

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

IN RE: 710 Long Ridge Operating Co. II, LLC  
d/b/a Long Ridge of Stamford  
710 Long Ridge Road  
Stamford, CT 06902

CONSENT ORDER

WHEREAS, 710 Long Ridge Operating Co. II, LLC (“Licensee”), has been issued License No.2279 to operate a Chronic and Convalescent Nursing Home known as Long Ridge of Stamford (“Facility”) under Connecticut General Statutes § 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 May 28, 2013 and concluding on June 13, 2013; 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 July 8, 2013 (Exhibit A – copy attached); and

WHEREAS, the Licensee, without admitting any guilt or wrongdoing, is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, FLIS of the Department acting herein and through Barbara Cass, Section Chief, and the Licensee, acting herein and through A. Alberto Lugo, Senior Vice President hereby stipulate and agree as follows:

1. On July 17, 2013 the Licensee executed a consulting contract with Maureen Canil, R.N., B.S.N., M.S (“Consultant”).
2. On September 5, 2013, the Consultant submitted a written report pursuant to an operational review of the Facility which included primary and secondary steps to effectuate improvement.

3. Within two (2) weeks of the effective date of this Consent Order, the Licensee shall execute a contract with the Consultant to review and assess implementation of the recommendations in accordance with her September 5, 2013 report ("Initial Report"). The terms of the contract executed with the Consultant shall include all pertinent provisions contained in this Consent Order.
4. In order to review and assess implementation of her recommendations and in order to identify any new areas of concern, the Consultant shall provide services for a minimum of eighty (80) hours at the Facility and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including weekends. If the Consultant completes her review in less than eighty (80) hours, she may request that the Department reduce the number of required hours at the Facility. If the Consultant needs additional time, beyond the eighty (80) hours to complete her review, she may request that the Department increase the number of required hours at the Facility. The Licensee agrees to incur any additional costs as a result of the Consultant requesting additional hours to complete her review. Decisions regarding reducing or increasing the hours of the Consultant shall be in the sole discretion of the Department. The Department shall retain the authority to extend the period of the Consultant if deemed necessary pursuant to the Department's review of the Consultant's findings.
5. The Consultant shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state laws and regulations and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
6. Within three (3) weeks of the execution of the contract with the Consultant, the Consultant shall conduct and submit to the Department a current assessment of the Facility including an evaluation of the implementation of all recommendations made pursuant to the Consultant's Initial Report.
7. The Consultant shall submit a written report to the Department regarding her assessment of the Facility's progress as related to:
  - a. Nursing systems;
  - b. Care delivery systems;
  - c. Duties and responsibilities of the charge nurse and effective completion of those duties by assigned staff;

- d. Shift to shift patient reporting systems, including licensed and unlicensed staff;
  - e. Supervision of nursing staff;
  - f. Staff to staff interactions;
  - g. Attendance at care planning meetings;
  - h. Dietary services;
  - i. Customer service;
  - j. The Consultant's assessment of the care and services provided to the patients;
  - k. The Licensees' compliance with all applicable federal and state laws and regulations; and
  - l. Any recommendations made by the Consultant and the Licensee's response to implementation of the recommendation(s).
8. Copies of the Consultant report shall be simultaneously provided to the Medical Director, Administrator, Director of Nurses and the Department.
  9. The Consultant shall make recommendations to the Licensee's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility. If the Consultant and the Licensee are unable to reach an agreement regarding the Consultant's recommendation(s), the Department, after meeting with the Licensee and the Consultant shall make a final determination, which shall be binding on the Licensee.
  10. 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 Consultant and the Department, upon request.
  11. The Consultant shall confer with the Administrator, Director of Nursing Services and other staff as the Consultant deems appropriate concerning the Consultant's assessment of nursing services and the Facility's continued compliance with the Public Health Code and applicable statutes. Said Consultant shall make recommendations to such parties for improvement in the delivery of direct patient care in the Facility.
  12. Effective immediately upon the execution of this Consent Order, the Licensee, through its Governing Body, Medical Director, Administrator and Director of Nursing Services shall ensure substantial compliance with the following:
    - a. Sufficient nursing personnel are available to meet the needs of the patients;
    - b. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;

- c. Patient consults, treatments, therapies and medications are administered as prescribed by the physician and/or in accordance with each patient's comprehensive care plan;
  - d. Each patient's care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
  - e. Nurse aide assignments accurately reflect patient needs and a mechanism is implemented to ensure that each nurse aide has reviewed their assignments prior to providing care and services to their assigned patients;
  - f. Each patient's behaviors are assessed and monitored in accordance with his/her individual needs and plan of care;
  - g. The personal physician or covering physician is notified in a timely manner of any significant change in patient condition including, but not limited to deterioration of mental and physical status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
  - h. Prompt efforts by the facility to resolve grievances the patient may have, including those with respect to the behavior of other patients; and,
  - i. Patient drug regimens will be free from unnecessary drugs.
13. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand dollars (\$2,000), 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 document shall be directed to:

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

14. 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 Exhibit 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.

15. The execution of this document 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.
16. The terms of this Consent Order shall remain in effect for a period of three (3) months from the effective date of this Consent Order.
17. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
18. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the July 8, 2013 violation letter referenced in this Consent Order.
19. The Licensee has consulted 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.

