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

IN RE: Brook Hollow Health Care Center, LLC of Wallingford, CT d/b/a Village Green of Wallingford Rehabilitation and Health Center
55 Kondracki Lane
Wallingford, CT 06492

CONSENT ORDER

WHEREAS, Brook Hollow Health Care Center, LLC of Wallingford, CT, ("Licensee") has been issued License No. 2223 to operate a Chronic and Convalescent Nursing Home known as Village Green of Wallingford Rehabilitation and Health Center ("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 October 27, 2014 and concluding on October 30, 2014; and,

WHEREAS, during the course of the aforementioned inspections, the Department identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated November 20, 2014 (Exhibit A – copy attached); and,

WHEREAS, an office conference regarding the November 20, 2014 violation letter was held between the Department and the Licensee on December 4, 2014, 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 Donna Kelsey, LLC, Manager, 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. Failure to pay the costs associated with the INC's duties may result in a fine not to exceed one thousand ($1000) dollars per day until such time the costs are paid.
3. 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 three (3) 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 twenty-four (24) 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 shall evaluate the hours of the INC at the end of the three (3) 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.
4. 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.

5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order. During the initial assessment, if the Independent Consultant identities any issues requiring immediate attention, he/she shall immediately notify the Department and the Licensee for appropriate response.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
8. The INC shall submit 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.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
10. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, and nurse aides, and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;

c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and,

d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated November 20, 2014 (Exhibit A).

11. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first four (4) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.

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

14. 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 Staffing needs, provision of Activities of Daily Living, Administration of treatments, therapies, and medications, patient assessment, care planning, nutritional needs, hydration, physician notification, physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, accident and fall prevention, and abuse and neglect prevention and investigation.

15. Within four weeks of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph fourteen (14).

16. Effective immediately upon execution of this Consent Order, the Licensee shall ensure that all staff, including but not limited to, temporary or contracted staff, receive

orientation prior to the start of their shift. Such orientation shall include but not be limited, emergency procedures and patient identification.

17. 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 clean, comfortable, and well-groomed;
    c. Patient treatments, therapies and medications are administered as prescribed by the physician, in accordance with each patient's comprehensive care plan and in a timely manner;
    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;
    g. Each patient's nutritional and hydration needs are assessed and monitored 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;
    i. Patients with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
    j. Necessary supervision and assistive devices are provided to prevent accidents;

k. 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;

l. Patients receive the necessary care, services, and assistance to maintain their highest practicable well-being;

m. Patients are free from abuse and neglect;

n. Allegations of abuse and patient injuries of unknown origin are thoroughly investigated, tracked, monitored, and reported; and

o. Supplies are adequate to meet the needs of the patients.

18. 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.

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

    b. Nurse Supervisors shall be provided with the following:

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

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

        iii. 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,

iv. Nurse Supervisors shall be responsible for ensuring that all care is provided to reside patients by all caregivers is in accordance with individual comprehensive care plans.

19. 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.

20. The Licensee shall establish a Quality Assessment and Performance Improvement Program ("QAPI") to review patient care issues including those identified in the November 20, 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.

a. 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.

b. The activities of the Quality Assurance Performance Improvement Committee shall include, but not be limited to, assessing all patients of the Licensee to identify appropriateness of care and services, determination and adoption of new policies to be implemented by the Licensee's staff to improve patient care practices, and routine assessing of care and response to treatment of patients affected with pressure sores and/or infections. In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall implement a quality assurance program that will measure, track and report on compliance with the requirements of this Pre-Licensure Consent Agreement. 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.

c. Within fourteen (14) days of the effective date of this Consent Order, the Licensee shall incorporate into its Quality Assessment and Performance Improvement Program ("QAPI") a method to monitor implementation of the requirements of the Consent Order and those recommendations implemented as a result of the INC assessment. A report on such measures shall be presented every three months to Medical Staff and Nursing Staff.

21. Upon the signing of this Consent Order, the Licensee shall pay a monetary penalty to the Department in the amount of seven thousand five hundred dollars ($7,500) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department. The money penalty and any reports required by this document shall be directed to:

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

22. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, 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.

23. 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.
24. 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.
25. 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.
26. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
27. 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 November 20, 2014 violation letter referenced in this Consent Order.
28. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.
29. The Licensee agrees that this Consent Order does not limit any other agency or entity in any manner including but not limited to any actions taken in response to the factual basis of this Consent Order.

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.

Donna Kelsey

Donna Kelsey, LLC, Manager

On this 13th day of April, 2015, before me, personally appeared Donna Kelsey who acknowledged herself to be the Manager of Brook Hollow Health Care Center, LLC of Wallingford and that she, as such Manager being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by herself as the Manager.

My Commission Expires April 30, 2019

My Commission Expires: _____
(If Notary Public)

Notary Public
Commissioner of the Superior Court [X]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

April 16, 2015

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A

November 20, 2014

Ms. Kimberly Coleman, Administrator
Village Green Of Wallingford Rehab & Health Center
55 Kondracki Lane
Wallingford, CT 06492

Dear Ms. Coleman:

Unannounced visits were made to Village Green Of Wallingford Rehabilitation & Health Center concluding on October 30, 2014 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a licensure inspection.

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

An office conference has been scheduled for **December 4, 2014** at **11:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish 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 **December 3, 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 violations to be presented at this conference. Each violation must be addressed with a prospective Plan of Correction which includes the following components:

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

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,

Cher Michaud RN BSN

Cher Michaud, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM/LMLjpf

Complaint #17190, #16263, #16404, #16950 and #16396

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: October 27, 28, 29 and 30, 2014

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 (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (l).

1. Based on review of the clinical record, review of facility documentation, observation, and interview for two of two residents reviewed for weight loss (Residents #50 and 140), the facility failed to notify the physician and/or dietician of weight changes and/or for one of four residents reviewed for medication administration (Resident #129), the facility failed to notify the physician in a timely manner when a medication was unavailable. The findings included:
    a. Resident #50's diagnoses included hip fracture, hypertension, and generalized muscle weakness. Annual minimum date set assessment (MDS) dated 09/19/14 identified the resident with severely impaired cognition and no mood indicators or behaviors, required extensive assistance with all activities of daily living except being independent with set-up for eating, was frequently incontinent of bladder and bowel, weighed 123 pounds, had no weight loss or gain, and had no dental issues.
    Care plan dated 09/26/14 identified potential for oral/dental health problems related to dentures. Interventions included to maintain diet consistency and monitor/document/report oral/dental problems. A care plan identified potential suboptimal intake with interventions to monitor weights, labs, and food intake and diet as prescribed. A care plan for diuretic therapy related to edema was noted with interventions including administering meds as ordered, weights, and labs as ordered.
    Review of Weights and Vitals Summary for April, 2014 through October, 2014 identified the following weights: 4/27/14, 135 pounds, 5/27/14, 125.5 pounds, 6/27/14, 123.6 pounds, 7/27/14, 125 pounds, 8/27/14, 124.6 pounds, 9/27/14, 122.3 pounds, 10/24/14, 116.8 pounds, an 18.2 pound (13.5%) weight loss in 6 months.
    Review of nursing assistant flowsheets for September and October 2014 identified that the flowsheets only noted initials and time of documentation. An additional screen noted the percentage eaten. The documentation failed to reflect the amount eaten for 55/90 meals in September and 57/90 meals in October.

    In an interview on 10/29/14 at 10:25am, the dietician identified that she was not aware of current dietary issues with Resident #50, but would check to see what her recommended interventions were for the weight changes. After investigating, the dietician noted that weight loss was over a six month period, the resident was on daily weights due to diuretic therapy, the resident remained within ideal body weight (IBW) range, and that, when asked, unit charge nurse noted Resident #50's recent edema was resolved, s/he eats well at breakfast and feeds self with set-up. The Dietician noted that she was not made aware of the weight decline from 09/01/14-10/27/14 (126 pounds to 119 pounds).

    Interview with Medical Director (MD #1), APRN #2, and charge nurse on 10/29/14 at 12:30pm identified that, in the event of a weight loss, the physician and dietician should be notified. The charge nurse identified that for residents on daily weights a three or

more pound change should be reported. The APRN noted that she was not informed of any recent weight change by nurses or dietician and that she last saw the resident in June 2014.

The facility failed to ensure the physician was notified of Resident #50's weight loss.

b. Resident #129's diagnoses included depressive disorder, cognitive communication deficit and senile dementia.

A quarterly assessment dated 10/16/14 identified the resident as moderately impaired for decision-making skills, was independent for most activities of daily living while requiring supervision of staff for some, and received antidepressant medications.

The RCP updated on 10/21/14 identified a focus for antidepressant medications. Interventions included giving antidepressant medications as ordered by the physician and monitor and document side effects and effectiveness of medication.

On 10/27/14 at 9:45 AM during an observation of a medication administration pass for Resident #129 with charge nurse (LPN #3) it was noted that the resident's medication Celexa 10mg was not available. The nurse searched for the medication throughout her medication cart as well as the med room and it was identified that the medication was unavailable.

A review of the clinical record identified a physician's order dated 10/22/14 directing Celexa 10mg po once a day at 9:00 AM.

On 10/27/14 at 10:00 AM an interview with the RN Supervisor (RN #4) identified that she had contacted the pharmacy to inquire why the medication which was ordered on 10/22/14 was not available and the pharmacy informed RN #4 that on 10/25/14 they contacted the facility requesting an authorization from the resident's physician in order to fill the prescription for Celexa due to a possible adverse reaction in association with the resident's other medications. Upon further review of the clinical record with RN #4 it was noted that documentation was lacking to reflect that physician was notified regarding the pharmacy's concerns.

On 10/29/14 at 2:45 PM an interview and review of the clinical record with LPN #10 identified that although he/she had received the call from the pharmacy on 10/25/14, LPN #10 delegated the task of notifying the physician to the relief nurse (RN #6) on the 3 PM-11 PM shift being that the call came in close to the end of his/her shift (7 AM-3 PM) and he/she was preparing to leave.

On 10/29/14 at 7:04 PM an interview and review of the clinical record with RN #6 regarding the delegated task of notifying the physician for LPN #10 indicated that he/she wasn't aware of the situation concerning the resident's medication and/or of LPN #10's expectations for him/her to follow up with the physician concerning the matter.

On 10/20/14 at 9:10 AM an interview and review of the clinical record with the DON indicated the expectation would have been to follow the facility's policy regarding an unavailable medication.

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

According to the facility medication non-availability policy and procedure identified in part, that when a medication is not available the emergency supply of medications will be checked for the drug. If the medication is not part of the emergency supply the physician will be notified that the medication is not available. If the physician does not direct a substation of the medication the nurse is to request an order to hold the medication until it is available.

c. Resident #140's diagnoses included dementia with behavioral disturbances, dysphagia oral phase, depressive disorder, gastro-esophageal reflux disease, and epilepsy.
Quarterly minimum data set assessment (MDS) dated 08/29/14 identified the resident with moderate cognitive impairment, without mood indicators or behaviors, required extensive assistance with all activities of daily living except supervision for eating, was always incontinent of bladder, was frequently incontinent of bowel, had no swallowing disorder, weighed 159, and had a weight gain.
Care plan dated 03/12/14 identified difficulty with swallowing resulting in coughing during meals at times, with interventions to follow diet as prescribed, instruct to eat in upright position, eat slowly, and chew each bite thoroughly. A care plan was in place for altered nutrition related to anemia, chronic kidney disease, hydration status, with interventions including medications as ordered, monitor weight daily, monitor labs, and diet as prescribed.
Admission nutrition assessment dated 01/02/14 identified Resident #140 with a weight of 144 pounds and a BMI of 28.2. It further identified the resident, as overweight, on a low sodium, mechanical soft diet, eats 51-75% of meals, feeds self, and had chewing difficulty.
Quarterly nutrition assessment dated 03/21/14 identified a weight of 145.8 with recommendations to weigh daily related to fluid shifts.
Quarterly nutrition assessment dated 08/25/14 identified a weight of 159 and identified the resident with a BMI of 31.1 and as obese. It further identified the resident with a meal intake 75-100%, no swallowing difficulty, an unintended weight gain related to excessive caloric intake as evidenced by a 10% weight gain in 6 months.

Review of Weights and Vitals Summary for September, 2014 through October, 2014 identified the following weights: 9/26/14, 163 pounds, 10/17/14, 158 pounds, and 10/25/14, 154 pounds, a 9 pound weight loss (5.5% decline in weight).
Review of nursing assistant flowsheets for September and October 2014 identified that the flowsheets only noted initials and time of documentation. No documentation was noted for the amount eaten for 37/90 meals in September and 25/90 meals in October.
In interview on 10/29/14 at 10:25am, the dietician identified that she was not aware of current dietary issues with Resident #140, but she had not been notified of the recent 5.5% weight change.
Review of the clinical record failed to reflect that the physician or advanced practice registered nurse (APRN) were notified of the 5.5% weight decline.

