   a. Resident #40 diagnoses included diabetes and congestive heart failure. A quarterly Minimum Data Set (MDS) assessment dated 3/4/14 identified intact cognition. Interview on 6/4/14 at 1:24PM with Resident #40 indicated that he/she was not informed by facility staff prior to receiving a new roommate. Resident #40 further identified on 6/10/14 at 11:20AM he/she had several roommates within the past few months however facility staff did not inform him/her prior to new roommate placement. Interview with the Admission Director on 6/10/14 at 12:15PM indicated Resident #40 had three new roommates during the past 6 months on 1/13/14, 3/12/14 and 4/1/14.
   A review of the clinical record from 12/13/13 through 6/3/14 failed to identify that the resident was informed prior to receiving new roommates and/or social service follow up visits. Interview with Social Worker 1 # on 6/10/14 at 11:07 AM indicated he/ she normally documents in the clinical record when a resident receives a new roommate, however the clinical record lacked documentation that Resident #40 was notified of his/her new roommates between 1/13/14 and 4/1/14.
   b. Resident #72 diagnoses included depression, glaucoma and hypothyroidism. A quarterly Minimum Data Set assessment dated 5/13/14 identified moderately impaired cognition. Interview on 6/4/14 at 1:52 PM with Resident #72 indicated that the facility staff did not inform him/her prior to placement of a new roommate on 3/4/14.
   A review of the clinical record from 11/12/13 through 5/12/14 failed to identify that the resident was informed prior to receiving a new roommate and/or social service follow-up visits were conducted with the resident following the placement of a new roommate.
   Interview with Social Worker 1 # on 6/10/14 at 11:07 AM indicated he/ she normally documents in the clinical record when a resident receives a new roommate. Social Worker #1 further indicated that although he/she might have informed Resident #72 the day prior to or the same day he/she received the roommate, the clinical record lacked

documentation of the notification . A review of facility room transfer/roommate change policy indicated that a roommate will be informed of any new transfers into his/her room. Information will be provided why the transfer is being made and any information that will assist the roommate in accepting his/her new roommate. Documentation of a room transfer and roommate change and a follow-up note is documented in the resident record.
And/or

7. Based on clinical record review and interview for one resident (Resident#65) reviewed for hospice care, the facility failed to provide medically related psycho-social services following a change in condition. The findings include:
    a. Resident#65's diagnoses included dementia with anxiety and depression. A significant change MDS dated 4/30/14 identified severely impaired cognitive skills, required extensive to total dependence for activities of daily living and a history of unplanned weight loss. The care plan dated 5/22/14 identified enrollment into Hospice care with interventions that included to initiate spiritual care consult with clergy, encourage to spend time with family and friends, spend time to talk and support with therapeutic conversation and provide medication and oxygen as needed. The nurse notes dated 5/22/14 identified the resident would at times refuse to eat, clench teeth and decline to open mouth to eat. Physician's progress notes dated 5/27/14 identified Resident #65's condition was declining, expect further weight loss and continue with hospice care. Clinical record review and interview with Social Worker #1 on 6/11/14 at 10:00AM identified the most recent notes pertaining to the resident's condition were completed on 4/30/14. The clinical record failed to provide documentation on maintaining contact with family/legal representative on health status, health care choices and their ramifications. In addition the medical record failed to provide documentation on referrals to the facility's various hospice providers and support in the family's decision on hospice care. The indicated he/she was the only Social Worker in the facility and was not able to provide social service interventions for Resident #65 since April due to his/her multiple responsibilities in the facility.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I).

8. Based on clinical record review and interview for one of four residents (Resident#105) reviewed for activities of daily living and/or for one of three residents (Resident#150) reviewed for accidents, the facility failed to develop a comprehensive plan of care to address the residents' grooming and/or non-compliance. The findings include:
    a. Resident # 105 was admitted to the facility on 3/1/13 with diagnoses that included dementia. A quarterly MDS assessment dated 6/1/14 identified severely impaired cognition and required limited to extensive assistance with ADLs. The care plan dated 6/2/14 indicated extensive assistance with ADLs to include grooming. Interventions

failed to address facial hair. Observations on 6/5/14 at 11:00AM,6/9/14 at 10:00AM and 6/10/14 at 10:51AM identified Resident #105 with excessively long facial hair on his/her chin. Interview and review of Resident#105's plan of care with LPN#6 on 6/10/14 at 10:56 AM identified that it lacked interventions and/or preferences regarding facial hair. Interview with the DNS on 6/10/14 at 12:00PM identified the expectation was for staff to ensure that the resident was groomed which included the removal of facial hair according to the resident's preference as directed in the plan of care.

