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

IN RE: Elm Hill Nursing Center, Inc.
Apple Rehabilitation of Rocky Hill
45 Elm Street
Rocky Hill, CT 06067

CONSENT ORDER

WHEREAS, Elm Hill Nursing Center, Inc. of Rocky Hill, CT ("Licensee"), has been issued License No. 2006-C to operate a Chronic and Convalescent Nursing Home known as Apple Rehabilitation of Rocky Hill ("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 April 26, 2016 and concluding on May 12, 2016; and,

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated June 1, 2016, (Exhibit A – copy attached); and,

WHEREAS, an office conference regarding the June 1, 2016 violation letter was held between the Department and the Licensee on June 8, 2016; and,

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

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

1. The Licensee shall execute a contract with an Independent Nurse Consultant credentialed in Infection Control ("INC") pre-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. Failure to pay the INC in a timely basis and in accordance with the contract, as determined by the Department in its sole and absolute discretion, shall constitute a violation of this Consent Order. Failure to pay the costs associated with the INC's duties may result in a fine not to exceed one thousand ($1000.00) dollars per day until such costs are paid.

2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The registered nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies. The INC shall provide consulting services for a minimum of six (6) months at the Facility, unless the Department identifies through inspections or any other information that the Department deems relevant that a longer time period is necessary, to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be present at the Facility thirty-two (32) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the three (3) month period and may, in its sole and absolute discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines, based upon any information it deems relevant, that the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order. The Department shall base any decision regarding a reduction in the hours of services of the INC upon onsite inspections conducted by the Department and based on all other information the Department deems relevant.

3. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the residents and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.

4. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order. During the initial assessment, if the Independent Consultant identities any issues requiring immediate attention, s/he shall immediately notify the Department and the Licensee for appropriate response.

5. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.

6. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct resident care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

7. The INC shall submit written reports every two weeks to the Department documenting:
    a. The INC's assessment of the care and services provided to residents;
    b. Whether the Licensee is in compliance with applicable federal and state statutes and regulations; and,
    c. Any recommendations made by the INC and the Licensee's response and implementation of the recommendations.

8. Copies of all INC reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.

9. The INC shall have the responsibility for:

   a. Assessing, monitoring, and evaluating the delivery of direct resident 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 resident care and services delivered by the various health care professionals providing services;

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

   d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated June 1, 2016. (Exhibit A).

10. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The 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.

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

12. 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 residents;
b. Residents are maintained, clean, comfortable and well groomed;
c. Resident treatments, therapies and medications are administered as prescribed by the physician and in accordance with each resident's comprehensive care plan;
d. Resident assessments are performed in a timely manner and accurately reflect the condition of the resident;
e. Care is provided in accordance with recognized standards of care;
f. Each resident care plan is reviewed and revised to reflect the individual resident's problems, needs and goals, based upon the resident assessment and in accordance with applicable federal and state laws and regulations;
g. Nurse aide assignments accurately reflect resident needs;
h. Evaluate staff on a routine basis, on all three shifts, implementation of infection control practices including but not limited to pressure sores, toileting, and incontinent care;
i. Evaluate staff on a routine basis, on all three shifts, implementation of policies on abuse prohibition, mistreatment, and resident rights;
j. Each resident shall have a social worker evaluate psychosocial needs as deemed necessary to promote psychosocial well-being;
k. Enforcement of the smoking policy or nonsmoking policy which includes alternative interventions as deemed appropriate;
l. Enforcement of the facility's elopement policy and code alert system;
m. Each resident's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
n. Ensuring physician orders are signed and history and physicals are completed timely; and,

o. Ensuring nurse aide certification is verified with the state registry and nurse aide competency evaluations and yearly performance evaluations are completed timely.

p. Ensuring licensed practitioners, direct employees and consultants, are licensed with the appropriate registry and professional licensing board;

q. The personal physician or covering physician is notified in a timely manner of any significant changes in resident 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 resident's needs or if the resident requires immediate care, the Medical Director is notified;

r. Resident's 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;

s. Necessary supervision and assistive devices are provided to prevent accidents; and,

t. Resident injuries of unknown origin or allegations of abuse or mistreatment is thoroughly investigated, tracked and monitored.

13. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating registered nurse supervisor on the first and second shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Such free floating registered nurse supervisor shall maintain a record of any resident 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 two (2) year period.

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

15. Nurse Supervisors shall be provided with the following:

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

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

c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for a period of three years and upon request be made available to the Department for review; and,

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

16. The Licensee shall maintain a minimum staffing ratios as follows:

a. 1st shift – ten (10) patients to one (1) nurse aide.

b. 2nd shift – twelve (12) patients to one (1) nurse aide.

c. 3rd shift – twenty (20) patients to one (1) nurse aide.

17. The Licensee shall maintain minimum licensed staffing ratios as follows:

a. 1st shift – thirty- two (32) patients to one (1) licensed nurse.

b. 2nd shift – thirty-two (32) patients to one (1) licensed nurse.

c. 3rd shift – forty (40) patients to one (1) licensed nurse.

If for any reason the staff ratios required under this Consent Agreement are unable to be maintained, the Department must be immediately notified along with a rationale for the inability to meet this provision.

18. Exception to paragraph sixteen (16) shall be permitted specific to the Lower Level unit, whereby the minimum staffing ratios shall be as follows:

a. 1st shift – ten (10) patients to one (1) nurse aide.

1. 2nd shift – twelve (12) patients to one (1) nurse aide.
2. 3rd shift – twenty-four (24) patients to one (1) nurse aide.

19. The Director of Nurses shall serve full-time at the facility and shall serve his/her entire shift between the hours of 7 a.m. and 9 p.m.

20. 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.

21. A Quality Assurance Performance Improvement Program shall be instituted by the Licensee, which will identify a Quality Assurance Performance Improvement Committee, consisting of, at least, the Administrator, Director of Nurses and Medical Director. The Committee shall meet at least once every thirty (30) days to review all reports or complaints relating to resident care and compliance with federal state laws and regulations. The INC shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Quality Assurance Performance Improvement Committee shall include, but not be limited to, assessing all residents of the facility to identify appropriateness of care and services, determination and adoption of new policies to be implemented by facility staff to improve resident care practices, and routine assessing of care and response to treatment of residents. In addition, this Committee shall review and revise, as applicable 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 Consent Order. The Committee shall measure and track the implementation of any changes in the facility'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.

22. Within fourteen (14) days of the effective date of this Consent Order, the Licensee shall incorporate into its 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.

23. At the time of signing this Consent Order, the Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars ($5,000), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this Consent Order shall be directed to:

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

24. 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.

25. The Licensee agrees 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.

26. 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.

27. 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.

28. 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.

29. The Licensee agrees 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.

30. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order and the state and federal statutes and regulations regarding chronic and convalescent nursing homes, the Department retains the right to issue charges including those identified in the June 1, 2016 violation letter referenced in this Consent Order.

31. 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.

32. The Licensee had the opportunity to consult with an attorney prior to the execution 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.

Brian Foley, President

On this 21st day of ~~August,~~ September 2016, before me, personally appeared Brian Foley, its President who acknowledged himself to be the President of Apple Rehabilitation of Rocky Hill and that he, as such President being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by herself as their President.

My Commission Expires: 03/31/2020
(If Notary Public)

Notary Public
Commissioner of the Superior Court [X]

KAREN DONORFIO
NOTARY PUBLIC
MY COMMISSION EXPIRES 03/31/2020

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

September 30, 2016
Date

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Exhibit A

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 1, 2016

Norma Bariffe, Administrator
Apple Rehab Rocky Hill
45 Elm Street
Rocky Hill, CT 06067

Dear Ms Bariffe:

Unannounced visits were made to Apple Rehab Rocky Hill on Commencing on April 26 and Concluding on May 12, 2016 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a certification 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 June 8, 2016 at 10:30AM 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 June 10, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

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

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

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

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

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

Respectfully,

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

KH:mb

Complaint #18562, 19849, 18573, 19913, 19874, 18862, 18603

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

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

1. Based on clinical record reviews, observation, facility documentation and interviews for one of three sampled residents (Resident #105) who received insulin daily, the facility failed to notify the physician of a low blood sugar level and/or obtaining an order prior to administering a medication. The findings include:
   a. Resident #105's diagnoses included cerebrovascular accident, seizures, diabetes mellitus, chronic kidney disease stage four with hemodialysis, hypertension, and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/17/16 identified Resident #105 had no cognitive impairments, received a therapeutic diet, received dialysis and insulin was administered daily. The resident care plan dated 3/24/16 identified the diagnosis diabetes mellitus and the resident may experience signs and/or symptoms of hyper or hypoglycemia. Interventions directed to check blood sugar as ordered and follow sliding scale, monitor for acute signs of hyper or hypoglycemia. The nurse's note dated 4/21/16 at 7:00 AM identified Resident #105's blood sugar at 6:00 AM was 57 with mild symptoms of confusion and lethargy and Glucagon was administered. The note indicated in one-half hour the resident's blood sugar was 159 and the physician was notified. The nurse's note dated 4/23/16 at 8:00 AM identified Resident #105's blood sugar at 6:00 AM was 82, orange juice was given, the blood sugar at 7:15 AM was 41, Glucagon 1 milligram (mg) was administered, the blood sugar at 7:30 AM was 75, the resident was alert and verbal. The note failed to reflect documentation the physician and/or Advanced Practice Registered Nurse (APRN) were notified. Review of the physician's orders from 4/14/16 through 4/26/16 failed to reflect documentation an order for Glucagon 1 ampule was obtained. The April 2016 Medication Administration Record (MAR) identified Glucagon 1 ampule as needed for low blood sugar, the documentation failed reflect parameters as to when to administer the Glucagon and/or physician notification. Review of the facility policy, Systemic Medical Emergencies, directs for hyperglycemia and/or hypoglycemia the physician was to be immediately notified when the resident who receives insulin exhibits altered behaviors or mental or physical state consistent with hyperglycemia and/or hypoglycemia. If the resident was having an insulin reaction, low blood sugar with symptoms, administer a highly concentrated sugar product while awaiting the physician's direction if the resident is able to take something by mouth. Glucagon is also available in the emergency drug box for administration per the physician's order, notify the responsible party of the change in condition and document in the clinical record all observations, findings and interventions. Interview with the Assistant Director of Nursing (ADON) on 4/28/16 at 1:15 PM identified that Glucagon would normally be administered for a blood sugar less than 60 and/or in accordance with the physician's order.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

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

2. Based on clinical record reviews, review of facility documentation and interviews for one of three sampled residents (Resident #97) who was reviewed for grievances, the facility failed to ensure the resident was ambulating as outlined in the functional maintenance program. The findings include:
   a. Resident #97's diagnoses included cerebrovascular disease with expressive aphasia and right sided weakness, bipolar disorder and generalized anxiety disorder. The quarterly Minimum Data Set assessment dated 8/27/15 through 2/25/16 identified Resident #97 had severe cognitive impairments and required limited to extensive one person assistance with activities of daily living. The resident care plan dated 3/3/16 identified an alteration in mood and behaviors, refused care and medications. Interventions directed to re-approach if the resident refused, encourage family input to help determine best approaches, and notify the family when the resident refused. The physical therapy screen dated 4/4/16 identified Resident #97 was seen related to problems with trunk flexibility, posture, and gait deficit. The assessment identified Resident #97 ambulated 250 feet with a straight cane. The recommendation was for an evaluation to determine appropriate transfer and ambulating status. The individualized resident assignment directed to ambulate 400 feet daily. Review of the activities of daily living flow record dated 4/3/16 through 4/9/16 identified Resident #97 did not ambulate in the hallway. Review of the functional maintenance program documentation from 4/1/16 through 4/12/16 identified Resident #97 ambulated 20 feet in the room only. The documentation failed to reflect that Resident #97 had refused to ambulate in the hallway, except for 4/7/16. In an interview on 4/27/16 at 9:20 AM, Person #1 identified from August 2015 through April 2016 he/she had voiced many concerns to the Administrator, the Director of Nursing (DON) and social worker in regards to Resident #97's care. Person #1 reported on several occasions that the resident was not ambulating according to the plan of care, received ineffective communication about Resident #97's progress, requested the DON to attend resident care conferences to address issues and never received appropriate follow through to his/her concerns. Person #1 further identified that he/she voluntarily discharged Resident #97 to another facility on 4/13/16. In an interview on 4/28/16 at 10:45 AM, the Director of Social Services identified Person #1 was very involved with Resident #97's care and recalls there were concerns identified but the main issue was the resident's ambulating schedule. The Director of Social Services identified there were no written documentation of Person #1's concerns and that the facility utilized concern forms to identify concerns. In an interview on 4/28/16 at 2:15 PM the Administrator and the Director of Nursing (DON) identified that Person #1 had many concerns about Resident #97 and they believed the issues were addressed. The Administrator and DON indicated they had no written documentation of Person #1's concerns and/or resolution of the concerns. Review of the resident's clinical record and the facility's grievance and concern log failed to note Person #1's concerns were addressed and/or resolved. The facility's Grievance procedure policy identified an investigation will

be conducted as soon as possible when a complaint/concern regarding any aspect of resident care is brought to the attention of staff. Concerns and/or complaints will be put in writing using the concern form.