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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 (f) Administrator (3)(D) and/or (j) Director of Nurses (2).

2. Based on observations, review of facility documentation, and clinical record review for 2 of 3 sampled residents (Resident #204 and 250) who were reviewed for grievances, the Director of Nurses failed to adequately investigate and/or resolve resident grievances. The findings include:
   a. Resident #204 was admitted to the facility on 12/1/13 with diagnoses that included end stage renal disease and diabetes. The MDS dated 12/8/13 identified the resident had intact cognition (BIMS 15) and required extensive assistance with care. A Resident/Family Contact Form dated 12/19/13 identified the resident stated that he/she had been getting medications late. Additionally, the resident complained that he/she did not get a meal tray twice. DNS #2 documented that he/she explained to Resident #204 about the medication pass, including that medications can be given one hour before and one hour after the actual time the medication is ordered. The DNS documented that dietary addressed the dietary concerns, however, it was not documented how and/or if the resident did miss two meals. DNS #2 documented that medications were given within Federal Guidelines and that staffing was adequate as the outcome.
   Physician's orders dated 12/1/13 directed to administer Renagel Tablet 800 MG 3 tablets (2400 mg) three times daily before meals. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Renagel late, after breakfast, for 23 doses on 12/2, 12/4, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18 and 12/19/13. The report documented the resident missed the breakfast dose on 12/12, 12/14 and 12/19/13 and the lunch dose on 12/6 and 12/17/13.
   Physician's orders dated 12/1/13 directed to administer Humulin N Insulin suspension 100 unit/ML inject 30 units subcutaneous daily before breakfast. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Humulin N Insulin late, after the meal, for 9 doses on 12/4, 12/7, 12/8, 12/9, 12/12, 12/13, 12/14, 12/15, and 12/17/13.
   Review of the physician's orders dated 12/1/13 directed to monitor finger sticks before every meal and at bedtime. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the finger sticks were checked late, after the meal, 20 times on 12/4 Breakfast & Lunch (B & L), 12/7 (B & L), 12/8 (B & L), 12/9 (B & L), 12/12 (B), 12/13 (B & L), 12/14 (B), 12/15 (B & L), 12/16 (L), 12/17 (B & L), 12/18 (B & L), and 12/19/13 (L).
   Interview with the Administrator on 10/30/14 at 1:45 PM identified that there is no additional information on how DNS #2 came to the conclusion that the medications were administered according to the Federal Guidelines. The Administrator stated that

he/she was unaware that medications and/or treatments were being given late and/or omitted. Additionally, the facility failed to provide a greivance policy.

b. Resident #250's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). Physician's order dated 1/1/14 directed that DuoNeb Solution 0.5-2.5 (3) ML/3ML (Ipratropium-Albuterol) 1 vial inhale orally four times a day for COPD at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A Resident/Family Contact Form dated 1/14/14 identified that the resident alleged that he/she was afraid that he/she had not received medications on 1/13/14 and that the supervisor was not as attentive as he/she could have been. DNS#2, who completed the investigation, documented the plan to address the issue was that the resident had an order to self-administer the nebulizer treatment after the nurse sets it up. The outcome/resolution documented was that the medication for nebulizer was to be done by the resident as this will help for when he/she goes home as his/her spouse is now working. Review of the January 2014 Medication Administration Audit Report identified that the resident did not receive the 5:00 PM dose of DuoNeb on 1/13/14 as per the physician's order. The report documented that the 5:00 PM and 9:00 PM dose were both administered at 2155 (9:55PM). Interview with the Administrator on 10/30/14 at 1:45 PM identified that DNS#2 no longer works for the facility and there is no additional documentation related to the grievance.

The facility failed to ensure that the greivances were adequately investigated or resolved.

The following are violations of the Connecticut General Statutes Section 19a-550 and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2).

3. Based on observation, clinical record review, review of facility documentation, and interview, for one resident reviewed for abuse (Resident #82), the facility failed to ensure that the resident was free from verbal abuse. The findings include:

   a. Resident 82's diagnoses included chronic respiratory failure, depression, and anxiety. A quarterly assessment dated 9/26/14 identified that the resident had no cognitive difficulties and was independent with activities of daily living (ADL). The resident care plan (RCP) dated 10/9/14 identified a problem with psychological well-being due to depression and anxiety. Interventions included providing support and assessing mood. During tour of facility on 10/28/14 at 7:47 AM NA#8 was observed speaking in a scolding manner to Resident #82. NA#8 verbalized to Resident #82 " that bed is not a drying rack " and " now it needs to be changed ". Resident #82 replied "it's not dirty" and NA #8 replied "yes it is and now needs to be made over." As NA #8 proceeded out of Resident #82's bedroom and past LPN#10 she spoke to LPN #10 who replied in a loud manner "yeah I'd like to slap her." Additionally noted, Resident #82's bedroom door was open as well as all other adjacent resident's bedroom doors as well as a resident seated in a wheelchair in the hallway.

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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

During an interview with Resident #82 on 10/28/14 at 8:53 AM he/she identified that LPN#10 and NA#8 "make me feel like I am a piece of dirt" and just this morning Resident #82 felt like he/she was being put down.

During an interview and review of facility accident incident documentation with the Director of Nursing on 10/29/14 at 11:08 AM she indicated that although LPN #10 acknowledged stating " Yeah I'd like to slap her " she could not explain the reason for the comment.

The facility failed to ensure the resident was free from verbal abuse.

The following are violations of the Connecticut General Statutes Section 19a-550 and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2).

4. Based on review of the clinical record and staff interviews for 2 sampled residents (Resident #64 and 201) the facility failed to ensure care and services were provided to ensure the residents were free from neglect. The findings include:
    a. Resident #64 was admitted to the facility on 11/26/13 with diagnoses that included dysphagia, irritable bowel syndrome, and diverticulitis of the colon. The admission MDS dated 12/3/13 identified the resident had intact cognition, required extensive assistance with care, and required a feeding tube. The care plan failed to identify the feeding tube and/or interventions to maintain it. Physician's orders dated 12/1/13 directed Bacitracin-Polymyxin B Ointment be applied to the Gastrostomy (G) tube site topically every day (7-3 shift). Review of the Medication Administration Audit Report identified that staff failed to document that the Bacitracin-Polymyxin B Ointment was applied ten times between 12/1/13 - 12/17/13 (17 days) on 12/2, 12/4, 12/6, 12/10, 12/11, 12/12, 12/13, 12/14, 12/16 or 12/17/13.
    Nurse's note dated 12/17/13 at 11:00 AM identified the G-tube site was red with purulent drainage, was painful to touch, and after APRN evaluation the resident was sent to the hospital for evaluation. The hospital discharge summary dated 12/24/13 identified the resident was admitted to the hospital on 12/17/13 with abdominal pain at the G-tube site and positive blood cultures. Diagnoses identified on the discharge summary dated 12/24/13 identified bacteremia and line sepsis. Interview with RN#3 on 10/29/13 at 1:00 PM identified that late in 2013 the corporation cut the nurse staffing on the star/step down unit from two nurses to one. At that time, it was so busy that staff couldn't get to all the treatments. The treatment to the resident's G-tube site was not done consistently because the nurses did not have enough time. The resident was later hospitalized with sepsis. RN #3 further identified that although DNS#2 was made aware of the staffing issues and that treatments were not being done, no help or assistance was provided to the nurses on the unit. RN#3 stated he/she resigned from the facility due to the unsafe conditions. Interview with LPN #4 on 10/29/14 at 3:21 PM identified that when the

staffing was cut on the star/step down unit it took almost 8 hours just to get the medications passed. LPN #4 stated that although he/she did make DNS#2 aware, no help was provided. LPN #4 stated that it could not be done with one nurse. Interview with the Administrator on 10/30/14 at 1:45 PM identified that he/she was aware that the nurse staffing had been cut on the star/step-down unit at that time in late 2013, however, he/she was unaware that nurses were unable to complete their work, including the G-tube treatment for Resident #64. Interview with LPN#3 on 10/29/14 at 3:35PM identified that when staffing was cut from two nurses to one on the star/step down unit, it made it impossible for all the work to get done. The facility failed to ensure that Resident #64 received treatments as ordered.

b. Resident #201 was admitted to the facility on 10/30/13 with diagnoses that included intractable progressive pain and pain in the right leg with foot drop related to severe for aminal stenosis at L5-S1, concomitant severe degeneration, spinal fusion, Autonomic Dysreflexia, and myoclonus. The MDS dated 11/6/13 identified the resident had intact cognition (BIMS 15), required assistance for bed mobility, transfers, toilet use and bathing, and had pain almost constantly that has limited day-to-day activities with a numeric rating of 9. The care plan dated 11/19/13 identified the resident had chronic pain related to disease process, arthritis and spinal stenosis. Interventions included that the resident preferred to have pain controlled by medication and for staff to respond immediately to complaints of pain. Physician's orders dated 12/1/13 directed to administer Oxycontin ER 10mg every 8 hours for chronic pain.

Review of the December 2013 Medication Administration Record (MAR) directed that the Oxycontin ER be administered daily at 12:00 AM, 8:00 AM and 4:00 PM.

i. Review of the Medication Administration Audit Report for the month of December 2013 identified the Oxycontin ER was administered late on the following shifts; 12/1/13 8:00 AM dose administered at 10:12 AM, 2 hour 12 minutes late, 12/3/13 8:00 AM dose administered at 11:04 AM, 3 hour 4 minutes late, 12/4/13 8:00 AM dose administered at 3:15 PM, 7 hour 15 minutes late, 12/7/13 8:00 AM dose administered at 10:56 AM, 2 hours 56 minutes late. 12/8/13 8:00 AM dose administered at 10:26 AM, 2 hour 26 minutes late. 12/9/13 8:00 AM dose administered at 12:28 PM, 4 hours 28 minutes late. 12/11/13 8:00 AM dose administered at 1:28 AM, 5 hours 28 minutes late. 12/16/13 8:00 AM dose administered at 10:22 AM, 2 hour 22 minutes late. 12/18/13 8:00 AM dose administered at 10:20 AM, 2 hour 20 minutes late.

ii. The December MAR, indicated that on 12/3/13 at 8:00 AM, 12/3/13 at 4:00 PM, 12/4/13 at 12:00 AM and 12/4/13 at 8:00 AM the resident did not receive the scheduled Oxycontin ER 10mg. Review of the progress notes identified that on 12/3/13 at 11:04 AM, 12/3/13 at 4:54 PM, 12/4/13 at 12:58 AM and 12/4/13 at 3:15 PM the Oxycontin ER10mg was not available. The resident missed 4 doses of Oxycontin ER 10mg. Interview with the DNS on 10/30/14 at 2:00 PM and review of the narcotic sign out reports identified the facility could not provide documentation of that Oxycontin ER 10mg was administered to the resident on

the above shifts/dates.

Review of the December 2013 MAR identified that staff documented a check mark every shift which indicated that pain was monitored, however, no pain scale and/or pain assessment and/or location of pain was documented in the record. The resident received Oxycodone 10mg for breakthrough pain twice on 12/3/13 at 11:04 AM and 4:52 PM, twice on 12/4/13 at 12:57 AM and 11:43 AM, and once on 12/7/13 at 8:31 AM. Pain assessments were not documented.

Physician's orders dated 12/1/13 directed to administer Flexeril 10mg two times daily. Review of the December 2013 MAR directed that the Flexeril be administered daily at 9:00AM and 1:00PM.

iii. Review of the Medication Administration Audit Report for the month of December 2013 identified Flexeril was administered late and/or omitted on the following shifts; 12/4/13 9:00AM dose administered at 11:40AM, 2 hour 40 minutes late, 12/9/13 9:00AM dose administered at 12:28PM, 3 hours 28 minutes late, 12/11/13 9:00AM was omitted, however, was documented as administered at 1:28PM, the same time the 1:00PM dose was documented as administered.

Review of the clinical record identified that on 12/11/13 the resident received the 8:00 AM dose of Oxycontin ER 10mg at 1:28 PM, 5 hours and 28 minutes late and missed the 9:00 AM dose of Flexeril 10mg. Review of a physician's consult dated 12/11/13 the physician documented the resident presented with seizure like activity. Physical examination identified the resident had acute generalized spasticity. Assessment documented the resident was unable to take anything by mouth due to the activity level so Ativan 1mg IM was administered. Review of physician's order dated 12/11/13 directed to administer Ativan 1mg IM now.

