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United for Quality Care

Testimony of Deborah Chernoff
Before the Public Health and Human Services Committees
Public Hearing, June 24, 2010

Senator Harris, Senator Doyle, Representative Walker and Representative Ritter, thank you and the other members of the committees for the opportunity to address the critical issue of nursing home care in Connecticut.

For the record, my name is Deborah Chernoff. I am an Elected Organizer of the New England Health Care Employees Union, District 1199 and direct the research and communications departments for our union. 1199 represents 22,000 health care workers in this state, including the 400 nurses, certified nursing assistants, housekeepers dietary, laundry, maintenance and other support staff who are engaged in an Unfair Labor Practice strike at four Spectrum Healthcare nursing homes: Birmingham Health Center in Derby, Hilltop Health Center in Ansonia, Laurel Hill Healthcare in Winsted and Park Place Health Center in Hartford. I also serve as a member of the Long Term Care Advisory Committee.

Today marks the 70th day of the strike. You'll hear more from others about the effect the strike is having on the care of the residents in the four Spectrum homes and I have attached to this testimony a copy of some DPH inspection reports citing 39 violations cited during just one two-week period at one of the facilities. But context is important here if we are to really address these issues, not just wring our hands over them.

Although the nature of this dispute and the outlier position taken by this particular employer, Spectrum, are unique, the strike didn't happen in a vacuum. I've lost count of the number of times I have appeared before these and many

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other legislative committees over the past dozen years advocating on issues that affect nursing home care in this state.

First, across the state, in every facility our union represents, **our members, the residents they care for, and the families of those residents identify short-staffing as the number one barrier to quality care in Connecticut's long-term care facilities.**

The case for better staffing leading to a higher quality of care has long been proven in the research literature. Yet here in Connecticut the public health code concerning staffing levels has not been adjusted for decades, set in the years when nursing homes were "old-age" or "rest" homes, not the chronic care hospitals they have become, caring for nursing home residents who grow increasingly frailer, older and more medically complex in their treatment needs. They will certainly intensify rapidly this year if Connecticut enacts the deep cuts to Medicaid funding now being contemplated by the Administration.

Second, we need to understand that the Medicaid reimbursement system in this state is completely broken. There is no correspondence between the actual costs of providing care for the majority of nursing home residents who rely on Medicaid funding and the rates at which nursing homes are reimbursed for providing that care. The periodic re-basing of rates mandated by state statute was suspended in the last budget cycle, removing the one existing way to try to match costs to rates. The system is designed to produce the result we are getting and the budgetary "savings" are realized by these cuts and budgetary gimmicks like paying June's bill in July become costs paid by the residents and their caregivers.

As we sit here, five Connecticut nursing homes remain in bankruptcy, teetering on the precipice of closure. Just within the last year, four Connecticut nursing

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homes have closed and a fifth, Courtland Gardens in Stamford, has just filed for a Certificate of Need to close despite an outpouring of outrage from residents, families, staff and the Stamford community who are passionate in their support for the high-quality care that our members deliver there every day. The urban center nursing homes are in particular distress as most if not all of their residents must rely on Medicaid to pay for care – and we know that on average, Medicaid providers lose at least \$12 a day, often much more, for every Medicaid resident. So those citizens of our state with the greatest need and the fewest resources suffer disproportionately under this system.

Residents and families are traumatized by the loss of care and community these closures represent. And for every bed lost to closure, our state loses at least one job, jobs our communities and state desperately need to recover from the economic downturn. In total, over the last ten years, we have lost more 25 nursing homes, over 2,800 beds, and at least that number of jobs, not even looking at the related jobs and business that suffer or fold as a result.

The reimbursement system also provides strong disincentives to providers if they attempt to do the right thing by raising staffing levels, providing jobs with reasonable compensation and benefits and maintain or improve their physical plant. Because reimbursement rates are capped, exceeding the lowest common denominator simply increases the financial pressures that often spill over into layoffs, hours cuts and closures. And like much of the public policy in this state, we disregard the warnings until a tragedy redirects our gaze. Let me cite one very sad example: in February 2003, 16 people lost their lives to a fire in the Greenwood Health Center which did not have an automated sprinkler system installed, like many other older nursing home buildings in Connecticut.

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Many of the people in this room were there that night, helping to rescue residents, because Greenwood was purchased by Spectrum Healthcare, renamed Park Place, and Park Place is one of the nursing homes now on strike. It took that tragedy for us to fund the installation of sprinkler systems in older nursing homes.

Yet every time a nursing closes, one of the key factors in the need for millions of dollars in physical plant improvements. Like the need for sprinklers, the need was there all along, but with disincentives to make the improvements built into the reimbursement system, combined with little or no enforcement, the only time we demand improvements is when a new buyer appears, usually guaranteeing that the buyer will back out, or, as was the case last year in Griswold, purchase the facility only to shut it down.

None of these factors excuse Spectrum Healthcare's behavior in violating labor law, refusing to settle on the same general terms as 36 other nursing homes or ensuring that the strike and the disruptions to resident care it is causing will continue indefinitely because the company has hired permanent replacements. Under the same difficult conditions, other providers have acted responsibly and settled modest but fair contracts. Yet if we don't understand the broader context of the difficulties elder care providers – workers and operators alike – face, we will surely march down this path again and again and it is the residents, as you will hear, who will bear the brunt of our collective failure.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 10, 2010

Mr. Douglas Melanson, Administrator
Park Place Health Center
5 Greenwood St
Hartford, CT 06106

Dear Mr. Melanson:

Unannounced visits were made to Park Place Health Center on commencing on April 15, and concluding on April 29, 2010 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of strike monitoring.

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 May 14, 2010 at 9:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

Please address each violation with a prospective plan of correction which includes the following components:

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

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

A handwritten signature in black ink that reads "Maria M. Cardona, R.N., M.S.N.".

Maria M. Cardona, R.N., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

MMC:NC:

c. Director of Nurses
Medical Director
President
vl



Phone: (860) 509-7400
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P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: April 15 - 29, 2010

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

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of nurses (2) (J) and/or (u) Emergency preparedness plan (5) identified on 4/15/10.

1. Based on interviews with three of six employees (NA #1, NA #2 and Dietary staff #1) on 4/15/10, the facility failed to ensure that employees were able to communicate the facility fire plan. The findings include:
 - a. Interviews on 4/15/10 with three employees, NA #1, NA #2 and Dietary staff #1 identified that all three employees were unable to communicate the facility's fire plan. Interview with the Administrator, on 4/15/10 identified that all employees had been educated on the facility fire plan prior to starting employment on 4/15/10.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (j) Director of nurses (2) and/or (m) Nursing staff (2)(A) and/or (m)(2)(B) and/or (m)(2)(C), identified on 4/19/10.