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

3. Based on clinical record review, interviews and review of facility documentation for one of three sampled resident reviewed for allegations of mistreatment (Resident #103), the facility failed to ensure the resident was free from physical abuse. The findings include:
   a. Resident #103 diagnoses included dementia and anxiety. A quarterly MDS assessment dated 1/21/16 identified severely impaired cognition, was independent with eating after set up and did not exhibit any behaviors. The care plan dated 1/28/16 identified cognitive/ behaviors related to dementia with delusions with interventions which included if agitated leave me in a safe situation and return later, use simple terms and offer one step at a time directions. The accident /incident report dated 4/23/16 at 12:50PM identified a staff member reported NA #2slapped Resident #103 on the hand while trying to stop the resident from pulling off the table cloth.Interview with Cook #1 on 5/9/16 at 3:20PM identified on 4/23/16 during the noon meal he/she was standing behind the steam table in direct view of NA #2 and Resident #103. Resident #103 grabbed the tablecloth and started to pull it off of the table. Residents who were seated at the table attempted to stop the tablecloth as the table was set with silverware and dishes for the meal. NA #2 observed the incident and approached the table, he/she placed one hand on the tablecloth to stop it from moving and with the other hand slapped Resident #103's hand and then proceeded to remove the resident from the dining room. Interview with RN#1 on 5/10/16 at 2:44PM identified he/she was in the dining room at the time of the incident but did not directly observe the incident as he/she was distributing beverages at the time. RN#1 identified he/she heard a commotion and heard NA #2 tell Resident #103 "to stop". RN#1 observed NA#2 hands in the air and then NA #2 removed the resident from the dining room. RN#1 identified Cook #1 immediately reported that NA #2 struck Resident #103 ' s hand. RN#1 instructed NA#2 to leave the unit and assisted Resident #103 out of the dining room. RN#1 identified NA#2 denied hitting Resident #103, however the incident was witnessed by Cook #1 and the event was verified by Resident # 118 during police questioning. A review of the facility abuse policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting physical harm, pain or mental anguish.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Events (6) and/or Connecticut General Statues 19a-550.

4. Based on clinical record review, interviews and review of facility documentation for one of three sampled resident reviewed for allegations of mistreatment (Resident #103), the facility

failed to ensure a comprehensive investigation was conducted following a witnessed incident of physical abuse. The findings include:

a. Resident #103 diagnoses included dementia and anxiety. A quarterly MDS assessment dated 1/21/16 identified severely impaired cognition, was independent with eating after set up and did not exhibit any behaviors. The care plan dated 1/28/16 identified cognitive/ behaviors related to dementia with delusions with interventions which included if agitated leave me in a safe situation and return later, use simple terms and offer one step at a time directions. The accident /incident report dated 4/23/16 at 12:50PM identified a staff member reported NA #2 slapped Resident #103 on the hand while trying to stop the resident from pulling off the table cloth.Interview with Cook #1 on 5/9/16 at 3:20PM identified on 4/23/16 during the noon meal he/she was standing behind the steam table in direct view of NA #2 and Resident #103. Resident #103 grabbed the tablecloth and started to pull it off of the table. Residents who were seated at the table attempted to stop the tablecloth as the table was set with silverware and dishes for the meal. NA #2 observed the incident and approached the table, he/she placed one hand on the tablecloth to stop it from moving and with the other hand slapped Resident #103's hand and then proceeded to remove the resident from the dining room. Interview with RN#1 on 5/10/16 at 2:44PM identified he/she was in the dining room at the time of the incident but did not directly observe the incident as he/she was distributing beverages at the time. RN#1 identified he/she heard a commotion and heard NA #2 tell Resident #103 "to stop". RN#1 observed NA#2 hands in the air and then NA #2 removed the resident from the dining room. RN#1 identified Cook #1 immediately reported that NA #2struck Resident #103 hand. RN#1 instructed NA#2 to leave the unit and assisted Resident #103 out of the dining room. RN#1 identified NA#2 denied hitting Resident #103, however the incident was witnessed by Cook #1 and the event was verified by Resident #118 during police questioning. A review of the facility investigation identified administration failed to question the Nursing Supervisor regarding the outcome of the police interviews immediately following the incident of physical abuse. Interview with RN#1 on 5/10/16 at 2:44PM identified immediately following the incident in the dining room on 4/23/16 she reported the incident to the DNS and the police. He /she accompanied the police officer who conducted the investigation later that afternoon. RN#1 identified Resident # 118 verified to the officer that he/she witnessed NA# 2slap the hand of Resident # 103 .Interview with the Administrator, DNS and Corporate nurse on 5/11/16 at 11:15AM identified that a copy of the police report was not available/obtained until surveyor inquiry on 5/11/16. The Administrator further identified she did not question RN#1 regarding the police interviews and he/she was not aware that Resident # 118 verified he/she witnessed NA#2 slap Resident #103 on 4/23/16.

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

5. Based on observation, review of the clinical record and staff interviews for one of four residents reviewed for privacy (Resident #2) and/or for one of three residents reviewed for mistreatment

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

(Resident#83) and/or for two of five residents reviewed for accidents (Resident# 89 and158), the facility failed to ensure private information was not posted and/or failed to ensure residents were treated in a manner that promoted dignity. The findings include:

a. Resident #2 was admitted to the facility on 5/17/11 with diagnoses which included diabetes, dementia and paraplegia. The 14 day PPS MDS dated 3/24/16 identified intact cognition, required extensive assistance of two staff for bed mobility, required total assistance of two staff for transfers, and total assistance with toilet use. The care plan dated 2/6/16 identified the resident had dysphagia and required specific interventions with feeding. Observation on all days of the standard survey 5/9/16 - 5/12/16 identified a sign posted behind the residents bed which documented the following feeding recommendations;
   1.) Prompt patient to sit upright if feeding in bed, and use pillows for support,
   2.) Offer total feeding assistance for solids and supervision for liquids
   3.) Cut solids as necessary
   4.) Feed at slow pace
   5.) Verbally cue patient to re-swallow or to wash with puree/thin liquid to clear food from mouth.
   6.) Wait for patient to clear food from mouth before presenting another bite.
   Interview with the ADNS on 5/12/16 at 1:00PM identified there was no facility policy on the posting of signs in resident rooms.

b. Resident # 83 ' s diagnoses included anxiety, cerebral vascular accident, meningioma, insomnia, and hypertension. The annual MDS assessment dated 2/25/2016 identified the staff assessed Resident #83 to be short tempered and easily annoyed nearly every day. The February 2016 care plan identified Resident #83 verbally lashes out at others and gets upset if requests are not met immediately by staff. Interventions directed to offer tender loving care and reassurance to the resident as needed and to acknowledge the resident ' s moods in 1:1 interactions. During stage one of the survey process it was identified that there was a concern between Resident #83 and NA #3.Interview with the Administrator on 5/11/2016 at 10:10 AM identified she was not aware of any incident between Resident #83 and NA #3. Interview with NA #3 on 5/11/2016 at 11:25 AM identified an incident with Resident # 83 that occurred 2-4 weeks ago. NA #3 identified the resident was being demanding. NA # 3 responded to the requests of the resident by asking him/her to precede his/her requests with please. Resident #83 responded by becoming angry and ordering NA #3 out of his/her room and calling NA #3 stupid. Interview with RN #1 on 5/11/2016 at 11:45 AM identified that she was made aware that the resident declined an offer for an earlier shower than scheduled but was unaware of NA#3's requests to Resident#83 to precede requests with a "please".Resident#83 indicated that she felt reprimanded when NA#3 requested him/her to say "please". Subsequent to surveyor inquiry an investigation into this alleged incident was initiated.

c. Resident #89's diagnoses included failed left patella open reduction internal fixation, quadriceps tendon repair, anxiety, hypertension, depression and a history of alcohol abuse. The Admission Record dated 12/7/15 identified Resident #89 was responsible for him/herself and a family member was an emergency contact. The quarterly Minimum Data

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

Set assessment dated 3/10/16 identified Resident #89 had no cognitive impairments exhibited no behavioral symptoms, no history of wandering and required supervision with transfers and ambulating. The elopement risk assessment dated 3/10/16 identified Resident #89 was not a risk for elopement. The Reportable Event Form dated 4/19/16 at 7:30 PM identified Resident #89 went out for an appointment and did not return. The missing person policy was implemented. The facility was unable to connect with the resident via cell phone when initially called. The resident returned the call later that evening and informed the staff he/she was at a friend ' s place and would get a ride back to the facility. Resident #89 did not return to the facility until 4/21/16 (two (2) days later). The nurse ' s note dated 4/21/16 identified when Resident #89 returned to the facility on 4/21/16 at 10:30 AM the resident agreed to wear an elopement bracelet, a wanderguard bracelet was applied and the resident was placed on every fifteen (15) minute checks to then be re-evaluated in one month. The social service note dated 4/21/16 identified that Resident #89 had agreed to be accompanied to future appointments and to sign in and out. Upon further review, the social service notes from 4/21/16 through 4/28/16 failed to reflect documentation regarding Resident #89 ' s response to the wanderguard bracelet and the fifteen minute checks. Interview with Resident #89 on 4/28/16 at 10:00 AM identified that after the dental appointment, she had waited for the transportation company to come to pick her up but after waiting a few hours, he/she wheeled herself to a friend ' s house nearby and stayed for two nights. In a second interview on 4/28/16 at 12:00 PM Resident #89 identified that he/she was upset about having to wear the wanderguard and felt like a prisoner. The Director of Social Services on 4/18/16 at 1:30 PM informed the surveyor that she spoke with Resident #89 and the resident did not want the wanderguard on, that he/she felt like a prisoner. Review of facility policy identified that all residents are to be treated with consideration, respect and full recognition of their dignity and individuality.

d. Resident#158's diagnoses included advanced dementia, osteoporosis, congestive heart failure and anxiety. An initial elopement assessment dated 4/5/16 identified the resident was not at risk for elopement. An admission MDS dated 4/12/16 identified severe cognitive impairment, required extensive assistance for transfers, ambulation, personal hygiene and toilet use. A care plan dated 4/15/16 identified activities of living deficit with interventions that included assisting resident for transfers and ambulation with walker, assist to bathroom throughout the day and ensuring eyeglasses are easily available. Nurse notes dated 4/14/16 identified the resident was reassessed for elopement and did not meet the criteria for a wanderguard transmitter. The wanderguard transmitter was removed from the resident's leg. Clinical record review and interview with the ADNS on 5/12/16 at 11:00am identified that during morning report of 4/14/16, the ADNS learned that R#158 had a wanderguard transmitter (an activated elopement bracelet) in place since the time of admission. A reassessment was then done that revealed the resident was not at risk for elopement, and the wanderguard transmitter was then removed. The ADNS further indicated that he was the RN Supervisor on duty the day of admission; however, he could not recall who applied the wanderguard. Review of the clinical record indicated that at no time was the resident at risk for elopement and the ADNS indicated he could not explain why the wanderguard

transmitter was applied. Review of the elopement risk evaluation policy with the ADNS identified that the all the risks for elopement were answered in the negative and therefore, the resident did not require an elopement device.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (2) and/or (7).

6. Based on clinical record review and interview for one sampled resident (Resident #62) reviewed for hospice, the facility failed to provide medically related psycho-social services to attain the highest practicable physical, mental and psycho-social well-being of each resident. The findings include:
   a. Resident # 62 ' s diagnoses included dementia, depression and anxiety. A significant change MDS assessment dated 3/21/16 identified severely impaired cognition, and required total assistance for bed mobility, dressing, toileting and required extensive assistance for transfers and eating. The care plan dated 3/25/16 identified the need for hospice care. Interventions included maintain comfort, maintain dignity, and offer emotional support to resident and family. Interview and clinical record review with Social Worker on 5/11/16 at 12:00PM identified that the clinical record lacked documentation to reflect that after hospice care was initiated, a social services assessment was completed or that emotional support was provided to the resident or his/her family. The last social services documentation in the clinical record was dated 1/28/16 and indicated that the resident was essentially unchanged. The social worker indicated that an assessment should have been completed when hospice care was initiated but he/she could not recall why it had not been done. Review of facility Hospice Services Policy identified that the social worker will document assistance provided in obtaining hospice services and the ongoing psychosocial need of the resident and/or responsible party in the clinical record.

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

7. Based observations and interviews for one of four nursing units (West Baldwin), the facility failed to provide the necessary housekeeping services to ensure that the environment was clean, comfortable and homelike. The findings include:
   a. Observations on 5/9/2016 through 5/11/2016 on the West Baldwin unit identified the following: room 19 behind the bedroom door were visible spider webs and dirt particles and the bathroom door contained visible dirt on the handle, room 31 had visible coffee stains on floor in front of bed one, stains on floor in between bed one and two, and in room 29 visible spider webs with in insect in the web and dirt particles behind the bedroom door. Observations and interview with the Housekeeper Supervisor on 5/10/2016 at 2:35PM identified that the Housekeeper is to sweep/mop and clean the resident room daily.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(l).