Interview with Person #3 on 11/3/14 at 1:50 PM identified that because of the resident's diagnosis of AD and recent back surgery, he/she required medications on a strict regimen to control the pain and reduce the chance for a AD flare up. In December 2013, after the staffing cuts, the medications were administered by staff later and later and it became a daily issue of getting medications late. Person #3 stated that he/she had spoken to DNS#2 and the nursing staff at length about the necessity of the medications being on time and DNS#2 was made aware of the seriousness of Resident #201 getting medications on time. Additionally, Person #3 stated that he/she made DNS#2 aware more than 5 times that the resident had received medications late. On December 11, 2013 the Resident called Person #3 from the facility sometime after noon and asked him/her to come in as he/she had not received any medications and was starting to go into a AD flare up. Person #3 stated that he/she went to the facility and the resident began to spasm, had a hard time breathing and looked like he/she was in

a stuper. After staff administered the shot of Ativan the spasms subsided.

Interview with RN #3 on 10/29/13 at 1:00 PM identified that late in 2013 the corporation cut the nurse staffing on the star/step down unit from two nurses to one. RN #3 stated that the last day he/she worked at the facility 12/6/13 it took between 7:30 AM - 3:00 PM just to get the medications passed out and that didn't include treatments. RN #3 stated it was not safe so he/she resigned and has not worked at the facility since. Additionally, although the DNS #2 was made aware of the staffing issues and that treatments were not being done and/or medications were being administered late, no help or assistance was provided to the nurses on the unit.
Interview with LPN #4 on 10/29/14 at 3:21 PM identified that when the staffing was cut on the star/step down unit it took almost 8 hours just to get the medications passed. LPN #4 stated that although he/she did make DNS #2 aware, no help was provided. LPN #4 stated that it could not be done with one nurse.
Interview with LPN #3 on 10/29/14 at 3:35 PM identified that when the staffing was cut on the star/step-down unit late in 2013, it was impossible to finish all that needed to be finished. LPN #3 stated that DNS #2 and the supervisors were aware and did nothing to help. LPN #3 stated that it was extremely difficult to give appropriate care.
Interview with LPN #5 on 10/30/14 at 10:00 AM identified that when staffing was cut in late 2013, it was too much and medications were given late. LPN #5 stated that he/she was aware that Resident #201 needed her medications on time because of his/her spasms and would cry and complain that he/she wasn't getting them on time. LPN #5 stated that the supervisors were aware of the problems.
Interview with the Administrator on 10/30/14 at 1:45 PM identified that he/she was aware that the nurse staffing had been cut on the star/stepdown unit at that time in late 2013, however, he/she was unaware that nurses were unable to complete their work.

The facility failed to ensure that Resident #201 received his/her medications as ordered resulting in the need for a dose of IM medication.

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

5. Based on clinical record review, interviews, review of facility documentation and, review of facility Abuse Policy for 1 of 6 sampled residents review for allegation of abuse (Resident #32) the facility failed report an allegation of abuse in a timely manner as stated in facility Abuse policy and procedures. The findings included:
    a. Resident #32 diagnoses included in part depression. Quarterly assessment dated 7/5/14 identified the resident was cognitively intact with decisions of daily living (BIMS score

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

13), required minimal/limited assistance with activities of daily living and had no behaviors documented.
Care plan dated 7/25/14 and updated on 10/6/14 identified the problem of psychosocial well being related to a statement made to her by facility staff with an intervention that included to remove the resident to a calm environment when a conflict occurs to allow her to vent and share feelings.
Review of nursing narrative identified as a late entry dated 10/3/14 identified that the resident stated a nurse aide spoke to him/her in an inappropriate manner and made the middle finger gesture towards him/her after Resident #32 asked to use the phone.
Nursing note dated 10/6/14 identified the resident reported a nurse aide was verbally inappropriate toward him/her and also stuck their the middle finger up at him/her.

Review of facility documentation and investigation dated 10/6/14 identified that Nurse Aide (NA #11) told the resident he/she belonged in an insane asylum and stuck up her middle finger to the resident.
Interview with Resident #32 on 10/30/14 at 10/:20 AM identified that he/she asked to use the phone at the nursing station and NA# 11didn't want to assist him/her with a phone call and when she continued to ask the aide for assistance, Resident #32 stated the nurse aide gave him/her the middle finger. Resident #32 further stated that he/she was more angry than upset with the treatment. Resident #32 further identified that the charge nurse told him/her to tell the Administrator when it occurred.
Review of the facility documentation and investigation identified that the facility failed to inform the Administer of the allegation until 10/6/14 (three days later). Interview with RN#11 on 10/29/14 at 12:30 PM identified that when she came to work Monday, a written statement was tagged at the nursing desk, read it, and then she immediately told the Administrator of the issue. Further interview identified that she began the investigation and abuse policy and procedure for an allegation of abuse

Interview with the Administrator and review of the reportable event documentation dated 10/6/14 on 10/29/14 at 11 AM , identified that the licensed staff failed to report the allegation immediately to her and start the investigation in a timely manner, Although the facility was unable to substantiated the allegation because NA #11 denied the event, the facility failed to report and/or investigate the allegation in a timely manner as per facility Abuse Policy and Procedures. Further interview with the Administrator identified that all who failed to report the allegation were given written warnings.

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 (C).

6. Based on clinical record review, interviews, review of facility documentation and investigation, and review of Facility Resident Rights Policy for three of seven residents reviewed for allegations of abuse (Residents #32, 124, 175) the facility failed to treat the resident in a respectful and dignified manner and/or for one sample resident observed and reviewed at dining (Resident #52) the facility

failed to provide a dignified dining experience. The findings included:

a. Resident #32 diagnoses included in part depression. Quarterly assessment dated 7/5/14 identified the resident was cognitively intact with decisions of daily living (BIMS score 23), required minimal/limited assistance with activities of daily leaving and had no behaviors. Care plan dated 7/25/14 and updated on 10/6/14 identified the problem of psychosocial well being related to a statement made to her by facility staff with intervention that included to remove the resident to a calm environment when a conflict occurs to allow her to vent and share feelings.
Review of nursing narrative noted as a late entry dated 10/3/14 identified that the resident stated a nurse aide spoke to him/her in an inappropriate manner and made the middle finger gesture towards him/her after asking to use the phone. Nursing note dated 10/6/14 identified the resident reported a nurse aide was verbally inappropriate toward him/her and also stuck the middle finger up towards him/her.
Review of facility documentation and investigation dated 10/6/14 identified that Nurse aide (NA #9) told the resident he/she belonged in an insane asylum and stuck up her middle finger to the resident. An investigation was done and nurse aide was suspended pending an allegation of abuse.
Interview with Resident #32 on 10/30/14 at 10/:20 AM identified that he/she asked to use the phone at the nursing station and NA #9 didn't want to assist him/her with a phone call and when the resident continued to ask the aide for assistance Resident #32 stated the nurse aide gave him/her the middle finger. Resident #32 further stated that he/she was more angry than upset with the treatment. Resident #32 further identified that the charge nurse told him/her to tell the Administrator.

Interview with RN #11 on 10/29/14 at 12:30 PM identified that when she came to work Monday a written statement was tagged at the nursing desk and then she immediately told the Administrator of the issue. Further interview identified that she began the investigation and abuse policy and procedure for an allegation of abuse. Although a phone call was made to Nurse Aide #9 on 10/30/14, NA # 9 failed to return the phone call back to the surveyor.

Although the facility was unable to substantiate the allegation because NA# 9 denied the event, the facility failed to ensure staff treated Resident #38 in a respectful and dignified manner.

b. Resident #124's diagnoses included congestive heart failure, muscle weakness, dysphagia, and closed dislocation of patella. The interim admission care plan dated 5/25/14 identified that the resident's congestive heart failure and respiratory difficulty, skin impairment, psychosocial needs, short-term admission and advanced directives were addressed. However the care plan failed to reflect that the resident's activities of daily living had been addressed. The admission Minimum Data Set assessment dated 6/1/14 identified that Resident #124 had no cognitive deficits, required two-person extensive assistance with bed mobility, transfers, and ambulating and one-person assistance with toilet use and personal hygiene, was occasionally incontinent of urine

and a stage two pressure ulcer on the coccyx. The Reportable Event Form dated 6/4/14 identified Resident #124 had reported that a nurse aide told the resident to urinate in the incontinent brief and another nurse aide stated "that to move the resident would break her back". Review of Nurse Aide (NA) #1's interview dated 6/5/2014 identified that when Resident #124 utilized the bedpan on two separate occasions, urine spilled out. NA #1 asked the resident if he/she wanted to go to the bathroom and Resident #124 replied that his/her knees were bothering him/her. NA #1 indicated that she had told the resident to go in the incontinent brief and as soon as the resident was done she would change Resident #124. Interview with Resident #124 on 10/28/14 at 11:15AM identified that on 6/4/14 he/she was having difficulty utilizing the a small style bedpan and the staff could not locate a regular size bedpan. Resident #124 identified that he/she was told to urinate in the brief. Interview with NA #1 on 10/28/14 at 1:20PM identified that a regular bedpan was not available and Resident #124 was a heavy wetter therefore the urine would spill out. NA #1 did not know how to transfer Resident #124. NA #1 indicated that she told Resident #124 to go in the brief. When asked if she had reported this to the charge nurse and asked for assistance, NA #1 answered no. Review of the facility's investigation identified that NA #1 was provided education on customer service and removed from the resident's assignment.

c. Resident #175's diagnoses include generalized anxiety disorder, congestive heart failure and difficulty walking. The admission Minimum Data Set assessment dated 5/14/2014 identified that Resident #175 had no memory or cognitive deficits, required two-person extensive assistance with bed mobility, personal hygiene and toilet use and was incontinent of bowel and bladder. The resident care plan dated 5/9/14 identified the resident required assistance with activities of daily living related to impaired mobility. Interventions directed one-person assistance for daily maintaining of appearance. The Reportable Event Form dated 6/4/14 identified Resident #175 had reported that an 11-7 AM nurse aide called the resident a derogitory name while walking out of the room. Review of Nurse Aide (NA) #1's statement dated 6/5/14 identified that Resident #175 had become agitated with care and started to talking nasty to her. NA #1 indicated that she responded by saying "let me do my job." Interview with Resident #175 on 10/27/14 at 2:30PM identified that he/she recalled the incident and stated that the aide called him/her a derogitory name. Interview with Registered Nurse (RN) #2 on 10/28/14 at 11:50AM identified that on 6/4/14 the 7-3 PM nurse aide, who was caring for Resident #175, reported that the resident had alleged rough treatment by NA #1. RN #2 went in and spoke to Resident #175 who was upset relayed to her what was said and RN #2 immediately reported the incident. Review of the facility's investigation identified that NA #1 was provided education on customer service and removed from the resident's assignment. Review of facility policy states that all reports of abuse be reported and thoroughly investigated. The facility has a zero tolerance and mandatory reporting policy for resident abuse. The facility recognizes that all residents have the right to be free from verbal, sexual, physical, emotional and mental abuse, mistreatment, neglect and the misappropriation of property.

d. Resident #52's diagnoses included dysphasia due to cerebravascular disease. A quarterly

assessment date 9/19/2014 identified that the resident required extensive assistance with bed mobility, was totally dependent for transfers between surfaces (ie bed to chair), and required supervision and set up only with eating. The resident care (RCP) plan dated 10/14/14 identified a activity of daily living (ADL) deficit related to limited range of motion. Interventions included to encourage the resident to use the bell to call for assistance.

Observation of Resident #52 on 10/28/14 at 7:55 AM noted the resident in bed with the breakfast tray on the over-bed table positioned at the resident's chin level. The head of bed position was at 40 degrees and the bed was in high position (off the floor). The breakfast tray was positioned at arms length from the resident and Resident #52 was observed with his/her finger tips in the coffee in an attempt to pick up the cup to consume. Further observation with the assistant director present noted food debris and liquid stain across the resident's chest and bed.

Subsequent to surveyor inquiry staff lowered the resident's bed and repositioned and raised the resident's head of bed. The staff further lowered the over-bed table and breakfast tray. The resident was observed drinking his /her coffee. Interview with the assistant director on 10/28/14 at 8:12 AM identified that the resident was positioned improperly.

An additional observation of Resident #52 on 10/29/14 at 5:20 PM with LPN# 9 identified the resident alone in his/her room seated in his/her electric custom wheel chair in a reclined position. The foot rests were positioned extended out to each side of the chair and the resident's legs were dangling without support. The over-bed table was positioned at the front of the wheel chair. The dinner tray was on the table with the plate of food uncovered. Interview with NA #4 and NA #5 on 10/29/14 at 5:45 PM identified that they were unable to position the resident properly because the wheel chair battery was depleted. Subsequent to surveyor inquiry LPN #9 directed staff to reposition the foot rest to support the resident's lower extremities.

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

7. Based on review of the resident council minutes and staff interview, the facility failed to respond and/or act upon resident grievances. The findings include:
    a. Review of the resident council minutes for 2/14-9/14 identified nursing concerns including requests for more staff, understaffed units, CNAs calling out, requests for consistent staff, concerns regarding needy residents who take time away from others and long wait times. Review of the minutes failed to reflect a response to the resident's concerns prior to the 7/28/14 and 8/26/14 meetings.
    Interview and review of the minutes with the recreation therapist on 10/30/14 at 10:30 AM indicated the procedure for resident council concerns and/or grievances is that after

the meeting the recreation therapist sends a form indicating the concern to the appropriate department for review and response. The therapist further indicated the previous DNS (DNS #2) did not respond to resident council concerns.

