2019

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Regency House Nursing & Rehab
187 East Main Street
Wallingford, CT 06492
M:

FLIS Staff
Maria Glendejardi
Damuta Bruzas
Kelly Modgil
Jeanne Dunlap
Joe Kingston III BFSI
Ray Kenitin BFSI

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 130

Census: 120

Date(s) of onsite inspection: 4/8, 4/9, 4/10, 4/11/2019

Date(s) additional information obtained: ___

Personnel contacted: DAVID BOND Administrator
Donna Dwyer RN

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes):* ___

[ ] Visit OR Revisit for the purpose of ___

[✓] See Complaint Investigation # CT00023992, CT00023782, CT00024018, CT00024140

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ___

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[✓] Narrative report/additional information attached.

[✓] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Damuta Bruzas **DATE OF REPORT:** 4/11/2019

[ ] Approval for issuance of license granted by: Supervisor/Title **DATE:** 3/8/21

s:\flis\hsr\FACESHEETS
Revised 2/2018

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

LICENSING INSPECTION REPORT

Regency House Niursing and Rehabilitation

Signature of FLIS Staff

Wallingford

M:

Licensure Category:
CCNH

Licensed Bed Capacity: 130

Census: 124

Date(s) of onsite inspection: _____

Date(s) additional information obtained: _____

Personnel contacted: ___

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. _____

[x] Desk Audit _6/17/19____ [x] Amended Letter: _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[X] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: _____ **DATE OF REPORT:**

[ ] Approval for issuance of license granted by: _____ **DATE:** ___6/17/19_____

Supervisor/Title

A Desk Audit was completed on 6/17/19 for the purpose of reviewing the plan of correction for the violation letters dated 6/4/19.

Based review of facility documentation and interviews, violations 1-4 were identified as corrected.

Siobhan O'Neill, RN, BSN
Nurse Consultant
Facility Licensing and Investigations Unit
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone - 860-509-7459
Siobhan.Oneill@ct.gov
Let us know how we are doing: Survey

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Regency House
181 E. Main St
Wallingford, CT 06492
M:

FLIS Staff

Kelly Mueller

Licensure Category:

CCNH

Licensed Bed-Bassinet Capacity: 119

Census: 131

Date(s) of onsite inspection: 9/4/19,

Date(s) additional information obtained: _____

Personnel contacted: Donna Dwyer - DNS David Bond - administrator

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[✓] See Complaint Investigation # CT 26022

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated _____

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Kelly Mueller **DATE OF REPORT:** 9/5/19

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Regency House Nursing & Rehab
187 East Main Street
Wallingford, CT 06492
M:

FLIS Staff

Maria Elena Legardi
Damuta Bivzas
Kelly Madden
Joe Kingston III BFSI
Ray Kenslin BFSI
Jeanne Overby

Licensure Category: CCNH

Licensed Bed / Bassinet Capacity: 130

Census: 120

Date(s) of onsite inspection: 4/8, 4/9, 4/10, 4/11/2019

Date(s) additional information obtained: ___

Personnel contacted: DAVID BOND Administrator
Donna Dwyer RN

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: ___

[ ] Visit **OR** Revisit for the purpose of ___

[✓] See Complaint Investigation # CT00023992, CT00023782, CT00024018, CT00024140

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 4-26-19

[ ] Desk Audit ___ [ ] Amended Letter: 6-4-19 Original Ltr. 4-26-19

[✓] Citation # 19-23 was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[✓] Narrative report/additional information attached.

[✓] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Damuta Bivzas **DATE OF REPORT:** 4/11/2019

[ ] Approval for issuance of license granted by: ___ **DATE:** ___
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

June 4, 2019

Mr. David Bond, Administrator
Regency House Nursing And Rehabilitation Center
181 E Main St
Wallingford, CT 06492

Dear Mr. Bond:

This is an AMENDED letter to violation letter originally dated April 26, 2019.

Unannounced visits were made to Regency House Nursing And Rehabilitation Center which concluded on April 11, 2019 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 survey.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by May 6, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

not responded to by May 6, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Cher Michaud RN (CAG)

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

CEM/DB:jf

Complaints #23992, #23782, #24018 and #24140

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

1. Based on a clinical record review, staff interviews and a review of facility documentation for one sampled resident reviewed for advance directives (Resident #36), the facility failed to ensure the code status was correctly identified in the clinical record. The findings include:
    a. Review of the clinical record identified Resident #36 was originally admitted to the facility on 8/31/12 with diagnoses that included dementia, psychosis, adjustment disorder, epilepsy and hypertension.

    Review of the Advanced Directive Consent form dated 8/15/17 identified that Resident #36's choices regarding the administration of life support systems were "Do not administer Cardiopulmonary resuscitation". The consent form was signed by the court appointed conservator and witnessed by RN #1.

    Review of the Active Order Summary Report as of 9/30/17 identified physician's orders dated 9/7/17 directed Cardiopulmonary resuscitation (CPR).

    Physician's progress note dated 1/7/18 identified advanced directives were in place and "Do Not Resuscitate" (DNR) had been reviewed.

    Review of the social service assessment dated 1/23/18 identified DNR was in place.

    Review of physician's orders dated 3/28/18 directed Cardiopulmonary Resuscitation.

    An annual Minimum Data Set (MDS) assessment dated 4/25/18 identified Resident #36 with intact cognition, independent with Activities of daily Living (ADL's), and no condition or chronic disease that may result in a life expectancy of less than six months.

    The residents care plan was revised on 4/26/18 and identified Resident #36's code status as CPR (cardiopulmonary resuscitation). Interventions included to honor Advanced Directives as directed by resident and/or power of attorney.

    Review of the social service assessment dated 4/26/18 and 7/24/18 identified a Full Code advance directive in place.

    APRN #1 progress notes dated 11/30/18 indicated advanced directives were reviewed/updated and the resident's code status was identified as a "Full code".

    Physician's progress note dated 12/2/18 identified advanced directives were in place and DNR was reviewed.

    APRN #1 progress notes dated 2/1/19 identified advanced directives were reviewed and/or updated and the code status was "Full code".

Physician orders dated 3/10/19 directed Cardiopulmonary resuscitation.

Review of SS#1 notes dated 4/9/19 identified Resident #36's court appointed conservator was contacted and at this time she/he would like for the resident to be DNR as she/he had this discussion in the past and those are the residents wishes.

Interview and review of the clinical record with the Director of Nursing (DON) on 4/10/19 at 2:35 PM identified that the resident's responsible party and the physician was contacted to discuss and/or verify code status. The physician orders and the care plan were revised on 4/9/19 to reflect a DNR code status per Resident #36's wishes and at the court appointed conservators request.

Review of the facility Advanced Directives policy directed if at any time during the resident's stay at this facility, the resident or the responsible party wishes to initiate a DNR, the facility would provide a full explanation as to the meaning and ramifications of such a decision. Once the required documents were in order the resident or responsible party's wishes shall be followed.

Plan of Correction to Violation #1:

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

2. Based on clinical record review, facility documentation, and interviews for one of three residents

reviewed for a change in condition, (Resident #128), the facility failed to ensure the responsible party was notified with a medication change and/or when a change in condition was identified. The findings include:

a. Resident #128 had diagnoses that included Alzheimer's dementia, diabetes with chronic kidney disease, and heart failure.

Review of a face sheet dated 11/2/2014 identified Person #2 was the responsible party.

A quarterly minimum data set dated 2/20/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

Review of a hospice skilled nursing note dated 5/4/18 identified that the resident was admitted to hospice for a terminal diagnosis of Alzheimer's dementia. Person #2 had consented to hospice care and had signed the papers electronically. The resident had been declining, with decreased intake and weight loss.

Review of a care plan dated 5/7/18 identified the resident was placed on hospice care and to administer medications as ordered for comfort.