8. Based on clinical record review and interview, for one of three sampled residents (Resident #83) reviewed for allegations of mistreatment, the facility failed to assess the resident ' s cognitive status. The findings include:
   a. Resident #83 diagnoses included: anxiety, cerebral vascular accident, and hypertension.Review of the quarterly MDS assessment dated 11/26/2015 and the annual MDS assessment dated 2/25/2016 identified the absence of a mental health status assessment. Further review of clinical record identified Resident #83 had not had a mental health status assessment documented since November of 2014. Interview with Social Worker on 5/12/16 at 11:30 AM identified she could not recall why the mental health assessment for Resident #83 was missing from the MDS assessment. Interview with Director of Clinical Reimbursement on 5/12/2016 at 12:15 PM identified that it is the responsibility of the MDS Coordinator to be certain the MDS assessment is complete and the absence of a mental health status assessment greater than three months is unacceptable. The Director of Clinical Reimbursement further identified that if a mental health status assessment is not documented in the MDS assessment it is the responsibility of the MDS coordinator to alert the Social Worker to complete the mental health assessment the following quarter.

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).

9. Based on clinical record reviews, observation, facility documentation and interviews for three of three sampled residents (Resident #50) who required hemodialysis, the facility failed to ensure physician orders were followed regarding medication time administration, and changes in medication dosage and/o rone of three sampled residents (Resident #105) who received insulin daily, the facility failed to obtain an order prior to administering a medication in accordance with standards of practice and/or for one of three sampled residents (Resident #162) with a history of falls, the facility failed to ensure a Registered Nurse was notified and had conducted an assessment of a resident who had an unwitnessed fall in accordance with the standards of practice and/or for one of three sampled residents (Resident #162) reviewed for pain medication, the facility failed to ensure documentation of medication administration in accordance with standards of practice and/or The findings include:
   a. Resident #50's diagnoses included diabetes mellitus, end stage renal disease with hemodialysis, aortic stenosis, and hypertension. Review of the physician ' s orders from 4/1/16 through 4/27/16 identified daily medication administration times were at 9:00 AM, twice a day 9:00 AM and 5:00 PM and three times a day 9:00 AM, 1:00 PM and 5:00 PM. Review of the April 2016 Medication Administration Record (MAR) identified Resident #50 received dialysis on Monday, Wednesday and Friday and the pick-up time was at 6:00 AM. The MAR identified the morning medications were signed as being administered at

the times ordered, 9:00 AM, 1:00 PM and 5:00 PM including on the days of dialysis and on the days of dialysis the 9:00 AM Renvela was held. A physician's order dated 4/27/16 to administer the 9:00 AM medications when the resident returned from dialysis on Monday, Wednesday and Friday, to change the administration times of the Renvela 2400 milligrams to 6:00 AM, 12:00 PM and 5:00 PM on Monday, Wednesday and Friday and continue to give the 9:00 AM, 1:00 PM and 5:00 PM times on Sunday, Tuesday, Thursday and Saturday, change the Lasix times to 6:00 AM and 5:00 PM and change the Lisinopril times from 9:00 AM and 9:00 PM to 11:00 AM and 11:00 PM. Interview with the 7-3PM charge nurse, Licensed Practical Nurse (LPN) #3 on 4/28/16 identified Resident #50 received the morning doses of medication when he/she returned from dialysis around 11:00 AM -12:00 PM and the 9:00 AM was not given. LPN #3 stated on 4/27/16 she reviewed the medication times and updated the attending physician at which time an order was obtained to change the times of the medication. 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. According to Drugs.com Renvela should be administered three times a day with meals.

b. Resident #105 ' s diagnoses included cerebrovascular accident, seizures diabetes mellitus, chronic kidney disease stage four with hemodialysis, hypertension, and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/17/16 identified Resident #105 had no cognitive impairments, received a therapeutic diet, received dialysis and insulin was administered daily. The resident care plan dated 3/24/16 identified the diagnosis diabetes mellitus and the resident may experience signs and/or symptoms of hyper or hypoglycemia. Interventions directed to check blood sugar as ordered and follow sliding scale, monitor for acute signs of hyper or hypoglycemia. The nurse ' s note dated 4/21/16 at 7:00 AM identified Resident #105 ' s blood sugar at 6:00 AM was 57 with mild symptoms of confusion and lethargy and Glucagon was administered. The note indicated in one-half hour the resident ' s blood sugar was 159 and the physician was notified. The nurse ' s note dated 4/23/16 at 8:00 AM identified Resident #105 ' s blood sugar at 6:00 AM was 82, orange juice was given, the blood sugar at 7:15 AM was 41, Glucagon 1 milligram (mg) was administered, the blood sugar at 7:30 AM was 75, the resident was alert and verbal. Review of the physician ' s orders from 4/14/16 through 4/26/16 failed to reflect documentation an order for Glucagon 1 ampule was obtained. The April 2016 Medication Administration Record (MAR) identified Glucagon 1 ampule as needed for low blood sugar, the documentation failed reflect parameters as to when to administer the Glucagon and/or physician notification. **According to Sec. 20-87a. Definitions. Scope of practice.** (a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse. A registered nurse may also execute orders issued by licensed physician assistants, podiatrists and optometrists, provided such orders do not exceed the nurse's or the ordering

practitioner's scope of practice.

c. Resident #162's diagnoses included status post right total hip replacement, arthritis, multiple sclerosis, osteoporosis, anemia and anxiety. The admission Minimum Data Set assessment dated 6/30/15 identified Resident #162 had intact cognition, required extensive two person assistance with transfers in and/or out of the bed and chair, assist of one person with locomotion on and off the unit, balance during transition was not steady but the resident was able to stabilize without staff assistance and a walker and wheelchair were utilized for mobility. The fall assessment dated 6/23/15 identified the resident was at risk for falls. The Resident Care Plan (RCP) dated 7/1/15 identified the resident was at risk for falls. Interventions directed to keep the bed in lowest position, transfer assist of one with a rolling walker, sensor alarm when in bed and check placement and function every shift, and call bell within reach when in bed or bedside chair. The 11-7 AM Registered Nurse (RN) nurse's note dated 8/23/15 at 3:00 AM identified that Resident #162 complained of left hip and thigh pain stating that he/she "fell this past evening" after supper and a nurse aide and nurse assisted him/her back to bed. The assessment identified there was no discoloration, no visible signs of trauma and there was positive range of motion with no distress. The physician and responsible party were notified and recommendations were pending. The 11-7 AM Nursing Supervisor nurse's note dated 8/23/15 at 5:00 AM identified Resident #162 was complaining of not feeling well, had a temperature of 100.3 degree Fahrenheit, pending x-ray for left hip pain and the resident requested to be sent to the hospital. Subsequent to an update a physician's order directed to send the resident to hospital for an evaluation. An addendum nurse ' s note dated 8/23/15 written by the 3-11 PM charge nurse, Licensed Practical Nurse (LPN) #4, for 8/22/15 identified at 6:45 PM the nurse aide assigned to Resident #162 notified LPN #4 that the resident had slid out of the wheelchair. On entering the resident's room LPN #4 observed Resident #162 sitting on the floor in front of the wheelchair and upon inquiry the resident stated "I was standing up and my legs felt very weak so I sat down and sat too close to the edge of the wheelchair and slid to the floor". The note indicated Resident #162 was insistent that the Nursing Supervisor not be notified and further stated "I did not hit my head or anywhere else ....I am not hurt ....I just want to be put back into my chair". The nurse's note identified that LPN #4 assessed Resident #162 with no findings to upper or lower extremities, noted ongoing edema to the right foot and elevated the right foot on a chair. Resident #162 was medicated with Oxycodone at 7:00 PM with a positive effect noted at 8:30 PM. The note identified that Resident #162 was assisted to the bathroom and to bed and rested comfortably for the remainder of the shift. The nurse's note failed to reflect documentation the 3-11 PM Supervisor was notified and/or an assessment was conducted by a registered Nurse. The Reportable Event Form dated 8/23/15 identified that Resident #162 complained of left hip pain and alleged that she slid from the wheelchair to the floor on 8/22/15. Review of facility investigation and staff statements identified Resident #162 was found on the floor in his/her room on 8/22/15 at 6:30 PM by the Nurse Aide (NA) #3. LPN #4 was notified by NA #3 of the incident. LPN #4 assessed the resident and with the assistance from NA #3 transferred the resident to the bed without notifying the supervisor. LPN #4 was terminated on 8/26/15. In an interview

on 4/28/16 at 9:15 AM, NA #3 identified during the 3:00-11:00 PM shift on 8/22/15 she found Resident #162 on the floor in the resident's room and reported this to LPN #4. NA #3 stated that LPN #4 assessed Resident #162 and then she and LPN #4 transferred the resident back to bed or the chair. Interview with the 3-11 PM Nursing Supervisor, RN #2, on 4/28/16 at 10:05 AM identified she was on duty 8/22/15 and was not informed that Resident #162 had fallen. RN #2 stated she was notified of the incident on 8/23/15 when she came in to work at 3:00 PM. Multiple attempts were made to contact LPN #4 with no return call.

Section 20-87a. Definitions. Scope of practice. The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

Resident #162's diagnoses included status post right total hip replacement, arthritis, multiple sclerosis, osteoporosis, anemia and anxiety. The admission Minimum Data Set assessment dated 6/30/15, with a look back period of seven (7) days, identified Resident #1 had no cognitive impairments, received a scheduled pain medication regimen, received an as needed pain medication, verbalized complaints of pain, and the pain was observed daily.

The admission physician's order dated 6/23/15 directed Oxycodone HCL Extended Release 40 milligram (mg) twice daily, Methocarbamol 500 mg two (2) tablets every six (6) hours as needed, Oxycodone 5 mg every three (3) hours as needed for moderate pain, and Oxycodone 10 mg every three (3) hours as needed. Review of the controlled substance record identified Resident #162 received Oxycodone 5 mg on 6/26/15 at 12:30 AM and Oxycodone 10 mg on 6/26/15 at 3:30 AM and 8:30 AM. Review of the clinical record failed to reflect documentation for the 11-7 shift on 6/25/15. Review of the June 2015 Medication Administration Record (MAR) and Pain Management Monitoring log failed to reflect documentation the Oxycodone 10 mg was administered on 6/26/15 at 3:30AM and 8:30AM. Review of the June 2015 MAR and Pain Management Monitoring log failed to reflect documentation that Methocarbamol 1000 mg was administered on 6/26/15 at 12:30AM. Interview and review of the clinical record with the 11-7 AM charge nurse, Licensed Practical Nurse (LPN) #2, on 4/28/16 at 7:45 AM identified she administered Oxycodone 5 mg and Methocarbamol 1000 mg on 6/26/15 at 12:30AM and Oxycodone 10 mg on 6/26/15 at 3:30 AM and 8:30 AM. LPN #2 stated she does not always sign off on the MAR and there were too many areas to document when administering pain medication. LPN #2 identified a resident on the short term rehabilitation unit a nurse's note should be written on each shift. In an interview on 4/28/16 at 3:00 PM, the Director of Nursing (DON) identified the licensed staff are to document on the MAR and Pain Management Monitoring log at the time of a medication administration as well as every shift for a resident who is on the short term rehabilitation unit. According to Basic Nursing, Mosby, Third edition, after administrating a drug, the nurse records it immediately on the appropriate record form. Recording of the drug includes the name of the drug, dosage, route, and exact time of administration.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

10. Based on clinical record review and interview for one of six residents (Resident #62) reviewed for pressure ulcers, the facility failed to complete weekly body audit assessments to identify alterations in skin integrity and/or for one of three sampled residents (Resident #81) who had difficulty with swallowing and was at risk of aspiration, the facility failed to notify the resident's physician and/or speech therapist to determine if the resident's diet should be downgraded secondary to ill-fitting dentures amd/or for one of ten sampled residents (Resident #89) who required monitoring of their location within the facility, the facility failed to ensure the resident was checked every fifteen minutes in accordance with the plan of care. The findings include:
    a. Resident # 62 ' s diagnoses included dementia, anxiety, depression, and a Stage 3 pressure wound to the coccyx. A significant change MDS assessment dated 3/21/16 identified severely impaired cognition, and required total assistance for bed mobility, dressing, toileting and required extensive assistance for transfers and eating. The care plan dated 5/8/16 identified a risk for pressure ulcers. Interventions included change position every 2 hours, perform body audit weekly on shower day, pressure relief mattress, and elevate heels. Interview and clinical record review with LPN#2 on 5/11/16 at 3:30PM, the LPN was unable to provide documentation that the resident ' s weekly skin body audit was done on 5/10/15. LPN#2 indicated that it was his/her responsibility to complete the body audit and could not explain why it was not done. Further review of the clinical record revealed that weekly body audits were not completed for 4 of 6 occurrences reviewed from 4/1/16 through 5/11/16. Review of facility body audit policy identified, a licensed nurse will conduct a weekly body audit preferably on shower day to identify alterations in skin integrity and will document findings on the weekly body audit form.
    b. Resident #81's diagnoses included dementia, dysphagia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 4/30/15 identified that Resident #4 had moderate cognitive impairments, required extensive one person assistance with eating, had functional limitation in range of motion of both upper extremities, received a mechanical altered diet. The assessment failed to reflect the resident had signs and/or symptoms of a possible swallowing disorder and the bottom dentures were not fitting properly or broken. The Resident Care Plan (RCP) dated 5/7/15 identified the resident had difficulty swallowing and was at risk aspiration. Interventions directed one to one supervision during meals, full feed, alternate liquids and solids, diet as ordered, to remain in an upright position at ninety (90) degrees for all oral intake and for at least thirty (30) minutes after, encourage to eat slowly and take time chewing and swallowing and follow up with the speech therapist as needed for safe swallowing techniques. A physician's order dated 6/1/15 directed a soft dysphagia diet, nectar thick liquids, one to one supervision, full feed and aspiration precautions. The nurse's note dated 6/14/15 at 7:50 PM identified the bottom dentures were not fitting properly or broken and social services was updated. Review of the clinical record failed to reflect documentation the physician and/or the speech therapist were notified of the

dentures not fitting properly. Resident #81 was discharge from speech therapy on 11/25/14 and a quarterly screen was conducted on 12/30/14 with no therapy recommended. The nurse's note dated 6/16/15 at 8:30 AM identified that a code blue was called when Resident #81 was observed to be in acute respiratory distress and undigested food was noted in the resident's mouth. The note indicated the Advanced Practice Registered Nurse (APRN) #1 was in the facility at the time and performed the Heimlich maneuver with back and abdominal thrusts. Interview with the Speech Therapist, (ST) #1, on 4/27/16 at 11:00 AM identified in the absence of dentition it would affect the resident's ability to chew and according to the incident the resident choked on a large piece of scrambled egg. ST #1 identified that the resident was impulsive and was the reason why he/she needed to be fed. ST #1 indicated she would expect the nursing staff to notify her of the dentures not fitting correctly to determine if a diet downgrade would be required. ST #1 identified that residents are screened quarterly and Resident #81 should have been screened in March 2015 and one was not completed under the previous speech therapist. Interview with the Director of Nursing (DON) on 4/28/16 at 2:15 PM identified that the nursing staff should informed the physician and speech therapy of the ill-fitting dentures.