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

8. Based on observations, review of facility policy and procedures, review of facility documentation, and interviews for a review of the environment, the facility failed to ensure that the residents' rooms were maintained in good condition and/or failed to maintain a clean and/or sanitary environment and/or failed maintain and/or properly store medical equipment in a clean and/or sanitary manner. The findings include:
    a. During tour, observations of the Claremont nursing unit with the RN Supervisor (RN#7) on 10/27/14 at 9:29 A.M. the following concerns were identified:
        i. The wallpaper in room 229 near bed #2 was ripped near the heater and at the head of the bed. It was further noted that the wall paper and molding along the base of the wall near the heater was dettached and/or separated from the structure of the wall.
        ii. The floor in room 228 near bed #1 was soiled with black stains and smudge marks and food. It was further noted that the wallpaper above the heater near bed #2 was ripped.
        iii. A tube-feeding pole in room 234 was identified as being stained and/or dirty with thick dried on splatter of matter all along the pole including the base of the pole. Upon further observation of the room it was noted that in the bathroom an opague plastic bag was taped to the wall with garbage inside without the benefit of it being in a receptacle.
        iv. Observation of room 236 identified that the radiator in the bathroom was missing its cover and the internal parts which were rusted were in plain view.
        v. An observation of the soiled utility room with RN #7 identified several items that were packed and/or scattered in disarray throughout the room and counter tops such as 4-empty card board boxes that once stored dialysate solutions were left scattered on the floor, a wheelchair with attachments blocked the doorway upon entry into the room, a large black rubber floor mat soiled with granules of sand, dirt, and debris was left on the counter top near the sink, a bedside floor matt and/or cushion that was impinged between the large empty grey utility bin and the cabinet doors of the counter was soiled with black smudge marks, the grey utility bin itself was noted as having dirt and debris adhering to its bottom, soiled with black smudge marks and between a large gray empty utility bin and the cabinet doors near a sink making it difficult to utilize the room, a commode was

also left in the middle of the room in front the sink and the floor of the utility room was soiled and/or stained with black smudge marks and dirt.
On 10/27/14 at 10:05 A.M. an interview with RN#7 indicated that he/she did recognize the uncleanliness of the unit and that he/she would prefer to direct the matter over to the Housekeeping Supervisor.
On 10/27/14 at 10:10 A.M. an interview with the Housekeeping Supervisor indicated that although he/she could not attest for the reason of the cluttered soiled utility room and/or the soiled environment in rooms 228, and 234 subsequent to surveyor's observation and inquiry, the housekeeping staff were observed on the unit cleaning and removing items from the soiled utility room, obtaining a trash receptacle for room 234 and removing the soiled tube-feeding equipment and replacing it with a clean one.

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

9. Based on review of the clinical record, review of facility documentation, and interviews for one of two sampled resident reviewed for behaviors (Resident #143) and/or for one resident reviewed for pain (Resident #201), the facility failed to develop a comprehensive plan of care to address the resident's needs. The findings include:
    a. Resident #143 was re-admitted to the facility on 9/14/14 with diagnoses that included dementia without behavioral disturbance, acute kidney failure, generalized muscle weakness, dysphagia, and a personal history of falls. Review of psych notes dated 9/17/14 identified a chief complaint of resident being combative with care with a plan to start Trazadone 25 mg every 4 hours, as needed, and may give prior to care.
    An admission assessment dated 9/21/14 identified the resident as severely cognitively impaired without behaviors, requiring extensive to total assistance from staff for some ADL's and requiring staff supervision for locomotion on the unit while utilizing a wheelchair.

    A review of the clinical record identified that during the period of 9/14/14 to 9/21/14 the resident was identified as exhibiting intermittent behaviors of combativeness, wandering, being resistive to care, yelling loudly and/or threatening staff and utilizing inappropriate language during care, episodes of confusion, agitation, insomnia and making attempts at ambulating independently resulting in falls without injuries.

    A psych noted dated 9/17/14 identified that the resident was seen by a Physician Assistant and Trazodone 25mg (milligrams) was order every four hours as needed.

    Upon further review of the clinical record although it was noted that during the period of 9/17 to 9/19/14 the resident continued to exhibit increased behaviors (i.e. agitation,

wandering into other residents' rooms and insomnia) and the resident was monitored by staff for safety and/or given Trazodone with fair to no effect at times, documentation was lacking to reflect that the facility developed a formalized plan of care with interventions to address the resident's behaviors and/or needs.

Review of facility documentation identified that on 9/22/14 Resident #143 was identified by staff (NA #9) at 12:30 A.M., in another resident's room (Resident #158) touching the resident in an inappropriate manner. Following the incident a plan of care addressing behaviors was developed.
On 10/30/14 at 9:10 A.M. an interview and review of the clinical record and facility documentation with the DON indicated that although nursing notes reflect that the resident was being frequently monitored for safety during the period of 9/14/14 to 9/21/14 into 9/22/14, documentation was lacking to reflect how the staff were monitoring the resident for safety and/or his/her whereabouts and/or that a plan of care was developed in a timely manner to address the resident's behaviors. The plan of care for behaviors with interventions was initiated on 9/25/14.
Subsequent to the event of 9/22/14 Resident #143 was transferred to an acute care facility for an evaluation. Upon return to the facility Resident #143 was placed on one to one monitoring, transferred to another unit and was followed by psych on 9/25/14.

b. Resident #201 was admitted to the facility on 10/30/13 with diagnoses that included recent spinal fusion, intractable progressive pain, concomitant severe degeneration and Autonomic Dysreflexia (AD). The MDS dated 11/6/13 identified the resident had intact cognition (BIMS 15), required assistance for bed mobility, transfers, toilet use and bathing, and had pain almost constantly that has limited day-to-day activities with a numeric rating of 9. The care plan dated 11/19/13 identified the resident had chronic pain related to disease process, arthritis, and spinal stenosis. Interventions included that the resident preferred to have pain controlled by medication and for staff to respond immediately to complaints of pain. Physician's orders dated 12/1/13 directed to administer Oxycontin ER 10mg every 8 hours for chronic pain, Flexeril 10mg twice daily at 9:00 AM and 1:00 PM and Lopressor 100mg daily at 9:00 AM. Review of the clinical record between 12/1/13 through 12/20/13 identified the medications were administered late 9 times.
Review of the clinical record identified that on 12/11/13 the resident received the 8:00 AM dose of Oxycontin ER 10mg at 1:28 PM, 5 hours and 28 minutes late, the 9:00 AM dose of Lopressor 100mg at 1:38 PM, 4 hours and 28 minutes late and the 9:00 AM dose of Flexeril 10mg was omitted. Nurse's note dated 10:54 AM reflected the resident had no complaints of pain or discomfort. Review of a physician's consult dated 12/11/13 identified the resident presented with seizure like activity. Physical examination identified the resident had acute generalized spasticity. The assessment identified the resident was unable to take anything by mouth due to the activity level and Ativan 1mg IM was administered. Review of physician's order dated 12/11/13 directed to administer Ativan 1mg IM now. The clinical record reflected the resident received 1mg IM Ativan.
The care plan failed to identify the resident's diagnosis of AD and/or interventions to

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

address the AD and/or its complications.

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

10. Based on clinical record reviews, review of facility documentation and interviews for one of two sampled residents (Resident #202) who were reviewed for care plan participation, the facility failed to ensure that the care plan was reviewed and/or revised quarterly by the interdisciplinary team and/or participation by the resident or responsible party. The findings include:
    a. Resident #202's diagnoses included end stage renal disease with hemodialysis, schizophrenia, hypertension, pulmonary congestion, and anemia. Review of the Resident Care Conference signature record and care plan from 3/27/13 through present 10/31/14 failed to reflect documentation that the interdisciplinary team reviewed and/or revised the care plan on a quarterly basis and/or as needed. Interview and review of the clinical record with the Minimum Data Set (MDS) Coordinator on 10/29/14 at 2:00 PM identified the clinical record failed to reflect that interdisciplinary care plan meetings were conducted after 6/27/13. Interview with Person #2 on 10/31/4 at 10:00 AM identified that Resident #202's responsible party was not contacted to attend the care plan meetings.

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).

11. Based on observations, review of the clinical record, and staff interviews for five residents (Residents #64, #129, #201, #204, and #250) who reviewed for gastrostomy feeding and/or medication administration and/or pain management, the facility failed to provide care and services according to professional standards. The findings include:
    a. Resident #64 was admitted to the facility on 11/26/13 with diagnoses that included dysphagia, irritable bowel syndrome, and diverticulitis of the colon. The admission MDS dated 12/3/13 identified the resident had intact cognition, required extensive assistance with care, and required a feeding tube. The care plan failed to identify the feeding tube and/or interventions to maintain it. Physician's orders dated 12/1/13 directed Bacitracin-Polymyxin B Ointment be applied to the Gastrostomy (G) tube site topically every day (7-3 shift)
        i. The order failed to direct that the area be cleansed prior to the application of the Bacitracin-Polymyxin B Ointment.
        ii. Review of the Medication Administration Audit Report identified that staff failed to document that the Bacitracin-Polymyxin B Ointment was applied ten times between 12/1/13 - 12/17/13 (17 days) on 12/2, 12/4, 12/6, 12/10, 12/11, 12/12, 12/13, 12/14, 12/16 or 12/17/13.
        Nurse's note dated 12/17/13 at 11:00 AM identified the G-tube site was red with

purulent drainage, was painful to touch, and after APRN evaluation the resident was sent to the hospital for evaluation. The hospital discharge summary dated 12/24/13 identified the resident was admitted to the hospital on 12/17/13 with abdominal pain at the G-tube site and positive blood cultures. Diagnoses identified on the discharge summary dated 12/24/13 identified bacteremia and line sepsis. Interview with RN#3 on 10/29/13 at 1:00 PM identified that late in 2013 the corporation cut the nurse staffing on the star/step down unit from two nurses to one. At that time, it was so busy that staff couldn't get to all the treatments. The treatment to the residents G-tube site was not done consistently because the nurses did not have enough time. The resident was later hospitalized with sepsis. RN #3 further stated that although DNS#2 was made aware of the staffing issues and that treatments were not being done, no help or assistance was provided to the nurses on the unit. RN#3 stated he/she resigned from the facility due to the unsafe conditions. Interview with LPN#4 on 10/29/14 at 3:21 PM identified that when the staffing was cut on the star/step down unit it took almost 8 hours just to get the medications passed. LPN#4 stated that although he/she did make DNS#2 aware, no help was provided. LPN #4 stated that it could not be done with one nurse. Interview with the Administrator on 10/30/14 at 1:45PM identified that he/she was aware that the nurse staffing had been cut on the star/stepdown unit at that time in late 2013, however, he/she was unaware that nurses were unable to complete their work, including the G-tube treatment for Resident #64. The facility policy on enteral nutrition directs that staff caring for residents with feeding tubes will be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as leaking and skin breakdown around insertion site.

According to Lippincott Manual of Nursing Practice 9th Edition, Gastrostomy care, nursing action identified special care of the ostomy tube insertion site should include cleaning around the tube with prescribed cleansing solution every shift and as needed and applying a sterile 4" by 4" gauze pad. When the gastrostomy tube insertion site is well healed, surrounding skin can be cleaned with soap and water and application of a gauze dressing as needed. Leakage around the tube or signs of peristomal skin irritation should be reported.

The facility failed to ensure the resident received care to the g-tube site as needed.

b. Resident #129's diagnoses included depressive disorder, cognitive communication deficit, and senile dementia. A quarterly assessment dated 10/16/14 identified the resident as moderately impaired for decision-making skills, independent for most activities of daily living while requiring supervision of staff for some, and received

antidepressant medications.
The RCP updated on 10/21/14 identified a focus for antidepressant medications. Interventions included giving antidepressant medications as ordered by the physician and monitor and document side effects and effectiveness of medication. A review of the clinical record identified a physician's order dated 10/22/14 directing Celexa 10mg po once a day at 9:00 AM.
On 10/27/14 at 9:45 AM during an observation of a medication administration pass for Resident #129 with charge nurse LPN #13 it was noted that the resident's medication Celexa 10mg was not available. The nurse searched for the medication throughout her medication cart as well as the med room and it was identified that the medication was unavailable.
On 10/27/14 at 10:30 AM an interview with the RN Supervisor (RN #4) identified that he/she had contacted the pharmacy to inquire why the medication which was ordered on 10/22/14 was not available on 10/27/14. The pharmacy informed the RN #4 that on 10/25/14 they contacted the facility requesting an authorization from the resident's physician in order to fill the prescription for Celexa due to a possible adverse reaction in association with the resident's other medications. The matter was directed to APRN#1 who gave approval on 10/27/14 at 11:00 A.M.
On 10/29/14 at 3:10 PM an interview with the pharmacy representative indicated that the facility was initially notified on Saturday (10/25/14) regarding the authorization and spoke with LPN#10 concerning the matter and that the approval for the Celexa was given by APRN#1 on Monday 10/27/14.
On 10/29/14 at 2:45 PM and 7:04 PM interview and review of the clinical record with LPN #10 indicated that although the pre-approval for utilizing the Celexa wasn't given until 10/27/14 and because the resident's personalized pill card for the Celexa had yet to be filled and was unavailable on 10/23, 10/24, 10/25 and 10/26 he/she borrowed the medication from another resident (R #75) and administered the Celexa 10mg to Resident #129 on the aforementioned dates.
On 10/30/14 at 9:10 A.M. an interview and review of the clinical record with the DON indicated that although the it is not the facility's policy to borrow medications, the expectation would have been for LPN#10 to follow the facility's policy concerning unavailable medications.
According to the facility medication non-availability policy and procedure identified in part, that when a medication is not available the emergency supply of medications will be checked for the drug. It the medication is not part of the emergency supply the physician will be notified that the medication is not available. If the physician does not direct a substation of the medication the nurse is to request an order to hold the medication until it is available.