Review of a hospice skilled nursing note dated 5/7/18 identified that the resident was somewhat arousable and Morphine, Ativan, and Levsin were ordered for comfort.

a) Physician's orders dated 5/7/18 directed to administer Morphine Sulfate solution 20 milligrams (mg) per milliliter (ml), give 0.25 ml sublingually (sl) every 3 hours as needed for pain/and or dyspnea, Ativan 2 mg/ml give 0.25 ml sl every 3 hours for anxiety and end of life care, and Levsin 0.125 mg/ml, administer 1 ml every four hours as needed for increased secretions, and end of life care.

Review of the clinical record identified that although on 5/7/19 the nurse's note identified that a family member had approved the Morphine, and/or Ativan orders, the note failed to identify that Person #2 that was notified.

Review of the clinical record identified that the resident received the Morphine sulfate and Ativan as needed daily and/or more often from 5/7/18 until 5/12/18, when the patient expired.

Interview with Person #2 on 4/11/19 at 10:30 AM identified that he/she was not notified that her family member (Resident #128) had physician's orders for and/or was receiving Morphine and Ativan prior to his/her death, and only found out after he/she was deceased that these medications were being administered to his/her family member. Person #2 further identified that it could have been one of her other family members that could have been notified about the medications, but she was the responsible party, and also had power of attorney (POA). Person #2 further identified that she would not have consented to the medications because her family member had a sensitivity to narcotics identified about 6-8 years ago.

Review of the medical record and/or interview with the pharmacy failed to identify Patient #128 with a sensitivity to narcotics.

Interview with Physician (MD) #3 on 4/11/19 at 12:30 PM identified that he was not aware of any medication sensitivities that the resident had, and the resident had received very small doses of Morphine and Ativan, and any sensitivity to those drugs would have been exhibited with the first doses administered to the resident, and none were noted.

b. Review of the nurse's notes from 5/7/18 through 5/11/18 identified that the resident had been stable and receiving Morphine and Ativan for pain and anxiety with no mention of increased secretions, and/or dyspnea.

Further review of the nurse's notes identified that on 5/11/18 at 6:06 PM and at 10:22 PM identified that the resident was medicated with Levsin for increased secretions.

A Nurse's note on 5/12/18 at 4:42 identified that the resident was medicated with Morphine and Ativan for pain and anxiety 4:42 AM with good effect.

A Nurses note dated 5/12/18 at 10:41 AM identified that the resident was not given medication because the resident was in a deep sleep and appeared to be comfortable and actively dying.

Review of the clinical record failed to identify that the responsible party was notified that the resident had a change in condition and/or was "actively dying".

A Nurses note dated 5/12/18 at 10:43 AM identified that the charge nurse had called him/her to the room, and the resident was pronounced deceased at 10:43 AM, with a family member at the bedside.

Interview with Person #2 on 4/11/19 at 10:30 AM identified that she had not been notified by the facility that her family member had been declining and/or was actively dying. Person #2 stated that when another family member entered the room on 5/12/18, he/she found Resident # 128 deceased.

Interview with RN #3 on 4/9/19 at 10:30 AM identified that she could not recall if she called the responsible party when the resident was actively dying, and/or if there was a family member was in the room with the resident was actively dying.

Interview with the Social Worker on 4/11/19 at 11:30 AM identified that she was aware that Person #2 had Power of Attorney (POA) for Resident # 128, but she was unsure if any paperwork had ever been submitted and entered into the computer.

Interview with the corporate nurse on 4/11/19 at 11:10 AM identified that the administration of Levsin for increased secretions on 5/11/18 would indicate a change in condition for Resident #128, since there was no other documentation of increased

secretions prior to 5/11/18. The responsible party should have been notified both of the change in condition, and if the nurse believed the resident was actively dying, and/or if a new medication had been initiated, but she was unable to find any documentation that Person #2 was notified.

Review of the family notification policy identified that the resident's family and/or legal representative will be notified when there is a significant change in the resident's status such as a deterioration in health, and/or at the commencement of a new treatment.

Plan of Correction to Violation #2:

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

3. Based on clinical record review, facility documentation, interviews, and observations, for one of three resident's reviewed for skin integrity impairment, (Resident #44), the facility failed to ensure that an impairment in skin integrity was addressed when identified and/or for one of two residents

reviewed for hospice services (Resident #128), the facility failed to ensure the hospice service was notified when a change in condition was identified. The findings include:

a. Resident #44 had diagnoses that included a pressure ulcer in the sacral region, anemia and muscle weakness. A quarterly minimum data set dated 2/6/19 identified that the resident was cognitively intact, required extensive assistance with activities of daily living and had a stage 4 pressure ulcer, and was at risk for impaired skin integrity.

Review of a care plan dated 2/27/19 identified that the resident had a potential for impairment because of fragile skin, with interventions to monitor and document location, size and treatment to the skin injury.

Review of a weekly skin integrity check performed by Licensed Practical Nurse (LPN) #1 dated 4/3/19 identified that there were no new areas of impaired skin integrity noted for Resident #44.

Interview and Observation of Resident #44 on 4/8/19 at 2:00 PM with LPN #5 and Registered Nurse (RN) #1 identified reddened scabbed areas to the left and right knee. LPN #5 identified that she was unsure about the scabs, but the resident did have a history of picking his/her skin. Interview with RN #5 identified that the areas on the knees appeared not to be a new injury, had a reddened perimeter, and she would review the clinical record to check on the scabbed areas on the bilateral knees.

Review of a weekly skin condition report dated 4/8/19 identified that there was a reddened scab to the right knee that measured 2 centimeters (cm) by 1.5 and a reddened scab to the left knee that measured 1.5 cm by 0.5 cm.

A physician's order dated 4/8/19 directed to apply bacitracin to the left and right knee every day.

Interview with RN#1 on 4/9/19 identified that she had reviewed the clinical record subsequent to surveyor inquiry, and had not found any documentation on the scabbed areas to the bilateral knees, so she measured them and contacted the physician for treatment orders.

Interview with Nurse Aide (NA) #2 on 4/10/19 at 1:00 PM identified that she had noted and reported the scabbed areas to Resident #44's knees to LPN #1 on 4/1/19.

Interview with LPN #1 on 4/10/19 at 1:05 PM identified that when NA#2 reported the scabbed areas to the knees, she looked at the resident's knees and identified the scabbed area on the left knee, but did not recall seeing a scabbed area on the right knee. The scabbed area appeared to be an old injury, and was dried, but not reddened. LPN#1 identified that she did not review the clinical record to identify if the areas were previously identified and/or treated, and furthermore, she did not notify the RN and/or physician because she thought the areas appeared to be old. Additionally, although she is aware that during the weekly skin check she is supposed to view the entire body, on

4/3/19 she only checked the resident's boney prominences and did not lift the residents pant legs to visualize the knees.

Interview with the Director of Nurses on 4/10/19 1:45 PM identified that subsequent to surveyor inquiry on 4/8/19 it was identified that the resident had impaired skin integrity that was not addressed by the licensed staff. A house wide body audit was then completed on 4/8/19 to ensure all areas of impaired skin integrity were properly documented and/or assessed, with no undocumented/untreated areas identified. Further interview with the DON identified that when LPN #1 had seen the area on the resident's knee, she should have measured the area and called the physician, and furthermore, when a nurse is conducting a weekly skin audit the nurse must visualize the resident's entire body.

The facility identified there is no specific skin audit policy, and/or non-pressure skin integrity impairment policy, but the expectation is that the entire body will be visualized during the body audit, and once and area of impaired skin integrity is identified it will be measured, and the physician notified.

b. Resident #128 had diagnoses that included Alzheimer's dementia, diabetes with chronic kidney disease, and, heart failure.