b. Resident#150's diagnoses included hypertension, diabetes mellitus, dementia, C-Difficile and a history of transient ischemic attacks. The Admission Nursing Assessment dated 2/5/14 identified that Resident #150 was hard of hearing, sometimes able to follow commands and not oriented to place and time continent of bowel and bladder and required assistance with ambulating. The Fall Risk Assessment dated 2/5/14 identified that Resident #150 was at risk for falls. The Interim Care Plan dated 2/5/14 identified Resident #150 as a safety/fall risk. Interventions directed to orient to the room and call light, therapies as ordered and utilize two half side rails elevated. Review of the Situation Background Assessment Recommendation dated 2/7/14 identified Resident #150 fell at 2:00 PM in the bathroom and hit his/her head sustaining a head injury and was sent to the hospital for an evaluation. Review of inter-agency communication dated 2/7/14 identified Resident #150 had a fall without injury except for minor bruising and was discharged back to the facility. Review of the Reportable Event Form and investigation dated 2/7/14 identified that Resident #150 fell in the bathroom, hit his/her head in the floor and was non-compliant with calling for assistance. Interview and review of the care plan with the Director of Nurses on 6/10/14 at 11:00 AM identified that the Admission Interim Care plan dated 2/5/14 had not been updated until the care plan was developed on 2/18/14. The care plan did not reflect the falls and/or Resident #150's non-compliant behavior and/or interventions to minimize the risk of falls. Interview and review of the clinical record with the Assistant Director of Nurses on 6/10/14 at 10:45 AM identified that Resident #150 had exhibited behaviors of not utilizing the call light, getting up out of bed and going to the bathroom without assistance from the day of admission 2/5/14. Review of the care plan failed to identify that the non-compliant behaviors were addressed with interventions and goals. And/or

9. Based on clinical record review for one of three residents (Resident #41) reviewed for accidents, the facility failed to ensure that the plan of care was reviewed and/ or revised following a fall. The findings include:

   a. Resident#41 diagnoses included senile dementia. The quarterly MDS assessment dated 5/4/14 identified short and long term memory deficits, modified independence with cognition and independent ambulation. The care plan dated 5/8/14 identified unsteady gait and residual effects from CVA; administration of daily medications that could alter gait and balance; poor safety awareness, a history of falls, and non-compliance with treatment regime. The facility accident /incident report dated 5/17/14 identified Resident#41 had fallen outside the facility while feeding the birds unsupervised. The

documentation further identified that the resident had has unsteady gait and had lost his/her balance while outside. Interventions following the fall included a referral to PT for an evaluation. Interview and review of the clinical record with the PT director on 6/10/14 at 3:11PM identified that the last PT screen was on 4/2/14 (prior to the fall on 5/17/14) and there was no record that PT had evaluated Resident #41 as identified on the A /I. Interview and review of the facility fall policy with the DNS on 6/11/14 at 11:00AM identified that the facility policy identifies that residents will be referred to PT for a screen and/or treatment upon recommendation of the interdisciplinary team however the clinical record lacked documentation of a PT screen following the fall on 5/17/14.

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

10. Based on clinical record review and interviews for one of five residents (Resident# 40) reviewed for accidents and/or for one resident (Resident #64) reviewed for fragile skin, and/or or one of three residents (Resident#68) reviewed for rehabilitation, the facility failed to follow the plan of care related to repositioning while in a wheelchair and/or failed to follow the care plan for the protection of upper extremities and /or transfer and/or for one of five residents reviewed for accidents(Resident #116) the facility failed to follow the plan of care for the use of an alarm, and/or for one of four residents reviewed for ADL ' s (Resident #121), the facility failed to provide services in a timely manner and/or follow the plan of care and/or notify licensed staff regarding the resident refusal of care. The findings include:
    a. Resident #40's diagnoses included arthritis and spinal stenosis. The MDS dated 12/15/13 identified intact cognition, required extensive assistance with bed mobility, transfers, toilet use, and was frequently incontinent of bladder/bowel. The care plan dated 12/27/13 identified extensive assistance with ADL'S with interventions which included providing incontinent care and repositioning every two hours and as needed. Physician orders dated 2/19/14 directed to transfer the resident out of bed via Hoyer lift. A review of facility documentation dated 2/28/14 identified Resident #40 was not provided assistance to the bathroom for 5 hours and 45 minutes. Interview with Resident #40 on 6/10/14 at 9:30AM identified he/she could not recall if he/she had been incontinent on 2/28/14 , at times he/she has to wait a long time for care and toileting. Interview with the ADNS on 6/10/14 at 9:50AM identified that the resident sits in the chair daily and can shift his/her weight while in the chair. The ADNS further identified that although Resident #40 is alert/oriented and can verbalize when he/she needs to be toileted, it would be the expectation that toileting and repositioning be offered every two hours. Interviews with NA#2 on 6/10/14 at 10:15AM and NA#4 on 6/10/14 at 1:40PM failed to provide evidence that repositioning and/or toileting was provided on 2/28/14 according to the plan of care.
    b. Resident #64 diagnoses included dementia with behaviors and Alzheimer 's disease. The quarterly MDS assessment dated 5/19/14 identified severe impaired cognition, required