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

c. Resident #201 was admitted to the facility on 10/30/13 with diagnoses that included intractable progressive pain and pain in the right leg with foot drop related to severe for aminal stenosis at L5-S1, concomitant severe degeneration, spinal fusion, Autonomic Dysreflexia (AD), and myoclonus. The MDS dated 11/6/13 identified the resident had intact cognition (BIMS 15), required assistance for bed mobility, transfers, toilet use, and bathing and had pain almost constantly that has limited day-to-day activities with a numeric rating of 9. The care plan dated 11/19/13 identified the resident had chronic pain related to disease process, arthritis, and spinal stenosis. Interventions included that the resident preferred to have pain controlled by medication and for staff to respond immediately to complaints of pain. Physician's orders dated 12/1/13 directed to administer Oxycontin ER 10mg every 8 hours for chronic pain.
Review of the December 2013 Medication Administration Record (MAR) directed that the Oxycontin ER be administered daily at 12:00AM, 8:00AM and 4:00 PM.

i. Review of the Medication Administration Audit Report for the month of December 2013 identified the Oxycontin ER was administered late on the following shifts; 12/1/13 8:00 AM dose administered at 10:12AM, 2 hour 12 minutes late,12/3/13 8:00AM dose administered at 11:04AM, 3 hour 4 minutes late,12/4/13 8:00AM dose administered at 3:15PM, 7 hour 15 minutes late, 12/7/13 8:00AM dose administered at 10:56AM, 2 hours 56 minutes late. 12/8/13 8:00AM dose administered at 10:26AM, 2 hour 26 minutes late. 12/9/13 8:00AM dose administered at 12:28PM, 4 hours 28 minutes late. 12/11/13 8:00AM dose administered at 1:28AM, 5 hours 28 minutes late. 12/16/13 8:00AM dose administered at 10:22AM, 2 hour 22 minutes late. 12/18/13 8:00AM dose administered at 10:20AM, 2 hour 20 minutes late.

ii. Although computerized documentation indicated the resident received Oxycontin ER 10mg on 12/3/13 at 11:04AM, 12/3/13 at 4:54PM and 12/4/13 at 12:58AM, interview with the DNS on 10/30/14 at 2:00PM and review of the narcotic sign out reports identified the facility could not provide documentation of where staff obtained the doses of Oxycontin 10mg ER, as a Drug Receipt/Record/Disposition record was not provided.

Physician orders dated 12/1/13 directed to administer Flexeril 10mg two times daily. Review of the December 2013 MAR directed that the Flexeril be administered daily at 9:00AM and 1:00PM.

iii. Review of the Medication Administration Audit Report for the month of December 2013 identified Flexeril was administered late and/or omitted on the following shifts; 12/4/13 9:00AM dose administered at 11:40AM, 2 hour 40 minutes late, 12/9/13 9:00AM dose administered at 12:28PM, 3 hours 28 minutes late, 12/11/13 9:00AM was omitted, however, was documented as administered at 1:28PM, the same time the 1:00PM dose was documented as administered.

iv. Review of the clinical record identified that on 12/11/13 the resident received the 8:00AM dose of Oxycontin ER 10mg at 1:28 PM, 5 hours and 28 minutes late

and missed the 9:00AM dose of Flexeril 10mg. Nurses note dated 10:54AM documented the resident had no complaints of pain or discomfort. Review of a physician consult dated 12/11/13 the physician documented the resident presented with seizure like activity. Physical examination identified the resident had acute generalized spasticity. Assessment documented the resident was unable to take anything by mouth due to the activity level so Ativan 1mg IM was administered. Review of physician order dated 12/11/13 directed to administer Ativan 1mg IM now. The MAR documented that the IM Ativan was administered at 2058 (8:58PM).

Review of the facility policy directs that pain management is a multidisciplinary care process that includes assessing the potential for pain, effectively recognizing it, identifying the characteristics, addressing the underlying causes, and developing and implementing approaches. Additionally, a pain assessment is conducted on admission, quarterly, and when there is a change. Staff should assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Monitor the resident's response to interventions and level of comfort over time, monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessment tools (pain scale) and relevant criteria for measuring pain (target signs andsymptoms). Document the resident's reported level of pain with adequate detail to gauge the status of pain and the effectiveness of interventions for pain as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record.
According to Lippincott Manual of Nursing, Ninth edition, 2010: To provide effective pain management, evaluate objectively the nature of the patient's pain including the location, quality, and intensity of the pain. Use a pain intensity scale or other pain scale as appropriate and base the initial analgesic choice on the patient's report of the pain. Assess relief from medications, using the same measuring scale, and record whether the pain relief intervention was effective.
The facility failed to ensure Resident #201's pain was assessed and/or managed according to professional standards.

d. Resident #204 was admitted to the facility on 12/1/13 with diagnoses including end stage renal disease and diabetes. The MDS dated 12/8/13 identified the resident had intact cognition (BIMS 15) and required extensive assistance with care. Physician's orders dated 12/1/13 directed to administer Renagel Tablet 800 MG 3 tablets (2400mg) three times daily before meals.

   i. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Renagel late for 23 doses on

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

12/2, 12/4, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18 and 12/19/13. Additionally, Resident #204 did not receive the breakfast dose on 12/12, 12/14 and 12/19/13 and the lunch dose on 12/6 and 12/17/13.

Physician's orders dated 12/1/13 directed to administer Humulin N Insulin Suspension 100 unit/ML inject 30 units subcutaneously daily before breakfast.

ii. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Humulin N Insulin late for 9 doses on 12/4, 12/7, 12/8, 12/9, 12/12, 12/13, 12/14, 12/15, 12/17/13.
Review of the physician's orders dated 12/1/13 directed to monitor finger sticks before every meal and at bedtime.

iii. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the finger sticks were completed late, after the meal, 20 times on 12/4 Breakfast & Lunch (B & L), 12/7 (B & L), 12/8 (B & L), 12/9 (B & L), 12/12 (B), 12/13 (B & L), 12/14 (B), 12/15 (B & L), 12/16 (L), 12/17 (B & L), 12/18 (B & L), and 12/19/13 (L).

iv. The facility failed to ensure medications and treatments were administered in a timely manner. According to Basic Nursing, Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.

e. Resident #250's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). Physician's order dated 1/1/14 directed DuoNeb Solution 0.5-2.5 (3) ML/3ML (Ipratropium-Albuterol) 1 vial inhale orally four times a day for COPD at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A Resident/Family Contact Form dated 1/14/14 identified that the resident alleged that he/she was afraid that he/she had not received medications on 1/13/14 and that the supervisor was not as attentive as he/she could have been. Review of the January 2014 Medication Administration Audit Report identified that the resident did not receive 5:00 PM DuoNeb on 1/13/14 as per the physician order. The report identified that the 5:00 PM and 9:00 PM dose were both administered at 2155 (9:55 PM).
The facility failed to ensure medications were administered in a timely manner. According to Basic Nursing, Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.

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 (C).

12. Based on observations, review of the clinical record, review of facility documentation, and staff interviews for five sampled residents (Residents #41, #64, #201, #204 and #250) who reviewed for gastrostomy feeding and/or medication administration and/or pain management, the facility failed to

ensure the physician's orders were followed. The findings include:

a. Resident #64 was admitted to the facility on 11/26/13 with diagnoses that included dysphagia, irritable bowel syndrome, and diverticulitis of the colon. The admission MDS dated 12/3/13 identified the resident had intact cognition, required extensive assistance with care, and required a feeding tube. The care plan failed to identify the feeding tube and/or interventions to maintain it. Physician's orders dated 12/1/13 directed Bacitracin-Polymyxin B Ointment be applied to the Gastrostomy (G) tube site topically every day (7-3 shift)

i. The order failed to direct that the area be cleansed prior to the application of the Bacitracin-Polymyxin B Ointment.

ii. Review of the Medication Administration Audit Report identified that staff failed to document that the Bacitracin-Polymyxin B Ointment was applied ten times between 12/1/13 - 12/17/13 (17 days) on 12/2, 12/4, 12/6, 12/10, 12/11, 12/12, 12/13, 12/14, 12/16 or 12/17/13.

Nurse's note dated 12/17/13 at 11:00 AM identified the G-tube site was red with purulent drainage, was painful to touch, and after APRN evaluation the resident was sent to the hospital for evaluation. The hospital discharge summary dated 12/24/13 identified the resident was admitted to the hospital on 12/17/13 with abdominal pain at the G-tube site and positive blood cultures. Diagnoses identified on the discharge summary dated 12/24/13 identified bacteremia and line sepsis. Interview with RN#3 on 10/29/13 at 1:00 PM identified that late in 2013 the corporation cut the nurse staffing on the star/step down unit from two nurses to one. At that time, it was so busy that staff couldn't get to all the treatments. The treatment to the residents G-tube site was not done consistently because the nurses did not have enough time. The resident was later hospitalized with sepsis. She further stated that although she told DNS#2 of the staffing issues and that treatments were not being done, no help or assistance was provided to the nurses on the unit. RN#3 stated he/she resigned from the facility due to the unsafe conditions. Interview with LPN#4 on 10/29/14 at 3:21 PM identified that when the staffing was cut on the star/step down unit it took almost 8 hours just to get the medications passed. LPN#4 stated that although he/she did make DNS#2 aware, no help was provided. LPN #4 stated that it could not be done with one nurse. Interview with the Administrator on 10/30/14 at 1:45PM identified that he/she was aware that the nurse staffing had been cut on the star/stepdown unit at that time in late 2013, however, he/she was unaware that nurses were unable to complete their work, including the G-tube treatment for Resident #64. The facility failed to ensure a treatment was provided.

b. Resident #201 was admitted to the facility on 10/30/13 with diagnoses that included intractable progressive pain and pain in the right leg with foot drop related to severe foraminal stenosis at L5-S1, concomitant severe degeneration, spinal fusion, Autonomic Dysreflexia, and myoclonus. The care plan dated 10/31/13 identified the resident will be as comfortable as possible with interventions that included to monitor pain, non-drug

interventions, administer pain medication as ordered, and establish causative factors and ways to alleviate them. The MDS dated 11/6/13 identified the resident had intact cognition (BIMS 15), required assistance for bed mobility, transfers, toilet use and bathing, and had pain almost constantly that has limited day-to-day activities with a numeric rating of 9. The care plan dated 11/19/13 identified the resident had chronic pain related to postoperative discomfort, disease process, arthritis, and spinal stenosis. Interventions included that the resident preferred to have pain controlled by medication and for staff to respond immediately to complaints of pain. Physician' orders dated 12/1/13 directed to administer Oxycontin ER 10mg every 8 hours for chronic pain and Oxycodone 10mg every 4 hours as needed for chronic pain.