710 Long Ridge Operating Co. II, LLC

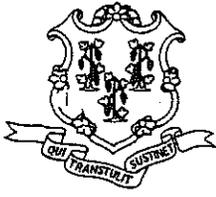
By:   
A. Alberto Lugo, Senior Vice President

On this 20<sup>th</sup> day of May, 2014, before me, personally appeared A. Alberto Lugo who acknowledged himself to be the Senior Vice President of Long Ridge Operating Company, II, LLC, a corporation, and that he, as such Senior Vice President being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as Senior Vice President.

My Commission Expires: 10/20/16   
(If Notary Public) Notary Public   
**JUSTINE L. COTTRELL**  
NOTARY PUBLIC OF NEW JERSEY  
My Commission Expires 10/20/2016  
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

May 28, 2014 By:   
Barbara Cass R.N., Section Chief  
Facility Licensing and Investigations Section



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

July 8, 2013

Nancy Kroszner, Administrator  
Long Ridge Of Stamford  
710 Long Ridge Road  
Stamford, CT 06902

Dear Ms. Kroszner:

Unannounced visits were made to Long Ridge Of Stamford on May 28, 29, 30, June 3, 4 and 13, 2013 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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by July 22, 2013 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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,

Kim Hriceniak, R.N., C., B.S.N.  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

KH:isl



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

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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 Connecticut General Statutes 19a-550 and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D).

1. Based on observations, clinical record review, review of facility documentation and interviews for one of three sampled residents (Resident #158) reviewed for dignity, the facility failed to address and/ or resolve a grievance in a timely manner. The finding includes:
  - a. Resident #158's diagnosis included benign prostatic hypertrophy and cerebrovascular accident with left sided weakness. An Annual Minimum Data Set dated 2/25/13 identified Resident #158 was cognitively intact and was totally dependent for bed mobility, transfers, dressing, toilet use and hygiene and is always incontinent of bowel and bladder. The care plan dated 5/8/13 identified a self-care deficit with toileting and hygiene with interventions that included allowing the resident to make choices, assist with toileting and preserve privacy and dignity during care. Interview on 5/29/13 at 10:40 AM with Resident #158's spouse identified a few months prior, her husband had wet himself and waited 35 minutes for the call bell to be answered on the 7AM-3PM shift sometime before lunch while she was visiting. When the call bell was answered care was provided. Eight days later another episode occurred and her husband waited 35 to 40 minutes for the call bell to be answered as he needed to be cleaned after having a bowel movement. When the call bell was answered, care was provided. Both events were brought to the attention of the Director of Nurse's. A third incident occurred on 5/28/13 on the 3PM-11PM shift that was reported by Resident #158's spouse to facility staff on 5/29/13. Interview, review of facility documentation and review of facility policy with the Assistant Director of Nurse's on 5/30/13 at 12:30 PM identified that a meeting had been held with Resident #158's spouse, the ADNS, the Administrator and the Registered Nurse Supervisor in November after the second incident to address concerns regarding incontinence and that a toileting plan had been implemented to ensure Resident #158 was not left soiled. The Assistant Director of Nurse's further identified that if there was a concern it should be reviewed, put on a grievance form and forwarded to the social services provider. The Assistant Director of Nurse's was unable to identify that a grievance form was completed and/or follow up to the grievance was completed to ensure that the issue was resolved. Interview, review of facility documentation and review of facility policy on 5/30/13 at 2:00 PM with social services, failed to identify that she was notified of a grievance by Resident #158's spouse per facility policy, did not participate in the November meeting, and did not see Resident #158 subsequent to the incidents. Interview, review of facility documentation and review of facility policy on 6/3/13 at 10:30 AM with the Director of Nurse's identified that she did not recall Resident #158's wife's first concern, that she did not participate in the November meeting and that a grievance/concern form or some type of documentation should have been generated regarding Resident #158's spouse's concerns and follow up to repeated concerns regarding the timeliness of response to calls for assistance.

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

2. Based on interview and review of facility documentation for four of six new hires, the facility failed to ensure pre-employment screening was conducted according to facility policy. The finding includes:
  - a. A review of six employee files conducted with the Benefits Coordinator on 6/4/13 at 10:10AM failed to provide documentation of reference checks on four of six newly hired employees. The Benefits Coordinator identified the expectation was for each Department Head to conduct their own reference checks. The facility Abuse Prevention policy directs that pre-employment screening be conducted including criminal background checks, license verification and two reference checks. The policy further directs that the reference checks will include date, time and name of the person giving the reference, and will be signed by the person taking the reference.

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

3. Based on review of the clinical record and interviews for one of three residents reviewed for choices (Resident # 216) the facility failed to accommodate the resident's requests related to care. The finding includes:
  - a. Resident# 216's diagnoses included a right shoulder dislocation and spina bifida. The physician's orders dated 5/9/13 direct to catheterize every six hours at 12:00 AM, 6:00AM, 12:00PM, and 6:00 PM. An admission MDS dated 5/16/13 identified intact cognition, no mood or behaviors exhibited, required extensive assistance with bed mobility, personal hygiene, and total dependence with toileting, was occasionally incontinent of bladder, required intermittent catheterization, and the presence of a stage two pressure ulcer. A care plan dated 5/16/13 identified an alteration in elimination; incontinent of bladder/bowel related to paraplegia. Interventions included bowel and bladder assessment per policy, reposition every two hours, and straight catheterize as ordered. Interview with Resident# 216 on 5/29/13 at 11:00AM identified he/she had requested to the nursing staff that the times of the catheterization be changed so as not to be disturbed during the night. A review of the nurses notes and/ or treatment administration record dated 5/15/13 through 6/4/13 identified Resident #216 continued to be catheterized every six hours at 12:00 AM, 6:00 AM, 12:00PM, 6:00AM. Interview with the DNS on 6/4/13 at 11:00AM identified residents have the right to participate in and/or choose their schedule consistent with their preferences. The DNS identified any resident concerns and/or complaints are addressed at the daily morning meeting, however failed to provide evidence that the catheterization schedule was revised to meet the resident's request.