c. Resident #89's diagnoses included failed left patella open reduction internal fixation, quadriceps tendon repair, anxiety, hypertension, depression and a history of alcohol abuse. The Admission Record dated 12/7/15 identified Resident #89 was responsible for him/herself and a family member was an emergency contact. The quarterly Minimum Data Set assessment dated 3/10/16 identified Resident #89 had no cognitive impairments exhibited no behavioral symptoms, no history of wandering and required supervision with transfers and ambulating. The elopement risk assessment dated 3/10/16 identified Resident #89 was not a risk for elopement. The Reportable Event Form dated 4/19/16 at 7:30 PM identified Resident #89 went out for an appointment and did not return. The missing person policy was implemented. The facility was unable to connect with the resident via cell phone when initially called. The resident returned the call later that evening and informed the staff he/she was at a friend's place and would get a ride back to the facility. Resident #89 did not return to the facility until 4/21/16 (two (2) days later). Upon return Resident #89 was transferred to the hospital for an evaluation, no ill effects were noted. The nurse's note dated 4/21/16 identified when Resident #89 returned to the facility on 4/21/16 at 10:30 AM the resident agreed to wear an elopement bracelet, a wanderguard bracelet was applied and the resident was placed on every fifteen (15) minute checks to then be re-evaluated in one month. Review of the Resident Locator Sheets from 4/21/16 through 4/27/16 failed to reflect documentation the resident's location was monitored every fifteen (15) minutes. Review of facility policy identified that fifteen minute checks was a visual observation by a facility staff member of a resident with documentation of the resident's location every fifteen minutes. Interview and review of the clinical record with the Corporate Regional Nurse on 4/28/16 identified the fifteen (15) minute check sheets failed to reflect documentation the checks were completed. Interview with Resident #89 on 4/28/16 at 10:00 AM identified that after the dental appointment, she had waited for the transportation company to come to pick her up but after waiting a few hours, he/she wheeled herself to a friend ' s house nearby

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and stayed for two nights.

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; clinical record review and staff interviews for for one of six residents reviewed for pain (Resident#149 and Resident #162) the facility failed to address the resident's pain during a treatment and/or according to physican orders and/or for one sampled resident (Resident #137), the facility failed to ensure the residents skin tear was treated according to professional standards and/or for two of six residents (Resident #158 , Resident #162) reviewed for accidents, the facility failed to ensure a Registered Nurse was notified and had conducted an assessment following a fall and/or for three of three sampled residents (Resident #72, #50 and #105) who required hemodialysis, the facility failed to monitor the residents' fluid consumption to ensure compliance with the fluid restriction in accordance with the physician's order and/or failed to ensure physician orders were followed regarding medication time administration and/or one of three sampled residents (Resident #72) who required hemodialysis, the facility failed to maintain communication with the dialysis center post treatment and/or one of three sampled residents (Resident #50) who required hemodialysis, the facility failed to conduct bladder scans in accordance with the physician ' s order . The findings include:
    a. Resident #149 ' s diagnoses include dementia, unstageable pressure ulcers of the right and left heel, acute osteomyelitis and muscle weakness. An admission assessment dated 03/30/16 identified the resident had severely impaired cognition, required extensive assistance of two for bed mobility, functional limitations in range of motion to bilateral lower extremities (i.e. hip, knee, ankle, foot) and 3 unstageable pressure ulcers. The care plan dated 04/06/16 identified the potential for pain related to bilateral heel pressure ulcers and osteomyelitis with interventions that included; determine the characteristics of pain such as quality, location, severity, onset, duration and any precipitating factors, offer a distraction to take thoughts away from the pain that the resident may be experiencing, listen to my complaints of pain and administer scheduled pain medication as ordered. A review of the monthly physician ' s orders for May 2016 identified an order for Tramadol HCL (Narcotic used to treat moderate to severe pain) 25mg, with directions to administer as needed every six hours. There was also an order for Tylenol 325mg with instructions to administer two tablets by mouth every 4 hours as needed for pain.Observation on 05/12/16 at 11:29 AM identified LPN #1 performing a dressing change to the unstageable pressure ulcer on the coccyx and to 3 unstageable pressure ulcers on the right and left heel and the left great toe.Resident #149's heels were placed on the bed and the resident immediately began verbalizing that his/her heels hurt and asked if his/her heels could hang off of the bed. Resident #149 moved her legs in a restless motion but was unable to relieve the pressure. Resident #149 verbalized that her heels were sore throughout the process of LPN#1 performing the dressing changes. The resident ' s feet were not offloaded during the treatment; they remained on the mattress surface throughout the entire time. The resident ' s heels were not relieved of pressure until 12:05 PM(thirty six minutes after the treatment

began).Interview with LPN #1 on 05/12/16 at 12:15 PM identified she had not pre-medicated the resident for pain and could not explain why she had not elevated the resident ' s heel off of the mattress surface upon resident request and continued to complaints of heel pain during the treatment.

b. Resident #162's diagnoses included status post right total hip replacement, arthritis, multiple sclerosis, osteoporosis, anemia and anxiety. The admission Minimum Data Set assessment dated 6/30/15, with a look back period of seven (7) days, identified Resident #162 had no cognitive impairments, received a scheduled pain medication regimen, received an as needed pain medication, verbalized complaints of pain, and the pain was observed daily. The admission physician's order dated 6/23/15 directed Oxycodone HCL Extended Release 40 milligram (mg) twice daily, Methocarbamol 500 mg two (2) tablets every six (6) hours as needed, Oxycodone 5 mg every three (3) hours as needed for moderate pain, and Oxycodone 10 mg every three (3) hours as needed. Review of the clinical record identified Resident #162 received the Methocarbamol on 6/25/15 at 12:30 PM and on 6/26/15 at 4:00 PM. The record failed to reflect documentation the Methocarbamol was administered on 6/26/15 from 8:30 AM through 4:00 PM. The Reportable Event Form dated 6/26/15, 11-7 AM shift, identified Resident #162 requested pain medication from the charge nurse but did not receive medication. In an interview and review of the clinical record with the 11-7 AM charge nurse, LPN #2, on 4/28/16 at 7:45 AM identified she administered Oxycodone 5 mg and Methocarbamol 1000 mg on 6/26/15 at 12:30 AM. LPN #2 stated at approximately 8:30 AM a nurse aide informed her that Resident #162 requested pain medication and she prepared Oxycodone 10 mg. LPN #2 identified when she went to administer the medication, the 7-3 PM Nursing Supervisor requested to conduct the narcotic count since the oncoming 7-3:00 PM charge nurse was late. LPN #2 stated after the narcotic count was completed she administered the Oxycodone 10 mg at 8:30 AM and at this time Resident #1 requested the Methocarbamol. LPN #2 identified she informed the resident she will return with the requested medication or she will inform the oncoming nurse of the request. LPN #2 stated that she informed the oncoming 7-3PM nurse of the resident's request. LPN #2 stated that she became aware that the resident did not receive the medication when she received a phone call from the DON. In an interview on 4/28/16 at 11:15 AM and review of a written statement dated 6/26/15, RN #3 could not recall the details of the incident on the morning of 6/26/15. In an interview on 4/28/16 at 2:15 PM, the DON identified that a resident's request for medication should be addressed at the time of the request.

c. Resident #137 was admitted to the facility on 8/24/15 with diagnoses which included dementia. The quarterly MDS assessment dated 3/10/16 identified severely impaired cognition, required extensive assistance with bed mobility, transfers and dressing and had no skin tears. A nurse's note dated 4/8/16 identified the resident was found with an abrasion to the left upper arm and after physician notification, the area was cleansed and a dry clean dressing was applied. Physician orders dated 4/8/16 directed to cleanse the left arm abrasion with normal saline, pat dry and apply a dry clean dressing every three days for fourteen days. Observation on 5/9/16 at 10:00AM identified the resident had a dressing on the left elbow area dated 4/27/16 (12 days prior).Interview and observation with the ADNS on 5/9/16 at

10:00AM identified he/she could not identify why the dressing had not been changed for 12 days. The ADNS removed the dressing dated 4/27 and a small open area was noted. The ADNS indicated the charge nurse is responsible to ensure the treatments are renewed and completed. Additionally, he/she indicated the treatment for the skin tear should have been renewed with the physician.Physician order dated 5/9/16 directed to cleanse the left elbow area with normal saline, apply skin prep to the periwound followed by AGB dressing, change every three days and check every shift. Review of the facility protocol on skin tears directed that current interventions should be re-assessed weekly to determine their appropriateness.

d. Resident#158 diagnoses included advanced dementia, osteoporosis, congestive heart failure and anxiety. The nursing fall risk assessment dated 4/5/16 identified the resident was a moderate risk for falls. The admission MDS assessment dated 4/12/16 identified severe cognitive impairment, extensive assistance for transfers, ambulation, personal hygiene and toilet use. The care plan dated 4/15/16 identified a risk for falls with interventions that included to keep the resident within visual field of the staff as resident allows, use of a sensor alarm when in bed or the wheelchair, frequent checks for safety and anticipate the resident needs. The nurses note dated 4/16/16 at 3:45PM identified that while the charge nurse was assisting the resident to the bathroom, the resident stumbled and the charge nurse was unable to break the fall. The nurse's note failed to identify the resident was assessed after the fall. A subsequent nurse ' s note indicated the resident sustained a large hematoma to the left arm. Interview with LPN#2 on 5/11/16 at 3:50PM identified on 4/16/16 Resident#158 was seated at the nurse's station. LPN #2 heard the chair alarm sound and the resident was observed to be independently ambulating off the unit. LPN#2 assisted the resident back to the unit at which time Resident #158 requested to use the bathroom. While LPN#2 was holding onto Resident #158 by the waist to lead R#158 back to his/her wheelchair, the resident bent forward to pick up toilet paper and lost his/her balance. LPN#2 then grabbed the resident's waist to break his/her fall and Resident #158 bumped the wall with his/her upper body . Further interview indicated that LPN#2 did not report the incident to the RN Supervisor for evaluation and assessment following the incident. LPN#2 indicated that since a fall did not occur, he/she did not believe a report and further assessment was warranted. Interview and clinical record with the DNS on 5/11/16 at 4:30PM identified that an assessment of the area and intervention was completed when a family member noted the area on the left arm more than two hours later. The nurse notes indicated that ice pack and Tylenol 650 mg was provided for pain control. The DNS further identified it is the responsibility of the charge nurse to notify the Nursing Supervisor regarding any incidents that require an assessment of the resident.