Review of the December 2013 Medication Administration Record (MAR) directed that the Oxycontin ER be administered daily at 12:00AM, 8:00AM, and 4:00PM.

i. Review of the Medication Administration Audit Report for the month of December 2013 identified the Oxycontin ER was administered late on the following shifts; 12/1/13 8:00AM dose administered at 10:12AM, 2 hour 12 minutes late,12/3/13 8:00AM dose administered at 11:04AM, 3 hour 4 minutes late,12/4/13 8:00AM dose administered at 3:15PM, 7 hour 15 minutes late, 12/7/13 8:00AM dose administered at 10:56AM, 2 hours 56 minutes late. 12/8/13 8:00AM dose administered at 10:26AM, 2 hour 26 minutes late. 12/9/13 8:00AM dose administered at 12:28PM, 4 hours 28 minutes late. 12/11/13 8:00AM dose administered at 1:28AM, 5 hours 28 minutes late. 12/16/13 8:00AM dose administered at 10:22AM, 2 hour 22 minutes late. 12/18/13 8:00AM dose administered at 10:20AM, 2 hour 20 minutes late.

ii. The December MAR, indicated that on 12/3/13 at 8:00 AM, 12/3/13 at 4:00 PM, 12/4/13 at 12:00AM and 12/4/13 at 8:00 AM the resident did not receive the scheduled Oxycontin ER 10mg. Review of the progress notes identified that on 12/3/13 at 11:04AM, 12/3/13 at 4:54 PM, 12/4/13 at 12:58 AM and 12/4/13 at 3:15 PM the Oxycontin ER10mg was not available. The resident missed 4 doses of Oxycontin ER 10mg. Interview with the DNS on 10/30/14 at 2:00 PM and review of the narcotic sign out reports identified the facility could not provide documentation of that Oxycontin ER 10mg was administered to the resident on the above shifts/dates.

iii. Review of the December 2013 MAR identified that staff documented a check mark every shift which indicated that pain was monitored, however, no pain scale and/or pain assessment and/or location of pain was documented in the record. The resident received Oxycodone 10mg for breakthrough pain twice on 12/3/13 at 11:04AM and 4:52PM, twice on 12/4/13 at 12:57AM and 11:43AM, and once on 12/7/13 at 8:31AM. Pain assessments were not documented. Physician's orders dated 12/1/13 directed to administer Flexeril 10mg two times daily. Review of the December 2013 MAR directed that the Flexeril be administered daily at 9:00AM and 1:00PM.

iv. Review of the Medication Administration Audit Report for the month of December 2013 identified Flexeril was administered late and/or omitted on the

following shifts; 12/4/13 9:00AM dose administered at 11:40AM, 2 hour 40 minutes late, 12/9/13 9:00AM dose administered at 12:28PM, 3 hours 28 minutes late, 12/11/13 9:00AM was omitted, however, was documented as administered at 1:28PM, the same time the 1:00PM dose was documented as administered.

v. Review of the clinical record identified that on 12/11/13 the resident received the 8:00AM dose of Oxycontin ER 10mg at 1:28 PM, 5 hours and 28 minutes late and missed the 9:00AM dose of Flexeril 10mg.
Nurse's note dated 10:54 AM identified the resident had no complaints of pain or discomfort. Review of a physician's consult dated 12/11/13 reflected the physician documented the resident presented with seizure like activity. Physical examination identified the resident had acute generalized spasticity. Assessment identified the resident was unable to take anything by mouth due to the activity level so Ativan 1mg IM was administered. Review of physician's order dated 12/11/13 directed to administer Ativan 1mg IM now. The MAR documented that the IM Ativan was administered at 2058 (8:58PM).

Interview with Person #3 on 11/3/14 at 1:50 PM identified that because of the resident's diagnosis of AD and recent back surgery, he/she required medications on a strict regimen to control the pain and reduce the chance for an AD flare up. In December 2013, after the staffing cuts, the medications came later and later and it became a daily issue of getting medications late. Person #3 stated that he/she had spoken to DNS#2 and the nursing staff at length about the necessity of the medications being on time and DNS#2 was made aware of the seriousness of Resident #201 getting medications on time. Additionally, Person #3 stated that he/she made DNS#2 aware more than 5 times that the resident had received medications late. On December 11, 2013 the Resident called Person #3 from the facility sometime after noon and asked him/her to come in as he/she had not received any medications and was starting to go into a AD flare up. Person #3 stated that he/she went to the facility and the resident begun to spasm, had a hard time breathing, and looked like he/she was in a stuper. After staff administered the shot of Ativan the spasms subsided.
Interview with RN#3 on 10/29/13 at 1:00 PM identified that late in 2013 the corporation cut the nurse staffing on the star/step down unit from two nurses to one. RN#3 stated that the last day he/she worked at the facility, 12/6/13 it took between 7:30AM - 3:00PM just to get the medications passed out and that didn't include treatments. RN#3 stated it was not safe so he/she resigned and has not worked at the facility since. Additionally, although the DNS#2 was made aware of the staffing issues and that treatments were not being done and/or medications were being administered late, no help or assistance was provided to the nurses on the unit.
Interview with LPN#4 on 10/29/14 at 3:21 PM identified that when the staffing was cut on the star/step down unit it took almost 8 hours just to get the

medications passed. LPN#4 stated that although he/she did make DNS#2 aware, no help was provided. LPN #4 stated that it could not be done with one nurse.
Interview with LPN#3 on 10/29/14 at 3:35PM identified that when the staffing was cut on the star/stepdown unit late in 2013, it was impossible to finish all that needed to be finished. LPN#3 stated that DNS#2 and the supervisors were aware and did nothing to help. LPN#3 stated that it was extremely difficult to give appropriate care.
Interview with LPN#5 on 10/30/14 at 10:00AM identified that when staffing was cut in late 2013, it was too much and medications were given late. LPN#5 stated that he/she was aware that Resident #201 needed her medications on time because of his/her spasms and would cry and complain that he/she wasn't getting them on time. LPN#5 stated that the supervisors were aware of the problems.

Review of the facility policy directs that pain management is a multidisciplinary care process that includes assessing the potential for pain, effectively recognizing it, identifying the characterisitics, addressing the underlying causes and developing and implementing approaches. Additionally, a pain assessment is conducted on admission, quarterly, and when there is a change. Staff should assess the residents pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Monitor the residents response to interventions and level of comfort over time, monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessment tools (pain scale) and relevant criteria for measuring pain (target signs andsymptoms). Document the residents reported level of pain with adequate detail to gauge the status of pain and the effectiveness of interventions for pain as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the residents medical record.
Interview with the Administrator on 10/30/14 at 1:45PM identified that he/she was aware that the nurse staffing had been cut on the star/step-down unit at that time in late 2013; however, he/she was unaware that nurses were unable to complete their work, including the G-tube treatment for Resident #64 and consistently late medications.
The facility failed to ensure medications were administered timely to meet the resident's needs.

c. Resident #41 was admitted on 8/15/11 and had diagnoses including Multiple Sclerosis, Cerebellar Ataxia, generalized muscle weakness, and gastrostomy. Review of the Minimum Data Sets (MDS) dated 12/6/13, 2/28/14, and 5/23/14 identified that Resident #41 was severely cognitively impaired and was totally dependent on staff for Activities of Daily Living. Review of physician ' s orders dated 12/31/14 identified for staff to cleanse the G-tube site with Normal Saline, pat dry followed by bacitracin and dry clean

dressing, twice a day. Review of the treatment administration record for December and January failed to reflect that the treatment was provided from 12/31/13 through 1/31/14. Additional review failed to reflect the treatment was provided on 2/22/14 (am), 3/20/14 (pm), 3/21/14 (pm), 3/24/14 (pm), 3/28 (am and pm), 3/29/14 (pm), 4/18/14 (pm), 4/26/14 (pm), 4/30/14 (pm), and 5/8/14 (am). A physician ' s order dated 5/13/14 identified for staff to cleanse G-tube site with Normal Saline, pat dry, apply bacitracin followed by dry clean dressing, every evening shift. Review of the treatment administration record failed to reflect that the treatment was provided on 7/1/14 and 7/8/14. The facility failed to ensure the treatment was provided as ordered.

d. Resident #204 was admitted to the facility on 12/1/13 with diagnoses that included end stage renal disease and diabetes. The MDS dated 12/8/13 identified the resident had intact cognition (BIMS 15) and required extensive assistance with care. Physician's orders dated 12/1/13 directed to administer Renagel Tablet 800 MG 3 tablets (2400mg) three times daily before meals. Facility documentation identified that Breakfast (B) is served between 7:15-8:15am and Lunch (L) is served between 11:30-12:30PM.

i. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Renagel late for 23 doses on 12/2, 12/4, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18 and 12/19/13 and missed the breakfast dose on 12/12, 12/14 and 12/19/13 and the lunch dose on 12/6 and 12/17/13. Interview with Pharmacy Consultant #1 on 11/4/14 at 11:40AM identified that Renagel should be given with the meal.

Physician's orders dated 12/1/13 directed to administer Humulin N Insulin Suspension 100 unit/ML inject 30 units subcutaneously daily before breakfast.

ii. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the resident received the Humulin N Insulin late for 9 doses on 12/4, 12/7, 12/8, 12/9, 12/12, 12/13, 12/14, 12/15, and 12/17/13. Review of the physician's orders dated 12/1/13 directed to monitor finger sticks before every meal and at bedtime.

iii. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the finger sticks were completed late, after the meal, 20 times on 12/4 Breakfast & Lunch (B & L), 12/7 (B & L), 12/8 (B & L), 12/9 (B & L), 12/12 (B), 12/13 (B & L), 12/14 (B), 12/15 (B & L), 12/16 (L), 12/17 (B & L), 12/18 (B & L), and 12/19/13 (L).

Resident #250 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). Physician's order dated 1/1/14 directed DuoNeb Solution 0.5-2.5 (3) ML/3ML (Ipratropium-Albuterol) 1 vial inhale orally four times a day for COPD at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A Resident/Family Contact Form dated 1/14/14 identified that the resident alleged that he/she was afraid that

he/she had not received medications on 1/13/14 and that the supervisor was not as attentive as he/she could have been. Review of the January 2014 Medication Administration Audit Report identified that the resident did not receive 5:00 PM DuoNeb on 1/13/14 as per the physician's order. The report identified that the 5:00 PM and 9:00 PM dose were both administered at 2155 (9:55PM). Interview with the Administrator on 10/30/14 at 1:45 PM identified he/she was unaware that treatments were not being completed on the star/step down unit after the corporate office cut nurse staffing in late 2013. Additionally, there was no additional information related to how the grievance was handled as DNS #2 no longer worked for the facility.

e. Resident #250 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). Physician's order dated 1/1/14 directed DuoNeb Solution 0.5-2.5 (3) ML/3ML (Ipratropium-Albuterol) 1 vial inhale orally four times a day for COPD at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. A Resident/Family Contact Form dated 1/14/14 identified that the resident alleged that he/she was afraid that he/she had not received medications on 1/13/14 and that the supervisor was not as attentive as he/she could have been. Review of the January 2014 Medication Administration Audit Report identified that the resident did not receive 5:00 PM DuoNeb on 1/13/14 as per the physician's order. The report identified that the 5:00 PM and 9:00 PM dose were both administered at 2155 (9:55PM). Interview with the Administrator on 10/30/14 at 1:45 PM identified he/she was unaware that treatments were not being completed on the star/step down unit after the corporate office cut nurse staffing in late 2013. Additionally, there was no additional information realted to how the grievance was handled as DNS #2 no longer worked for the facility

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).

13. Based on observation and interview, for one resident reviewed during dining (Resident #52), facility failed to provide assistance with appropriate positioning during a meal. The findings include:

a. Resident #52's diagnoses included dysphasia due to cerebravascular disease. A quarterly assessment dated 9/19/2014 identified the resident required extensive assistance with bed mobility, was totally dependent for transfers between surfaces i.e. bed to chair, and required supervision and set up only with eating. The resident care (RCP) plan dated 10/14/14 identified an activity of daily living (ADL) deficit related to limited range of motion. Interventions included to encourage the resident to use the bell to call for assistance.

Observation of Resident #52 on 10/28/14 at 7:55 AM noted the resident in bed with breakfast tray on over-bed table positioned at the resident's chin level. The head of bed was positioned at 40 degrees and the bed was in the high position (off the floor). The breakfast tray was positioned at arms length from the resident and resident was observed with his/her finger tips in the coffee cup in an attempt to pick up the cup to consume.

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

Further observation with the assistant director present noted food debris and liquid stain across the resident's chest and bed.
Subsequent to surveyor inquiry staff lowered the resident's bed, repositioned the resident, and raised the resident's head of bed. The staff further lowered the overbed table and breakfast tray. The resident was observed drinking his /her coffee. Interview with the assistant director on 10/28/14 at 8:12 AM indicated that the resident had been positioned improperly.
An additional observation of Resident #52 on 10/29/14 at 5:20 PM with LPN# 9 identified the resident alone in his/her room seated in his/her electric custom wheel chair in a reclined position. The foot rests were positioned extended out to each side of the chair and the resident's legs were dangling without support. The overbed table was positioned at the front of the wheel chair. The dinner tray was on the table with the plate of food uncovered. Interview with NA# 4 and NA# 5 on 10/29/14 at 5:45 PM indicated that they were unable to position the resident properly because the wheel chair battery was depleted. Subsequent to surveyor inquiry LPN #9 directed staff to reposition the foot rest to support the resident's lower extremities.

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).