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

4. Based on interview and review of facility documentation, the facility failed to act on group grievances and /or recommendations. The finding includes:
  - a. Interview with Resident Council President, (Resident#41) on 5/30/13 at 11:30AM indicated that grievances identified by the Resident Council have not been addressed and or acted upon in a timely manner and there are certain issues repeatedly discussed without improvement(s) noted. Resident#41 identified Resident Council is not satisfied with the facility response to the concerns discussed stating the Recreation Director each month reports that the concerns are discussed in the morning meeting however, the Resident Council does not receive follow up and/or resolutions to the concerns. Interview with Director of Recreation on 6/3/13 at 10:00AM identified that she is responsible for attending Resident Council and recording the meeting minutes. The Director of Recreation identified concerns/issues from Resident Council are communicated to the Department Heads via email and discussed at morning report with the expectation that a follow-up resolution be submitted by the applicable Department Head; however follow-up resolutions were not consistently completed. Review of the Resident Council Meeting Minutes from May 2012 through May 2013 identified a pattern of repeat concerns including, but not limited to: poor call bell response time, name badges not being worn by staff, multiple food complaints, resident snacks not being offered and Nurse Aide staff not speaking English in resident care areas. Review of the Resident Council minutes failed to identify documentation of follow-up resolutions with the exception of a dietary department action plan dated 3/4/12, 2/5/13, 3/26/13 and 3/29/13. The Director of Recreation was unable to provide any further documentation of follow-up resolutions. Interview with Administrator on 6/4/13 at 7:50AM identified it is the expectation of the facility to have a follow-up resolution developed by the Department Head to address the concerns/recommendations applicable to their department. A review of the facility's Resident Council Policy identified documentation of the meeting minutes and follow-up resolutions are to be kept on file in the Activity Department and by the President of Resident Council.

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).

5. Based on clinical record review, interviews and review of facility policy and procedure for one of six residents reviewed for medication administration (Resident #132), the facility failed to administer medications according to the physician's order. The finding includes:
  - a. Resident# 132's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, hypertension, and depression. The physician's order dated 4/29/13 directed

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to administer Nitroglycerin patch 0.4mg apply one patch topically every day at 9:00AM and remove at 9:00PM, Aggrenox 25-200mcg capsule SR two times day at 9:00AM and 9:00 PM, Advair Diskus 250-50mcg one inhalation every twelve hours at 9:00AM and 9:00 PM, Wellbutrin SR 100mg daily at 9:00AM, Spiriva 18mcg one capsule via handheld every day at 9:00 AM. Interview with Resident #132 on 5/29/13 at 11:50AM identified his/her medications ordered to be administered at 9:00AM were administered at 11:50AM that morning. Interview with LPN #4 on 5/29/13 at 11:55AM identified Resident #132's medications were due at 9:00 AM, however they were not administered until 11:50AM. LPN #4 indicated that he/she was unable to get to the resident until that time, however, did not identify a reason why he/she did not administer the medications on time per the physician's order. LPN #4 indicated he/she did not report being unable to administer the medications timely to the unit manager. Interview with the DNS on 5/29/13 at 12:30PM identified that it is the expectation that the licensed staff will administer medications as directed by the physician and to notify the Nursing Supervisor and /or Unit Manager if they are unable to complete the medication administration in a timely manner.

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).

6. Based on review of the clinical record, interviews and review of facility policy and procedure for one of three residents reviewed for pressure ulcers (Resident # 216) the facility failed to implement interventions to prevent the development of a pressure ulcer. The finding includes:
  - a. Resident# 216 diagnoses included a right shoulder dislocation and Spina Bifida. The admission nursing assessment dated 5/9/13 identified intact skin. The Braden scale dated 5/9/13 identified a score of 14 which indicates a high risk for pressure ulcer development. The interim care plan dated 5/9/13 identified an alteration in mobility and a risk for skin breakdown related to right shoulder fracture. Interventions included providing two person assistance with bed mobility. The physician ' s orders dated 5/9/13 directed to turn and reposition the resident every two hours. The admission MDS dated 5/16/13 identified intact cognition, extensive assistance of two staff members for bed mobility, impairment in range of motion of the right upper extremity and the presence of a stage two pressure ulcer. The comprehensive care plan dated 5/16/13 identified actual alteration in skin integrity related to a stage two pressure ulcer. Interventions included conducting weekly skin checks, encouraging and assisting the resident to turn and reposition every two hours, check settings and function of the air flotation alternating mattress every shift. Although a risk for skin breakdown was identified on 5/9/13, the facility failed to implement interventions to prevent the development of a pressure ulcer until after the resident was observed with a stage two pressure ulcer on 5/16/13 (7 days following admission). The nurses notes dated 5/16/13 at 3:00PM identified a stage two open area at the coccyx measuring 3.0 centimeters(cm) x 0.7 cm. Observation and interview with Resident# 216 on 5/29/13 at 11:30AM identified a right arm immobilizer

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being utilized. Resident# 216 identified that prior to admission he/she was independent with activities of daily living but with the shoulder fracture, non-weight bearing status of the right arm and the use of the immobilizer he/she was unable to turn and reposition independently, and required assistance from staff to turn and reposition. Resident# 216 identified at that time staff had not been assisting him/her with turning and/or repositioning since admission. Interview and review of the clinical record with the DNS on 6/4/13 at 11:00AM failed to reflect that turning and repositioning was implemented upon admission. The DNS identified that according to the facility pressure ulcer policy, any resident assessed at risk for skin breakdown will have interventions immediately implemented to prevent skin breakdown and these interventions will be documented on the treatment kardex and in the plan of care.