2. Based on observation of care, interview and review of facility policy and procedure for one of two sampled residents incontinent of bladder (Resident #93), the facility failed to ensure that the patient received incontinent care according to the facility policy and procedure. The findings include:
 - a. Resident #93 was admitted to the facility on 4/03/07 with the diagnosis of dementia. Review of the Minimum Data Set (MDS) dated 4/01/10 identified Resident #93 as severely cognitively impaired, required total care for bathing and personal hygiene and incontinent of bowel and bladder. Observation on 4/19/10 at 6:41 A.M., identified the resident incontinent of bladder. NA #6 washed the resident's body with water, dried the area with a towel and then applied a disposable brief. Interview with NA #6, on 4/19/10 identified that she washed Resident #93 with water and this is her usual practice when providing incontinent care. Review of the facility policy and procedure identified that staff providing incontinent care must use soap and/or perineal cleansing product to wash the resident's body.
 - b. Additionally, observations at 7:30 PM identified Resident #93 seated in a tilt-in-space wheelchair in the hallway across from the nurse's station. The resident's pants were noted to be wet from the waist down to the upper thighs. The nurse aide was observed to wheel Resident #93 into the bath suite to toilet the resident. Subsequent to surveyor inquiry, the Director of Nurses (DON) observed Resident #93 and instructed the nurse aide to transfer the resident back to bed to provide evening care. Observations of incontinent care at 7:45 PM with the DON present identified that the incontinent brief was saturated with urine, a strong urine odor was noted, the buttocks was reddened and the back of the pants was saturated with urine. Interview with the 3-11 PM nurse aide on 4/19/10 at 7:40 PM identified that Resident #93 was provided care at the change of shift between 3:00-3:30 PM and had not been toileted and/or provided incontinent care for four to four and one half hours. The nurse aide was counseled

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by the DON.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) (A) and/or (o) Medical records (2)(D) identified on 4/18/10.

3. Based on clinical record review, staff interview and observation for one sampled resident identified as incontinent of bladder (R #20) the facility failed to provide incontinent care was provided in a timely manner and/or the back to bed schedule was followed per the plan of care. The finding include:
 - a. Resident #20's diagnoses included dementia and malnutrition. An assessment dated 3/19/10 identified the resident with long and short- term memory impairment, required total assistance with activities of daily living and intact skin. Physician's order dated 3/17/10 identified the resident with a history of pressure ulcer to the right scrotum. Review of the nurse aide information sheet reflected that on 3/17/10 R #20 had an activity schedule that directed the resident out of bed at 11:30 AM to 1:30 PM and 5:00 PM to 7:00 PM. Nurse's narrative note dated 4/18/10 at 11:15 AM indicated R#20's right scrotum had reopened. The area measured 0.2 centimeters (cm) by 0.2 cm. Interventions included, "perishield" to the area and a back to bed schedule. A plan of care dated 4/18/10 identified excoriation to the right scrotum. Observation on 4/18/10 at 4:44 PM identified R #20 in a wheelchair and not in bed according to schedule. Further observation during incontinent care indicated the resident had an opened area to the right of the scrotum. The scrotum was extremely reddened, had a bowel movement and R #20 complained of pain to the area. Interview with Nurse Aide (NA#5) on 4/18/10 at 5:00 PM identified her shift started at 3:00 PM. The interview further identified she observed R #20 to be in a wheelchair when she started her shift and she did not realize the resident had a back to bed schedule. NA#5 indicated that 4/18/10 was her first day on the unit.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (g) Dietary Services (2)(A) identified on 4/18/10.

4. Based on clinical record review for one sampled resident (R #4) on a specialized diet, the facility failed to ensure the diet was followed. The findings include:
 - a. Resident #4's diagnoses included End Stage Renal Disease. The resident was maintained on a therapeutic diet that excluded banana. Observation on 4/18/10 at 6:45 PM identified R #4 was served two bananas as part of the supper meal. Review of the dietary card indicated R #4 was not to be served bananas. Interview with R #4 on 4/18/10 at 6:45 PM identified the resident was served items that were not in accordance with the therapeutic diet.

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5. Based on clinical record review, interview and observations for one sampled resident (R #75) with impaired skin, the facility failed to follow the plan of care. The findings include:
 - a. Resident #75's diagnoses included bilateral Stage 3 pressure ulcers to the heel. An assessment dated 4/07/10 identified the resident with intact memory, understood expressed information, required extensive assistance with activities of daily living and multiple pressure ulcers including stage 3 and 4. A care plan dated 3/18/10 identified the resident with impaired skin integrity secondary to chronic wounds. Physician's order dated 4/06/10 directed heels to be up while in bed. Intermittent observations on 4/18/10 and 4/19/10 at 4:00 PM and 6:00 PM identified R #75 without benefit of the heels being off the bed. Review of the nurse aide's informationsheet failed to reflect interventions for R #75's heels. Review of the facility care grid failed to include interventions for R#75's heels.
 - b. Additionally, R #75 utilized a low air loss mattress. The setting was noted to be on #9. Review of plan of care dated 4/03/10 directed the setting to be set at #8. Interview with the Infection Control/Wound Nurse (IC/WN) on 4/19/10 at 6:00 PM identified she was unaware the care card did not reflect interventions regarding R #75's heels. The IC/WC nurse indicated that the care grid did not reflect that R #75 heels needed to be off the bed.

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6. Based on clinical record review, observations and staff interview for three of nine sampled resident (R #26, #74, #102) observed for pressure ulcer prevention interventions, the facility failed to implement the plan of care. The findings include:
 - a. Resident #26's diagnoses included dementia, failure to thrive, diabetes, chronic sacral ulcer and heart disease. A Minimum Data Set dated 1/15/10 identified the resident with short and long term memory problems, severely impaired cognition, the need for total care including bed mobility, total incontinence of bowel and an indwelling catheter. Physician's order dated 4/01/10 directed, to turn and reposition side to side every two hours, off load bilateral heels at all times and leave brief open in while in bed.
Observation on 4/22/10 at 8:00 AM with LPN #5 identified the following:
 - i. The resident's heels were not elevated and were resting on the heels up pad.
 - ii. The resident's brief was closed.Interview and observation of the resident at that time with LPN #5 identified that the

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- brief is to be left open to allow air and decrease moisture in the area.
- b. Resident #74's diagnoses included diabetes and congestive heart failure. A Minimum Data Set dated 3/30/10 identified the resident with short-term memory impairment, modified decision making ability, edema and required total assist with all care. Physician's order dated 4/01/10 directed to keep the resident's right leg elevated. The facility's wound documentation dated 4/15/10 identified the resident with Stage I pressure ulcers to bilateral heels. Observation on 4/22/10 at 6:50 AM identified the resident's heels were not elevated. A heels-up device was noted on the resident's wheelchair. Interview with the LPN #1 on 4/22/10 at 7:00 AM identified she was made aware that the resident refused to have her heels elevated at about 4:00 AM in the morning. LPN #1 indicated that although she did know the resident's heels were not elevated, she did not provide the resident with education regarding the consequences of not relieving pressure off the heels. Interview with LPN #7 on 4/22/10 at 6:55 AM identified that she was made aware of the resident's refusal to elevate the heels but did not address it at that time. Subsequent to surveyor inquiry, LPN #7 requested the resident elevate her heels and the resident allowed LPN #7 put a blanket under the calves to float the heels. Interview with the Infection Control Nurse on 4/22/10 at 11:14 AM identified that although, patient education had been provided, if the resident refused to elevate his/her heels, she would expect a nurse to provide further education at the time of refusal.
- c. Resident #102's diagnoses included diabetes and dementia. A Minimum Data Set dated 4/2/10 identified the resident with short and long term memory impairment, significant impairment of decision making ability, edema and required extensive assistance with all care including bed mobility and a stage 3 pressure ulcer. A facility pressure ulcer report dated 4/15/10 identified the resident with a stage 4 pressure ulcer to the right hip. Physician's order dated 4/03/10 directed to utilize a low air loss mattress, which is to be set at 155. Observation on 4/22/10 at 7:30 AM with RN #1 identified the air mattress was set at 170, and the heels were noted to be directly on the heels-up pad. Additionally, RN #1 was noted to re-set the mattress to 155 and float the heels on the pad.