e. Resident #162's diagnoses included status post right total hip replacement, arthritis, multiple sclerosis, osteoporosis, anemia and anxiety. The admission Minimum Data Set assessment dated 6/30/15 identified Resident #162 had no cognitive impairments, required extensive two person assistance with transfers in and/or out of the bed and chair, assist of one person with locomotion on and off the unit, balance during transition was not steady but the resident was able to stabilize without staff assistance and a walker and wheelchair were

utilized for mobility. The fall assessment dated 6/23/15 identified the resident was at risk for falls. The Resident Care Plan (RCP) dated 7/1/15 identified the resident was at risk for falls. Interventions directed to keep the bed in lowest position, transfer assist of one with a rolling walker, sensor alarm when in bed and check placement and function every shift, and call bell within reach when in bed or bedside chair. The 11-7 AM Registered Nurse (RN) nurse's note dated 8/23/15 at 3:00 AM identified that Resident #162 complained of left hip and thigh pain stating that he/she "fell this past evening" after supper and a nurse aide and nurse assisted him/her back to bed. The assessment identified there was no discoloration, no visible signs of trauma and there was positive range of motion with no distress. The physician and responsible party were notified and recommendations were pending. The 11-7 AM Nursing Supervisor nurse's note dated 8/23/15 at 5:00 AM identified Resident #162 was complaining of not feeling well, had a temperature of 100.3 degree Fahrenheit, pending x-ray for left hip pain and the resident requested to be sent to the hospital. Subsequent to an update a physician's order directed to send the resident to hospital for an evaluation. An addendum nurse's note dated 8/23/15 written by the 3-11 PM charge nurse, Licensed Practical Nurse (LPN) #4, for 8/22/15 identified at 6:45 PM the nurse aide assigned to Resident #162 notified LPN #4 that the resident had slid out of the wheelchair. On entering the resident's room LPN #4 observed Resident #162 sitting on the floor in front of the wheelchair and upon inquiry the resident stated "I was standing up and my legs felt very weak so I sat down and sat too close to the edge of the wheelchair and slid to the floor". The note indicated Resident #162 was insistent that the Nursing Supervisor not be notified and further stated "I did not hit my head or anywhere else ....I am not hurt ....I just want to be put back into my chair". The nurse's note identified that LPN #4 assessed Resident #162 with no findings to upper or lower extremities, noted ongoing edema to the right foot and elevated the right foot on a chair. Resident #162 was medicated with Oxycodone at 7:00 PM with a positive effect noted at 8:30 PM. The note identified that Resident #162 was assisted to the bathroom and to bed and rested comfortably for the remainder of the shift. The nurse's note failed to reflect documentation the 3-11 PM Supervisor was notified and/or an assessment was conducted by a registered Nurse. The Reportable Event Form dated 8/23/15 identified that Resident #162 complained of left hip pain and alleged that she slid from the wheelchair to the floor on 8/22/15. Review of facility investigation and staff statements identified Resident #162 was found on the floor in his/her room on 8/22/15 at 6:30 PM by the Nurse Aide (NA) #3. LPN #4 was notified by NA #3 of the incident. LPN #4 assessed the resident and with the assistance from NA #3 transferred the resident to the bed without notifying the supervisor. LPN #4 was terminated on 8/26/15. In an interview on 4/28/16 at 9:15 AM, NA #3 identified during the 3:00-11:00 PM shift on 8/22/15 she found Resident #162 on the floor in the resident's room and reported this to LPN #4. NA #3 stated that LPN #4 assessed Resident #162 and then she and LPN #4 transferred the resident back to bed or the chair. Interview with the 3-11 PM Nursing Supervisor, RN #2, on 4/28/16 at 10:05 AM identified she was on duty 8/22/15 and was not informed that Resident #162 had fallen. RN #2 stated she was notified of the incident on 8/23/15 when she came in to work at 3:00 PM. Multiple attempts were made to contact LPN #4 with no return call.

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

f. Resident #72's diagnoses included end stage renal disease, peripheral vascular disease, heart failure and hypertension. The admission Minimum Data Set (MDS) assessment dated 1/1/16 and the quarterly MDS assessment dated 4/2/16 identified Resident #72 had severe cognitive impairment, required extensive one person assistance with activities of daily living, received a therapeutic diet and required dialysis. The Resident Care Plan dated 1/12/16 and 4/7/16 identified hemodialysis. Interventions directed to monitor the fluid intake and output, monitor the dialysis site as ordered, monitor weights, administer medications, and provide a therapeutic diet. A physician's order dated 1/4/16 directed to increase the resident's the fluid restriction from 1000 cubic centimeters (cc) to 1300cc per day. Observations on 4/26/16 at 12:30 PM Resident #72 was lying in bed with the over the bed table in front of the resident. Noted on the table was a 20 ounce bottle of iced tea with a quarter of the bottle missing, a water pitcher, a small cup of water that was almost empty and a bowl of soup. On 4/27/16 at 11:05 AM Resident #72 was out of bed sitting in the wheelchair with the over the bed table in front of the resident with a 20 ounce bottle of iced tea, a large cup of water half gone and a small glass of cranberry juice. On 4/28/16 at 2:10 PM Resident #72 was observed sitting in his/her room with the over the bed table in front of the resident. The table had a water pitcher, a large cup of water, a small cup of water, a large cup of cranberry juice, a small cup of juice not opened, a cup of ice cream and on the night stand was a 20 ounce bottle of iced tea and ginger ale, both half gone. The Advanced Practice Registered Nurse (APRN) progress note dated 2/3/16 identified the resident's blood pressure was usually acceptable, and the dates when there were evaluated intake records corresponded with increased blood pressures. The note indicated the APRN discussed with the patient and staff the need to remain at and/or under the fluid restriction limit. An APRN order dated 2/3/16 directed strict intake and output, fluid restriction of 1300 cc per day and do not exceed the fluid restriction secondary to an increase of fluids can elevated the resident's blood pressure. Review of the intake and output sheets from 1/4/16 through 4/26/16 identified out of one hundred and fourteen days (114) days the resident ' s fluid intake, seventy-one (71) days the resident was over the 1300cc fluid restriction, the excess ranged from 1320cc to 1920cc. Interview with the APRN on 4/27/16 at 10:45 AM identified the reason for the resident's fluid restriction was due to the dialysis and a history of congestive heart failure. The APRN stated that if the resident was exceeding the fluid restriction then staff should have notified the dialysis center and/or the resident's physician. Interview with the Registered Dietician on 4/27/16 at 2:45 PM identified the dietary department does not monitor how the resident receives fluids and/or how much. The Dietician stated that she does not always look at the resident's intake and output, but when she did she had in the past reported the results to the dialysis unit. Interview with the Director of Nursing (DON) on 4/27/16 at 1:25 PM identified the 11-7 shift was responsible for totaling the intake and output and if the resident was going over the fluid restriction the physician is to be made aware. Review of the clinical record at that time with the DON failed to reflect documentation that the physician was informed the resident exceeded the fluid restriction.

The admission Minimum Data Set (MDS) assessment dated 1/1/16 and the quarterly MDS

assessment dated 4/2/16 identified Resident #72 had severe cognitive impairment, required extensive one person assistance with activities of daily living, received a therapeutic diet and required dialysis. The Resident Care Plan dated 1/12/16 and 4/7/16 identified hemodialysis. Interventions directed to monitor the fluid intake and output, monitor the dialysis site as ordered, monitor weights, administer medications, and provide a therapeutic diet. Review of the physician's orders from 12/25/15 through 5/13/16 identified Resident #72's scheduled morning medication administration times was 9:00 AM. Review of the Medication Administration Record (MAR) identified Resident #72 received dialysis on Tuesday, Thursday and Saturday and the pick-up time was at 6:00 AM. The MAR identified the morning medications were signed as being administered at 9:00 AM. Upon further review the MAR identified the three times a day medications were administered at 9:00 AM, 1:00 PM and 5:00 PM on the days of dialysis. Interview with Resident #72 on 4/26/16 at 12:30 PM identified he/she went to dialysis on Tuesday, Thursday, and Saturday. Resident #72 stated that he/she eats breakfast before going and takes the medications upon returning to the facility. Interview with the Director of Nursing (DON) on 4/27/16 at 1:25 PM identified Resident #72 usually arrived back to the facility from dialysis between 10:00 and 11:00 AM and was unaware the resident was receiving the 9:00 AM medications upon return from dialysis until approximately two weeks ago. The DON stated that after she was told she had the medication times changed so Resident #72 received the morning dose of medications before going to dialysis.

A physician's order dated 1/4/16 directed to administer the Phoslo with each Nepro. Review of the January 2016 Medication Administration Record (MAR) identified the Phoslo was administered from 1/4/16 through 1/11/16 three (3) times a day. A physician's order dated 1/11/16 directed to discontinue the Phoslo secondary to a decrease lab value. Review of the dialysis communication book identified on 1/16/16 the physician directed to decrease the Phoslo 667 milligram (mg) tablet to be taken at lunch only. The note further identified the residents Phosphorus was low at 2.6 (the normal ranger 3.0-5.5mg/dl) and if there any questions to contact the doctor at the dialysis center. Review of the clinical record and interview with the Director of Nursing (DON) on 4/27/16 at 1:25 PM identified that the Phoslo 667mg three times a day was originally ordered on 1/4/16. Upon further review the MAR and clinical record failed to reflect documentation the 1/16/16 order from the dialysis center to decrease the Phoslo was transcribed. Review of the January 2016, February 2016 (missing), March 2016 and April 2016 Medication Administration Record (MAR) identified Resident #72 continued to receive the Phoslo 667 mg three times day. Interview at that time with the DON stated that when a resident returns from treatment the charge nurse reviews the communication book and transcribes any orders that came from dialysis. The DON stated no one reviewed the book when the resident returned from treatment. Interview and review of the April MAR with the Assistant Director of Nursing on 5/9/16 at 2:10 PM identified the Phoslo was discontinued on 4/28/16.

A physician's order dated 1/4/16 directed to administer Nephro 240 milliliters (ml) three times a day and to document the percentage taken. Review of the January 2016 MAR identified ten (10) times the percentage consumed was not documented. The February 2016

MAR was unable to be located. The March 2016 MAR failed to reflect documentation of the percentage consumed for any day and documentation of the drink being administered was omitted ten (10) times. The April 2016 MAR failed to reflect documentation of the percentage consumed from 5/1/16 through 5/27/16. Interview and review of the clinical record with the Dietician on 4/27/16 at 2:45 PM identified she was not aware the staff was not recording the percentage of supplement Resident #6 consumed.

Resident #72's diagnoses included end stage renal disease, peripheral vascular disease, heart failure and hypertension. The admission Minimum Data Set (MDS) assessment dated 1/1/16 and the quarterly MDS assessment dated 4/2/16 identified Resident #72 had severe cognitive impairment, required extensive one person assistance with activities of daily living, received a therapeutic diet and required dialysis. The Resident Care Plan dated 1/12/16 and 4/7/16 identified hemodialysis. Interventions directed to monitor the fluid intake and output, monitor the dialysis site as ordered, monitor weights, administer medications, and provide a therapeutic diet. Review of the communication book between the dialysis center and the facility identified Resident #72 had received fifty-two (52) days of treatment since admission and nine (9) days there was no communication back from the dialysis center. Review of the nurse's notes failed to reflect documentation that the facility contacted the dialysis center for a report of the resident's treatment on 1/7/16, 1/12/16, 1/30/16, 2/2/16, 2/20/16, 2/23/16, 4/5/16, 4/7/16 and 4/16/16. Interview and review of Resident #72's clinical record with the Director of Nursing (DON) on 4/27/16 at 1:25 PM identified that if the resident comes back to the facility and there is no documentation, staff are to call over to the dialysis center and document the report in the nursing notes. Review of the clinical record with the DON identified that the nurse's notes failed to reflect documentation the dialysis center was called on the above dates.

g. Resident #50's diagnoses included diabetes mellitus, end stage renal disease with hemodialysis, aortic stenosis, and hypertension. The admission Minimum Data Set assessment dated 3/3/16 identified that Resident #50 had no cognitive impairments, required extensive one to two person assistance with activities of daily living, was frequently incontinent of urine, received a therapeutic diet, and received dialysis.
The resident care plan dated 3/9/16 identified a history of renal disease and hemodialysis. Interventions directed to administer medications in a timely manner, any questions contact the dialysis center, dialysis three times a week, a renal diet 2 Gram Sodium , low fat, low cholesterol fluid restricted diet, monitor the fluid intake and output, monitor blood work, monitor weight as ordered, and observe the dialysis site as ordered. A physician's order dated 3/27/16 directed to discontinue the fluid restriction of 1000 cubic centimeters (cc) and start 1200 cc per day fluid restriction. Review of the intake and output report from 2/26/16 through 4/27/16 identified that out of fifty-nine (59) days Resident #50 exceeded the fluid forty-seven days and four days the intake and output report failed to reflect documentation of the fluid amount consumed for a twenty-four (24) hour time frame.
Resident #50's diagnoses included diabetes mellitus, end stage renal disease with hemodialysis, aortic stenosis, and hypertension. The admission Minimum Data Set assessment dated 3/3/16 identified that Resident #50 had no cognitive impairments, required

extensive one to two person assistance with activities of daily living, was frequently incontinent of urine, received a therapeutic diet, and received dialysis. The resident care plan dated 3/9/16 identified a history of renal disease and hemodialysis. Interventions directed to administer medications in a timely manner, any questions contact the dialysis center, dialysis three times a week, a renal diet 2 Gram Sodium, low fat, low cholesterol fluid restricted diet, monitor the fluid intake and output, monitor blood work, monitor weight as ordered, and observe the dialysis site as ordered. Review of the physician's orders from 4/1/16 through 4/27/16 identified daily medication administration times were at 9:00 AM, twice a day 9:00 AM and 5:00 PM and three times a day 9:00 AM, 1:00 PM and 5:00 PM. Review of the April 2016 Medication Administration Record (MAR) identified Resident #50 received dialysis on Monday, Wednesday and Friday and the pick-up time was at 6:00 AM. The MAR identified the morning medications were signed as being administered at the times ordered, 9:00 AM, 1:00 PM and 5:00 PM including on the days of dialysis and on the days of dialysis the 9:00 AM Renvela was held. Interview with the 7-3PM charge nurse, Licensed Practical Nurse (LPN) #3 on 4/28/16 identified Resident #50 received the morning doses of medication when he/she returned from dialysis around 11:00 AM -12:00 PM and the 9:00 AM was not given. LPN #3 stated on 4/27/16 she reviewed the medication times and updated the attending physician at which time an order was obtained to change the times of the medication.