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

7. Based on clinical record review, review of facility documentation and interviews for one sampled resident (Resident #96) reviewed for behaviors, the facility failed to provide appropriate care and services. The facility failed to obtain a Physician Emergency Certificate (PEC) per recommendations when the resident exhibited threatening, paranoid and intrusive behaviors which placed other residents at risk for harm. The facility failed to identify the immediacy of the PEC recommendation, and failed to protect Resident #96 and other residents from potential harm resulting in the finding of Immediate Jeopardy. The findings include:
  - a. Resident # 96 was admitted to the facility to the facility on 4/16/12 with diagnoses which included Bipolar disorder and dementia. The 14 day MDS assessment dated 2/6/13 identified severe cognitive impairment, displayed problem behaviors including socially and verbally inappropriate behaviors and wandering that intruded on others, and independence for ambulation.

The care plan dated March 2013 identified the potential for violence due to a history of threatening to harm a roommate and hiding knives in a drawer. Interventions included conducting a room search for objects that may be used as weapons, identifying behaviors that signal impending violence, use of plastic utensils only, provides redirection when agitated, and psychiatric services as needed.

The nurse's note dated 1/16/13 for the 7-3PM shift identified Resident #96 was screaming and pacing the hallways stating "I'm going to die". The resident was sent to the emergency department and admitted for psychiatric treatment of bipolar disorder. The resident returned to the facility on 2/6/13.

The nurse's notes from 2/6/13 through 2/26/13 identified Resident #96 exhibited behaviors that included wandering in other resident's rooms, continuously talking to self, walking the hallways naked, refusing to get dressed, and locking him/herself in the

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bathroom. On 2/26/13, Resident #96 requested a knife because he/she wanted to die. The resident was transferred to the emergency department and admitted for psychiatric treatment. The resident returned to the facility on 3/12/13.

The nurse's note dated 3/12/13 for the 3-11PM shift identified Resident #96 was restless and talking incoherently upon readmission to the facility. The resident was noted wandering in the hallways. On 3/13/13 during the 11- 7AM shift, nurse's notes identified that the resident was wandering into other resident rooms, banging on walls, throwing garbage all over the floor and was unable to be redirected. The physician was notified and directed to administer Ativan 1.0 milligram (mg) by mouth immediately (stat). Although Ativan 1.0 mg was administered the resident continued to wander and refused to put clothes on and every thirty (30) minute checks were initiated.

On 3/14/13 at 1:00 AM, Resident #96 approached the nurse's station with a pen and threatened to stab the nursing staff. The staff followed the resident back to the room which was noted covered in trash. The resident screamed at the charge nurse to get out of the room and threatened to kill him/her. Resident #96 exited the room naked and locked him/herself in a hall bathroom. The physician was notified and directed to transfer the resident to the emergency department for evaluation and the resident was transferred at 1:40 AM. The emergency department diagnosed the resident with a urinary tract infection and Resident #96 returned to the facility at 5:15 AM without certification that the resident was not a danger to self and/or others. The nurse's note dated 3/14/13 for the 11-7AM and 7-3PM shifts identified Resident #96 refused medications from staff, would not allow staff to enter the room, and refused care.

The psychiatric Physician's Assistant (PA) #1 progress note dated 3/14/13 on the evening shift (not timed) identified threatening and intrusive behaviors and paranoia and PA #1 recommended to obtain a Physician's Emergency Certificate and transfer the resident to an inpatient psychiatric facility.

The nurse's note dated 3/14/13 for the 3-11PM shift failed to reflect that increased supervision was provided to the resident and/or that the facility obtained the PEC and transfer to an inpatient psychiatric facility as recommended by the psychiatric consultant.

The nurse's note dated 3/15/13 at 8:00 AM identified Resident #96 was wandering and pacing the hallways unclothed, screaming that he/she was the devil, was unable to be redirected and was pulling his/her hair. At 8:30 AM, the resident was noted exiting another resident's room (Resident#97) and screaming at the Occupational Therapist pointing a butter knife at him/her. Resident #96 then pointed the knife at the nurse and screamed "I'm going to kill you". The knife was removed, the physician was notified and the resident transferred to the emergency department and admitted.

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A review of facility investigation identified that the Occupational Therapist was treating another resident when he/she heard calls for help. The Occupational Therapist found Resident #97 sitting on the side of the bed calling for help stating that Resident #96 had a knife. The Occupational Therapist observed Resident #96 with 2 knives in his/her hand standing at the foot of Resident #97's bed wearing an open robe with no clothing under the robe. The Occupational Therapist called for help from staff who removed the knives from the resident's hands.

Interview with the DNS on 6/7/13 at 8:00 AM failed to provide evidence that the facility initiated inpatient psychiatric treatment when notified by Psychiatric Physician Assistant (PA) #1 to obtain a PEC and/or failed to provide one to one supervision per facility policy when the resident exhibited threatening behaviors directed toward staff and residents. The DNS was unable to identify the immediacy of a PEC and was unable to provide a clear understanding pertaining to the staff member who was responsible to obtain a PEC for a resident when recommended.