A quarterly minimum data set dated 2/20/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

Review of a hospice skilled nursing note dated 5/4/18 identified that the resident was admitted to hospice for a terminal diagnosis of Alzheimer's dementia. Person #2 had consented to hospice care and had signed the papers electronically. The resident has been declining, with decreased intake and weight loss.

Review of a care plan dated 5/7/18 identified the resident was placed on hospice care and to administer medications as ordered for comfort.

Review of a hospice skilled nursing note dated 5/7/18 identified that the resident was somewhat arrousable, and Morphine, Ativan, and Levsin were ordered for comfort.

Review of a hospice skilled note dated 5/9/18 identified that the resident was lethargic, but easily aroused, the resident denied pain and/or difficulty breathing and had clear lungs.

Review of the nurse's notes from 5/7/18 through 5/11/18 identified that the resident had been stable and receiving Morphine and Ativan for pain and anxiety with no mention of increased secretions and/or dyspnea.

Further review of the nurse's notes identified that on 5/11/18 at 6:06 PM and at 10:22 PM the resident was medicated with Levsin for increased secretions.

A Nurse's note on 5/12/18 at 4:42 identified that the resident was medicated with Morphine and Ativan for pain and anxiety 4:42 AM with good effect.

A Nurses note dated 5/12/18 at 10:41 AM identified that the resident was not given medication because the resident was in a deep sleep, appeared to be comfortable, and actively dying.

Review of the clinical record failed to identify that the hospice was notified that the resident had a change in condition and/or was "actively dying".

A Nurses note dated 5/12/18 at 10:43 AM identified that the charge nurse (LPN #2) had called him/her to the room, and the resident was pronounced deceased at 10:43 AM.

Review of the clinical record failed to identify that the hospice service had been notified that the resident was experiencing increased secretions and/or was actively dying.

Interview with RN #3 on 4/9/19 at 10:30 AM identified that she could not recall if she had notified hospice when the resident was noted to be "actively dying".

Interview with the hospice nurse on 4/9/19 at 9:30 AM identified that she had last assessed the resident on 5/9/18, and the resident appeared comfortable and/or did not have any increased respiratory secretions, and death was not imminent. She further identified that hospice should be notified at any change of condition so a re-assessment of the resident's needs can be done, and hospice visits could be increased from 1 to 2 times a week to 1-2 times daily. The hospice nurse identified that subsequent to her visit on 5/9/18 she was not notified of a change in condition, only that the resident had expired on 5/12/18.

Interview with the corporate nurse on 4/11/19 at 11:10 AM identified that the administration of Levsin for increased secretions on 5/11/18 would indicate a change in condition for Resident # 128, since there was no other documentation of increased secretions prior to 5/11/18. The hospice service should have been notified both of the change in condition and if the nurse believed he/she was actively dying, but she was unable to find any documentation.

The facility identified that they did not have a hospice policy.

Review of the hospice and facility staff referral and admission paperwork identified that nursing home staff will call the hospice program to report changes in the resident's condition.

Plan of Correction to Violation #3:

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

4. Based on a review of clinical records, facility documentation, interviews, and policies, for one six residents reviewed for medication administration (Resident #19), the facility failed to ensure that the resident received a medication in accordance with a physician's order, which resulted in a significant medication error during the period of 727/18 through 8/8/18. The significance of the error resulted in Immediate Jeopardy (IJ). On 8/8/18 the facility immediately did education on the medication and/or the five rights of medication administration, conducted audits of physician orders, and audits to ensure medications were administered in accordance with the orders. On 4/11/19, compliance with the action plan was verified resulting in Immediate Jeopardy past non-compliance. The finding includes:
    a. Resident #19 had diagnoses that included Rheumatoid Arthritis (RA), polyosteoarthritis, and anemia. Review of a physician's order dated 7/1/18 directed to administer methotrexate sodium 15 mg by mouth every Saturday (weekly).

Review of bloodwork dated 7/9/18 identified a platelet level of 314 (normal level is 150-450), and a Hemoglobin (Hgb) level of 7.9 (normal level is 12.5 to 16), and a White Blood Cell (WBC) count of 9.3 (normal level is 5 to 10).

A quarterly minimum data set assessment dated 7/11/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

A care plan dated 7/25/18 identified that the resident had a history of chronic pain related to RA with interventions that included to monitor the resident for pain, and to administer medications as ordered.

Review of a report of consultation dated 7/25/18 identified that the resident had been seen by his/her rheumatologist, the exam was negative for tenderness and/or swollen joints, with recommendations to reduce methotrexate to 10 milligrams (mg) every week.

Review of a physician's order dated 7/26/18 directed to administer methotrexate 10 mg by mouth every day for a diagnosis of polyosteoarthritis.

Review of the Medication Administration Record for July 2018 and August 2018 identified that the resident received the methotrexate daily at 9:00 AM from 7/27/18 through 8/8/18.

Review of a nurse's note dated 8/7/18 identified that the resident was noted with swollen cheeks, and a moderate sized bump on the left outer cheek with increased complaints of pain noted. Upon assessment the resident was unable to open his/her mouth wide enough to thoroughly inspect the oral cavity, but white patches were noted on the left cheek and gum line also with increased pain. The Advanced Practice Registered Nurse (APRN) was called and ordered a dental consult, a clear liquid diet, warm water rinses, augmentin 875 mg for 10 days, a Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP) were ordered for a dental infection.

Review of a medication incident report and investigation dated 8/8/18 identified that the resident had been seen by his/her rheumatologist on 7/25/18 with recommendations for the methotrexate to be reduced to 10 mg weekly. The order was transcribed into the electronic medical record on 7/27/18 to be administered daily, the resident received a total of 13 doses, 11 doses in error.. The APRN was notified and consulted with the physician with new orders to start intravenous fluids for a total of 5 liters, complete blood counts daily, and the methotrexate was discontinued.

Review of the APRN progress notes dated 8/9/18 identified that the resident had acute mucositis with ulcerative areas in the bilateral mucosa possibly due to the increased dosing of the methotrexate. Antibiotics will continue to minimize risk of a bacterial infection, the folic acid will be increased, and IV fluids will continue at 75 milliliters (ml) an hour, the diet will be changed to puree foods and will be upgraded as possible with ensure nutritional supplement to help with nutritional needs.

Review of an APRN progress note dated 8/10/18 identified that the resident was being treated for methotrexate toxicity and mucositis. The blood work was reviewed and WBC count was 2.4 (normal level is 5 to 10), Hgb was 7.3 (normal level is 12.5 to 16) and platelets were 89 (normal level is 150-450), with a methotrexate level of 0.5 (normal is less than 0.01). Luecovorin (a medication that is used for an antidote for methotrexate toxic) 15 mg every 6 hours has been started and will continue until methotrexate level decreases to less than 0.1. The patient received 4 liters of IV fluids and when the IV site infiltrated and resident refused to have another IV site inserted.

Review of an APRN progress note dated 8/13/18 identified that the WBC was 3.2, Hgb was 7.4, and the platelet count was 31. The family member was called and informed of bloodwork, and although the resident had previously stated that s/he did not want a transfusion, The APRN informed the family that if platelet count dropped below 20 the resident would need to have a platelet transfusion.

Review of an APRN progress note dated 8/14/18 identified that the WBC had dropped to 2.6, the Hgb had dropped to 7.1 and the platelet level was 20, the resident agreed to a transfer to the emergency department for a platelet transfusion.

Review of the nurse's notes from 8/9/18 through 8/14/18 identified that the resident continued to complain of oral pain that was treated with acetaminophen and topical benzocaine.