The following are violations of the Regulation 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) identified on 4/23/10.

7. Based on clinical record review, observation and interview for one sampled resident (R#145) the facility failed to follow physician's order. The findings include:
- a. Resident #145's diagnoses included diabetes. Physician's order dated 4/22/10 directed to administer Insulin NPH 70/30 units daily before breakfast. Observation on 4/23/10 at 10:30 AM identified that LPN #8 had not administered the insulin as ordered. Interview with LPN #8 on 4/23/10 at that time identified that the insulin was late due to a lack of communication between three nurses. One nurse was

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assigned to complete finger sticks, one nurse to complete treatments and LPN #5 was assigned to administer medications.

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8. Based on clinical record review, review of facility documentation and staff interviews for one of three sampled residents (Resident #74) who required a mechanical lift for transfers and/or incontinent of bladder, the facility failed to ensure that the resident was transferred in accordance to the plan of care. The findings include:
 - a. Resident #74's diagnoses included depression and pressure ulcer. A Minimum Data Set (MDS) dated 3/30/10 identified that the resident as cognitively impaired, with problems with short- term memory and that the resident totally dependent on the staff for all activities of daily living and transfers.
The Nurse Aide's Information Sheet obtained on 4/22/10 for Resident # 74 included interventions to transfer the resident via mechanical lift and to use an extra large Hoyer pad, when transferring the resident. Observation on 4/22/10 at 5:05 PM identified nurse aides (NA #13, #14, and #15) entering Resident #74's room with a small Hoyer pad. Resident #75's family member who was present at the time of the observation stated to the nurse aides, " You are not going to use that pad it is too small." NA #14 left the room and returned with a different sized Hoyer pad. NA #14 and #15 placed the second Hoyer pad underneath the resident. When the nurse aides attempted to transfer the resident the Hoyer pad began to slide from underneath the resident. The Director of Nursing (DNS) intervened and stopped the transfer. The DNS informed NA #14 and #15 that they did not have the correct Hoyer pad. Interview with the DNS on 4/22/10 at 5:10 PM identified that the nurse aides had used the incorrect Hoyer pad to transfer the resident out of the wheelchair.
 - b. Resident # 74's diagnoses included Urinary Tract Infection (UTI) and pressure ulcer. A MDS dated 3/30/10 identified that the resident as incontinent of bowel and bladder and totally dependent on the staff for all bed mobility. A care plan dated 4/06/10 identified the resident at risk for skin impairment with interventions that included to reposition the resident every two hours and to check the resident for incontinence every two hours and when needed. A physician's order dated 4/20/10 directed staff to cleanse the Stage 2 on the left buttocks area with Normal Saline Solution, dry the area and to apply a Hydrocolloid dressing every three days and when necessary. Observations on 4/22/10 at 5:00 PM identified Resident #74 in the room in a customize wheelchair with a strong urine odor noted, while visiting with a family member. At 5:05 PM Resident #74 placed the call bell on and staff entered the room at 5:05 PM. Observations on 4/22/10 identified from 5:05 PM to 5:35 PM (total of 30 minutes), the resident was sitting in the wheelchair incontinent of urine until NA

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#14 and #15 could find an extra large Hoyer pad. Observations on 4/22/10 at 5:40 PM identified that NA #14 and #15 with the assistance of two licensed staff transferred Resident #74 out of the wheelchair into the bed. Resident #74's draw sheet which was located in the wheelchair was saturated with urine and the resident's was noted to be incontinent of a large amount of urine and stool. Resident #74's groin and buttocks were noted to be reddened and the left buttock was noted with two small open areas. Nurse Aide #14 stated to Resident # 74, "sorry for making you wait we had to wait for the correct Hoyer pad size." The DNS on 4/22/10 at 9:25 PM indicated she would have physical therapy re-assess the resident in the morning to ensure the appropriate Hoyer pad was being used and that NA #13, #14 and #15 would receive reeducation regarding using the appropriate size Hoyer pads for transfers.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) (A) and/or (o) Medical records (2)(1) identified on 4/16/10.

9. Based on clinical record review, observation and interview for one sampled resident observed for medication administration (R #18) the facility failed to administer medication as per physician's order. The findings include:
- Resident #18's diagnoses included cardiovascular accident (CVA). A MDS dated 3/22/10 identified the resident with impaired cognition and required a feeding tube. A care plan dated 3/25/10 identified the resident with a feeding tube per physician's order with interventions that included to monitor for aspiration and intake and output (I&O) until stable. Physician's order dated 3/26/10 identified Fibersource HN at 63 cubic centimeters(cc) via gastrostomy tube for 24 hours- 12:00 AM off, 2:00 AM on-12:00 noon off and 2:00 PM on. Observation with the DNS on 4/16/10 at 5:20 PM identified the tube feeding not infusing. Review with the DNS identified only 50cc out of a possible 140 cc had infused if started at 2:00 PM.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) (a) identified on 4/16/10.

10. Based on clinical record review, observation and interview for one sampled resident observed during a medication pass (R #23) the facility failed to administer medications per physician's order. The findings include:
- Resident #23's diagnoses included CVA and dementia. A MDS dated 3/26/10 identified the resident as moderately cognitively impaired. Observation of a medication administration pass on 4/16/10 at 4:00 PM with the medication nurse (LPN #1) identified the nurse failed to administer Teargen artificial tears 1.4% as ordered twice a day. Interview with LPN #1 on 4/16/10 at 4:30 PM identified there was some confusion at that time.