Subsequent interview and review of the clinical record with the DNS on 6/7/13 at 9:00 AM failed to reflect that Resident #96 was provided direct supervision by staff from 3/14/13 at 5:15 am upon return from the hospital until 3/15/13 at 8:30 AM (27 hours and fifteen minutes) when he/she was found threatening another resident with a knife. Further review identified that although every 15 minute checks had been signed off as completed, the checks lacked documentation of the staff's name and/or the resident's whereabouts/condition during the checks. Review of the staffing worksheets failed to identify the staff assigned to monitor Resident #96.

Interview with the Psychiatric Physician Assistant (PA) #1 on 6/7/13 at 9:30 AM identified that a PEC was requested due to threatening behavior to staff and peers, and paranoid, disorganized, intrusive, inappropriate, and markedly altered behaviors from baseline. The PA indicated he/she informed the DNS of the need to obtain the PEC from the physician.

Resident #97 reported during an interview on 6/7/13 at 9:40 AM identified Resident #96 came into his/her room uninvited, and fiddled with silverware that was on the breakfast tray which was located on the over bed table. Resident #96 had rambling speech that was unintelligible. Resident #96 grabbed the knife, and bent over the bed with the knife toward Resident #97 and screamed. Resident #97 thought Resident #96 would hit him/her with the knife. Resident #96 turned and left the room and Resident #97 warned the staff who had come to see if everything was okay that Resident #96 still had a knife in his/her possession.

Interview with the DNS on 6/7/13 at 10:00 AM identified if the psychiatry consultant

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recommended to obtain a PEC, it was the responsibility of the facility staff to call the Psychiatrist and if no response to call the primary physician for further direction. The DNS although aware of PA #1's recommendations, failed to follow through to ensure staff were aware of their responsibilities regarding the recommendations to obtain a PEC. Although aware of the resident's threatening behaviors, the DNS failed to ensure the facility's continuous one to one policy was implemented to protect the safety of Resident #96 and other residents.

Review of the facility One to One Staff Supervision Policy directed to provide continuous one to one supervision when a resident is exhibiting behaviors that put the resident at immediate risk of harm to him/herself or others. Continuous one to one supervision will be maintained until the resident is stabilized.

Review of the facility Discharge to Psychiatric Center Policy identified when a decision is made to provide transfer to a specialized setting in order to provide a structured approach to behavioral and psychological management an order for transfer will be obtained from the physician. Arrangements for the transfer will be made by the facility.

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

8. Based on clinical record review, review of facility documentation and interviews for one sampled resident (Resident #96) reviewed for behaviors, the facility failed to provide the necessary supervision to protect the resident and other residents from a resident who exhibited threatening intrusive behaviors and expressed a desire to die resulting in the finding of Immediate Jeopardy. The findings include:
  - a. Resident # 96 was admitted to the facility to the facility on 4/16/12 with diagnoses which included Bipolar disorder and dementia. The 14 day MDS assessment dated 2/6/13 identified severe cognitive impairment, displayed problem behaviors including socially and verbally inappropriate behaviors and wandering that intruded on others, and independence for ambulation.

The care plan dated March 2013 identified the potential for violence due to a history of threatening to harm a roommate and hiding knives in a drawer. Interventions included conducting a room search for objects that may be used as weapons, identifying behaviors that signal impending violence, use of plastic utensils only, provides redirection when agitated, and psychiatric services as needed.

The nurse's note dated 1/16/13 for the 7-3PM shift identified Resident #96 was screaming and pacing the hallways stating "I'm going to die". The resident was sent to the emergency department and admitted for psychiatric treatment of bipolar disorder. The resident returned to the facility on 2/6/13.

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The nurse's notes from 2/6/13 through 2/26/13 identified Resident #96 exhibited behaviors that included wandering in other resident's rooms, continuously talking to self, walking the hallways naked, refusing to get dressed, and locking him/herself in the bathroom. On 2/26/13, Resident #96 requested a knife because he/she wanted to die. The resident was transferred to the emergency department and admitted for psychiatric treatment. The resident returned to the facility on 3/12/13.

The nurse's note dated 3/12/13 for the 3-11PM shift identified Resident #96 was restless and talking incoherently upon readmission to the facility. The resident was noted wandering in the hallways. On 3/13/13 during the 11- 7AM shift, nurse's notes identified that the resident was wandering into other resident rooms, banging on walls, throwing garbage all over the floor and was unable to be redirected. The physician was notified and directed to administer Ativan 1.0 milligram (mg) by mouth immediately (stat). Although Ativan 1.0 mg was administered the resident continued to wander and refused to put clothes on and every thirty (30) minute checks were initiated.

On 3/14/13 at 1:00 AM, Resident #96 approached the nurse's station with a pen and threatened to stab the nursing staff. The staff followed the resident back to the room which was noted covered in trash. The resident screamed at the charge nurse to get out of the room and threatened to kill him/her. Resident #96 exited the room naked and locked him/herself in a hall bathroom. The physician was notified and directed to transfer the resident to the emergency department for evaluation and the resident was transferred at 1:40 AM. The emergency department diagnosed the resident with a urinary tract infection and Resident #96 returned to the facility at 5:15 AM without certification that the resident was not a danger to self and/or others. The nurse's note dated 3/14/13 for the 11-7AM and 7-3PM shifts identified Resident #96 refused medications from staff, would not allow staff to enter the room, and refused care.

The psychiatric Physician's Assistant (PA) #1 progress note dated 3/14/13 on the evening shift (not timed) identified threatening and intrusive behaviors and paranoia and PA #1 recommended to obtain a Physician's Emergency Certificate and transfer the resident to an inpatient psychiatric facility.