Review of the hospital record dated 8/17/18 identified that the resident was admitted on 8/14/18 with methotrexate toxicity from erroneous ingestion of methotrexate. The patient had mucositis, leukopenia, a drop in platelets, and increased bleeding form oral sores. The patient had worsening thrombocytopenia and remained at high risk for increased bleeding and an intracranial bleed, and required an inpatient stay for a blood and platelet transfusion.

Interview with Registered Nurse (RN) #1 on 4/9/19 at 2:00 PM identified that when Resident #19 returned from the rheumatologist on 7/25/18 she reviewed the consult and identified that the resident's methotrexate order had recommendations to be decreased to 10 mg weekly. RN #1 called the APRN to verify the weekly dosing of the methotrexate 10 mg, and when placing the order in the Electronic Medical Record (EMR) entered the methotrexate 10 mg to be administered daily instead of weekly, she further identified that when entering the order into the EMR, there is a drop down box to enter dosage times, and she accidentally entered daily instead of weekly. RN#1 further identified that she did not enter the diagnosis for the medication as rheumatoid arthritis, she entered polyosteoarthritis because it was in his/her diagnosis, and the resident had arthritis in 4 or more joints.

Interview with Licensed Practical Nurse (LPN) #4 on 4/11/19 at 6:30 AM identified that on the 11:00 PM to 7:00 AM shift the nurses are responsible for verifying that orders are

entered correctly. She further stated that she will take the physicians order and ensure that it is entered correctly into the EMR, and since she was unaware that the medication order came from a consult, she did not check the consult for verification, and furthermore was not aware that methotrexate should only be given weekly for a resident with RA.

Interview with LPN #5 on 4/9/19 at 11:30 AM identified that she was doing the medication pass upon return from her vacation on 8/8/18 and noted that the methotrexate order was daily, when she was aware that the resident normally received it weekly, she then notified her supervisor of the error.

Interview with the Director of Nurses on 4/9/18 identified that RN #1 entered the methotrexate 10 mg order daily into the EMR, instead of weekly. The error was found upon the charge nurse's return from vacation on 8/8/18. The DON further identified that 8 different nurses worked on the unit while the charge nurse was on vacation between 7/26/18 and 8/8/18, all were unaware that methotrexate should not be given daily for residents with RA. The DON further identified that if a nurse is uncertain of a drug he/she is administering and/or dosing of a medication she should either look up information on the medication and/or call the physician for clarification.

Interview with APRN #2 on 4/9/18 identified that when she was notified of the medication error on 8/8/18 she consulted with the medical director on the course of treatment for the resident. New orders included, 5 liters of IV fluids in an attempt to keep the resident hydrated and to "flush out" the methotrexate. The Leucovorin was ordered because the methotrexate level was elevated at 0.5, and blood work was monitored daily, until 8/14/18 when the platelet level dropped to 20 and a transfer to the hospital was necessary.

Interview with Physician (MD) #1 on 4/10/18 at 12:10 PM identified that methotrexate is not given daily for a resident with RA, but weekly. Methotrexate is mostly given daily for cancer patients receiving chemotherapy, and can be a very toxic medication. The resident experienced methotrexate toxicity with corresponding mouth ulcerations and decreased blood counts which required hospitalization. The resident and family refused transport to the hospital for a transfusion, up until 8/14/18 when the platelet level dropped to 20, a discussion with the resident and family was held about the urgency to be transferred to the hospital to decrease the risk of bleeding, and the resident and family agreed to the transport.

Interview with Pharmacist Supervisor #1 from the facility's contracted pharmacy on 4/8/19 at 1:30 PM identified that pharmacist #1 had reviewed the methotrexate order sent by the EMR on 7/26/18, she further identified that the pharmacist should always check the medication dosing with the diagnosis prior to dispensing medications.

The Pharmacy supervisor stated that the guidelines for methotrexate dosing for a patient with rheumatoid arthritis should be weekly. The supervisor further identified that if the

diagnosis for the methotrexate 10 mg was rheumatoid arthritis, pharmacist #1 would have called the facility to question the daily order. She further identified that the diagnosis that came with the order on 7/26/18 was polyosteoarthritis, and some medications can be used for other diagnoses (off label use), the pharmacist did not question the medication because the dose and/or frequency because the dose itself was acceptable, and the frequency could be different for off label use.

Attempts to reach pharmacist #1 were unsuccessful.

Review of a memorandum from the facility's pharmacy dated 8/10/19 identified that effective immediately, all methotrexate orders would be flagged with an alert. This alert will appear during order entry, initial review, and the final review screen. All pharmacists will be required to initial that the methotrexate order was evaluated for clinical appropriateness.

Review of the medication administration policy identified that medication orders will be accurately transcribed and executed to ensure accurate administration of all physician's orders.

The facility immediately implemented corrective measures on 8/8/18 that included RN#1 receiving disciplinary action for the error in transcription. The facility provided staff education regarding dosing and frequency of residents receiving methotrexate for rheumatoid arthritis, the five rights of medication administration, and second nurse verification once an order is noted, as well as a verification of the order on the 11:00 PM to 7:00 AM shift, all education began on 8/8/18 when the error was identified, and staff were educated before the start of subsequent shifts. The DON immediately audited Resident #19's medications for accuracy and any resident who had received new orders on consults, these audits continued weekly for 4 weeks and then randomly monthly and continue to be conducted with no further medication errors noted.

Plan of Correction to Violation #4:

VPOC
P IDR
P CEN
7-14-19

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch
IMPORTANT NOTICE - PLEASE READ CAREFULLY

June 4, 2019

Mr. David Bond, Administrator
Regency House Nursing And Rehabilitation Center
181 E Main St
Wallingford, CT 06492

Dear Mr. Bond:

This is an AMENDED letter to violation letter originally dated April 26, 2019.

Unannounced visits were made to Regency House Nursing And Rehabilitation Center which concluded on April 11, 2019 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 survey.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by May 6, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation(s) and you may be provided with the opportunity to be heard. If the violation(s) is/are not responded to by May 6, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall

be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Cher Michaud R.N. (CAG)
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM/DB:jf

Complaints #23992, #23782, #24018 and #24140

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

1. Based on a clinical record review, staff interviews and a review of facility documentation for one sampled resident reviewed for advance directives (Resident #36), the facility failed to ensure the code status was correctly identified in the clinical record. The findings include:
    a. Review of the clinical record identified Resident #36 was originally admitted to the facility on 8/31/12 with diagnoses that included dementia, psychosis, adjustment disorder, epilepsy and hypertension.

    Review of the Advanced Directive Consent form dated 8/15/17 identified that Resident #36's choices regarding the administration of life support systems were "Do not administer Cardiopulmonary resuscitation". The consent form was signed by the court appointed conservator and witnessed by RN #1.

    Review of the Active Order Summary Report as of 9/30/17 identified physician's orders dated 9/7/17 directed Cardiopulmonary resuscitation (CPR).

    Physician's progress note dated 1/7/18 identified advanced directives were in place and "Do Not Resuscitate" (DNR) had been reviewed.

    Review of the social service assessment dated 1/23/18 identified DNR was in place.

    Review of physician's orders dated 3/28/18 directed Cardiopulmonary Resuscitation.

    An annual Minimum Data Set (MDS) assessment dated 4/25/18 identified Resident #36 with intact cognition, independent with Activities of daily Living (ADL's), and no condition or chronic disease that may result in a life expectancy of less than six months.

    The residents care plan was revised on 4/26/18 and identified Resident #36's code status as CPR (cardiopulmonary resuscitation). Interventions included to honor Advanced Directives as directed by resident and/or power of attorney.

    Review of the social service assessment dated 4/26/18 and 7/24/18 identified a Full Code advance directive in place.

    APRN #1 progress notes dated 11/30/18 indicated advanced directives were reviewed/updated and the resident's code status was identified as a "Full code".

    Physician's progress note dated 12/2/18 identified advanced directives were in place and DNR was reviewed.