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11. Based on clinical record review, observation and interview for one sampled resident (R #94) the facility failed to ensure the tube feeding was turned to the off position when providing incontinent care. The findings include:
 - a. Observation on 4/23/10 at 4:00 PM identified R #74 laying flat in bed with the gastrostomy tube (g-tube) feeding on the "off" position. NA #5 and NA #9 provided incontinent care, turned the resident side to side in order to adjust the incontinent pad and elevated the head of bed prior to departure. Observations at 4:30 PM identified LPN #4 went in to apply a treatment to the left foot and the g-tube remained on the "off" position. Observation at 5:00 PM identified LPN #4 go into the room to apply a treatment to the left buttock and noted the g-tube was off and should have been on the "on" position. At the time LPN #4 indicated the g-tube should have been on the "on" position. Interview with NA #5 and NA #9 at 7:45 PM identified they had been informed by RN #4 to report to LPN #4 when they were finished with care so LPN #4 could turn the g-tube back on. Interview with RN #4 at 7:35 PM identified that she had communicated to NA #5 and NA #9 to inform the floor nurse when they were finished with care so she could turn the g-tube back on.
 - b. Additionally, at 5:00 PM LPN#4 went in to Resident #74's room to change a left stage 2 dressing to the buttock. When the resident was turned the resident was noted to be without benefit of the hydrocolloid dressing and the area was reddened. LPN #4 identified the dressing should have been on and was not communicated that the dressing was off. Review of physician's order directed to apply hydrocolloid dressing every 3 days and check every shift. Interview with NA #5 and #9 at 8:50 PM identified that the resident had a dressing when they provided care at 4:00 PM.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) (A) and/or (o) Medical records (2)(I) and/or (o) Medical Record (1) identified on 4/24/10.

12. Based on clinical record review, observation and interview for one sampled resident (R #124), the facility failed to ensure a complete and accurate medical record. The findings include:
 - a. Resident #14's quarterly assessment dated 2/28/10 identified the resident as independent regarding cognitive status and continent of bowel and bladder. On 4/24/10 at 7:00 PM the resident complained to NA #5 of not having a bowel movement for 9 days. Review of the clinical record with the supervisor, RN#5 at 8:00 PM identified that from 4/17/10 to 4/20/10 the resident was hospitalized and may have had a bowel movement at the hospital. Review of the Interagency referral (W-10) dated 4/20/10 identified no documentation of a bowel movement. Review of the bowel record documentation by

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staff identified 9 zeros and 2 blank spaces for the period of 4/20/10 (3-11) to 4/24/10 (11-7) shift (11 shifts). Nurses' note dated 4/21/10 at 3:00 PM identified the resident complained of not having a bowel movement in 4 days, the abdomen was firmly distended and the physician was updated with no new orders. Nurse's note dated 4/23/10 identified the resident complained of not having a bowel movement in 6 days, Dulcolax suppository was administered with no results, then enema with results pending, Nurse's note at 10:00 PM identified milk of magnesium (MOM) was given with results. Review of the Medication Administration Record failed to reflect that dulcolax, enema and MOM was administered.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(A) and/or (m) Nursing staff (2)(C) identified on 4/27/10.

13. Based on clinical record review, observation and interview for one sampled resident (R #92) the facility failed to utilize appropriate technique when bathing a resident. The findings include:
- Resident #92's quarterly MDS dated 4/17/10 identified the resident required total assistance with all activities of daily living. Observation of care on 4/27/10 at 8:00 AM identified NA #12 provided incontinent care and without benefit of changing the water and/or gloves washed the lower extremities.
 - Additionally, physician's order dated 3/20/10 directed out of bed to the recliner with pelvic positioning belt and Dycem. Observation at 8:20 AM identified NA #22 assisting resident out of bed via a chest hug, as the resident lifted the arms towards NA #22, she turned the resident into the recliner with pelvic belt in place. Observations at 8:35 AM the identified R #92 with the pelvic belt across the chest and the resident was noted sliding down the recliner. Interview with RN#2 identified the resident should have had a Dycem in the recliner because the resident moves around causing the resident to slide down in the recliner. Review of the resident care plan identified resident out of bed to the reliner with Dycem with positioning belt.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(A) and/or (o) Medical records (2) and/or (o) Medical records (2)(G) and/or (o) Medical records (2)(I) identified on 4/19/10.

14. Based on review of clinical records, interviews and review of facility policy and procedure for two of three sampled residents (Resident #58 and #71) on 4/19/10 that had orders for care and services written by a licensed practitioner on 4/18/10, the facility failed to ensure that those orders were noted, transcribed and/or followed as ordered. The findings include:
- Resident #58 was admitted to the facility on 10/28/08 with diagnoses that included congestive heart failure, coronary artery disease, hypertension and Diabetes Mellitus. Review of the clinical record, dated 4/18/10, identified that Nurse Practitioner (NP #1)

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- directed the staff to administer an additional dose of Lasix for four days starting on 4/18/10 at 4:00 PM, schedule labwork, weigh and report the resident's weight, and apply compression stocking for Resident #58's leg edema. Review of the clinical record on 4/19/10 failed to reflect that the resident received the Lasix dose on 4/18/10 at 4:00 P.M. and/or that the other orders were noted, transcribed and/or carried out.
- b. Resident #71 was admitted to the facility on 10/8/04 with diagnoses that included insulin dependent Diabetes Mellitus, non-healing ulcer right foot, hypertension, and obesity. Review of the resident's clinical record on 4/19/10 identified a verbal order written by LPN #4 on 4/18/10, directing Lotrisone twice daily. This order was not noted and/or transcribed. Interview with the RN #2, on 4/19/10, identified it is the responsibility of the charge nurse to note and transcribe the orders. Interview with LPN #4, on 4/19/10, identified that she was the charge nurse on 4/18/10 and she did not note and/or transcribe the identified orders.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (j) Director of nurses (2) and/or (m) Nursing staff (2)(A) and/or (o) Medical records (2) identified on 4/19/10.

15. Based on observations on 4/19/10, review of clinical documentation, interview and review of facility policy and procedure for eight of eight residents (Residents #58, 59, 60, 62, 66, 69, 71 and 72) identified by the facility as residents that should receive snacks, the facility failed to ensure that the residents received the snack and/or documented if they refused the snack. The findings include:
- a. Observation on unit 400 on 4/19/10 at approximately 8:25 A.M., identified snacks in the refrigerator marked 4/18/10 8:00 P.M. for Residents #58, 59, 60, 62, 66, 69, 71 and 72. Review of resident "Care Cards", failed to identify residents that were to receive a snack at 8:00 PM and review of the 4/18/10 "CNA Daily Flow Sheet" for these residents failed to reflect documentation that the residents ate and/or refused the 8:00 P.M. snack. Interview with the Registered Dietician, on 4/19/10, identified that it is the responsibility of the nurse aide to give the resident the appropriate snack then document the amount of the snack taken on the "CNA Daily Flow Sheet". Review of the facility policy and procedure identified that the CNA assigned to provide care and services for the resident must document the percentage of each snack the resident eats.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (j) Director of nurses (2) and/or (m) Nursing staff (2)(A) identified on 4/19/10.

16. Based on observations, interview and review of facility policy and procedure for fourteen of eighteen residents (Residents #59, 61, 62, 63, 64, 65, 66, 69, 70, 71, 72, 73, 74, and 75) the facility failed to ensure that medications were administered in a timely manner. The findings include:
- a. Observation of medication administration and interview with LPN #4 on 4/19/10 at 10:35 A.M., on the 400 unit, identified that fourteen residents, Residents # 59, 61, 62,

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63, 64, 65, 66, 69, 70, 71, 72, 73, 74, and 75 had not received their scheduled 8:30 A.M. medications. Review of the facility policy and procedure identified that medication doses may be given within sixty minutes before or after the scheduled administration time.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) identified on 4/20/10.