The nurse's note dated 3/14/13 for the 3-11PM shift failed to reflect that increased supervision was provided to the resident and/or that the facility obtained the PEC and transfer to an inpatient psychiatric facility as recommended by the psychiatric consultant.

The nurse's note dated 3/15/13 at 8:00 AM identified Resident #96 was wandering and pacing the hallways unclothed, screaming that he/she was the devil, was unable to be redirected and was pulling his/her hair. At 8:30 AM, the resident was noted exiting

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another resident's room (Resident#97) and screaming at the Occupational Therapist pointing a butter knife at him/her. Resident #96 then pointed the knife at the nurse and screamed "I'm going to kill you". The knife was removed, the physician was notified and the resident transferred to the emergency department and admitted.

A review of facility investigation identified that the Occupational Therapist was treating another resident when he/she heard calls for help. The Occupational Therapist found Resident #97 sitting on the side of the bed calling for help stating that Resident #96 had a knife. The Occupational Therapist observed Resident #96 with 2 knives in his/her hand standing at the foot of Resident #97's bed wearing an open robe with no clothing under the robe. The Occupational Therapist called for help from staff who removed the knives from the resident's hands.

Interview with the DNS on 6/7/13 at 8:00 AM failed to provide evidence that the facility initiated inpatient psychiatric treatment when notified by Psychiatric Physician Assistant (PA) #1 to obtain a PEC and/or failed to provide one to one supervision per facility policy when the resident exhibited threatening behaviors directed toward staff and residents. The DNS was unable to identify the immediacy of a PEC and was unable to provide a clear understanding pertaining to the staff member who was responsible to obtain a PEC for a resident when recommended.

Subsequent interview and review of the clinical record with the DNS on 6/7/13 at 9:00 AM failed to reflect that Resident #96 was provided direct supervision by staff from 3/14/13 at 5:15 am upon return from the hospital until 3/15/13 at 8:30 AM (27 hours and fifteen minutes) when he/she was found threatening another resident with a knife. Further review identified that although every 15 minute checks had been signed off as completed, the checks lacked documentation of the staff 's name and/or the resident's whereabouts/condition during the checks. Review of the staffing worksheets failed to identify the staff assigned to monitor Resident #96.

Interview with the Psychiatric Physician Assistant (PA) #1 on 6/7/13 at 9:30 AM identified that a PEC was requested due to threatening behavior to staff and peers, and paranoid, disorganized, intrusive, inappropriate, and markedly altered behaviors from baseline. The PA indicated he/she informed the DNS of the need to obtain the PEC from the physician.

Resident #97 reported during an interview on 6/7/13 at 9:40 AM identified Resident #96 came into his/her room uninvited, and fiddled with silverware that was on the breakfast tray which was located on the over bed table. Resident #96 had rambling speech that was unintelligible. Resident #96 grabbed the knife, and bent over the bed with the knife toward Resident #97 and screamed. Resident #97 thought Resident #96 would hit him/her with the knife. Resident #96 turned and left the room and Resident #97 warned

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the staff who had come to see if everything was okay that Resident #96 still had a knife in his/her possession.

Interview with the DNS on 6/7/13 at 10:00 AM identified if the psychiatry consultant recommended to obtain a PEC, it was the responsibility of the facility staff to call the Psychiatrist and if no response to call the primary physician for further direction. The DNS although aware of PA #1's recommendations, failed to follow through to ensure staff were aware of their responsibilities regarding the recommendations to obtain a PEC. Although aware of the resident's threatening behaviors, the DNS failed to ensure the facility's continuous one to one policy was implemented to protect the safety of Resident #96 and other residents.

Review of the facility One to One Staff Supervision Policy directed to provide continuous one to one supervision when a resident is exhibiting behaviors that put the resident at immediate risk of harm to him/herself or others. Continuous one to one supervision will be maintained until the resident is stabilized.

Review of the facility Discharge to Psychiatric Center Policy identified when a decision is made to provide transfer to a specialized setting in order to provide a structured approach to behavioral and psychological management an order for transfer will be obtained from the physician. Arrangements for the transfer will be made by the facility.

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

9. Based on clinical record review and interviews for two of four sampled residents reviewed for accidents, (Resident # 85 and Resident #174) the facility failed to provide assistive devices during care resulting in an injury and/or failed to provide a safe and secure environment to prevent an elopement. The findings include:
  - a. Resident # 85 (R # 85) diagnoses included multiple sclerosis, abnormal posture and trigeminal neuralgia. A quarterly Minimum Data Set assessment dated 10/29/12 identified moderately impaired cognition, total care with bed mobility, transfer and non-ambulatory. The care plan dated 11/5/12 identified a risk for falls with interventions which included mechanical lift for transfers with assist of 2 staff members and assist of 1 with bathing. A customized wheelchair therapy report dated 11/28/12 identified after positioning from mechanical lift a pelvic positioning belt is utilized in the customized wheelchair for positioning. A nurse's note dated 11/28/12 at 10:40 AM identified Resident # 85 was observed sitting on the shower room floor with NA #1 at his/her side. Resident #85 complained of bilateral knee and back pain and was transferred to the emergency room. A reportable event form dated 11/28/12 indicated the resident was observed sitting on the shower room floor, with a nurse aide at his/her side. The resident was assessed and transferred to the emergency room via 911 and admitted