    APRN #1 progress notes dated 2/1/19 identified advanced directives were reviewed and/or updated and the code status was "Full code".

    Physician orders dated 3/10/19 directed Cardiopulmonary resuscitation.

Review of SS#1 notes dated 4/9/19 identified Resident #36's court appointed conservator was contacted and at this time she/he would like for the resident to be DNR as she/he had this discussion in the past and those are the residents wishes.

Interview and review of the clinical record with the Director of Nursing (DON) on 4/10/19 at 2:35 PM identified that the resident's responsible party and the physician was contacted to discuss and/or verify code status. The physician orders and the care plan were revised on 4/9/19 to reflect a DNR code status per Resident #36's wishes and at the court appointed conservators request.

Review of the facility Advanced Directives policy directed if at any time during the resident's stay at this facility, the resident or the responsible party wishes to initiate a DNR, the facility would provide a full explanation as to the meaning and ramifications of such a decision. Once the required documents were in order the resident or responsible party's wishes shall be followed.

Plan of Correction to Violation #1:

Regency House Nursing and Rehabilitation provides the plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

The code status for resident #36 is correct and is reflected in the M.D. orders and plan of care.All residents have the potential to be affected. Education will be provided to Licensed Nursing staff and Social Services staff regarding a new or change in code status be will be in the physician order and the plan of care.Audits were conducted on all current residents ensuring the signed advanced directive paper works corresponds with the physician order and the care plan. Audits will be conducted on new admission weekly x 4 weeks and then monthly x 3 months. Audits will be conducted at care plan reviews weekly x 4 weeks and then monthly x 3.The Social Service Director will be responsible for monitoring compliance. Audits will be reviewed at the QAPI meetings monthly x3 then quarterly thereafter. Completed 5/2/19

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

2. Based on clinical record review, facility documentation, and interviews for one of three residents reviewed for a change in condition, (Resident #128), the facility failed to ensure the responsible party was notified with a medication change and/or when a change in condition was identified. The findings include:
    b. Resident #128 had diagnoses that included Alzheimer's dementia, diabetes with chronic kidney disease, and heart failure.

    Review of a face sheet dated 11/2/2014 identified Person #2 was the responsible party.

    A quarterly minimum data set dated 2/20/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

    Review of a hospice skilled nursing note dated 5/4/18 identified that the resident was admitted to hospice for a terminal diagnosis of Alzheimer's dementia. Person #2 had consented to hospice care and had signed the papers electronically. The resident had been declining, with decreased intake and weight loss.

    Review of a care plan dated 5/7/18 identified the resident was placed on hospice care and to administer medications as ordered for comfort.

    Review of a hospice skilled nursing note dated 5/7/18 identified that the resident was somewhat arousable and Morphine, Ativan, and Levsin were ordered for comfort.

    a) Physician's orders dated 5/7/18 directed to administer Morphine Sulfate solution 20 milligrams (mg) per milliliter (ml), give 0.25 ml sublingually (sl) every 3 hours as needed for pain/and or dyspnea, Ativan 2 mg/ml give 0.25 ml sl every 3 hours for anxiety and end of life care, and Levsin 0.125 mg/ml, administer 1 ml every four hours as needed for increased secretions, and end of life care.

    Review of the clinical record identified that although on 5/7/19 the nurse's note identified that a family member had approved the Morphine, and/or Ativan orders, the note failed to identify that Person #2 that was notified.

    Review of the clinical record identified that the resident received the Morphine sulfate and Ativan as needed daily and/or more often from 5/7/18 until 5/12/18, when the patient expired.

    Interview with Person #2 on 4/11/19 at 10:30 AM identified that he/she was not notified that her family member (Resident #128) had physician's orders for and/or was receiving Morphine and Ativan prior to his/her death, and only found out after he/she

was deceased that these medications were being administered to his/her family member. Person #2 further identified that it could have been one of her other family members that could have been notified about the medications, but she was the responsible party, and also had power of attorney (POA). Person #2 further identified that she would not have consented to the medications because her family member had a sensitivity to narcotics identified about 6-8 years ago.

Review of the medical record and/or interview with the pharmacy failed to identify Patient #128 with a sensitivity to narcotics.

Interview with Physician (MD) #3 on 4/11/19 at 12:30 PM identified that he was not aware of any medication sensitivities that the resident had, and the resident had received very small doses of Morphine and Ativan, and any sensitivity to those drugs would have been exhibited with the first doses administered to the resident, and none were noted.

c. Review of the nurse's notes from 5/7/18 through 5/11/18 identified that the resident had been stable and receiving Morphine and Ativan for pain and anxiety with no mention of increased secretions, and/or dyspnea.

Further review of the nurse's notes identified that on 5/11/18 at 6:06 PM and at 10:22 PM identified that the resident was medicated with Levsin for increased secretions.

A Nurse's note on 5/12/18 at 4:42 identified that the resident was medicated with Morphine and Ativan for pain and anxiety 4:42 AM with good effect.

A Nurses note dated 5/12/18 at 10:41 AM identified that the resident was not given medication because the resident was in a deep sleep and appeared to be comfortable and actively dying.

Review of the clinical record failed to identify that the responsible party was notified that the resident had a change in condition and/or was "actively dying".

A Nurses note dated 5/12/18 at 10:43 AM identified that the charge nurse had called him/her to the room, and the resident was pronounced deceased at 10:43 AM, with a family member at the bedside.

Interview with Person #2 on 4/11/19 at 10:30 AM identified that she had not been notified by the facility that her family member had been declining and/or was actively dying. Person #2 stated that when another family member entered the room on 5/12/18, he/she found Resident # 128 deceased.

Interview with RN #3 on 4/9/19 at 10:30 AM identified that she could not recall if she called the responsible party when the resident was actively dying, and/or if there was a family member was in the room with the resident was actively dying.

Interview with the Social Worker on 4/11/19 at 11:30 AM identified that she was aware that Person #2 had Power of Attorney (POA) for Resident # 128, but she was unsure if any paperwork had ever been submitted and entered into the computer.

Interview with the corporate nurse on 4/11/19 at 11:10 AM identified that the administration of Levsin for increased secretions on 5/11/18 would indicate a change in condition for Resident #128, since there was no other documentation of increased secretions prior to 5/11/18. The responsible party should have been notified both of the change in condition, and if the nurse believed the resident was actively dying, and/or if a new medication had been initiated, but she was unable to find any documentation that Person #2 was notified.

Review of the family notification policy identified that the resident's family and/or legal representative will be notified when there is a significant change in the resident's status such as a deterioration in health, and/or at the commencement of a new treatment.

Plan of Correction to Violation #2:

Regency House Nursing and Rehabilitation provides the plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

Resident #128 is no longer in the facility. Other family members were notified in regards to the change in condition and stated they would share changes with other family members. All residents have the potential to be affected. Education will be provided for licensed nursing staff regarding updating of responsible party and proper documentation after medication changes or change in condition. Audits on notifying responsible parties for residents will be conducted weekly x 4 and then monthly x 3. Audits will be reviewed at the QAPI meetings monthly x3 and quarterly thereafter. The DNS will be responsible for monitoring compliance. Completed 5/21/19

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

3. Based on clinical record review, facility documentation, interviews, and observations, for one of three resident's reviewed for skin integrity impairment, (Resident #44), the facility failed to ensure that an impairment in skin integrity was addressed when identified and/or for one of two residents reviewed for hospice services (Resident #128), the facility failed to ensure the hospice service was notified when a change in condition was identified. The findings include:

    d. Resident #44 had diagnoses that included a pressure ulcer in the sacral region, anemia and muscle weakness. A quarterly minimum data set dated 2/6/19 identified that the resident was cognitively intact, required extensive assistance with activities of daily living and had a stage 4 pressure ulcer, and was at risk for impaired skin integrity.