17. Based on observation on 4/20/10 and interview, the facility failed to ensure the medication cart was secured and not left unattended. The findings include:
- Observation on 4/20/10 from 8:30 A.M. to 8:45 A.M., on the 300 unit identified that LPN #6 walked away from the medication cart for approximately 5 to 8 minutes and the cart was left unlocked with ambulatory residents noted in the area.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (i) Director of nurses (2) and/or (m) Nursing staff (2)(A) and/or (k) Nurse supervisor (1) identified on 4/20/10.

18. Based on review of the clinical record, interview and review of facility policies and procedures for one sampled resident (Resident #59) with a change in condition the facility failed to ensure that the family was informed of the change in condition and/or transfer to the hospital/or failed to obtain a physician order. The findings include:
- Resident #59 was admitted to the facility on 3/12/10 with diagnoses that included schizoaffective disorder, bipolar disorder, Diabetes Mellitus, alcohol abuse and chronic obstructive pulmonary disease. Review of the clinical record on 4/20/10 identified that at approximately 3:30 A.M. Resident #59 had a change in his/her condition and was transferred to the hospital. In addition documentation did not identify a physician order for transfer out of the facility and/or that the family had been informed of the resident's change in condition and/or transfer to the hospital. Review of the facility policies and procedures identified that if a resident has a change in condition the family will be informed and the nurse must obtain an order from the physician to transfer the resident to the hospital then inform the family of the transfer.

The following is a violation of the Regulation 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) identified on 4/20/10.

19. Based on review of facility documentation and interview for one resident (Resident #109) who was readmitted to the facility on 4/19/10, the facility failed to ensure that there was a "Care Card" for the resident. The findings include:
- Patient #109 was readmitted to the facility on 4/19/10 at approximately 5:00 PM with diagnoses that included asthma, hypertension and coronary artery disease. Review of

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facility documentation, on 4/20/10 at approximately 6:30 AM identified that there was no "CNA Care Card" for Resident #109. Interview with the Director of Nursing, on 4/20/10 at 7:10 PM identified that the CNA provides care and services to each resident according to the, "CNA Care Card".

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(C) and/or (t) Infection control (2)(3) identified on 4/19/10.

20. Based on review of the clinical record, observation of care and interview for one sampled resident (Resident #67) with a change in his/her condition the facility failed to ensure that a Registered Nurse assessed the resident. The findings include:
- a. Resident #67 was admitted to the facility 3/19/07 with diagnoses that included status post cerebrovascular accident and dementia. Review of the clinical record identified the resident received antibiotic treatment for shingles that concluded on 4/15/10, the resident was on contact isolation precautions and was in a private room. On 4/17/10 Resident #67 was transferred to a semiprivate room and no longer was on contact isolation precautions. Review of nurse's notes failed to reflect an assessment of Resident #67's status including if the shingles vesicles were open and/or draining fluid, and/or if the resident was itching and/or had complaints of pain. Observation of care, on 4/19/10 at 10:20 AM identified the resident was not maintained on and/or provided care guided by contact isolation precautions. Interview with the Infection Control Registered Nurse, on 4/19/10 at 10:30 AM identified that Resident #67 did not require contact isolation precautions because the shingles vesicles were not open and/or draining fluid. Review of the clinical record, dated 4/19/10 at 2:55 PM, identified that the resident was scratching and some areas were draining, although documentation did not reflect an assessment of the area. Additionally, Resident #67 the antibiotic was reordered contact isolation precautions initiated and the resident was transferred to a private room.

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(K) and/or (o) Medical records (2) identified on 4/20/10.

21. Based on observation, review of the clinical record, interviews and review of facility policy and procedure for one sampled resident (Resident #41) that required assistance with eating and bathing, the facility failed to ensure that the staff provided the care and services and/or document the resident's meal intakes. The findings include:
- a. Patient #41 was admitted to the facility on 5/17/07 with diagnoses that included dementia, Insulin Dependent Diabetes Mellitus and osteoporosis. Review of the Minimum Data Set (MDS) assessment, dated 3/30/10, identified that the resident had severely impaired cognition, required total staff assistance with eating, positioning in bed, bathing and personal hygiene needs and incontinent of bladder and bowel.

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Observations on 4/20/10 at 8:55 AM identified the resident asleep in bed with the breakfast tray was in the room. Interview with LPN #6, and all of the nursing assistants assigned to the unit on 4/20/10 from 8:56 AM to 9:04 AM, failed to identify which nursing assistant was assigned to Resident #41. After discussion with facility staff NA #7 was identified as the nurse aide assigned to provide the resident with any care and services that he/she required. Interview with NA #7, on 4/20/10 at 9:05 A.M. identified that he/she had not provided any care or services to the resident since the start of the shift at 7:00 AM. Interview with the Director of Nursing, on 4/20/10, identified that it is the charge nurse's responsibility to ensure that each resident is provided the care and services that he/she requires.

Additionally, review of the "CNA Daily Flow Sheet", dated 4/15/10 to 4/19/10; did not reflect documentation of the resident's meal intakes. Interview with the Corporate Registered Nurse, on 4/20/10 at 8:38 AM, identified that it is the responsibility of the charge nurse to ensure that the CNA appropriately completes the daily flowsheet. Review of the facility policy and procedure identified that the CNA assigned to provide care and services for the resident must document the percentage of each meal that the resident eats.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (m) Nursing staff (2)(C) and/or (t) Infection control (2)(3) identified on 4/20/10.

22. Based on review of facility documentation, interviews and review of the clinical record for one of two residents (Resident #25) that required contact isolation precautions, the facility failed to obtain a physician order in a timely manner and/or update the care card to reflect that the resident required contact isolation precautions. The findings include:
- a. Patient #25 was admitted to the facility with diagnoses that included pancreatitis, Diabetes Mellitus; status post craniotomy. Observation of the resident's private room on 4/15/10, 4/19/10 and on 4/20/10 identified a sign posted at the doorway that directed the staff and/or visitors to check with the nurse regarding the resident's needs and a cart containing personal protective equipment outside the resident's room. Interview with LPN #5, on 4/20/10 identified that Resident #25 was on contact isolation precautions for Methicillin Resistant Staphylococcus Aureus in a hand wound and Clostridium Difficile infection. Review of the nurse aide Care Card failed to identify that Resident #25 required isolation precautions. Review of the clinical record, dated 4/20/10, identified a verbal order written by LPN #5 that directed the staff to initiate contact isolation precautions for Resident #25, although the resident required isolation precautions since 4/15/10.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) and/or (o) Medical records (2)(K) identified on 4/20/10.