Resident #50's diagnoses included diabetes mellitus, end stage renal disease with hemodialysis, aortic stenosis, and hypertension. A physician's order dated 2/27/16 directed to conduct a bladder scan daily and straight cath if the bladder volume was greater than 200 milliliters (ml). The admission Minimum Data Set assessment dated 3/3/16 identified that Resident #50 had no cognitive impairments, required extensive one to two person assistance with activities of daily living, was frequently incontinent of urine and received a diuretic medication. The resident care plan dated 3/9/16 identified the resident required assistance with activities of daily living. Interventions directed to assist to the bathroom throughput the day, offer frequent incontinent care and monitor for signs and symptoms of urinary tract infection. Review of the April 2016 Treatment Administration Record (TAR) and the clinical record failed to reflect documentation bladder scans were conducted and/or if the resident had voided the scan was conducted on another shift and/or the amount of urine when the scan was completed. The facility policy directs to use the bladder scan per the physician's order and attach the results to the nurse's note and add to the chart.

h. Resident #105's diagnoses included cerebrovascular accident, seizures diabetes mellitus, chronic kidney disease stage four with hemodialysis, hypertension, and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/17/16 identified Resident #105 had no cognitive impairments, required limited one person assistance with personal hygiene, received a therapeutic diet, and received dialysis. The resident care plan dated 3/24/16 identified a history of renal disease and hemodialysis. Interventions directed to administer medications in a timely manner, any questions contact the dialysis center, dialysis three times a week, a consistent carbohydrate, renal diet with a 1500 cubic centimeter (cc) fluid restriction, monitor the fluid intake and output, monitor blood work,

monitor weight as ordered, and observe the dialysis site as ordered. A physician's order dated 4/15/16 directed to resume the 1500 cc fluid restriction. Review of the intake and output report from 4/15/16 through 4/26/16 identified that on four (4) of eleven (11) days Resident #105 exceeded the fluid of 1500 cc and one day the intake and output report failed to reflect documentation of the fluids consumed for a twenty-four (24) hour time frame. The facility policy, Intake and Output (I&O) directs that I&O are instituted on admission and then quarterly for all residents and if there is a physician ' s order on a resident with a fluid restriction, to record all fluids in the proper column and do not leave a column blank.

i. Resident #105's diagnoses included cerebrovascular accident, seizures diabetes mellitus, chronic kidney disease stage four with hemodialysis, hypertension, and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/17/16 identified Resident #105 had no cognitive impairments, received a therapeutic diet, received dialysis and insulin was administered daily. The resident care plan dated 3/24/16 identified the diagnosis diabetes mellitus and the resident may experience signs and/or symptoms of hyper or hypoglycemia. Interventions directed to check blood sugar as ordered and follow sliding scale, monitor for acute signs of hyper or hypoglycemia. The nurse's note dated 4/23/16 at 8:00 AM identified Resident #105's blood sugar at 6:00 AM was 82, orange juice was given, the blood sugar at 7:15 AM was 41, Glucagon 1 milligram (mg) was administered, the blood sugar at 7:30 AM was 75, the resident was alert and verbal. The note failed to reflect documentation the physician and/or Advanced Practice Registered Nurse (APRN) were notified of the low blood sugar level of 41. Review of the physician ' s orders from 4/14/16 through 4/26/16 failed to reflect documentation an order for Glucagon 1 ampule was obtained. The April 2016 Medication Administration Record (MAR) identified Glucagon 1 ampule as needed for low blood sugar, the documentation failed reflect parameters as to when to administer the Glucagon and/or physician notification. Review of the facility policy, Systemic Medical Emergencies, directs for hyperglycemia and/or hypoglycemia the physician was to be immediately notified when the resident who receives insulin exhibits altered behaviors or mental or physical state consistent with hyperglycemia and/or hypoglycemia. If the resident was having an insulin reaction, low blood sugar with symptoms, administer a highly concentrated sugar product while awaiting the physician's direction if the resident is able to take something by mouth. Glucagon is also available in the emergency drug box for administration per the physician's order, notify the responsible party of the change in condition and document in the clinical record all observations, findings and interventions. Interview with the Assistant Director of Nursing (ADON) on 4/28/16 at 1:15 PM identified that Glucagon would normally be administered for a blood sugar less than 60 and/or in accordance with the physician's order.

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).

12. Based on observations, review of the clinical records and staff interviews for four of six residents (Resident #50,Resident #149, Resident #2 and Resident #137) reviewed for pressure

ulcers, the facility failed to implement interventions to prevent the development of a pressure ulcer. The findings include:

a. Resident #50 was admitted on 2/25/16 with diagnoses which included end stage renal disease. The Braden score completed upon admission identified a score of 19 which represented a mild risk for the development of pressure ulcers. The nursing admission assessment dated 2/25/16 identified redness to the buttocks and boggy heels. The admission MDS assessment dated 3/3/16 identified intact cognition and required extensive assistance of two staff members for bed mobility and transfers and no pressure ulcers. The care plan dated 3/9/16 identified a risk for skin breakdown with interventions which included to elevate legs when out of bed, inspect skin when giving care for signs of skin breakdown and to offload heels. A review of the weekly body audit dated 3/10/16 identified no pressure areas. The wound APRN note dated 3/11/16 identified a new stage 3 pressure ulcer on the right buttock and recommended treatment with medihoney and AGB every three days and as needed, initiate MA65 mattress((low air loss with alternating pressure) and repositioning. Interview and review of the clinical record with LPN#3 on 5/11/16 at 2:25PM identified that although Resident #50 utilized a pressure reducing mattress, she was unable to provide documentation that additional interventions such as turning and repostioning were implemented at the time of admission to prevent the development of a pressure ulcer. LPN#3 identified it is the responsibility of the licensed staff who admitted the resident to implement measures to prevent the development of a pressure ulcer. Interview with Wound APRN#1 on 05/12/16 at 2:00PM identified that the resident ' s skin condition is fragile and that it was possible for the skin to develop a pressure ulcer over a short period of time if interventions such as a turning and repositioning schedule was not implemented in a timely manner.

b. Resident #149 ' s was readmitted on 3/23/16 with diagnoses which included dementia, unstageable pressure ulcers of the right and left heel, acute osteomyelitis and muscle weakness. An admission MDS assessment dated 03/30/16 identified severely impaired cognition, required extensive assistance of two for bed mobility, was always incontinent of bowel and bladder, functional limitations in range of motion to bilateral lower extremities (i.e. hip, knee, ankle, foot) and 3 unstageable pressure ulcers. A care plan dated 04/06/16 identified a risk for alteration in skin integrity related to decreased mobility and incontinence, three unstageable pressure ulcers from admission on the heels and left great toe with interventions which included a MA65 mattress (alternating air), assess skin when providing care for signs and symptoms of breakdown, bruising, infection and report any issues as needed, offer to assist with turning and positioning approximately every two hours as needed. The care plan further identified that the MA65 (rented mattress) mattress was changed to a APM (facility mattress) on 05/02/16.
Review of the skin/wound tracking record identified on 05/09/16 Resident #149 developed a new unstageable pressure ulcer on the coccyx area that measured 1.0cm by 1.0 cm with 100% slough in the wound bed. A physician ' s order dated 05/09/16 directed to cleanse the coccyx wound with Normal Saline, pat dry, apply skin prep to the peri-wound area and apply Santyl ointment and secure with a dry clean dressing daily. The physician orders

also directed to discontinue the APM mattress and change to the MA65 mattress. Review of the clinical record and facility documentation failed to identify documentation of a positioning plan/schedule. Interview with the Infection Control Nurse on 05/12/16 at 10:20 AM identified the MA65 mattress was discontinued on 5/2/16 due to budgetary constraints. The Infection Control Nurse further identified the pressure ulcer developed because the resident was changed from the MA65 mattress to the facility mattress which was not as therapeutic as the MA65 mattress. An interview with Wound APRN#1 on 05/12/16 at 2:00PM identified that the resident ' s skin condition is fragile and that it was possible for the skin to develop an unstageable pressure ulcer over a short period of time. Wound APRN #1 further identified that the resident could not change position/off load her weight off of her back/coccyx independently, as she had to assist the resident to turn in order to assess the coccyx wound. An interview with the ADNS on 05/12/16 at 2:15 PM identified that there was no documentation of position changes for the resident because the resident was not on a formal positioning plan.

Observation on 05/12/16 at 11:29 AM of the dressing change to the coccyx identified LPN #1 failed to apply the Santyl to the wound bed as ordered. Resident # 149 required assistance with changing position during the dressing change process by LPN #1. Interview with LPN #1 on 05/12/16 at 12:15 PM identified that she had not applied the Santyl because it was not available.

c. Resident #2's diagnoses included diabetes mellitus, dementia, and paraplegia. A significant change MDS assessment dated 1/24/16 identified intact cognition, requires extensive assistance of two staff members for bed mobility, transfers and the presence of one unstageable pressure ulcer. The care plan dated 2/4/16 identified the resident was at risk for skin breakdown with interventions that included to encourage the resident to reposition every two hours and offload pressure to heels with a pillow.A physician order dated 3/3/16 directed to discontinue skin prep to the right heel ulcer because it was resolved, but continue to monitor the heels. The 14 day PPS MDS dated 3/24/16 identified intact cognition, required extensive assistance of two staff for bed mobility, required total assistance of two staff for transfers, and total assistance for toilet use. Additionally, the resident had intact skin but was at risk to develop a pressure ulcer.Physician order dated 4/1/16 directed to off load the heels at all times in bed and complete a body audit weekly on shower day.Nurse's note dated 4/19/16 identified the resident went to the hospital for elective day surgery at 7:00AM. A nurses note dated 4/19/16 identified the resident returned to the facility at 10:00PM, 15 hours later. The interagency transportation report dated 4/19/16, sent with the resident to the hospital for outpatient surgery, identified the residents skin was intact, however, there was no documentation that the resident had a recently healed a pressure ulcer on the right heel or the physician order that directed the heels to be offloaded at all times in bed. The clinical record failed to show a skin assessment was completed when the resident returned from the hospital on 4/19/16 at 10:00PM, after having been at the hospital for 15 hours. A skin check dated 4/21/16, done during the 3:00PM-11:00PM shift by LPN# 4 identified the residents skin was clean, dry and intact. A nurse's note dated 4/22/16 during the 7:00AM-3:00PM shift, identified that a new unstageable pressure ulcer on the right heel

was identified that measured 0.5cm by 0.5cm x 0.0cm with 100% eschar.A wound care specialist note, by Wound APRN #1, dated 5/9/16 identified the resident previously had a pressure ulcer to this area on the right heel that had resolved. Recommendations included offloading the heel with a heel lift and continuing with skin prep twice daily. Interview with LPN# 4 on 5/11/16 at 2:40PM identified that after the resident ' s bed bath on 4/21/16 during the 3:00PM-11:00PM shift and he/she did go in and look at the residents skin. LPN# 4 indicated that there were no noted areas. Interview with the ADNS on 5/9/16 at 1:15PM identified that the facility does not have a policy that directs staff to complete a skin assessment when the resident returns from a procedure. However, if the resident had an incident while out, then he/she would expect a skin assessment to be completed. Interview with Wound APRN #1 on 5/11/16 at 3:15PM identified that regarding the skin check by LPN#4 of 4/21/16 that documented the resident ' s skin as intact; he/she indicated that eschar takes time to develop. The skin would become red and non blanchable, then purple then brown then with eschar. It is not likely that eschar would have developed in less than 24 hours between the clear skin audit of 4/21/16 and the identification of the eschar on the heel on 4/22/16. When the resident was transported to the hospital on 4/19/16, it would have been good practice to communicate to the hospital the intervention of offloading the heels. Wound APRN #1 indicated that the resident had something in that area on the right heel in past, so it's more likely to have skin breakdown in that area. Being at the hospital without pressure relief for an extended time could have caused the skin to decline. Wound APRN #1 indicated that it is prudent to communicate to the hospital that there is a need for elevation of the heels, but APRN #1 indicated that he/she does not see that type of communication occurring.

d. Resident #137 was admitted to the facility on 7/24/15 with diagnoses that included dementia.The quarterly MDS assessment dated 10/29/15 identified severely impaired cognition, required assistance with bed mobility, transfers and toilet use and was at risk to develop pressure ulcers.Physician order dated 11/1/15 directed to complete a full body audit every week on shower day.The care plan dated 11/4/15 identified a risk for pressure ulcer development with interventions that included to consult with the dietitian as needed and to lotion the skin everyday with care. A skin audit dated 11/23/15 identified no pressure ulcers were present and the skin was intact. Review of the clinical record, skin audit sheet and TAR identified that a complete skin check was not completed on 11/30/15 per the physician order.The wound record dated 12/2/15 identified the resident developed a Suspected Deep Tissue Injury (SDTI) on the left lateral heel. The physician was notified and directed to provide offloading of both heels at all times in bed, no shoes, non-skid socks only and a special mattress for the bed. The physician's order dated 1/16/16 directed to apply Prevalon heel lift boots to offload heels and remove for care.
Observation on 5/12/16 at 11:00AM identified the resident in bed, without the benefit of the Prevelon boots or another device to afford offloading of the heels. Additionally, the resident ' s left heel pressure ulcer was directly in contact with the mattress. Interview with NA#7 on 5/12/16 at 11:15AM identified that he/she did not see the boots on the resident today or yesterday 5/11/16. Interview with the ADNS on 5/12/16 at 11:20AM he/she checked the

resident's room and could not find the Prevelon boots. The ADNS indicated he/she would check to see where the Prevelon boots were and placed a pillow under the resident ' s calves to offload the heels. Interview with LPN #3 on 5/12/16 at 1:00PM identified a wound note dated 4/18/16 indicating the APRN discontinued the Prevelon boots because the resident was noncompliant with wearing them. Review of the clinical record failed to reflect documentation that other measures to offload the heels were implemented when the resident was noncompliant. Although, LPN#3 indicated staff had attempted to use a heel lift manager and other measures to offload the heels the clinical record failed to reflect other pressure relieving interventions were implemented after the discontinuation of the Prevelon boots. Review of the facility policy on body audits identified that all residents will have a weekly body audit completed and documented, by a licensed nurse. The procedure directed that a licensed nurse will conduct a weekly skin audit, preferably on shower day to identify any alterations in skin integrity.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C).