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to the acute care hospital with a diagnosis of a fracture of the femur. The hospital discharge summary dated 12/4/2012 identified Resident #85 was diagnosed with a right femur fracture that required an open reduction internal fixation (ORIF) on 11/29/12. An interview on 5/28/13 at 1:20 PM with NA # 1 identified he/she attempted to apply a gait belt on Resident #85 prior to the shower, however, the resident refused the gait belt. NA#1 did not notify the nurse that the resident had refused the gait belt. NA # 1 identified when he/she was washing the resident's back, Resident #85 slipped out of the chair onto his/her knees. An interview on 5/29/13 at 10:40 AM with RN # 2 identified he/she observed Resident # 85 on the floor in the shower room and did not observe a safety belt on the resident and/or shower chair at the time of the fall. A review of the facility shower policy and interview on 5/29/13 at 10:50 AM with the Director of Nurse's (DNS) identified it was not the facility policy to use a seat belt in the shower chair on all residents in November 2012. The DNS further identified that if the resident required a seat belt in a custom wheelchair for positioning, he/she would have expected a shower chair seat belt to be used and if the resident refused the belt he/she would have expected the nurse aide to notify the nurse.

- b. Resident # 174 diagnoses included Parkinson's disease and dementia. An elopement risk/data collection screen dated 12/7/12 identified a risk for elopement. A significant change Minimum Data Set Assessment dated 3/5/13 identified cognitive impairment and independence with walking and locomotion on the unit. The resident care plan dated 3/12/13 identified at risk for elopement with interventions which included wander guard in place, check every shift and redirect as needed. The nurse's note dated 4/13/13 at 3:00 PM indicated Resident #174 was found outside of the building near the lobby. A review of the reportable event and investigation dated 4/13/13 indicated the alarm sounded on the 3rd floor east-side stairwell. Resident # 174 was found outside of the lobby doors being escorted into the building by a visitor. An interview on 5/23/13 at 2:40 PM with RN # 4 indicated he/she was the manager on duty on 4/13/13 and although staff currently check the exit doors to assure the wander guard alert system is functioning on all the doors, he/she did not check the door alarms on 4/13/13 as it was not the practice of the Manager on Duty to check the functioning of the door alarms prior to the incident on 4/13/13. An interview on 5/28/13 at 2:15 PM with the DNS indicated Resident # 174 exited into the stair well on the 3rd floor and went outside via the stairwell exit door. The DNS indicated Resident #174 was able to open the door to the stairwell and exit because the magnet on the door was broken. He/ She further indicated although the door to the stairwell sounded on the unit, the door to the outside is not audible unless you are in the vicinity of that door and does not sound at any of the nurse's stations to indicate the outside door has been opened. A review of the door security systems monitoring log and interview with the Maintenance Director on 6/3/13 at 10:35 AM indicated the magnet on the east-side door of the 3rd floor failed which allowed the resident to open and exit the door into the stairwell. He/she indicated the doors are checked daily which includes magnet testing by the maintenance department during the week and by the manager on duty on the weekend. A review of a facility policy on wandering/exit

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seeking systems indicated door alarms will be tested for function daily by maintenance staff and documented on a preventative maintenance log.

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).

10. Based on clinical record review, observations, facility documentation and interviews for three of ten sample residents Resident (#27, #112 and #124) the facility failed to monitor psychotropic medications side effects in a timely manner and/or perform a laboratory tests as recommended by the pharmacy consultant in a timely manner. The findings include:
- a. Resident # 27's diagnoses included in syncope, dementia with behavioral disturbances and depression. A quarterly minimum data set assessment dated 3/26/13 identified severe cognitive impairment and received anti-psychotic medications during the past 7 days. The care plan dated 4/2/13 identified psychotropic drug use related to anti-psychotic medication with interventions which included completing an Abnormal Involuntary Movement Scale (AIMS) every six months as indicated. A review of the clinical record identified the last AIMS testing was completed on 8/10/12. Review of monthly pharmacy review dated 3/25/13 identified that AIMS testing was due to be completed. Interview and review of clinical record with the Assistant Director of Nursing(ADNS) on 6/4/13 at 10:30 AM failed to identify that the AIMS testing required every six months was completed as per the plan of care. The ADNS further identified that Behavioral Health consultants are in the building three days a week and have been given a list of the needed AIMS testing and it is the responsibility of the licensed staff to follow up on the recommendations of the pharmacy consultant.
  - b. Resident #112's diagnosis included hypothyroidism. A quarterly Minimum Data Set Assessment dated 3/26/13 identified intact cognition and required extensive assistance for bed mobility, transfers and dressing. A care plan dated 4/2/13 identified a potential for complications of hypothyroidism with interventions which included labs as ordered, report changes to MD and assess for cold intolerance, weight gain or loss, muscle weakness/aches fatigue, confusion, and or chest pain. Review of the clinical record and interview with RN#1 on 6/3/13 at 1:45 PM identified although the pharmacist had recommended a thyroid stimulating hormone level on 2/21/13 a level had not been done until 5/3/13 as Resident #112 was on medical leave between 2/21/13 and 2/26/13. RN#1 identified an agency nurse had been assisting with the pharmacy recommendations in May and the recommendation was overlooked upon the resident's return from the medical leave. Review of the pharmacy recommendation identified that the recommendation for a TSH had been made in February, March and April. RN #1 identified that pharmacy recommendations are put into his/her mailbox to be acted upon and then filed in the record.
  - c. Resident #124's diagnosis included organic mental syndrome with associated psychotic and/or agitated features. An annual Minimum Data Set Assessment dated 5/28/13 identified severe cognitive impairment and was totally dependent for bed mobility,