    Review of a care plan dated 2/27/19 identified that the resident had a potential for impairment because of fragile skin, with interventions to monitor and document location, size and treatment to the skin injury.

    Review of a weekly skin integrity check performed by Licensed Practical Nurse (LPN) #1 dated 4/3/19 identified that there were no new areas of impaired skin integrity noted for Resident #44.

    Interview and Observation of Resident #44 on 4/8/19 at 2:00 PM with LPN #5 and Registered Nurse (RN) #1 identified reddened scabbed areas to the left and right knee. LPN #5 identified that she was unsure about the scabs, but the resident did have a history of picking his/her skin. Interview with RN #5 identified that the areas on the knees appeared not to be a new injury, had a reddened perimeter, and she would review the clinical record to check on the scabbed areas on the bilateral knees.

    Review of a weekly skin condition report dated 4/8/19 identified that there was a reddened scab to the right knee that measured 2 centimeters (cm) by 1.5 and a reddened scab to the left knee that measured 1.5 cm by 0.5 cm.

    A physician's order dated 4/8/19 directed to apply bacitracin to the left and right knee every day.

    Interview with RN#1 on 4/9/19 identified that she had reviewed the clinical record subsequent to surveyor inquiry, and had not found any documentation on the scabbed areas to the bilateral knees, so she measured them and contacted the physician for treatment orders.

Interview with Nurse Aide (NA) #2 on 4/10/19 at 1:00 PM identified that she had noted and reported the scabbed areas to Resident #44's knees to LPN #1 on 4/1/19.

Interview with LPN #1 on 4/10/19 at 1:05 PM identified that when NA#2 reported the scabbed areas to the knees, she looked at the resident's knees and identified the scabbed area on the left knee, but did not recall seeing a scabbed area on the right knee. The scabbed area appeared to be an old injury, and was dried, but not reddened. LPN#1 identified that she did not review the clinical record to identify if the areas were previously identified and/or treated, and furthermore, she did not notify the RN and/or physician because she thought the areas appeared to be old. Additionally, although she is aware that during the weekly skin check she is supposed to view the entire body, on 4/3/19 she only checked the resident's boney prominences and did not lift the residents pant legs to visualize the knees.

Interview with the Director of Nurses on 4/10/19 1:45 PM identified that subsequent to surveyor inquiry on 4/8/19 it was identified that the resident had impaired skin integrity that was not addressed by the licensed staff. A house wide body audit was then completed on 4/8/19 to ensure all areas of impaired skin integrity were properly documented and/or assessed, with no undocumented/untreated areas identified. Further interview with the DON identified that when LPN #1 had seen the area on the resident's knee, she should have measured the area and called the physician, and furthermore, when a nurse is conducting a weekly skin audit the nurse must visualize the resident's entire body.

The facility identified there is no specific skin audit policy, and/or non-pressure skin integrity impairment policy, but the expectation is that the entire body will be visualized during the body audit, and once and area of impaired skin integrity is identified it will be measured, and the physician notified.

e. Resident #128 had diagnoses that included Alzheimer's dementia, diabetes with chronic kidney disease, and, heart failure.

A quarterly minimum data set dated 2/20/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

Review of a hospice skilled nursing note dated 5/4/18 identified that the resident was admitted to hospice for a terminal diagnosis of Alzheimer's dementia. Person #2 had consented to hospice care and had signed the papers electronically. The resident has been declining, with decreased intake and weight loss.

Review of a care plan dated 5/7/18 identified the resident was placed on hospice care and to administer medications as ordered for comfort.

Review of a hospice skilled nursing note dated 5/7/18 identified that the resident was somewhat arrousable, and Morphine, Ativan, and Levsin were ordered for comfort.

Review of a hospice skilled note dated 5/9/18 identified that the resident was lethargic, but easily aroused, the resident denied pain and/or difficulty breathing and had clear

lungs.

Review of the nurse's notes from 5/7/18 through 5/11/18 identified that the resident had been stable and receiving Morphine and Ativan for pain and anxiety with no mention of increased secretions and/or dyspnea.

Further review of the nurse's notes identified that on 5/11/18 at 6:06 PM and at 10:22 PM the resident was medicated with Levsin for increased secretions.

A Nurse's note on 5/12/18 at 4:42 identified that the resident was medicated with Morphine and Ativan for pain and anxiety 4:42 AM with good effect.

A Nurses note dated 5/12/18 at 10:41 AM identified that the resident was not given medication because the resident was in a deep sleep, appeared to be comfortable, and actively dying.

Review of the clinical record failed to identify that the hospice was notified that the resident had a change in condition and/or was "actively dying".

A Nurses note dated 5/12/18 at 10:43 AM identified that the charge nurse (LPN #2) had called him/her to the room, and the resident was pronounced deceased at 10:43 AM.

Review of the clinical record failed to identify that the hospice service had been notified that the resident was experiencing increased secretions and/or was actively dying.

Interview with RN #3 on 4/9/19 at 10:30 AM identified that she could not recall if she had notified hospice when the resident was noted to be "actively dying".

Interview with the hospice nurse on 4/9/19 at 9:30 AM identified that she had last assessed the resident on 5/9/18, and the resident appeared comfortable and/or did not have any increased respiratory secretions, and death was not imminent. She further identified that hospice should be notified at any change of condition so a re-assessment of the resident's needs can be done, and hospice visits could be increased from 1 to 2 times a week to 1-2 times daily. The hospice nurse identified that subsequent to her visit on 5/9/18 she was not notified of a change in condition, only that the resident had expired on 5/12/18.

Interview with the corporate nurse on 4/11/19 at 11:10 AM identified that the administration of Levsin for increased secretions on 5/11/18 would indicate a change in condition for Resident # 128, since there was no other documentation of increased secretions prior to 5/11/18. The hospice service should have been notified both of the change in condition and if the nurse believed he/she was actively dying, but she was unable to find any documentation.

The facility identified that they did not have a hospice policy.

Review of the hospice and facility staff referral and admission paperwork identified that

nursing home staff will call the hospice program to report changes in the resident's condition.

Plan of Correction to Violation #3:

Regency House Nursing and Rehabilitation provides the plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

Resident #44 and resident #128 are no longer in the facility. All residents have the potential to be affected. Education will be provided to Licensed Nursing staff regarding proper execution of weekly skin checks, identification of skin impairments and proper documentation. Education will also be provided for licensed nursing staff regarding updating of responsible party and hospice nurse on change in condition. Audits on weekly skin sheets and notifying responsible parties and hospice nurse on change in condition will be conducted on all residents x 4 and then monthly x 3 at QAPI meetings until compliance is 100% on audits. The ADNS will be responsible for monitoring compliance. Completed 5/21/19.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j)

Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

4. Based on a review of clinical records, facility documentation, interviews, and policies, for one six residents reviewed for medication administration (Resident #19), the facility failed to ensure that the resident received a medication in accordance with a physician's order, which resulted in a significant medication error during the period of 727/18 through 8/8/18. The significance of the error resulted in Immediate Jeopardy (IJ). On 8/8/18 the facility immediately did education on the medication and/or the five rights of medication administration, conducted audits of physician orders, and audits to ensure medications were administered in accordance with the orders. On 4/11/19, compliance with the action plan was verified resulting in Immediate Jeopardy past non-compliance. The finding includes:

   f. Resident #19 had diagnoses that included Rheumatoid Arthritis (RA), polyosteoarthritis, and anemia. Review of a physician's order dated 7/1/18 directed to administer methotrexate sodium 15 mg by mouth every Saturday (weekly).