limited to extensive assistance with ADLs and the application of ointment to areas of the body other than the feet. The care plan dated 5/23/14 indicated the resident could self-propel in the wheelchair, required two NA ' s for care, transfer via mechanical lift, and was prone to self-inflicted skin tears due to frequent scratching and fragile skin. Interventions included the encouragement to wear long sleeves, trim fingernails and protection of the extremities during transfers. Observation on 6/5/14 at 10:42 AM identified Resident #64 with several bruises on his/her bilateral hands. Intermittent observations on 6/5/14, 6/9/14 and 6/10/14 identified Resident #64 without the benefit of skin protection to the upper extremities. Interview with the LPN #7 on 6/10/14 at 10:11 AM identified it was the responsibility of the nurse aides to ensure the upper extremities were protected as directed in the plan of care.

c. Resident#68's diagnoses included dementia, hypertension, chronic atrial fibrillation and status post left hip fracture. The physician orders dated 4/14/14 directed partial weight bearing on the left foot and assist of two with a rolling walker. The admission MDS assessment dated 4/21/14 identified intact cognition, required extensive assistance for bed mobility, transfer and dressing and was unsteady moving from seated to a standing position. The care plan dated 4/30/14 identified a fall risk due to weakness with interventions that included transfer with extensive assistance of one person and physical and occupational therapy to increase strength. Interview with Resident #68 on 6/10/14 at 12:45PM identified that bed to wheelchair transfers were done with the assistance of one staff member. The resident further pointed to the walker at the far end of the room and indicated it was not used during transfers. Review of the nurse aide flow sheets with LPN#1 and the DNS on 6/9/14 at 1:00PM identified that since admission a transfer device was not being utilized and that the transfer was completed with one person providing limited to extensive assistance. Interview with the Physical Therapist on 6/10/14 at 12:45PM identified the resident's knees had a tendency to buckle at times and therefore required the use of a walker for stability and assistance of two staff members. Additionally, review of the CNA card directed the nurse aides to transfer with assist of one and without the use of a transfer device. The MDS Coordinator indicated that although a review of the clinical record was done, therapy orders were not clear on the resident's needs for transfers. Upon surveyor inquiry, the Corporate Nurse on 6/10/14 at 12:45PM indicated that therapy orders will be reviewed and revised to address the resident's needs and functional status.

d. Resident #116's diagnoses included history of falls, dementia with behavioral disturbances and agitation, epilepsy, and expressive aphasia. The care plan dated 3/22/14 a risk for falls due to impaired cognition and safety awareness, cardiac condition, history of falls and vision deficit. Interventions directed call bell within reach, non-skid footwear on when in and out of bed, offer nap after lunch and get out of bed before dinner. The care plan further identified that Resident #116 needed limited assistance with most of the activities of daily living. Interventions directed stand pivot transfer with assist of two and to apply a bed and chair alarm for safety. The fall risk assessment dated 3/22/14 identified Resident #116 was at risk for falling. The physician order dated

3/22/14 directed the use of a clip alarm when in bed and wheelchair. The Significant change in status Minimum Data Set (MDS) assessment dated 3/28/14 identified that Resident #116 had moderate cognitive impairment, had short and long-term memory problem, and required extensive assistance for transfers and locomotion on and off the unit, toilet use and personal hygiene, experienced a fall in the last month and had a fracture related to fall in the last six months. The Reportable Event Form dated 3/28/14 identified that at 12:20 PM Resident #116 fell from the wheelchair to the floor in his/her room. Resident #116 complained of hitting his/her head and was transferred to the hospital for evaluation and returned to the facility at 7:30PM without any injuries. Review of the facility investigation identified Resident #116 was brought back from physical therapy session to his/her room on 3/28/14. Resident #116 stated that he/she asked to go back to bed, however the Physical Therapist told him/her to wait until after dinner. The investigation further identified that Resident #116 does have an alarm; however the alarm was not in place at the time of fall. Interview and review of facility documentation with the Assistant Director of Nurses (ADNS) on 6/10/14 at 10:30 AM identified the Physical Therapist failed to reapply the clip alarm after Resident#116 completed his/her physical therapy session and was brought back to his/her room.

e. Resident #121 diagnoses included traumatic brain injury and spastic hemiplegia. The quarterly MDS assessment dated 11/25/13 identified intact cognition; required supervision and setup help for eating, extensive assistance for personal hygiene and dressing, and extensive assistance of two staff members for transfer and toilet use. The care plan dated 11/26/13 identified extensive assistance was required with ADL's with interventions which included to offer assistance with tasks that the resident is not able to complete and set up for dressing and bathing. The care plan further identified cognitive deficits and refusal of care with interventions which included using short, simple sentences and one step at a time directions.