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23. Based on observations, review of clinical documentation, interview and review of facility policy and procedure for nine of nine residents (Residents #58, 59, 60, 62, 66, 69, 70, 72 and 75) that were identified by the facility as residents that should receive snacks, the facility failed to document that the residents received the snack and/or a refusal. The findings include:
- a. Observation of the refrigerator on unit 400 on 4/20/10 at approximately 8:00 AM, identified snacks dated 4/19/10 8:00 P.M. for eight residents, Residents #58, 59, 60, 62, 66, 69, 70, 72 and 75. Review of the 4/19/10 "CNA Daily Flow Sheet" for the above noted residents failed to reflect that the residents received and/or refused the 8:00 P.M. snack. Interview with the Registered Dietician, on 4/19/10, identified it is the responsibility of the CNA to provide the resident with the appropriate snack then document the amount taken on the "CNA Daily Flow Sheet". Review of the facility's policy and procedure identified that the CNA assigned to provide care and services to the residents must document the percentage of each snack taken.

The following is a violation of the Regulation 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)(C) and/or (t) Infection control (2)(3) identified on 4/20/10.

24. Based on observation, review of facility documentation and review of facility policy and procedure for one sampled resident (R #41), the facility failed to ensure that standard precautions were implemented. The findings include:
- a. Observation on 4/20/10 identified NA #8 repositioning R #41 in bed. NA #8 failed to apply gloves and/or wash his/her hands prior to and/or after direct contact with the resident. Interview with NA #8 on 4/20/10 identified that he/she was not aware that he/she should wear gloves while providing care and/or that he/she should wash his/her hands after providing care. Review of NA #8's employee file identified that he/she was educated on standard precautions. Review of the facility policy and procedure identified staff must wear gloves when providing resident care and must wash his/her hands after providing care to any resident.

The following is a violation of the Regulation 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) identified on 4/20/10.

25. Based on observation, interview and review of facility policy and procedure for fifteen of eighteen residents (Residents #58, 61, 62, 63, 64, 65, 66, 67, 69, 70, 72, 73, 74, 75 and 76) the facility failed to ensure that medications were administered in a timely manner. The findings include:
- a. Observation of the medication administration pass on the 400 unit on 4/20/10 at 10:55 AM with LPN#13, identified Residents #58, 61, 62, 63, 64, 65, 66, 67, 69, 70, 72, 73, 74, 75 and 76 had not received their scheduled 8:30 A.M. medications. Review of the facility policy and procedure identified that medication doses may be given within sixty

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minutes before or after the scheduled administration time.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(C) identified on 4/20/10.

26. Based on observation, interviews and review of facility policy and procedure for one resident (Resident #72) that required a mechanical lift for transfer out of bed to a chair, the facility failed to ensure the safety of the resident by not providing education to staff on mechanical lift transfers.

The findings include:

- a. Resident #72 was admitted to the facility on 9/3/09 with diagnoses that included Diabetes Mellitus, status post cerebrovascular accident with hemiplegia and chronic obstructive pulmonary disease. Observation of a mechanical lift transfer on 4/20/10 at 11:30 AM identified NA #10 and NA #11, transferring the resident from the bed to the wheel chair. NA #10 failed to support Resident #72's body and/or head while the resident was lifted from the bed into his/her wheel chair. When the resident was lowered into the wheelchair NA #11 failed to guide the resident's left leg to protect him/her from hitting the mechanical lift support structure. Interview with NA #10, on 4/20/10 at 11:41 AM, identified that he/she had not transferred a resident in a mechanical lift previously and was not aware of the facility's policy and procedure. Interview with NA #11, on 4/20/10 at 11:44 AM, identified that he/she could not explain why the resident's left foot hit the lift support structure. Review of the facility policy and procedure identified that during the mechanical lift transfer from the bed to chair, one nursing assistant is to keep his/her hands on the resident for support during the transfer. Additionally, interview with NA #10 on 4/21/10 at 7:20 A.M. identified that he/she worked until 11:00 P.M. on 4/20/10 and assisted another nursing assistant transfer a resident using a mechanical lift in the evening without any nursing supervision. NA #10 also identified that he/she had not received any education and/or information regarding how to perform a resident transfer using a mechanical lift.

The following is a violation of the Regulation 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)(C) and/or (o) Medical records (2)(H) and/or (o) Medical records (2)(1)(K) identified on 4/21/10.

27. Based on review of clinical record, interview and review of facility policy and procedure for one resident (Resident #60) with a change in condition the facility failed to ensure that the resident was assessed by a Registered Nurse and/or that the family was updated on the resident's change in condition. The findings include:

- a. Resident #60 was re-admitted to the facility on 3/31/10 with diagnoses that included urosepsis, decubitus ulcer, acute renal failure and cellulitis of the left foot. Review of the clinical record, dated 4/21/10, identified that the resident became febrile, the physician was informed and directed diagnostic testing. In addition documentation did

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not reflect that a Registered Nurse assessed resident and/or that the resident's family was informed of the change in his/her condition. Review of the facility policies and procedures identified that when a resident has a change in condition the Registered Nurse assesses the resident and family will be informed "immediately" after a change. A second review of Resident #60's clinical record on 4/21/10 at 11:30 AM identified that although RN #8 documented an assessment on 4/21/10 at 10:15 AM, the documentation did not include the resident's vital signs and/or if the resident's family had been informed of the change in condition. Interview with RN #8, on 4/21/10 at 11:45 AM identified that vital signs were completed, however he/she did not inform the resident's family of the change in his/her condition. Review of the facility policy and procedure identified that when a resident has a change in condition the family will be informed "immediately" after the change.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (l) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2) and/or (o) Medical records (2)(K) identified on 4/21/10.

28. Based on observations on 4/21/10, review of clinical documentation and review of facility policy and procedure for three of eight residents (Residents #30, #60, #69) identified by the facility as residents that receive snacks, the facility failed to ensure that the residents received the snack and/or documented refusals. The findings include:
- Observation on unit 400 on 4/21/10 at approximately 6:10 A.M., identified that in the refrigerator there were snacks dated 4/20/10 8:00 P.M. for Residents #60, #69 and #30. Review of the 4/20/10 "CNA Daily Flow Sheet" for the residents failed to reflect whether the resident took the snack or refused. Interview with the Registered Dietician, identified that it is the responsibility of the CNA to give the resident the appropriate snack then document the amount of the snack that the resident eats on the "CNA Daily Flow Sheet". Review of the facility policy and procedure identified that the CNA assigned to provide care and services for the resident must document the percentage of each snack that the resident eats.

The following is a violation of the Regulation 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) and/or (o) Medical records (2)(H) and/or (o) Medical records (2) (I) and/or (o) Medical records (2)(k) and/or (t) Infection control (2) identified on 4/21/10.