13. Based on clinical record review and interview for one of three residents (Resident #72) reviewed for bladder function, the facility failed to complete a reassessment after a change in urinary pattern. The findings include:
    a. Resident #72 diagnoses included End Stage Renal Disease.The admission MDS assessment dated 1/1/2016 identified severely impaired cognition and required extensive assistance with toilet use and Activities of Daily Living (ADL'S) and was occasionally incontinent of urine. The care plan dated 1/5/2016 identified that resident as incontinent. Interventions included to provide incontinent care as needed and inspect my skin when giving care for sign/symptoms of breakdown .The quarterly MDS assessment dated 4/2/2016 identified severely impaired cognition and required extensive assistance with toilet use and Activities of Daily Living (ADL'S) and was frequently incontinent of urine. Interview and clinical record review with the DNS on 5/12/2016 at 1:40PM identified the nursing flow sheets dated 3/27/2016 through 4/2/2016 identified Resident #72 had multiple incontinent episodes daily on all shifts. The DNS indicated that she was not aware that there had been a change in resident's bladder function. The DNS further identified that it is the responsibility of the Licensed Nursing Staff to conduct a bladder assessment when a decline in bladder function is identified. Review of clinical record failed to demonstrate evidence that a bladder assessment was completed when a decline in bladder function was identified.Review of the facility policy on bladder assessment and rehabilitation identifies that each resident will have a comprehensive assessment of bladder elimination upon admission, annually, quarterly and with any significant change in condition.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

14. Based on clinical record review and interview for two of three residents (Resident #158) reviewed for accidents, the facility failed to revise the care plan for a resident with a history of falls to address the residents impulsive behavior of standing and ambulating independently and/or for one of three sampled residents(Resident #10) reviewed for accidents, the facility failed to ensure that the resident was provided adequate supervision during a transfer and/or for one of three sampled residents (Resident #81) who had difficulty with swallowing and was at risk of aspiration, the facility failed to ensure the resident was supervised during a meal. The findings include:
    a. Resident#158 diagnoses included advanced dementia, osteoporosis, congestive heart failure and anxiety. The nursing fall risk assessment dated 4/5/16 identified the resident was a moderate risk for falls. The admission MDS assessment dated 4/12/16 identified severe cognitive impairment, extensive assistance for transfers, ambulation, personal hygiene and toilet use. The care plan dated 4/15/16 identified a risk for falls with interventions that included to keep the resident within visual field of the staff as resident allows, use of a sensor alarm when in bed or the wheelchair, frequent checks for safety and anticipate the resident needs. The nurses note dated 4/16/16 at 3:45PM identified that while the charge nurse was assisting the resident to the bathroom, the resident stumbled and the charge nurse was unable to break the fall. The nurse's note failed to identify the resident was assessed after the fall. A subsequent nurse ' s note indicated the resident sustained a large hematoma to the left arm. Interview with LPN#2 on 5/11/16 at 3:50PM identified on 4/16/16 Resident#158 was seated at the nurse's station. LPN #2 heard the chair alarm sound and the resident was observed to be independently ambulating off the unit. LPN#2 assisted the resident back to the unit at which time Resident #158 requested to use the bathroom. While LPN#2 was holding onto Resident #158 by the waist to lead R#158 back to his/her wheelchair, the resident bent forward to pick up toilet paper and lost his/her balance. LPN#2 then grabbed the resident's waist to break his/her fall and Resident #158 bumped the wall with his/her upper body . Further interview indicated that LPN#2 did not report the incident to the RN Supervisor for evaluation and assessment following the incident. LPN#2 indicated that since a fall did not occur, he/she did not believe a report and further assessment was warranted. Interview and clinical record with the DNS on 5/11/16 at 4:30PM identified that an assessment of the area and intervention was completed when a family member noted the area on the left arm more than two hours later. The nurse notes indicated that ice pack and Tylenol 650 mg was provided for pain control. The DNS further identified it is the responsibility of the charge nurse to notify the Nursing Supervisor regarding any incidents that require an assessment of the resident.
    The nurse notes dated 4/22/16 at 1:55PM identified the resident was found on the floor near a waste basket. Interview with the Social Worker (SW) on 5/11/16 at 12:39PM identified Resident #158 chair alarm sounded and the resident was observed in front of the nurse's station walking independently toward a waste basket and discarded a piece of paper. The

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SW called the resident's name in an attempt to redirect the resident, however the resident lost his/her balance and was assisted to the floor by the SW. No injuries were identified following the incident.The accident/indicdent report dated 4/22/16 at 1:55PM identified actions taken following the incident included to provide adult coloring sheet, magazine or musical instrument. The clinical record lacked documentation that the care plan was revised to include the diversional activities as identified on the accident/incident report following the fall.

The accident/incident report dated 4/29/16 at 6:25PM identified the staff responded to the alarm sounding and the found the resident on the floor in his/her room. Resident#158 complained of right shoulder pain and a small laceration was found on the back of the head. The resident was then sent to the emergency room for an evaluation. The Orthopedic consultation identified the resident sustained a minimally displaced right distal clavicle fracture with interventions to apply sling when out of bed, non-weight bearing on the right upper extremity pain control and follow-up in two weeks. The hospital evaluation further identified the resident sustained a fractured right second rib. Interview with NA#5 on 5/11/16 at 3:10PM identified the resident normally eats supper in the dining room, however the resident requested to eat in her room on 4/29/16. NA #5 identified she passed by the resident's room and observed the resident eating supper in between providing care to other residents. NA#5 indicated that she then walked into the adjoining hallway and was notified shortly after that the resident was on the floor. Although the care plan was updated regarding the fall, the care plan was not revised and/or new interventions implemented to address the residents implusive behavior.

The nurse notes dated 5/7/16 identified the resident was seated at nurse's station, stood up and immediately fell to the floor, striking her forehead on the floor . The forehead was bleeding and a ecchymotic right eye was observed. Emergency 911 was called and the resident was sent to the Emergency Room for an evaluation. Review of hospital records dated 5/7/16 identified the resident sustained a fractured maxilla. Interview with RN#2 on 5/11/16 at 3:15PM identified that the resident was observed to stand up suddenly but she could not respond quick enough to prevent the resident from falling.

Interview and review of the clinical record with the DNS on 5/11/16 at 3:30PM failed to identifiy that interventions were implemented following the 4/29/16 fall to address Resident # 158's implusive behaviors of standing and ambulating independently.

The DNS identified Resident #158 was placed at the nurse station due to its high visibility so that staff can monitor the resident, however he/she was not able to ensure staff remained at the nurse's station to provide supervison.

b. Resident #10 ' s diagnoses include hypothyroidism, diabetes mellitus type 2, paranoid schizophrenia, and osteoarthrosis. A quarterly MDS assessment dated 02/25/16 identified moderately c impaired cognition, required extensive assistance of two staff members for transfers, did not ambulate, had upper and lower extremity functional limitations in range of motion and was unsteady and only able to stabilize with human assistance with surface to surface transfers which would include transfers from the wheelchair to the bed. A fall risk assessment dated 02/25/16 identified a score of 17 which represented a risk for falls. The

current care plan identified a history of falls, decreased balance and strength with interventions that included encouraging the resident to wear nonskid socks only. The May 2016 physician orders directed to utilize nonskid socks only.An observation on 05/09/16 at 12:45 PM identified the resident in his/her room requesting to go to bed. LPN#5 and NA#4 transferred the resident from the wheelchair to the bed without the benefit of a gait belt and/or nonskid socks. NA#4 provided support and guidance to the resident by holding and pulling on to the waist band of the resident ' s pants. The resident did not stand erect; she remained in a bent over position during the transfer and did not appear steady on her/his feet. In an interview on 05/12/16 at 9:50 AM with NA #4, she identified that she is supposed to use a gait belt for all transfers and noted that that the resident usually stands and pivots but the transfer was more difficult. An interview on 05/12/16 at 10:00 AM with the ADNS identified that the staff had recently been in serviced on the use of gait belts and the facility policy directs for the use of a gait belt for all resident transfers.Review of the facility ' s gait belt policy identified that each nurse aid will have a gait belt on his/her person, or readily available and gait belts will be used for transfers of residents who need the assist of 1 or 2 or who are unsteady with ambulation.

c. Resident #81's diagnoses included dementia, dysphagia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 4/30/15 identified that Resident #81 had moderate cognitive impairments, required extensive one person assistance with eating, had functional limitation in range of motion of both upper extremities, received a mechanical altered diet and failed to reflect the resident had signs and/or symptoms of a swallowing disorder. The Resident Care Plan (RCP) dated 5/7/15 identified the resident had difficulty swallowing and was at risk for aspiration. Interventions directed one to one supervision during meals, total assist for feeding, alternate liquids and solids, provide diet as ordered, to remain in an upright position at ninety (90) degrees for all oral intake and for at least thirty (30) minutes after, encourage to eat slowly and take time chewing and swallowing and follow up with the speech therapist as needed for safe swallowing techniques. A physician's order dated 6/1/15 directed a soft dysphagia diet, nectar thick liquids, one to one supervision, total assist for feeding and aspiration precautions. The nurse's note dated 6/16/15 at 8:30 AM identified that a code blue was called when Resident #81 was observed to be in acute respiratory distress and undigested food was noted in the resident's mouth. The note indicated the Advanced Practice Registered Nurse (APRN) #1 was in the facility at the time and performed the Heimlich maneuver with back and abdominal thrusts. Circumoral cyanosis, a bluish discoloration of the skin and mucous membranes resulting from inadequate oxygenation of the blood was noted, the resident was suctioned, placed on oxygen via a non-rebreather and transferred to the hospital at 9:15 AM. The Reportable Event Form dated 6/16/15 identified during breakfast Resident #81 was observed to be in acute respiratory distress. In a written statement the cook identified she served Resident #81 breakfast on 6/16/15 and at the time a nurse aide was seated at the table. The report identified Nurse Aide (NA) #1 was feeding Resident #81 and left the resident to attend to another resident. When NA #1 returned to Resident #81 she noted the resident was attempting to retrieve something from his/her mouth. NA #1 called for assistance, the

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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Heimlich maneuver was performed, an obstruction blocking the airway was removed and the resident was transferred to the hospital. The facility's conclusion identified Resident #81 was an impulsive eater and that was the reason why he/she needed to be fed. The hospital discharge summary dated 6/19/15 identified Resident #81's discharge diagnosis was hypoxic secondary to choking. The discharge orders directed a pureed diet, honey thickened liquids and that the resident could not eat by him/herself. The APRN progress note dated 6/22/15 identified that during transport to the hospital on 6/16/15, a large food bolus was removed by the Emergency Medical Technician. Interview with NA #1 on 4/27/16 at 10:20 AM identified on 6/16/15 during the breakfast meal she was assigned to the residents who required assistance with feeding. NA #1 stated Resident #81 was seated at the table and prior to feeding the resident she went to attend to another resident. NA #1 recalled the meal was uncovered, placed out of Resident #81's reach and there was another nurse aide (NA #2) at the other end of the table. NA #1 identified that she did not tell the other she was leaving Resident #81 unattended. NA #1 stated upon return to Resident #81 she noted the resident had removed something from his/her mouth, looked "funny" and told NA #2 to get help while she remained with the resident. In an interview on 4/27/16 at 10:40 AM, NA #2 identified on the morning of 6/16/15 she was in the dining room setting up residents who were independent with their meals when NA #1 called for assistance. NA #2 stated Resident #81 looked like he/she was choking and proceeded to get help from the Nursing Supervisor who was in close proximity at the time. Interview with the Director of Nursing (DON) on 4/28/16 at 2:15 PM identified that the tray should not have been left in front of the resident while unattended. Subsequent to the incident all nursing and dietary staff received an in-service education on the Heimlich maneuver and not to leave food unattended for a resident that required assistance.