The reportable event form dated 2/4/14 and subsequent investigation indicated Resident #121 reported that he/she did not receive lunch on 2/3/14. Interview with the Director of Dietary on 6/10/14 at 3:02 PM indicated that prior to 2/3/14; the facility was providing Resident #121 with the breakfast meal only unless there was a specific request for lunch and dinner meals. The Director of Dietary also indicated that the resident ' s family members would bring in food from home for lunch and dinner meals and the resident would often refuse facility food. Review of the Individualized Resident Assignment (Nurse Aide Assignment) indicated that the resident required setup and could then feed self. Interview with Nurse Aide #9 (NA#9) on 6/11/14 at 6:05 PM indicated that although Resident#121 required assistance with meal setup and food to be cut, NA#9 was assigned to assist in the dining room during lunch service on 2/3/14 and did not follow-up to ensure that Resident#121 had eaten lunch, either provided by the facility or his/her family members. Facility documentation dated 2/13/14 indicated that the resident ' s plan of care was revised to include the dietary staff offering all meals to the resident and a daily check by the nurse to determine that lunch and dinner had been served to the resident.

DATES OF VISIT: June 4, 5, 9, 10, and 11, 2014

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

Review of the facility ' s reportable event form dated 2/4/14 and subsequent investigation indicated that Resident#121 reported that he/she did not receive care on 2/3/14 until the 7:00AM-3:00PM shift on 2/4/14. Interview with NA#9 who was assigned to the resident on 2/3/14 for the 7:00 AM to 3:00 PM shift indicated that he/she had offered to provide AM care (bathing and dressing) to Resident#121 on three occasions during the shift, but the resident refused. NA#9 indicated that he/she did not document the refusals of care in the clinical record. In addition, NA#9 identified that although he/she did assist Resident#121 with using the bedpan on several occasions during the shift, there was not a second staff member in the room when he/she provided care to the resident. Review of the Individualized Resident Assignment indicated that an addendum added on 11/15/13 directed that two staff members are required to provide care to Resident#121 at all times. Interview with the DNS on 6/11/14 at 1:00 PM indicated it was the expectation that staff follow the plan of care as directed in the Individualized Resident Assignment.

Review of the facility ' s reportable event form dated 2/4/14 and subsequent investigation indicated that Resident#121 stated that he/she did not receive care from 2/3/14 until the day shift 2/4/14. Interview with NA#9 who was assigned to the resident on 2/3/14 for the 7:00 AM to 3:00 PM shift indicated that he/she had offered to provide AM care (bathing and dressing) to Resident#121 on three occasions during the shift, but the resident refused. NA#9 indicated that he/she did not document the refusals of care in the clinical record. Interview with LPN#5 on 6/11/14 at 5:47 PM indicated that he/she was assigned to Resident#121 on 2/3/14 for the 7:00 AM to 3:00 PM shift and that he/she did not receive any notification from NA#9 that the resident had refused care on three occasions that shift. In addition, LPN#5 indicated that if a nurse aide notified him/her of a resident refusing care, he/she would document those refusals in the nursing progress note. Interview with the DNS on 6/11/14 at 1:00 PM indicated that refusal of care should be documented and reported to the nurse.

The following is 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)(B).

11. Based on clinical record review, observations and interviews for one of three sampled residents (Resident#105) reviewed for activities of daily living, the facility failed to ensure that the resident was clean shaven. The findings include:
    a. Resident # 105 was admitted to the facility on 3/1/13 with diagnoses that included dementia. A quarterly MDS assessment dated 6/1/14 identified severely impaired cognition and required limited to extensive assistance with ADLs. The care plan dated 6/2/14 indicated extensive assistance with ADLs to include grooming. Observations on 6/5/14 at 11:00AM,6/9/14 at 10:00AM and 6/10/14 at 10:51AM identified Resident #105 with excessively long facial hair on his/her chin. Interview with NA #5 on

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

6/10/14 at 11:04 AM identified that it was the first time he/she had taken care of the resident that week. Interview with the DNS on 6/10/14 at 12:00PM identified the expectation was for staff to ensure that the resident was groomed which included the removal of facial hair.