   Review of bloodwork dated 7/9/18 identified a platelet level of 314 (normal level is 150-450), and a Hemoglobin (Hgb) level of 7.9 (normal level is 12.5 to 16), and a White Blood Cell (WBC) count of 9.3 (normal level is 5 to 10).

   A quarterly minimum data set assessment dated 7/11/18 identified that the resident was cognitively intact and required extensive assistance with activities of daily living.

   A care plan dated 7/25/18 identified that the resident had a history of chronic pain related to RA with interventions that included to monitor the resident for pain, and to administer medications as ordered.

   Review of a report of consultation dated 7/25/18 identified that the resident had been seen by his/her rheumatologist, the exam was negative for tenderness and/or swollen joints, with recommendations to reduce methotrexate to 10 milligrams (mg) every week.

   Review of a physician's order dated 7/26/18 directed to administer methotrexate 10 mg by mouth every day for a diagnosis of polyosteoarthritis.

   Review of the Medication Administration Record for July 2018 and August 2018 identified that the resident received the methotrexate daily at 9:00 AM from 7/27/18 through 8/8/18.

   Review of a nurse's note dated 8/7/18 identified that the resident was noted with swollen cheeks, and a moderate sized bump on the left outer cheek with increased complaints of pain noted. Upon assessment the resident was unable to open his/her mouth wide enough to thoroughly inspect the oral cavity, but white patches were noted on the left cheek and gum line also with increased pain. The Advanced Practice Registered Nurse (APRN) was called and ordered a dental consult, a clear liquid diet, warm water rinses, augmentin 875 mg for 10 days, a Complete Blood Count (CBC) and a Complete Metabolic Panel (CMP) were ordered for a dental infection.

Review of a medication incident report and investigation dated 8/8/18 identified that the resident had been seen by his/her rheumatologist on 7/25/18 with recommendations for the methotrexate to be reduced to 10 mg weekly. The order was transcribed into the electronic medical record on 7/27/18 to be administered daily, the resident received a total of 13 doses, 11 doses in error. The APRN was notified and consulted with the physician with new orders to start intravenous fluids for a total of 5 liters, complete blood counts daily, and the methotrexate was discontinued.

Review of the APRN progress notes dated 8/9/18 identified that the resident had acute mucositis with ulcerative areas in the bilateral mucosa possibly due to the increased dosing of the methotrexate. Antibiotics will continue to minimize risk of a bacterial infection, the folic acid will be increased, and IV fluids will continue at 75 milliliters (ml) an hour, the diet will be changed to puree foods and will be upgraded as possible with ensure nutritional supplement to help with nutritional needs.

Review of an APRN progress note dated 8/10/18 identified that the resident was being treated for methotrexate toxicity and mucositis. The blood work was reviewed and WBC count was 2.4 (normal level is 5 to 10), Hgb was 7.3 (normal level is 12.5 to 16) and platelets were 89 (normal level is 150-450), with a methotrexate level of 0.5 (normal is less than 0.01). Luecovorin (a medication that is used for an antidote for methotrexate toxic) 15 mg every 6 hours has been started and will continue until methotrexate level decreases to less than 0.1. The patient received 4 liters of IV fluids and when the IV site infiltrated and resident refused to have another IV site inserted.

Review of an APRN progress note dated 8/13/18 identified that the WBC was 3.2, Hgb was 7.4, and the platelet count was 31. The family member was called and informed of bloodwork, and although the resident had previously stated that s/he did not want a transfusion, The APRN informed the family that if platelet count dropped below 20 the resident would need to have a platelet transfusion.

Review of an APRN progress note dated 8/14/18 identified that the WBC had dropped to 2.6, the Hgb had dropped to 7.1 and the platelet level was 20, the resident agreed to a transfer to the emergency department for a platelet transfusion.

Review of the nurse's notes from 8/9/18 through 8/14/18 identified that the resident continued to complain of oral pain that was treated with acetaminophen and topical benzocaine.

Review of the hospital record dated 8/17/18 identified that the resident was admitted on 8/14/18 with methotrexate toxicity from erroneous ingestion of methotrexate. The patient had mucositis, leukopenia, a drop in platelets, and increased bleeding form oral sores. The patient had worsening thrombocytopenia and remained at high risk for increased bleeding and an intracranial bleed, and required an inpatient stay for a blood and platelet transfusion.

Interview with Registered Nurse (RN) #1 on 4/9/19 at 2:00 PM identified that when Resident #19 returned from the rheumatologist on 7/25/18 she reviewed the consult and

identified that the resident's methotrexate order had recommendations to be decreased to 10 mg weekly. RN #1 called the APRN to verify the weekly dosing of the methotrexate 10 mg, and when placing the order in the Electronic Medical Record (EMR) entered the methotrexate 10 mg to be administered daily instead of weekly, she further identified that when entering the order into the EMR, there is a drop down box to enter dosage times, and she accidentally entered daily instead of weekly. RN#1 further identified that she did not enter the diagnosis for the medication as rheumatoid arthritis, she entered polyosteoarthritis because it was in his/her diagnosis, and the resident had arthritis in 4 or more joints.

Interview with Licensed Practical Nurse (LPN) #4 on 4/11/19 at 6:30 AM identified that on the 11:00 PM to 7:00 AM shift the nurses are responsible for verifying that orders are entered correctly. She further stated that she will take the physicians order and ensure that it is entered correctly into the EMR, and since she was unaware that the medication order came from a consult, she did not check the consult for verification, and furthermore was not aware that methotrexate should only be given weekly for a resident with RA.

Interview with LPN #5 on 4/9/19 at 11:30 AM identified that she was doing the medication pass upon return from her vacation on 8/8/18 and noted that the methotrexate order was daily, when she was aware that the resident normally received it weekly, she then notified her supervisor of the error.

Interview with the Director of Nurses on 4/9/18 identified that RN #1 entered the methotrexate 10 mg order daily into the EMR, instead of weekly. The error was found upon the charge nurse's return from vacation on 8/8/18. The DON further identified that 8 different nurses worked on the unit while the charge nurse was on vacation between 7/26/18 and 8/8/18, all were unaware that methotrexate should not be given daily for residents with RA. The DON further identified that if a nurse is uncertain of a drug he/she is administering and/or dosing of a medication she should either look up information on the medication and/or call the physician for clarification.

Interview with APRN #2 on 4/9/18 identified that when she was notified of the medication error on 8/8/18 she consulted with the medical director on the course of treatment for the resident. New orders included, 5 liters of IV fluids in an attempt to keep the resident hydrated and to "flush out" the methotrexate. The Leucovorin was ordered because the methotrexate level was elevated at 0.5, and blood work was monitored daily, until 8/14/18 when the platelet level dropped to 20 and a transfer to the hospital was necessary.

Interview with Physician (MD) #1 on 4/10/18 at 12:10 PM identified that methotrexate is not given daily for a resident with RA, but weekly. Methotrexate is mostly given daily for cancer patients receiving chemotherapy, and can be a very toxic medication. The resident experienced methotrexate toxicity with corresponding mouth ulcerations and decreased blood counts which required hospitalization. The resident and family refused transport to the hospital for a transfusion, up until 8/14/18 when the platelet level dropped to 20, a discussion with the resident and family was held about the

urgency to be transferred to the hospital to decrease the risk of bleeding, and the resident and family agreed to the transport.

Interview with Pharmacist Supervisor #1 from the facility's contracted pharmacy on 4/8 /19 at 1:30 PM identified that pharmacist #1 had reviewed the methotrexate order sent by the EMR on 7/26/18, she further identified that the pharmacist should always check the medication dosing with the diagnosis prior to dispensing medications.