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

15. Based on clinical record review and interviews for one of five residents (Resident #2) reviewed for unnecessary medications, the facility failed to ensure that medications were administered according to the physician's order and/or that one medication had an indication for use. The findings include:
    a. Resident #2 was admitted to the facility on 5/17/11 with diagnoses which included dementia with behavioral disturbances and tachycardia. The PPS 14 day MDS assessment dated 3/24/16 identified intact cognition and required extensive assistance with care. The physician orders dated 4/9/16 directed to administer Digoxin 0.125mg daily Monday through Friday and Depo-Testosterone 100mg/1ml (100mg) IM monthly on the 28th. Review of the May 2016 MAR identified Digoxin 0.125mg was signed as administered on Sunday 5/1/16 at 9:00AM. Interview with LPN#5 on 5/12/16 at 1:00PM, who as the charge nurse responsible for administering medications on 5/1/16, identified he/she administered the Digoxin on Sunday May 1st if the MAR did not reflect that it should not be given by a line being draw through the day of the week on the MAR.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

Review of the May 2016 MAR identified that Depo-Testosteron 100mg/1ml (100mg) was signed as administered on 5/1/16. Interview with the LPN#5 on 5/12/16 at 1:00PM identified that he/she administered the Depo-Testosteron 100mg/1ml (100mg) on May 1st if the MAR did not reflect that it should not be given by a line being draw through the day of the week on the MAR. Interview with the ADNS on 5/12/16 at 1:30PM identified he/she was not aware of the medication errors and that it is the responsibility of the licensed staff auditing the monthly kardexes to ensure the proper days for administering the medications are transferred to the next month's kardex.

A consultant pharmacist review dated 9/14/15 identified the clinical record lacked a diagnoses for the use of Depo Testosterone. The pharmacy requested a diagnosis for the use of the Depo Testosterone. A subsequent consultant pharmacist review dated 11/5/15 documented a diagnosis for the use of the Depo Testosterone was not provided. Interview and clinical record review with the ADNS on 5/12/16 at 1:30PM identified the clinical record lacked a diagnosis for the use of the Depo-Testosterone.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) General Conditions (2)(D).

16. Based on observation and interview, the facility failed to ensure the kitchen cleaning schedule for the stove vent was followed. The findings included:
    a. Observation of the kitchen on 5/9/16 at 9:30AM with Dietary staff #1 identified a build-up of grease on the wall behind the stove below the hood vent. A review of the kitchen cleaning schedule identified the cleaning of the wall was to be completed by the Cook every Wednesday morning which included wiping down the hood vents and the cooks area. Interview with the Interim Dietary Manager on 5/11/16 at 9:45AM identified the Cook is responsible to wipe down the walls and clean the hood area every Wednesday. The Interim Manager was unable to identify why the area was not cleaned according to the schedule as she is new to the facility. Subsequent tour of the kitchen on 5/11/16 at 10:30AM identified the hood vents and wall to be clean and the grease build-up had been removed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

17. Based on clinical record review, review of facility documentation and interviews for one of three sampled residents (Resident #50) was a new admission, the facility failed to ensure that the physician's orders were reviewed monthly for the first ninety (90) days. The findings include:
    a. Resident #50's diagnoses included diabetes mellitus, end stage renal disease with hemodialysis, aortic stenosis, and hypertension. The admission record identified Resident #50 was admitted to the facility on 2/25/16 and the admission orders were signed by the attending physician on 2/27/16. Review of the physician's orders from 2/27/16 through 4/27/16 failed to reflect documentation the attending physician had reviewed and renewed

the orders for thirty (30) more days in March and April 2016.

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

18. Based on observation, clinical record review and interviews for one sampled resident (Resident #23) reviewed for dental services, the facility failed to follow through on the dentist's recommendations in a timely manner. The findings include:
    a. Resident#23's diagnoses included Parkinson's disease, dementia, anemia and hypertension. A quarterly MDS assessment dated 3/31/16 identified the resident with reasonable and consistent decision making skills, independent for eating, on a therapeutic diet and no history for weight loss. A care plan dated 4/15/16 identified an oral care deficit with interventions that included to instruct with proper storage of dentures, provide with oral hygiene twice a day, refer to dentist/oral surgeon if pain or swelling occurs. Interview with Resident #23 identified problem with dentures during chewing and the dentures being loose. Clinical record review identified the resident was seen initially by the dentist on 7/31/15 with complaints of a loose partial lower denture. The dentist recommended extracting abutment teeth due to their poor/fractured condition. The resident however, declined the extractions. The 9/11/15 dental visit identified the resident complained of difficulty with the lower dentures with recommendations to fabricate full lower dentures. A follow-up dental visit on 3/16/16 identified the resident has not had extractions and continued to request new dentures with recommendations to refer to oral surgeon. Clinical record review and interview with LPN#4 on 5/11/16 at 1:18PM identified she was not aware of the dental recommendations and that follow through of the dental recommendations were done only upon surveyor inquiry. LPN#4 identified it is the responsibility of the charge nurse to follow up on the dental consultants recommendations.

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

19. Based on review of the clinical record and staff interview for one of five residents (Resident #2) reviewed for unnecessary medications, the facility failed to act on a pharmacy request for the indication of the use of a medication. The findings include:
    a. Resident #2 was admitted to the facility on 5/17/11 with diagnoses that included dementia with behavioral disturbances and tachycardia. The PPS 14 day MDS assessment dated 3/24/16 identified intact cognition and required extensive assistance with care. The physician order dated 4/9/16 directed to administer Depo-Testosterone 100mg/1ml (100mg) IM monthly on the 28th. A consultant pharmacist review dated 9/14/15 identified there was no diagnoses for the use of Depo Testosterone. The pharmacy requested diagnoses for the use of the Depo Testosterone. A subsequent consultant pharmacist review dated 11/5/15 documented a diagnoses for the use of the Depo Testosterone was not provided. Review of the clinical record failed to document a diagnoses for the use of the Depo Testosterone.

DATES OF VISIT: Commencing on April 26 and Concluding on May 12, 2016

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

Interview with the ADNS on 5/12/16 at 1:30PM identified it is the responsibility of the Nursing Supervisor to follow up on pharmacy recommendations and he/she could not provide a diagnosis for the use of the Depo-Testosterone.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1).

20. Based on clinical record reviews, observation, facility documentation and interviews for one of three sampled residents (Resident #105) who received an as needed medication, the facility failed to document when a medication was administered. The findings include:
    a. Resident #105's diagnoses included cerebrovascular accident, seizures diabetes mellitus, chronic kidney disease stage four with hemodialysis, hypertension, and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/17/16 identified Resident #105 had no cognitive impairments, received a therapeutic diet, received dialysis and insulin was administered daily. The resident care plan dated 3/24/16 identified the diagnosis diabetes mellitus and the resident may experience signs and/or symptoms of hyper or hypoglycemia. Interventions directed to check blood sugar as ordered and follow sliding scale, monitor for acute signs of hyper or hypoglycemia. The nurse ' s note dated 4/21/16 at 7:00 AM identified Resident #105's blood sugar at 6:00 AM was 57 with mild symptoms of confusion and lethargy and Glucagon was administered. The note indicated in one-half hour the resident ' s blood sugar was 159 and the physician was notified. The nurse's note dated 4/23/16 at 8:00 AM identified Resident #105's blood sugar at 6:00 AM was 82, orange juice was given, the blood sugar at 7:15 AM was 41, Glucagon 1 milligram (mg) was administered, the blood sugar at 7:30 AM was 75, the resident was alert and verbal. Review of the April 2016 Medication Administration Record (MAR) identified Glucagon 1 ampule as needed for low blood sugar. Upon further review, the MAR failed to reflect documentation acknowledging the Glucagon was administered on 4/21/15 and 4/23/16 as indicated in the corresponding nurse's note. Review of the April 2016 Medication Administration Record (MAR) from 4/14/16 through 4/26/16 identified Humalog 100 units per milliliter (ml) subcutaneous, sliding scale coverage per the finger stick results. The MAR identified the blood sugar results however the documentation failed to reflect the coverage.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(4).

21. Based on clinical record reviews and interviews for one of ten sampled residents (Resident #72) reviewed for care and services, the facility failed to safe guard the clinical record from loss. The findings include:
    a. Resident #72's diagnoses included end stage renal disease, peripheral vascular disease, heart failure and hypertension. Review of the clinical record with the Administrator on 4/26/16 at 2:30 PM identified the February 2016 Medication Administration Record and Treatment

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

Administration Records were unable to be located. The Administrator stated the facility has been unable to locate the records for a couple of weeks. The Administrator indicated they have searched other clinical records and the nursing units but have not been able to locate the missing records.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (p) Discharge planning (1).

22. Based on clinical record reviews and interviews for one of three sampled residents (Resident #165) discharged from the facility, the facility failed to ensure a discharge note was written upon discharge. The findings include:
    a. Resident #165's diagnoses included subdural hemorrhage, a history of falls, and anxiety. Review of the clinical record identified Resident #165 was discharged from the facility on 12/22/14. Although the clinical record identified home care was set up for the resident in the community, the clinical record failed to reflect documentation that included an interdisciplinary discharge plan of care and/or a nurse's note at the time of discharge. Interview on 4/26/16 at 11:00 AM with the DON identified that a discharge summary was not completed and no nurse's note was written. The DON stated that when a resident was discharged an assessment should be completed and documented in the clinical record of how the resident was at time of discharge and any education provided.

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

23. Based on clinical record reviews and interviews for one of three sampled residents (Resident #165) reviewed for a weight loss, the facility failed to ensure interventions were implemented to prevent further weight loss. The findings include:
    a. Resident #165 was admitted to the facility on 11/17/14 with diagnoses that included subdural hemorrhage, a history of falls, and anxiety. The resident's weight at the time of admission was documented at 143 pounds. The admission Nutrition Assessment dated 11/20/14 identified the resident received a puree diet with nectar liquids and was eating approximately 75% of the meals. The admission Minimum Data Set assessment dated 11/24/14 identified Resident #165 had severe cognitive impairment, exhibited no behavioral symptoms, required limited assistance of one person with eating, was on a mechanically altered diet and no weight loss was noted. The Resident Care Plan dated 12/5/14 identified the resident was at risk for aspiration. Interventions directed to be aware of meal intake, encourage to alternate solids and liquids while eating, speech therapy evaluation and treatment, offer and assist as needed. Review of the activities of daily living flow sheets from 11/18/14 through 12/22/14 identified out of ninety-nine (99) meals, the resident consumed 100% at seven (7) meals, sixty-six (66) meals the resident consumed 75%, six (6)

meals at 50%, one (1) meal at 25%, one (1) meal zero, and eighteen (18) meals no percentage was documented. Review of the speech therapy discharge summary dated 12/16/14 identified Resident #165 required assistance with feeding. Review of the weight sheet identified Resident #165's weight on admission was 143 pounds (lb.), on 11/24/14 the weight was 136.6 lb. with a reweight to confirm, on 12/2/14 the weight was 136 lb. and on 12/2/14 the resident's weight was 134 lb., a 9 lb. or 6.2% weight loss since admission. Review of the Nutritional Assessments and interview with the Registered Dietician on 4/27/16 at 11:00 AM identified that no further dietary notes were documented after the initial assessment on 11/20/14. The Dietician stated that although she was aware of the resident's weight loss she did not implement any new interventions at that time because staff said Resident #165 was eating about 75 % of most meals. The Dietician identified she should have reviewed the resident's chart and formulated a plan to help prevent further weight loss.

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

24. Based on clinical record reviews, facility documentation and interviews for one of three sampled residents (Resident #165) who had a history of falls, the facility failed to ensure an assessment was completed after the fall according to facility policy. The findings include:
    a. Resident #165 was admitted to the facility on 11/17/14 with diagnoses that included subdural hemorrhage, a history of falls, and anxiety. The admission Minimum Data Set assessment dated 11/24/14 identified Resident #165 had severe cognitive impairment, required extensive assistance with activities of daily living and a history of falls and fractures. The Resident Care Plan dated 12/5/14 identified the resident was at risk for falls. Interventions directed to maintain a clutter free environment, the bed in a low position, anticipate the resident's needs, and alarms while in the bed and/or the chair. The Reportable Event Form dated 12/14/14 identified the resident was found on the floor lying face down. The resident was sent to the hospital for an evaluation. The documentation further identified the resident was placed on neurological checks. The nurse's notes dated 12/14/14 noted the resident was transferred to the hospital for an evaluation at 9:00 PM and returned to the facility at 2:15 AM. Review of the neurological checks form dated 12/14/14 failed to reflect documentation on eight (8) occasions the neurological checks were completed: on 12/15/14 at 2:15 PM, 6:15 PM, and 10:15 PM; on 12/16/14 the 7-3, 3-11 and 11-7 shifts and on 12/17/14 the 3-11 and 11-7 shifts. Interview with the Director of Nursing (DON) on 4/26/16 at 11:00 AM identified that the neuro- checks were not complete noting the resident's level of consciousness, strength of extremities and vital signs. The DON stated that the facility policy was to assess the resident and include all of the above documentation. The facility policy and procedure for Neurological Checks identified after a suspected head injury the sheet shall include level of consciousness, pupillary response, strength and sensation of extremities and vital signs.