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

12. Based on clinical record review and interview for one of four residents (Resident# 150) reviewed for accidents, the facility failed to provide address behaviors to prevent an accident and/or minimize the risk of falls .The findings include:
    a. Resident#150's diagnoses included hypertension, diabetes mellitus, dementia, C-Difficile and a history of transient ischemic attacks. The Admission Nursing Assessment dated 2/5/14 identified that Resident #150 was hard of hearing, sometimes able to follow commands and not oriented to place and time continent of bowel and bladder and required assistance with ambulating. The Fall Risk Assessment dated 2/5/14 identified that Resident #150 was at risk for falls. The Interim Care Plan dated 2/5/14 identified Resident #150 as a safety/fall risk. Interventions directed to orient to the room and call light, therapies as ordered and utilize two half side rails elevated. Review of the Situation Background Assessment Recommendation dated 2/7/14 identified Resident #150 fell at 2:00 PM in the bathroom and hit his/her head sustaining a head injury and was sent to the hospital for an evaluation. Review of inter-agency communication dated 2/7/14 identified Resident #150 had a fall without injury except for minor bruising and was discharged back to the facility. Review of the Reportable Event Form and investigation dated 2/7/14 identified that Resident #150 fell in the bathroom, hit his/her head in the floor and was non-compliant with calling for assistance. A physician's order directed a pad alarm to the bed check function and placement every shift. Interview and review of the care plan with the Director of Nurses on 6/10/14 at 11:00 AM identified that the Admission Interim Care plan dated 2/5/14 had not been updated until the care plan was developed on 2/18/14. The care plan did not reflect the falls and/or new interventions to minimize the risk of falls. Interview and review of the clinical record with the Assistant Director of Nurses on 6/10/14 at 10:45 AM identified that Resident #150 had exhibited behaviors of not utilizing the call light, getting up out of bed and going to the bathroom without assistance from the day of admission 2/5/14.

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

13. Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one of four sampled residents (Resident #116) reviewed for weight loss, the facility failed to implement interventions in a timely manner to a prevent significant weight loss.

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

The findings include:

a. Resident #116' s diagnoses included anemia, dementia with behavioral isturbances and agitation. The care plan dated 3/22/14 identified impaired cognition; his/her appetite may fluctuate, required a therapeutic restrictive diet to manage cardiac disease, and was at risk for changes in weight. Interventions directed weights as ordered, offer supplements as needed, offer to set up for meals, cut food into small pieces and provide lip plate. The monthly physician ' s order dated 3/27/14 directed to provide a no added salt, low cholesterol, regular consistency, thin liquid diet. The 14-day Minimum Data Set (MDS) assessment dated 4/3/14 identified moderately impaired cognition, short and long-term memory deficits , required limited assistance with eating and had broken or loosely fitting full or partial dentures . A review of weekly weight monitoring audit documentation noted the following weights: 4/3/14- 207 lbs., 4/7/14- 193 lbs., 4/14/14- 193 lbs., 4/28/14- 183 lbs., 5/5/14- 182 lbs., 5/12/14- 182 lbs. (which represents a 5% weight loss since 4/14/14). The dietary progress note dated 4/16/14 identified Resident #116 ' s weight was trending down, now 193 pounds (lbs.) and recommended weekly weights. The physician orders dated 4/16/14 directed to obtain weekly weights. A review of the clinical record from 4/14/14 through 6/11/14 failed to identify that weekly weights were completed as directed by the physician as the weight for 4/21/14 was not completed. The clinical record identified an additional 10 pound weight loss on 4/28/14 and failed to provide evidence that the dietician followed up on the weekly weights and /or was notified of the 5% weight loss in a timely manner.
Interview and review of facility documentation with the Dietician on 6/11/14 at 11:20 AM indicated that Resident #116 weight was trending down and he/ she recommended weekly weights on 4/16/14, however he/she was not made aware of the subsequent April weights and continued weight loss until surveor inquiry on 6/11/14(six weeks later). The dietitian indicated he/she would have expected to have been notified of the additional weight loss. Interview with ADNS on 6/11/14 at 11:25 AM identified that it is the charge nurse's responsibility to notify the dietitian of weight loss. Subsequent to surveyor inquiry, Resident#116 was reassessed on 6/11/14 and interventions included to provide Resource 60ml between meals and to continue weekly weights.
Review of the facility weight monitoring procedure directed weights to be taken and recorded on the weight sheet. The charge nurse should then review the weight and compare this to the previous weight to determine a 5% weight change in 30 days or 10% change in 180 days. Significant changes will be handled accordingly. Residents who have experienced significant weight loss should be identified to the health care team at morning report, since all departments can play a part in observing resident ' s routines or playing a part in the interventions.

DATES OF VISIT: June 4, 5, 9, 10, and 11, 2014

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

The following is 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).