14. Based on observation, clinical record review, facility policy and interviews for 2 of 3 sampled residents reviewed for heel pressure ulcers (Resident #45 and Resident #136) the facility failed to ensure care and services to prevent pressure ulcer development on the heel were implemented. The findings included:.
    a. Resident #45 was admitted on 7/4/14 with diagnoses that included cerebral vascular accident, dysphagia, and osteoarthritis. The admission nursing evaluation dated 7/4/14 dated identified mild risk for skin breakdown, right sided weakness but able to turn in bed independently to right to hold bedrails, and no open areas. A quarterly MDS assessment dated 10/11/14 identified the resident with short and long term memory problems, with moderate impairment in decision making, now requiring extensive assistance of two staff for bed mobility, transfers and toilet use, with functional limitation of lower extremity range of motion on one side, at risk for developing pressure ulcers but no current pressure ulcers, utilization of pressure reducing devices for the chair and bed, and utilization of a turning and repositioning program. The resident care plan for potential impairment to skin integrity related to mobility had interventions which included pressure relieving/reducing mattress and pillows to protect the skin while in bed. Review of the weekly resident skin audits identified no abnormalities with completed skin checks on 7/28/14, 9/8/14 x 2, 9/15/14, 9/22/14 and 10/13/14.
    Nursing note dated 10/21/14 indicated 2.6 x 4.2 clear blister of latereral right heel and resident encouraged to elevate heels in bed. Physician's orders dated 10/21/14 included Non Sting Barrier Spray (NSBS) (skin prep), to right lateral heel every shift for 14 days,

to elevate right heel to eliminate pressure while in bed every shift, and shoe off right foot when possible.
Observation of Resident#45 on 10/30/14 at 7:05 AM identified the resident laying in bed with a pillow underneath the legs with the right heel on the bed surface. Interview with LPN#11 at that time identified offloading should be done with a pillow although it was observed that the heel was on the bed. LPN#1 requested the resident move her legs but the resident was unable to do so.
Facility policy for residents "at risk" for skin integrity issues includes to elevate the resident's heels off a bed with a pillow.
The facility failed to ensure this measure was in place prior to the breakdown of the Resident's skin integrity.

b. Resident #136 was admitted to the facility on 1/21/14 with diagnoses that included chronic respiratory failure with tracheostomy, stroke, and a stage II pressure ulcer. The MDS dated 7/25/14 identified the resident had short and long term memory impairment, had moderately impaired cognition, required extensive assistance of two staff for bed mobility, was totally dependent on staff for transfers, was totally incontinent of bowel and bladder, required a feeding tube, and was at risk to develop a pressure ulcer. The care plan dated 8/4/14 identified the resident had a history of a stage II pressure ulcer related to his/her disease process, immobility, and decontitioning. Interventions included to utilize pressure relieving devices in the bed and chair, avoid positioning the resident on his/her back, side to side turning frequently every shift, and out of bed with turning schedule. The Braden scale dated 9/26/14 identified the resident was at high risk for breakdown with a score of 11.
Nurse's note dated 10/6/14 at 9:24AM identified that RN#11 was called to the room to observe the Resident's heel and noted large closed hematoma on the heel. A pressure ulcer record dated 10/6/14 documented a Deep Tissue Injury (DTI) to the right lateral heel which measured 5cm by 5cm. Physician's order dated 10/7/14 directed Non Sting Barrier Spray (NSBF) to right and left heel every shift and offload heels with boots on at all times. Review of the clinical record failed to reflect that staff offloaded the resident's heels consistantly prior to 10/6/14 when the resident was identified with a DTI of the right heel.

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).

15. Based on review of the clinical record, review of facility policies and procedures, and interviews for one of three residents reviewed for urinary incontinence (Resident #70), the facility failed to provide services to improve bladder function after a decline was noted. The findings include:

a. Resident #70's diagnoses included dysphagia, diabetes mellitus II, dementia without behavioral disturbance, bipolar disorder, hypertension, chronic kidney disease, and generalized muscle weakness.
An admission assessment dated 5/27/14 identified the resident as independent for decision-making skills with occasional urinary incontinence. A quarterly assessment

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

date 8/22/14 identified the resident as cognitively intact with frequent episodes of urinary incontinence.

On 10/29/14 at 11:00 AM an interview and review of the clinical record with the unit charge nurse (LPN#13) indicated that although there were no updated bladder assessments and/or changes to the plan of care regarding the resident's urinary incontinence, the resident was fine during the day shift, but may be more incontinent in the evening.

On 10/29/14 at 11:20 A.M. an interview with Resident #70 identified that he/she has been incontinent of urine for years prior to being admitted to the facility and more so since having a "stroke" a few years ago. He/she further indicated that although the staff is very good about assisting the resident with his/her toileting needs in the evening for some reason, the resident tends to leak urine when being transferred to the bathroom by staff.

On 10/29/14 and 10/30/14 at 2:00 P.M. and 9:10 A.M. interviews with the DON failed to reflect that the facility provided care and/or services to improve and/or prevent further decline related to the resident's bladder status when it was initially identified during the admission assessment and upon changes identified during the resident's quarterly assessment.

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).

16. Based on observation, clinical record review, and review of facility smoking policy, for 2 of 3 sampled residents reviewed and/or observed for smoking (Resident #18 and Resident #128), the facility failed to have smoking aprons available that were not in disrepair and/or the intact assistive devices to prevent an accident during smoking activity. The findings include:
    a. Observation of smoking on 10/29/14 at 11:10 AM identified two residents, Resident #18 and Resident #128 were noted to have on blue smoking aprons that had areas of the blue fire resistant material in disrepair. Interview with NA#10 at the time of observation identified this was the first time she/he had observed smoking and was unaware that the aprons were not in proper condition. Further observation with the Director of Nursing at 11:15 AM identified that the aprons were in disrepair and needed to be replaced. She further identified that new smoking aprons would be ordered.

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).

17. Based on review of the clinical record, review of facility documentation, and staff interview for one resident (Resident #250) the facility failed to ensure the resident received proper treatment related to respiratory care. The findings include:
    a. Resident #250's diagnoses included Chronic Obstructive Pulmonary Disease (COPD). Physician's order dated 1/1/14 directed DuoNeb Solution 0.5-2.5 (3) ML/3ML (Ipratropium-Albuterol) 1 vial inhale orally four times a day for COPD at 8:00 AM,

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

12:00 PM, 5:00 PM, and 9:00 PM. A Resident/Family Contact Form dated 1/14/14 identified that the resident alleged that he/she was afraid that he/she had not received medications on 1/13/14 and that the supervisor was not as attentive as he/she could have been. Review of the January 2014 Medication Administration Audit Report identified that the resident did not receive 5:00 PM DuoNeb on 1/13/14 as per the physician' order. The report reflected that the 5:00 PM and 9:00 PM dose were both administered at 2155 (9:55PM). Interview with the Administrator on 10/30/14 at 1:45 PM identified he/she was unaware that treatments were not being completed on the star/step down unit after the corporate office cut nurse staffing in late 2013. Additionally, there was no additional information related to how the grievance was handled as DNS #2 no longer works for the facility.

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 (C).

18. Based on clinical record reviews, observations, review of facility policies and procedures, and interviews, the facility failed to ensure sufficient nurse staffing levels to maintain the residents' highest practicable physical, mental, and psychosocial well-being as determined by their assessments and individual plans of care. The findings include:
    a. This regulation was not met as evidence by noncompliance in response to grievances, neglect, abuse, dignity, care plan implementation/revision, medication administration, pain management, dialysis management, G-tube care, ADL care, pressure ulcers, nurse supervision, physician notification, and infection control.

       Please refer to violations #1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 19, 20, 21, 22, 23, 24, 26, and 28.

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 (q) Dietary Services (2)(C).

19. Based on observation and interview for 3 of 4 facility units, the facility failed to ensure adequate staff was present to meet resident needs in regards to meal service. The findings include:
    a. During tour of facility and/or observation of the evening meal service on 10/29/14 at 4:55 PM it was noted that the evening cart with meal trays was observed leaving the dietary department at 4:55 PM. The cart was delivered to the Claremont unit at 4:58 PM.

       Day supervisor RN#4 was observed on the Claremont unit on 10/29/14 at 5:05 PM ambulating with Resident #73. LPN #3 indicated at that time that it was not the facility's usual practice and without RN#4's assistance with Resident #73, it was usually very difficult to pass medications and /or assist with meal service.
       Continued observation on Claremont unit noted two (2) nurse aide NA#6 and NA #7 delivering trays to resident rooms and assisting with feeding four (4) residents (required total assistance with feeding/eating) located in dining/lounge room.

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

Observation of woodhouse unit on 10/29/14 at 5:22 PM noted LPN #8 sitting in the back of the nurse's station at a computer. Further tour and/or observation of the unit identified that in the dining/lounge were six residents and no staff present in the area. Subsequent observation noted LPN #8 feeding residents in the same dining area.

Observation of Resident #52 on 10/29/14 at 5:29 PM with LPN# 9 identified the resident alone in his/her room seated in his/her electric custom wheel chair in a reclined position. The foot rests were positioned extended out to each side of the chair and the resident's legs were dangling without support. The overbed table was positioned at the front of the wheel chair. The dinner tray was on the table with the plate of food uncovered. Interview with NA# 4 and NA# 5 on 10/29/14 at 5:45 PM they indicated that they were unable to position the resident properly because the wheel chair battery was depleted. Subsequent to surveyor inquiry LPN #9 directed staff to reposition the foot rest to support the resident's lower extremities.

Subsequent observation of the Claremont meal service, staff was noted completing tray delivery and began feeding last resident at 6:05 PM.

A test tray was measured and evaluated for temperature and taste/palatability at 6:05 PM with RD #1 and the Director of Nursing present, and the following temperatures were identified at that time: Chicken 130 deg., broccoli 120 deg., potatoes 129 deg. soup 107 deg., coffee 107 and the milk was 66 degrees. During an interview and review of meal test tray and taste with the DNS and RD#1 they identified that the temperatures were too cool and/or (milk too warm) to taste. Interview with dietary corporate person on 10/30/14 at 8:21 AM indicated that soup and coffee temperatures should range greater than 140 degrees and milk should be in the range of 40 degrees. He further indicated that dietary department makes efforts to support nursing in the prompt and accurate delivery of meals.

Interview with nurse aides (NA #6 and NA #7) indicated that it is a very busy unit and there was usually only two (2) staff to deliver and feed the residents. In addition to monitoring Resident #73 who wanders, there was six (6) residents that required assistance with feeding at a slower pace.
During an interview with the DNS and RN #4 on 10/30/14 at 10:30 AM they indicated that it was the (facility) expectation that staff are present in resident dining rooms to provide assistance safety monitoring.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(C).

20. Based on observation and interview, the facility failed to provide meals in a timely manner to ensure appropriate palatable temperatures. The findings include:

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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

a. Tour of facility and/or observation of the evening meal service on 10/29/14 at 4:55 PM noted that the evening cart with meal trays was observed leaving the dietary department at 4:55 PM. The cart was delivered to the Claremont unit at 4:58 PM. Two (2) nurse aides, NA#6 and NA#7 were observed delivering trays to resident rooms and assisting with feeding four (4) residents (who required total assistance with feeding/eating) located in dining/lounge room. The staff was noted to complete tray delivery and began feeding the last resident at 6:05 PM. A test tray was measured and evaluated for temperature and taste/palatability at 6:05 PM with RD#1 and the Director of Nursing present, and the following temperatures were identified at that time: Chicken 130 deg., broccoli 120 deg., potatoes 129 deg. soup 107 deg., coffee 107 and the milk was 66 degrees. During an interview and review of meal test and taste with the DNS and RD#1 they identified that the temperatures were too cool and/or (milk too warm) to taste. Interview with dietary corporate person on 10/30/14 at 8:21 AM indicated that soup and coffee temperatures should range greater than 140 degrees and milk should be in the range of 40 degrees.

The facility failed to ensure food temperatures were maintained and/or that meals were served in a timely manner.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(C).

21. Based on observation and interview, facility failed to maintain the dietary department in a clean and sanitary manner. The findings include:
    a. During tour of the dietary department with the food service director (FSD) on 10/27/14 at 10:10 AM, the following was identified:
        i. The ice making machine was noted with pink black mold and slime along the icer defector shied, and along door contact surface.
        ii. Floors under the steam table/cook's prep table, cook's stove/ovens walk-in freezer and/or refrigerator were noted with dirt, debris, and food items.
        iii. Two food preparation surface cleaning buckets (red-buckets) with rags in each were noted under the cook's food preparation table across from cook's stove and one located under steam table. The sanitizer concentration was tested by the FSD and found indicating no chemical/sanitizer present.

        Interview and review with the FSD on 10/30/14 at 09:48 AM failed to reflect completed /signed off as completed master cleaning schedule and/or cleaning assignment documentation. He further indicated that although it was facility policy to test sanitizer chemical concentration prior to use, there was something wrong with the chemical dispenser.

        Facility sanitizing food contact surface policy and procedure identified in part, red bucket sanitizer solution concentration must be at 200 ppm to 400 ppm. The

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

facility failed to ensure that the solution in the red buckets met this requirement.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (n) Medical and Professional Services (8)(B)(v).