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transfers, and dressing. A current care plan identified psychotropic drug use related to antipsychotic medications with interventions to communicate with MD and the pharmacy consultants concerns identified at review and to observe for movement disorders. Review of the clinical record, review of facility policy and interview with RN#2 on 6/4/13 at 10:30 AM identified that an abnormal involuntary movement scale had been completed on 7/12/12 and not completed again until 5/20/13. Further review of the clinical record identified that the pharmacy consultant had recommended an abnormal involuntary movement scale be performed in February, March and April. RN#2 was unable to identify that an abnormal involuntary movement scale had been done in January, 2013 per the facility policy and/or per the pharmacist consultant recommendation. Interview and review of clinical record on 6/4/13 at 10:30AM with the ADNS identified it is the responsibility of the licensed staff to follow up on the recommendations of the pharmacy consultant.

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

11. Based on observation, interview and review of facility policy for one of three residents reviewed for pressure ulcers (Resident # 216) the facility failed to follow infection control standards of practice related to wound care. The finding includes:
  - a. Observation of the treatment to Resident# 216 coccyx on 6/3/13 at 11:30AM with LPN # 3 identified LPN #3 applied gloves, removed the soiled dressing, discarded the soiled dressing and gloves, then reapplied clean gloves and continued with cleansing the wound without the benefit of washing and/or sanitizing his/her hands after removing the soiled gloves and dressing. The facility policy and procedure for clean dressing changes identified that gloves should be removed, hands washed or sanitized, and new gloves applied after removing the soiled dressing. Interview with the DNS on 6/4/13 at 11:00AM identified when the LPN removed the soiled dressing and gloves he/she should have washed and/or sanitized his/ her hands prior to reapplying the new gloves and continuing with the treatment.

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

12. Based on clinical record review, interviews and review of facility documentation, the Administrator failed to maintain the highest level of well- being for the residents. The finding includes:
  - a. A survey was completed on 6/10/13 which identified problems related to ensuring the safety and well- being of the residents and ensuring that appropriate psychiatric services were obtained for a resident with frequent aggressive behaviors. Interview with Person #2 on 6/13/13 at 10:30 AM, who was Acting Administrator during February and March 2013 failed to provide evidence that interventions were implemented which protected

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the resident and/or prevented harm to other residents and staff.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (2).

13. Based on review of facility policies and procedures and review of facility documentation, the facility failed to have an effective and functioning governing body. The findings include:
- a. A review of the facility governing body bylaws identified that the general responsibility of the governing body was to set policy, oversee the management and operation of the facility and to ensure the financial viability of the facility.

The Governing body will convene and document at least annually to review in part the facility by-laws, resident care policies and procedures, resident rights and staff code of conduct.

A review of facility documentation identified the Governing Body last convened on 1/4/2012, and not annually as directed.

Interview and review of facility documentation on 6/13/13 at 12:00 PM with the Administrator identified that the facility's Medical Board should convene every quarter. Review of facility documentation identified that although the Medical Board convened on 4/17/12 and 4/25/13, the facility failed to provide documentation of meetings in January, July, and October of 2012 and January 2013.

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

14. Based on review of the personnel records for 4 of 4 Nurse Aides, the facility failed to complete annual performance evaluations. The findings include:
- a. NA #10 was employed at the facility on 7/28/06. The last performance evaluation was completed on 8/6/10.
  - b. NA #11 was employed at the facility on 7/28/06. And the last performance evaluation was completed on 9/1/10.
  - c. NA#12 was employed at the facility on 1/24/11. There was no documentation that a performance evaluation had been done.
  - d. NA#13 was employed at the facility on 9/12/11. There was no documentation that a performance evaluation had been done.

Interview and review of the personnel records on 6/13/12 at 1:00 PM with the DNS and the Administrator identified that although the facility policy directs to complete performance evaluations annually, the evaluations were not completed due to a change in Administrative staff.

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

15. Based on review of the clinical record, review of facility policies/ procedures and documentation, the Medical Director failed to participate in Governing Body and Medical Board meetings as directed by policy and/or failed to assist the facility to address clinical care concerns for a resident with behaviors. The findings include:
- a. The Governing body is comprised of an Administrator, the Director of Nurses, and the Medical Director and will convene and document at least annually to review in part the facility 's by-laws, resident care policies and procedures, resident rights and staff code of conduct. A review of facility documentation identified that the although Medical Director participated in last Governing Body meeting that convened on 1/4/2012, and the facility failed to provide documentation of meeting in January 2013.
  - b. A review of facility policy and documentation identified that the facility's Medical Director should attend the quarterly Medical Board meetings. Review of facility documentation identified that although the Medical Board convened on 4/17/12 and 4/25/13, the facility failed to provide documentation of meetings in January, July, and October of 2012 and January 2013.
  - c. A review of the facility Monthly Medical Director meetings with the Director of Nurse's on 6/13/13 at 12:30 PM identified that although the Administrator, DNS and Medical Director met monthly, the facility failed to provide evidence of Medical Director Rounds since June 2012 and/or failed to provide evidence of discussions with the Medical Director regarding the behaviors of Resident #96 and ensuring the safety and well-being of the other residents in the facility.

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

16. Based on review of the clinical records, review of facility documentation and interviews, the facility failed to ensure that the Quality Assurance (QA) Committee identified, discussed deficient practices and/or developed and implemented plans of actions to correct deficient practices. The findings include:
- a. The regulation of Quality Assurance is not met as evidence by:  
Please refer to F-319 and F-323.