29. Based on review of the clinical record, interviews and review of facility policies and procedure for one resident (Resident #131) with a change in condition the facility failed to ensure that the family and/or physician was informed of the resident's change in condition and/or that the staff obtained physician orders for laboratory testing and/or treatments and/or that the Registered Nurse assessed the resident and/or that a plan of care was initiated regarding the resident's change status and/or that the staff followed the appropriate isolation precautions. The findings include:

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- a. Resident #131 was admitted to the facility on 1/28/95 with diagnoses that include chronic obstructive pulmonary disease, status post pneumonia and schizophrenia. Review of the clinical record, identified that although Resident #131 experienced a change in condition and diagnostic test were completed on 4/18/10 the clinical record failed to reflect that the physician and/or the family member was informed of the resident's change in condition and/or that the staff obtained a physician order for diagnostic testing and/or that a Registered Nurse assessed the resident. Observation of care provided to Resident #131 on 4/21/10, identified a sign posted at the doorway that directed the staff and/or visitors to check with the nurse regarding the resident's needs and a cart containing personal protective equipment located outside the resident's room. Review of Resident #131's clinical record failed to reflect a physician's order directing contact isolation precautions and/or any plan of care to direct care relative to contact isolation precautions.
- Additionally, observations identified NA #12, wearing a facemask in the resident's room. Interview with NA #12 identified she must wear a mask due to an infection. Observations and interview with Housekeeper #1, who was standing outside of Resident #131's room and was donning a disposable gown, mask and gloves identified that a nurse aide told him/her that whenever he/she enters Resident #131's room all personal protective items must be applied.
- Interview with the Infection Control Nurse, on 4/21/10 at 11:45 AM, identified that if a resident is suspected to be infected the nurse needs to obtain physician orders for diagnostic tests and contact isolation. The Registered Nurse must assess the resident for a change in condition, update the physician and family member and initiate a plan of care to address the infection. The Infection Control Nurse further identified that if a resident requires contact isolation precautions all staff must wear gloves and personal protective equipment if soiling is likely and wash his/her hands after each resident contact.
- Review of the facility policies and procedures identified that if a resident has a change in condition the physician is informed, the physician then communicates his medical plan of care including diagnostic tests and/or treatments and the family will be informed "immediately" of the change in condition. Review of facility's policy and procedures identified that when a resident has a change in condition the Registered Nurse assesses the resident and a plan of care initiated to meet resident's needs.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (d) General Conditions identified on 4/21/10.

30. Based on observations and review of facility policy and procedure for one resident (Resident #135) that had a room transfer, the facility failed to ensure that the resident's name was placed on his/her new room doorplate and/or on his/her clinical record. The findings include:
- a. Resident #135 was admitted to the facility on 1/12/06 with diagnoses that included dementia, hypertension and chronic obstructive pulmonary disease. Review of facility

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documentation identified that on 4/15/10 Resident #135 was transferred from room 616 to room 617. Observations on 4/21/10 identified that R#135's name did not appear on the door plate and facility staff were overheard asking where R #135 was located. In addition, on 4/21/10, review of Resident #135's clinical record reflected that the resident was in room 616. Review of the facility policy and procedure regarding room transfers failed to address issues with nameplate and/or that the clinical record must identify the room number.

The following is a violation of the Regulation 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)(C) identified on 4/21/10.

31. Based on observation, interviews and review of facility policy and procedure for one resident (Resident #130) that required a mechanical lift for transfer out of bed to a chair, the facility failed to ensure that the staff were provided with resident information so that the transfer could be completed in a safe manner and/or according to the facility policy and procedure. The findings include:
- a. Resident #130 was admitted to the facility on 9/4/96 with the diagnoses that included schizoaffective disorder, alcohol related dementia and osteoarthritis. Observations of a mechanical lift transfer with the Director of Nursing on 4/21/10 at 11:00 AM, identified two nurse aides and the charge nurse attempting to transfer the resident with the incorrect size pad. Interview with the DNS at the time identified the facility has different sized pads for the mechanical lift and the clinical record nor the care plan reflects the appropriate size for each resident. Subsequently to surveyor inquiry the facility identified that all residents that require a mechanical lift for transfer will be assessed for the correct size lift pad and the pad size would be reflected on the nurse aide care card, the appropriate staff would be in-serviced and random audits would be conducted.

The following is a violation of the Regulation 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) and/or (o) Medical records (2)(k) identified on 5/25/10.

32. Based on observations, review of facility documentation, interview and review of facility policy and procedure for two of eight sampled residents (Residents #69 and 72) identified by the facility as requiring snacks, the facility failed to ensure that the residents received the snack and/or documented refusal. The findings include:
- a. Observation on unit 400 on 4/25/10 at approximately 6:00 PM, identified snacks dated 4/24/10 8:00 PM and 4/25/10 at 2:00 PM for two residents (Residents #69 and 72). Review of the 4/24/10 and the 4/25/10 "CNA Daily Flow Sheet" failed to reflect that the residents received and/or ate refused the snack. Interview with the Registered Dietician, identified is the responsibility of the nurse aide assigned to pass out snacks to give the resident the appropriate snack and then document the amount of the snack taken

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"CNA Daily Flow Sheet". Review of the facility policy and procedure identified that the CNA assigned to provide care and services for the resident must document the percentage of each snack taken.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (i) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(A) identified on 4/25/10.

33. Based on observation, interview and review of facility policy and procedure for one sampled resident (Resident #74) that required a weight while being transferred via mechanical lift, the facility failed to ensure that the staff zeroed out the scale in order to obtain an accurate weight according to the facility policy and procedure. The findings include:
- Resident #74 was re-admitted to the facility on 3/26/10 with diagnoses that included Diabetes Mellitus, hypertension, chronic obstructive pulmonary disease, osteoarthritis and congestive heart failure. Observation on 4/25/10 identified NA #5, NA #18 and LPN #10 attempting to obtain a weight on the mechanical lift. The lift pad was placed under the resident, the pad was then secured onto the mechanical lift, NA #18 set the scale at zero, the resident was then lifted from the wheelchair and the staff weighed the patient while he/she was in the air. In addition the resident's family member, present in the room for the transfer and weighing process, identified that the weight was not accurate by twenty pounds and LPN #10 responded that the resident would be re-weighed at a later time. Review of the facility policy and procedure identified that the staff zero out the scale on the mechanical lift prior to attaching the patient to the lift.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of nurses (2)(J) identified on 4/25/10.

34. Based on observation and interviews the facility failed to ensure that the nurse supervisor was provided with an appropriate orientation to the facility prior to employment.
- Observation of interactions on 4/25/10 between RN #5 and the nursing assistants on units 200 and 300 identified RN #5 directing the nursing assistants to complete resident assignments. Interview with RN #5 and Corporate Nurse on 4/25/10 at 4:15 P.M. identified that he/she was not oriented to the facility policy and procedure, including fire emergency response, staff assignments and change in resident's condition. Interview with the Corporate Nurse, on 4/25/10 at 5:20 P.M. identified that RN #5 had not received orientation to the facility and the facility does require that the Registered Nurse supervisor complete an orientation to the facility.

The following is a violation of the Regulation 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) identified on 4/25/10.

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35. Based on observation, interview and review of facility policy and procedure for one sampled resident (Resident #20) the facility failed to ensure that medications were administered in a timely manner. The findings include:
- a. Observation of medication pass and interview with LPN #11 on 4/25/10 at 7:20 P.M., identified Resident #20 had not received his/her scheduled 4:30 P.M. medications. Review of the facility policy and procedure identified that medication doses may be given within sixty minutes before or after the scheduled administration time.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of nurses (2) and/or (k) Nurse supervisor (1) identified on 4/25/10.