22. Based on review of the clinical record, review of facility documentation, review of facility policies and/or procedures, and interviews for 2 of 3 residents reviewed for dental services (Residents #82 and 144), the facility failed to ensure that the residents received routine dental. The findings include:

a. Resident 82's diagnoses included chronic respiratory failure, depression, and anxiety. A quarterly assessment dated 9/26/14 identified that the resident had no cognitive difficulties and was independent with activities of daily living (ADL). The resident care plan (RCP) dated 10/9/14 identified a problem with oral/dental problems. Interventions included monitoring, documenting, and reporting to MD oral/dental problems needing attention such as pain and to coordinate arrangements for dental care.
In an interview on 10/28/14 at 9:16 AM Resident #82 identified he/she had tooth pain. He/she further indicated that he/she told facility staff. Review of Resident #82's dental examination dated 03/20/14 identified recommendations that included making an appointment with clinic for teeth extractions.

During an interview and review of Resident #82's clinical record with the Director of Nursing on 10/30/14 she indicated that she was unable to provide documentation that Resident #82 received follow up dental care and that NA#9 was responsible for scheduling appointments.
During an interview with NA#9 on 10/30/14 at 11:32 AM she indicated that a dentist comes to facility and evaluates the residents that are identified as possibly requiring dental care. He makes recommendations. She indicated that that she makes a copy of the recommendation, provides a copy to the assistant director of Nursing and to a staff person responsible for scheduling transportation. She further indicated that she could not explain why Resident #82 was not provided with an appointment and was unable to state who was responsible for follow up to assure appointments were provided.
Facility dental policy and procedure identified in part "upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist.

b. Resident #144's diagnoses included dementia with behavioral disturbance, end stage renal disease, depressive disorder, difficulty walking, and generalized muscle weakness. A quarterly assessment dated 7/18/14 identified the resident as cognitively intact and requiring total assistance from staff for personal hygiene that included brushing the resident's teeth.
The RCP updated on 7/31/14 identified a focus for a deficit in ADL self-care performance. Interventions included that with personal and/or oral hygiene care staff participation is required.
On 10/28/14 at 11:45 A.M. during an interview with Resident #144, it was noted that the

several front teeth in the resident's lower jaw and/or mandible were dark brown in color with gaps and/or spaces between the lateral and central incisors. The resident indicated upon interview that he/she did not require assistance with brushing his/her own teeth and that he/she had no eating and/or chewing problems in spite of the condition of the resident's teeth.

On 10/29/14 at 10:13 A.M. an interview with NA #13 indicated that that he/she has provided care for the resident for the past two years and that the resident has the ability to brush his/her own teeth independently. The aide further indicated that the present routine would be setting the resident up with his/her oral hygiene supplies and clearing away the supplies when the resident has finished brushing his/her teeth without the benefit of providing total assistance according to the resident's plan of care.

On 10/29/14 at 12:40 A.M. an interview with the restorative nurse's aide (NA#9) indicated that he/she is responsible for setting up dental appointments and was further directed by the new DON to notify the resident's responsible parties and provide them with consent for treatment form regarding dental services. The restorative aide further indicated that to his/her knowledge, Resident #144 had not been offered dental services by the facility and that he/she would be contacting the resident's POA to obtain consent for services.

On 10/29/14 at 2:40 P.M. an interview with Resident #144's POA indicated that he/she had never been asked by the facility to give consent for dental treatment since the resident's admission in 2012 and further indicated that Dental Services for Resident #144 would be appreciated.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8v (b)(4).

23. Based on observation and interview, for one of four units reviewed for medication storage, the facility failed to ensure that medications are stored and labeled properly. The findings include:
    a. During review of medication storage on the Tamarac/Wharton unit on 10/30/14 at 12:00pm, an opened 30 ml vial of 1% Lidocaine Solution was noted on the shelf with the OTC medications. The opened vial was without the benefit of a date. Interviews with the Unit nurses failed to reflect when the vial might have been opened or what 1% Lidocaine is used for in the facility.

    Interview with the Nursing Supervisor on 10/30/14 at 1:00pm identified that Lidocaine is used as a diluent for intramuscular injections, and that it should have been dated when it was opened.

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

24. Based on observations, review of facility documentation, and interviews the facility failed to consistently practice current infection control principles to prevent cross contamination and/or maintain a clean and/or sanitary environment. The findings include:

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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

a. During tour, observations of the Claremont nursing unit with the RN Supervisor (RN#7) on 10/27/14 at 9:29 A.M. the following was identified:

i. An observation of a tube-feeding set-up on a pole in room 234 identified that the pole was heavily stained and/or thickly coated with old tube-feeding formula that had splattered along the pole and at the base where the pole was mounted. Observation of the bathroom in room 234 identified an opaque plastic bag filled with trash was taped against the wall without the benefit of being placed in a receptacle.

ii. Observations of a soiled utility room identified a combination of clean items being stored with soiled and/or dirty items. It was noted that in the cabinet as well as on top of the counter tops in the soiled utility room the facility were storing 4- clean toilet hat/specimen collection containers, 4-clean emesis basins, 4-clean wash basins and 2 additional wash basins were noted in an adjacent sink (question as to whether these two items were clean and/or dirty). Twenty-two (clean) grey tops and 29 (clean) red and yellow tops vaccutainers were stored out in the open on the counter with a bottle of chem-strips for urinalysis and 1-1/2 ounce bottle of hemacrit developer with two-cotton swabs were also noted. The dirty items in the soiled utility room consisted of several items that were packed and/cluttered in disarray throughout the room and counter tops such as 4-empty card board boxes that once stored diasylate solutions were left scattered on the floor, a wheelchair with attachments that blocked the doorway upon entry into the room, a large black rubber floor mat soiled with granules of sand, dirt and debris was left on the counter top near the sink, a bedside floor matt and/or cushion that was impinged between a large, empty, grey utility bin and the cabinet doors of the counter was soiled with black smudge marks, the grey utility bin itself was noted as having dirt and debris adhering to its bottom. A commode was also left in the middle of the room in front the sink and the floor of the utility room was also soiled and/or stained with black smudge marks and dirt.

In addition on 10/27/14 at 10:15 A.M. and 10:20 A.M. observation of medical supplies were noted on the floor in room 236 and in the nurse emergency supply room. A box of containing two bottles of tube-feeding formula and an opened box of tube-feeding and/or medication administration syringes were identified on the floor of room 236 and an opened box of blue ventilator tubing was noted on the floor of the emergency supply room. Subsequent to observation and surveyor's inquiry RN#4 (who was assisting RN#7) indicated that the medical items in both instances were not to have been stored on the floor and were removed immediately by RN#4.

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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

On 10/31/14 at 2:20 P.M. an interview with the Infection Control Nurse (ICN) in the presence of the DON indicated that clean items are not to be stored in the soiled utility room and that there is a clean storage area on the unit for the storage of clean items and that he/she would direct these concerns with nursing and the housekeeping staff. The ICN further indicated that a trash receptacle was to have been available in the bathroom of room 234 and that medical supplies are not to be stored on the floor as well.

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

25. Based on observations, review of facility policy and/or procedures, review of facility documentation, and interviews in the area of the environment, the facility failed to provide a safe, functional, sanitary and/or comfortable environment for residents. The findings include:
    a. During tour, observations of the Claremont nursing unit with the RN Supervisor (RN#7) on 10/27/14 at 9:29 A.M., the following was identified:
        i. The wallpaper in room 229 near bed #2 was ripped near the heater and at the head of the bed. It was further noted that the wall paper and molding along the base of the wall near the heater was detached and/or separated from the structure of the wall.
        ii. The floor in room 228 near bed #1 was soiled with black stains and smudge marks and debris. It was further noted that the wallpaper above the heater near bed #2 was ripped.
        iii. A tube-feeding pole in room 234 was identified as being stained and/or dirty with thick dried on splatter of tube-feeding formula all along the pole including the base of the pole. Upon further observation of the room it was noted that in the bathroom an opaque plastic bag was taped to the wall with garbage inside without the benefit of being in a receptacle.
        vi. Observation of room 236 identified that the radiator in the bathroom was missing its cover and the internal parts which were rusted were in plain view.
        v. An observation of the soiled utility room with RN#7 identified several items that were packed and/cluttered in disarray throughout the room and counter tops such as 4-empty card board boxes that once stored diasylate solutions were left scattered on the floor, a wheelchair with attachments that blocked the doorway upon entry into the room, a large black rubber floor mat soiled with granules of sand, dirt and debri was left on the counter top near the sink, a bedside floor matt and/or cushion that was impinged between the large empty grey utility bin and the cabinet doors of the counter was soiled with black smudge marks, the grey utility bin itself was noted as having dirty and debri adhering to its bottom, soiled

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

with black smudge marks. The floor of the utility room was soiled and/or stained with black smudge marks and dirt.

On 10/27/14 at 10:10 A.M. an interview with the Housekeeping Supervisor indicated that although he/she could not attest for the reason of the cluttered soiled utility room and/or the soiled environment in rooms 228, and 234 subsequent to surveyor's observation and inquiry, the housekeeping staff were observed on the unit cleaning and removing items from the soiled utility room, obtaining a trash receptacle for room 234 and removing the soiled tube-feeding equipment and replacing it with a clean one.

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

26. Based on observations, review of the clinical records, review of facility policies, review of facility documentation, and interviews, the facility lacked effective administration to maintain the highest practicable physical, mental and psychosocial well-being of residents. The findings include:

The Administrator failed to:

a. Ensure timely notification of physicians when appropriate.
b. Ensure Residents #64 and 201 were from neglect and/or that Resident #82 was free from abuse and/or that Residents #32, 52, 124 and 175 were treated with dignity.
c. Ensure that complaints of abuse/neglect were reported and/or investigated in a timely manner.
d. Ensure that nursing developed comprehensive care plans, revised when necessary, followed acceptable standards of care, followed physician orders/plans of care, and provided care to prevent/improve pressure ulcers and manage pain.
e. Ensure that residents were provided with ADL care according to a comprehensive assessment and plan of care.
f. Ensure that Residents were provided with dental services.
g. Ensure an efficient housekeeping/maintenance services.
h. Ensure adequate nurse staffing and timely administration of medications and treatments.
i. Ensure an effective infection control program was developed and maintained, including wound management.
j. Ensure the clinical record accurately reflected the resident and was inclusive of all necessary documentation.
k. Ensure a functioning and effective QA program.

Please refer to violations #1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, and 28.

DATES OF VISIT: October 27, 28, 29 and 30, 2014

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 (j) Director of Nurses (2) and/or (o) Medical Director (1).

27. Based on review of the clinical record and staff interviews for 2 sampled residents (Resident #202 and 204) the facility failed to maintain clinical records in accordance with accepted professional standards that are complete and accurately documented. The findings include:
    a. Resident #202's diagnoses included acute and chronic kidney disease, end stage renal disease with hemodialysis. The physician's order date 11/21/13 directed a renal, no added salt, low fat, low cholesterol diet with a 1500 cubic centimeter (cc) per twenty-four hours, to check the left arm bruit and thrill every shift, hemodialysis three times a week and weight three times a week. The Minimum Data Set dated 12/6/13 identified that Resident #202 had no cognitive impairments, was independent with activities of daily living. Review of the intake and output documentation from 1/1/14 through 1/19/14 identified only two out of nineteen days had documentation on all three shifts. Interview with the Corporate Registered Nurse on 10/28/14 at 1:00PM identified that the intake and output records were incomplete.
    b. Resident #204 was admitted to the facility on 12/1/13 with diagnoses included end stage renal disease and diabetes. The MDS dated 12/8/13 identified the resident had intact cognition (BIMS 15), and required extensive assistance with care. Physician's orders dated 12/1/13 directed Peritoneal Dialysis 15 Liters (L) of 2.5% Dextrose (use 5L green bag) and (1) bag of 4.25% (use 5 L red bag) total of 20 L one time daily at 8:00 PM. Review of the Medication Administration Audit Report between 12/1/13 through 12/19/13 identified that the Peritoneal Dialysis exchange was not documented as completed on 12/5, 12/6, 12/7, 12/11, 12/13, and 12/17/13.

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

28. Based on observations, review of clinical records, review of facility documentation, and interviews, the facility failed to ensure that the Quality Assurance (QA) Committee identified, discussed deficient practices, and/or developed and implemented plans of action to correct the identified deficiencies. The findings include:
    a. The regulation of Quality Assurance is not met as evidenced by:

    Please refer to violations #2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, and 26.

    Interview with the Administer on 10/30/14 at 1:38 PM identified that although he/she was aware that the corporation cut the staffing in the latter part of 2013, he/she was unaware of the extent of the issues that were occurring and the prior DNS, DNS#2 did not keep him/her informed.

EXH: B

FLIS Independent Nurse Consultant Guidelines

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

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