14. Based on facility documentation, clinical record review and interviews for 1 of 3 residents, (Resident # 65) reviewed for nutrition the facility failed to provide sufficient fluids to maintain proper hydration. The findings include:
    a. Resident # 65 diagnoses included dehydration and dementia. The Significant change MDS dated 4/30/14 identified severe cognitive impairment, required extensive assistance with eating and experienced a weight loss. The physician orders dated 4/30/14 directed to provide a puree thin liquid diet, Resource supplement 60ml two times a day in between meals and whole milk 180ml with chocolate syrup three times a day. The NA flow sheets dated 4/24/14 through 5/1/14 indicated Resident #65 consumed 0 % and 25 % of meals. In addition, several meal intakes were not recorded during this time frame.
    The nurse's note dated 5/1/14 for the 7:00AM-3:00PM shift identified Resident #65 was noted with a temperature of 97.3, pulse 96, respirations 22 and blood pressure 104/64. Resident #65 was lethargic, had decreased fluid intake and had not met his/her fluid goals for 9 days. The nurse's note further identified that tenting was noted to the chest area, the supervisor was notified and an order was obtained by the physician to encourage fluids. A physician's order dated 5/2/14 directed to administer Dextrose 5 1/2 normal saline at 50 cc an hour for 48 hours intravenously for dehydration. Physicians order dated 5/4/14 directed to continue the IV fluids for 24 hours. Interview with LPN # 6 on 6/11/14 at 11:00 AM identified that he/she observed Resident #65 to be lethargic on 5/1/14 and then reviewed the I & O 's which identified that the resident did not meet his/her fluid needs for 9 days . LPN # 6 further identified that although he/she identified Resident #65 had not met his/her fluid goals for nine days on 5/1/14, the clinical record lacked documentation of the Intake and Output (I & O) records for the dates of 4/24/14-5/3/14 . The physician was notified by the nursing supervisor and directed to encourage fluids. LPN # 6 identified on 5/2/14 he/she asked the physician to conduct an assessment of Resident # 65 because LPN #6 was concerned about the resident's hydration status. The physician evaluated the resident and identified IV fluids were required for a diagnosis of dehydration for a total of seventy two hours. Interview with the ADNS on 6/9/14 at 2:30 PM identified that she was unable to locate the I & O's for the dates of 4/24/14-5/3/14. The ADNS further identified that it is the responsibility of the 11-7 nurse to file the I & O's in the clinical record once the sheet is completed. Interview with the Director of Nurses on 6/11/14 at 9:30 AM identified that it is the responsibility of the 11:00PM-7:00AM nurse to tally the I & O's for the past 24 hours and identify which residents are not meeting their fluid needs to pass onto the next shift. The DNS further identified that it would be her expectation that when a resident is not meeting their fluid goals and is exhibiting signs of dehydration an assessment would be completed and reported to the physician immediately. A review of the facility

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

hydration protocol identified that if a resident does not meet fluid goals and does show signs of dehydration the physician, dietician and family will be notified to determine any changes to the plan of care.

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

15. Based on clinical record review and interviews for one of five sampled residents (Resident#105), reviewed for unnecessary medications, the facility failed to ensure that specific target behaviors were monitored with the use of antipsychotic medications and/or that lab work was monitored according to standards of practice. The findings include:
    a. Resident # 105 diagnoses included anemia, chronic kidney disease, diabetes type 2 and dementia. A behavioral health follow up dated 11/4/13 identified the behavior to be monitored was striking staff. The physician orders dated 5/18/14 directed to administer Seroquel 25mg at time of sleep, Vitamin D 400 U daily and Humulin R insulin 7 units subcutaneously at 8:00AM and 12:00 PM, and 5 units at 4:40PM. The quarterly MDS assessment dated 6/1/14 identified severely impaired cognition, required limited to extensive assistance with activities of daily living and did not exhibit behaviors. The care plan dated 6/2/14 identified dementia with depression with interventions which included to administer medications as ordered, psychiatry follow up as needed and check labs per MD order. A review of the Monthly Antipsychotic Records from April 2014 to June 2014 identified the behaviors being monitored for the use of Seroquel were depression, agitation, and delusions. A review of the clinical record from August 2013 to June 2014 identified the A1C was last monitored on 8/31/13 and Vitamin D was not being monitored. Interview and review of the clinical record with the DNS on 6/10/14 at 2:30 PM identified that the specific target behavior of striking out at staff was not being monitored and the clinical record lacked evidence of a recent A1C and/or Vitamin D level. According to the Standards of Medical Care in Diabetes 2013, Hemoglobin A1C should be monitored 2-4 times per year.

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

16. Based on observation, clinical record review and interviews , review of facility policy and procedures, the facility failed to ensure sufficient nurse staffing levels to maintain the resident's highest practicable physical, mental and psychosocial well being as determined by their assessments and individual care plans . The findings include:
    a. This regulation was not met as evidence by noncompliance in neglect, dignity, care plan implementation, ADL care, accident/ hazards, nutrition/hydration, specialized rehab and infection control.
    Interview and review of facility staffing on 6/11/14 at 12:00PM with the Corporate Nurse identified that although the posted staffing meets the requirements for the resident

census, the nurse aides were frequently pulled from their assignments to accompany residents to medical appointments and not replaced on the nursing unit.
Please refer to to F157, F224, F226, F 241, F282, F 312, F323, F325, F327, F406 and F441.