36. Based on observation, interviews and review of facility documentation the facility failed to ensure that the staff was assigned to provide oversight for the residents during the assigned smoking times. The findings include:
- a. Observation on 4/25/10 from 5:15 PM to 5:19 PM identified five residents sitting in the smoking area and were overheard voicing concerns that smoking was late. A sign posted near the supervised smoking area identified that the smoking times include from 3:00 to 3:15 PM and from 5:00 to 5:15 PM. Interview with facility administrative staff, on 4/25/10, identified that it is the responsibility of the nurse aide to supervise the designated smoking times and NA #21 was assigned to supervise the 3:00 to 3:15 P.M. smoking time and NA #20 was assigned to supervise the 5:00 to 5:15 PM smoking breaks. Interview with the Director of Recreation, on 4/25/10 at 5:25 PM while supervising the residents that were smoking, identified that he/she supervised the resident in the smoking area at 3:30 PM and 5:25 PM. Interviews with NA #20 and #21, identified that he/she was not aware that he/she was responsible to supervise smoking. Review of facility documentation identified that it is the responsibility of the designated nurse aide to supervise the smoking area at specific times.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse supervisor (1) and/or (m) Nursing staff (2)(C) identified on 4/27/10.

37. Based on observations and staff interview, the facility failed to ensure that sharp items and chemical agents were secured. The findings include:
- a. Observations on 4/27/10 at 5:25 PM on the 600 Unit identified an unlocked soiled utility room with a page of razors that contained 11 razors in an unlocked drawer and a second unlocked drawer was noted with a 14 ounces can of Ant and Roach spray. Two confused Residents #130 and #131 were observed in the area of the unlocked utility room. Interview with RN #9 on 4/27/10 at 5:30 PM identified she did not know why the razors or the Ant and Roach spray was left in the unlocked drawer. Additionally, RN #9

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identified that staff failed to secure the razors in a locked drawer.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (j) Director of nurses (2) and/or (k) Nurse supervisor (1) and/or (o) Medical Records (2)(f)(1) identified on 4/28/10.

38. Based on clinical record review, review of facility documentation and staff interviews for one of three sampled residents (Resident #18) who required a mechanical lift for transfer, the facility failed to ensure the resident's plan of care was revised to reflect the appropriate size of the resident's Hoyer pad. The findings include:
- Resident # 18's diagnoses included Cerebrovascular Accident (CVA) and anxiety. A Minimum Data Set (MDS) dated 3/22/10 identified the resident as moderately cognitively impaired, had problems with short-term and long-term memory and required total assistance with all transfers. A care plan dated 3/29/10 identified the resident required assistance with transfers. Interventions included to have two staff members assist with the Hoyer transfer, to have nurse aides instructed on the use of Hoyer lifts and to inspect the Hoyer (type of lift) pad prior to the transfer. Observations on 4/28/10 at 3:25 PM identified NA #29 and #30 using a purple trim Hoyer pad to transfer Resident #18 out of the wheelchair. Subsequent to surveyor intervention and review of Resident #18's Nurse Aide Assignment card identified Resident #18's required a green trim Hoyer pad for the transfer. Interview with Nurse Aides #29 and #30 on 4/28/10 at 3:30 PM. identified that the licensed staff informed them that Resident #18 required a purple trim Hoyer pad. NA # 29 additionally indicated that there are two types of Hoyer pads, small and large. Interview with Registered Nurse (RN) #4 on 4/28/10 identified that the facility used three different types of Hoyer pads for Hoyer lifts based on the resident's weight. RN #4 on 4/28/10 indicated that the green trim Hoyer pad on the NA Assignment was incorrect. Subsequently the nurse aides received in-servicing on the various types of Hoyer pads and Resident #18's NA Assignment card was revised to reflect the use of a purple Hoyer pad.

The following is a violation of the Regulation 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) 9A) and/or (q) Dietary (2)(a) and/or (o) Medical records (2)(1) identified on 4/28/10.

39. Based on review of the clinical record, observation and interview for one of three sampled residents (Resident #115) who required a specialized diet as prescribed by physician, the facility failed to ensure that the resident was served the appropriate diet in accordance to the plan of care. The findings include:
- Resident #115's diagnoses included Cerebral Palsy and depression. The MDS dated 4/12/10 identified that the resident's cognition was intact, that the resident had a problem with short-term memory and required set up for meals. The Resident Care Plan

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(RCP) for alteration in nutrition dated 4/14/10 directed staff to provide the resident a regular, non- concentrated sweet and chopped diet, to monitor the resident for choking and aspiration. A physician's order dated 4/27/10 directed staff to provide a plastic fork, no knife and to supervise the resident during mealtime.

Observation on 4/28/10 at 6:45 PM to 6:50 PM. identified Resident #115 in the room with LPN #1. The resident was noted with half a roast beef sandwich chopped and the other half sliced. At 6:52 PM LPN #1 and a nurse aide were noted repositioning Resident #115 in bed at and placed the half chopped and sliced roast beef sandwich within the resident's reach. Subsequent to surveyor intervention LPN # 1 reviewed Resident #115's dietary card and physician's orders. At 6:55 PM RN #10 came into Resident #115's room and removed the dietary tray and requested a chopped diet from dietary.

Interview with RN #10 on 4/28/10 at 7:00 PM identified that staff failed to ensure that Resident #115 had the prescribed diet. Interview with LPN #1 on 4/28/10 at 7:05 PM identified that she did not look at the resident's dietary card because she was focused on ensuring that the resident had plastic utensils.

NURSING HOME CLOSURES IN CT SINCE 2000

	Date Closed	Facility	Town	Beds
1	5/23/2001	Greenery of Cheshire	Cheshire	210
2	6/8/2001	Mediplex Grtr. Hartford	Bloomfield	113
3	7/2/2001	Lutheran Middletown	Middletown	28
4	7/19/2001	Optimum-Elm City	New Haven	91
5	10/22/2001	Olympus Waterbury	Waterbury	148
6	9/12/2002	Strawberry Hill	Norwalk	120
7	9/27/2002	La Casa Lexington	New Britain	67
8	12/31/2002	The Lydian	Orange	27
9	6/11/2003	Victorian Heights	Manchester	110
10	8/26/2003	Thirty-Thirty Park	Bridgeport	100
11	10/27/2003	Ridgewood	Southington	38
12	12/3/2003	Heritage Heights	Danbury	120
13	12/11/2003	Pond Point	Milford	75
14	6/2004	Windsor Hall	Windsor	165
15	9/7/2004	Atrium Plaza	New Haven	240
16	10/7/2004	Homestead	Stamford	87
17	12/1/2005	Hamilton	Norwich	160
18	12/1/2006	Mercyknoll	West Hartford	59
19	5/1/2007	Darien Health Care Ctr	Darien	120
20	Sep-08	The New Coleman Park	Bridgeport	90
21	Dec-08	Haven of Waterford	Waterford	90
22	Mar-09	Griswold Health and Rehab	Griswold	90
23	Mar-09	Sterling Manor	East Hartford	90
24	Nov-09	Crescent Manor	Waterbury	115
25	Jun-10	West Rock	New Haven	90
26	Jul-10	Courtland Gardens?	Stamford	180
		Total Beds		2,823