The following is violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

17. Based on clinical record review, facility documentation and interviews for 1(Resident #56) reviewed for preadmission screening and resident review (PASARR), the facility failed to implement recommendations identified in PASARR. The findings include:
    a. Resident # 56 diagnoses included Parkinson's disease, Bipolar Disorder, and anxiety. The Admission MDS assessment dated 12/4/13 identified t moderately impaired cognition and required limited assistance with activities of daily living. The care plan dated 12/9/13 identified impaired memory and decision making ability with interventions to obtain Harvest Health consult as indicated. A review of the preadmission screening and resident review recommendations dated 2/4/14 identified that the facility should arrange or provide an evaluation for a diagnosis of dementia, Alzheimer's or other organic mental disorder. A review of the clinical record on 6/10/14 failed to identify that the PASSAR recommendations were implemented. Interview with the Social Worker on 6/10/14 at 10:00 AM identified that he/she is responsible for reviewing the preadmission screenings and had reviewed Resident # 56's screening but must have overlooked the recommendation to obtain the evaluation for dementia, Alzheimer's or organic mental disorder. Subsequent to surveyor inquiry on 6/10/14 the Social Worker identified that arrangements have been made with Harvest to have the evaluation completed.

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

18. Based on clinical record review and interviews for one of five sampled residents (Resident #105), reviewed for unnecessary medications the pharmacist consultant failed to identify irregularities in the medication regimen. The findings include:
    a. Resident # 105 diagnoses included anemia, chronic kidney disease, diabetes type 2 and dementia. A behavioral health follow up dated 11/4/13 identified the behavior to be monitored was striking staff. The physician orders dated 5/18/14 directed to administer Seroquel 25mg at time of sleep, Vitamin D 400 U daily and Humulin R insulin 7 units subcutaneously at 8:00AM and 12:00 PM, and 5 units at 4:40PM. The quarterly MDS assessment dated 6/1/14 identified severely impaired cognition, required limited to extensive assistance with activities of daily living and did not exhibit behaviors. The care plan dated 6/2/14 identified dementia with depression with interventions which included to administer medications as ordered, psychiatry follow up as needed and check

labs per order. A review of the Monthly Antipsychotic Records from April 2014 to June 2014 identified that the behaviors being monitored for the use of Seroquel were depression, agitation, and delusions. A review of the clinical record from August 2013 to June 2014 identified the A1C was last monitored on 8/31/13 and Vitamin D was not being monitored. Interview and review of the clinical record with the DNS on 6/10/14 at 2:30 PM identified that the specific target behavior of striking out at staff was not being monitored and the clinical record lacked evidence of a recent A1C and/or Vitamin D level. Interview with the Pharmacist Consultant on 6/11/14 at 10:54 AM identified if he/she had identified irregularities in the medication regimen it would have been communicated to the DNS.

The following is violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervisor (1) and/or (t) Infection Control (2)(A).

19. Based on observation, clinical record reviews and interviews for one of three (Resident#11) residents reviewed for transfers via Hoyer lift, the facility failed to demonstrate infection control practices to prevent cross contamination/spread of infection. The findings include:
    a. Resident#40's diagnoses included clostridium difficile. Laboratory results dated 5/30/14 identified the presence of clostridium difficile (c-diff) toxin the stool sample and directed to initiate contact precautions. The physician orders dated 5/30/14 directed to administer Flagyl 500mg three times a day for fourteen days. Observation on 6/10/14 at 10:45AM identified NA#4 looking for the Hoyer pad of Resident#40 to use for transfer. Interview with NA#4 on 6/10/14 at 2:00PM indicated that the Hoyer pad was found. However, the Hoyer pad was used in the transfer of another resident, Resident#11 earlier in the shift. Further interview indicated that the Hoyer pad for Resident#40 was usually left in the room when not in use either inside the closet or by the bedside chair. Interview with NA#6 on 6/11/14 at 9:30AM indicated that when Resident#11 needed to be transferred from the bed to the wheelchair for a therapy session earlier in the shift, two Hoyer pads were found hanging from the Hoyer lift. NA#6 indicated that she opted for the bigger Hoyer pad to use for Resident#11 and was unaware that the pad chosen was Resident#40's. Interview and review of the clinical record with the ICN on 6/11/14 at 10:00AM indicated that Resident#40's Hoyer is dedicated for use by Resident#40 only secondary to active c-diff. Further interview and review of the clinical record of Resident#11 identified the presence of open areas on the resident's buttocks. Upon surveyor inquiry, the Hoyer pads were removed from use and sent to laundry for cleaning and staff in-services were initiated to prevent the spread of infection. Additionally, interview with NA#4 and NA#8 who were identified as consistent nurse aides for Resident#40 on 6/10/14 at 3:00PM failed to provide knowledge of cleaning of the lift after Resident#40's use. Review of the facility's policy identified using a clean damp cloth with disinfectant cleaner to wipe surfaces of the equipment to prevent the spread of infection.

DATES OF VISIT: June 4, 5, 9, 10, and 11, 2014

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

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

20. Based on review of facility documentation and interviews for one of two personnel files, the facility failed to ensure an annual performance review was completed. The findings include:
    a. NA#1's date of hire was 3/29/12. Review of the personnel file identified that a performance review could not be located. Interview with the ADNS on 6/10/14 at 12:00PM identified that the DNS is responsible for completing the performance reviews and one could not be found. Interview with the DNS on 6/10/14 at 1:00PM identified it must have been an oversight that the performance review was not completed for NA#1. The facility policy directed that employees would be given a formal and documented performance review at the end of the introductory period and annually thereafter.

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

21. Based on clinical record review and interview for one of three residents (Resident#28) reviewed for pressure ulcer and/or for one of two residents (Resident#65) reviewed for hydration and/or for one of three residents (Resident#150) reviewed for accidents, the facility failed to ensure the medical record was secure and/or complete. The findings include:
    a. Resident #28 was admitted to the facility on 3/4/14. During the stage one survey process, on 6/4/14 the facility provided a medical record that was not within the requested time frame. Upon several requests on 6/5/14 the facility was unable to locate the record for the admission dated 3/4/14. On 6/9/14 at 9:40 AM the facility provided sections of the medical record, however physician orders and nurses narrative notes were lacking. Interview with the ADNS on 6/9/14 at 1:51 PM indicated that the facility had identified issues regarding securing medical records several months ago, however a formal system had not been established to address the problems of securing and maintaining accurate medical records.
    b. Resident # 65 diagnoses included dehydration and dementia. The Significant change MDS dated 4/30/14 identified severe cognitive impairment, required extensive assistance with eating and experienced a weight loss. The care plan dated 5/3/14 identified that the resident was receiving IV hydration due to dehydration and failed fluid goals with interventions to administer IV fluids for 72 hours. Review of the clinical record on 6/9/14 failed to identify Intake and Output (I & O) records for the dates of 4/24/14-5/3/14.Interview and review of the clinical record with LPN # 6 on 6/9/14 at 12:00 PM identified that he/she was unable to locate the I & O's for the dates of 4/24/14 to 5/3/14.Interview with the ADNS on 6/10/14 at 2:00 PM identified that the facility was unable to locate the I & O records for the dates requested, and was unable to determine the reason for the missing documentation. The ADNS further identified that it is the responsibility of the 11-7 nurse to file the I & O sheets once they are completed. Interview with the Administrator on 6/10/14 at 2:15 PM identified that they have

identified an issue with medical records and are currently putting systems in place to organize the medical records.

c. Resident #150's diagnosis includes hypertension, diabetes mellitus, dementia and a history of transient ischemic attacks. The Admission Nursing Assessment dated 2/5/14 identified that Resident #150 was hard of hearing, sometimes able to follow commands and not oriented to place and time continent of bowel and bladder and required assistance with ambulating. The Fall Risk Assessment dated 2/5/14 identified Resident #150 was at risk for falls. The Interim Care Plan dated 2/5/14 identified R#150 as a safety/fall risk with interventions to orient to room and call light, therapies as ordered and utilize two half side rails elevated. Review of the Situation Background Assessment Recommendation dated 2/7/14 identified Resident #150 fell at 2:00 PM in the bathroom and hit his/her head sustaining a head injury and was sent to acute care. Review of the nurses' notes failed to reflect documentation of the fall. Interview with the Director of Nurses on 6/10/14 at 11:00 AM identified that the Situation Background Assessment Recommendation documentation was recently instituted and the fall should have been documented in the nurse's notes also.

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

22. Based on facility documentation review and interviews, the facility failed to implement plans of action to correct an identified quality deficiency in the area of screening new hires. The findings include:
    a. Review of the employee records of four of five newly hired staff members identified that the screening process of obtaining at least two references were not completed. Interview and review of the facility's survey history with the Administrator on 6/11/14 at 10:00AM identified the same deficiency was cited in the previous two successive surveys ending 7/16/2012 and 8/8/2013. The Administrator indicated that the Human Resources Manager was recently employed and that although training was provided on the hiring process, the Administrator was unaware that references were not done consistent with facility policy. The Administrator further indicated that he/ she had joined the facility three months ago and prioritized items that needed immediate action.

EXHIBIT B
PAGE ___ OF ___

DHSR Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.