The Pharmacy supervisor stated that the guidelines for methotrexate dosing for a patient with rheumatoid arthritis should be weekly. The supervisor further identified that if the diagnosis for the methotrexate 10 mg was rheumatoid arthritis, pharmacist #1 would have called the facility to question the daily order. She further identified that the diagnosis that came with the order on 7/26/18 was polyosteoarthritis, and some medications can be used for other diagnoses (off label use), the pharmacist did not question the medication because the dose and/or frequency because the dose itself was acceptable, and the frequency could be different for off label use.

Attempts to reach pharmacist #1 were unsuccessful.

Review of a memorandum from the facility's pharmacy dated 8/10/19 identified that effective immediately, all methotrexate orders would be flagged with an alert. This alert will appear during order entry, initial review, and the final review screen. All pharmacists will be required to initial that the methotrexate order was evaluated for clinical appropriateness.

Review of the medication administration policy identified that medication orders will be accurately transcribed and executed to ensure accurate administration of all physician's orders.

The facility immediately implemented corrective measures on 8/8/18 that included RN#1 receiving disciplinary action for the error in transcription. The facility provided staff education regarding dosing and frequency of residents receiving methotrexate for rheumatoid arthritis, the five rights of medication administration, and second nurse verification once an order is noted, as well as a verification of the order on the 11:00 PM to 7:00 AM shift, all education began on 8/8/18 when the error was identified, and staff were educated before the start of subsequent shifts. The DON immediately audited Resident #19's medications for accuracy and any resident who had received new orders on consults, these audits continued weekly for 4 weeks and then randomly monthly and continue to be conducted with no further medication errors noted.

Plan of Correction to Violation #4:

Regency House Nursing and Rehabilitation provides the plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

The facility immediately implemented corrective measures on 8/8/18 that included RN#1 receiving disciplinary

action for the error in transcription. The facility DON provided staff education regarding dosing and frequency of residents receiving methotrexate for rheumatoid arthritis, the five rights of medication administration, and second nurse verification once an order is noted, as well as a verification of the order on the 11:00 PM to 7:00 AM shift, all education began on 8/8/18 when the error was identified, and staff were educated before the start of subsequent shifts. The DON immediately audited Resident #19's medications for accuracy and any resident who had received new orders on consults, these audits continued weekly for 4 weeks and then randomly monthly and continue to be conducted with no further medication errors noted. Completed 8/8/18.

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity		*Signature of FLIS Staff*
Regency House - Nursing & Rehab	Patricia Tyrell	Maria Elena Lejardi
81 East Main St.	Richard Haverstock	Carol Briand
Wallingford, CT. 06492	Lisa Rotta	Henrietta Simmons
M:		Da Mocerri

Licensure Category:

	Licensed Bed Bassinet Capacity:	Census:
CCNH	130	125

Date(s) of onsite inspection: 02/26, 02/27, 02/28 and 03/01/18

Date(s) additional information obtained: _____

Personnel contacted: David Bond Administrator ; Donna Dwyer (DNS)

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [✓] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[✓] See Complaint Investigation # CT # 21847 CT # 22556

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 3/19/18

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Da Mocerri **DATE OF REPORT:** 3/5/18

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

INTRAVENOUS THERAPY PROGRAM REVIEW

IN ACCORDANCE WITH THE PUBLIC HEALTH CODE OF THE STATE OF CONNECTICUT
SECTION 19-13-D8u

Facility:	Address:
Regency House Wallingford	181 East main St Walingford CT
Inspected by: P. Tyrell	**Date:** 2/28/18

Area of review	MET	NOT MET	N/A
1. IV therapy prohibited unless ordered by a physician or other provider with prescriptive authority.			
2. Written policies and procedures are developed that ensure safe care for all patients including:			
a. Objectives/Goals/Scope	✓		
b. Names/Titles/Duties/Responsibilities	✓		
c. Education/Training/Supervision/Competencies	✓		
d. Physician Orders	✓		
e. Safe administration/monitoring/documentation and termination of therapy			
f. Preparation, labeling, and handling of IV admixtures			
g. Procurement, maintenance and storage of equipment and solutions			
h. Recognition of signs and symptoms of complications including sepsis			
i. Infection control, surveillance, review and prevention of infections			
j. Quality management, review, safety and effectiveness			
k. Only physician/extender and/or credentialed R.N. may remove central vein access			
l. Prohibit blood draws, IV push, without waiver			
3. IV Therapy Nurse based on physician order may; a. Initiate venipuncture in a peripheral vein and administer IV fluids and/or admixture into vein			
b. Deliver IV fluid and/or admixture into central vein access.			
4. Licensed nurses deliver IV fluids, admixtures, monitor, care for site, terminate procedure and record events and observations.			
5. IV log is maintained including outcome of therapy and any complications.			
6. IV supplies are maintained in accordance with policy minimums.			

Revised 8/2015

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

March 19, 2018

Mr. David Bond, Administrator
Regency House Nursing And Rehabilitation Center
181 E Main Street
Wallingford, CT 06492

Dear Mr. Bond:

Unannounced visits were made to Regency House Nursing And Rehabilitation Center concluding on March 1, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a licensure inspection.

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

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 April 2, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

We do not anticipate making any practitioner referrals at this time.

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

Connecticut Department of Public Health

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

DATES OF VISIT: February 26, 27, 28 and March 1, 2018

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

Respectfully,

Cher Michaud RN SRC

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CM/JM:jf

Complaints #21847 and #22556

DATES OF VISIT: February 26, 27, 28 and March 1, 2018

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

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

1. Based on clinical record review, observation, and interview, for one resident reviewed for edema, (Resident #276), the facility failed to ensure that the resident's care plan identified the resident's edema and/or that the resident was being provided comprehensive education to ensure readiness for discharge. The findings include:
   a. Resident #276 was admitted on 2/19/18 with diagnoses that included Coronary Artery Disease (CAD), status post open heart surgery, and obesity. The admission nursing assessment dated 2/19/18 reflected that Resident #276 was admitted to the facility for short term rehab related to Coronary Artery Bypass Graft (CABG) and Gastro-intestinal (GI) bleed.

      The care plan dated 2/20/18 identified that Resident #276 had cardiovascular alteration. Interventions included assess for shortness of breath and cyanosis, monitor vital signs and notify the MD with any changes, and monitor and report any changes with lung sounds and/or edema and/or weight changes.
      Review of the physician's orders dated 2/19/18 directed the staff to document under cardiac protocol, incentive spirometer every hour each shift.

      Observation on 2/26/18 and 2/27/18 identified Resident #276 out of bed in the chair with bilateral upper extremities and bilateral lower extremities noted to be edematous. The lower extremities were in a dependent position with some drainage noted to the compression stockings. Interview with Resident #276 indicated that he/she was comfortable and that he/she elevated his/her feet at times when in bed.

      A review of the Physician's (MD) orders indicated that at the time of admission (2/19/18) the staff was directed to administer furosemide 40mg daily orally for fluid overload. Further review of the MD orders dated 2/28/18 directed the staff to increased the dose of furosemide to 80mg daily. Additional review of the MD orders dated 2/28/18 directed the staff to increase the furosemide to 160mg daily.

      Review of the nursing notes and laboratory findings dated 2/23/18 reflected that Resident #276's chest xray identified a lower lobe left infiltrate. Further review of the nursing notes indicated that Resident #276 continued to have +2 to +3 edema to the upper and lower bilateral extremities. Review of the nursing notes indicated that Resident #276 was compliant with care.

      A review of Resident #276's care plan, cardiac pathway education flow sheets, and nursing notes failed to reflect that Resident #276 was being educated on elevating the dependent limbs, incentive spirometer, and/or medications.

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

Interview with LPN #2 on 3/1/18 at 10:15AM indicated that nursing education is documented via electronic records, however a review of the record only reflected that Resident #276 was educated however the record did not reflect what the education was regarding.

Interview with the Director of Nurses and the Corporate Nurse on 3/1/18 11:40 indicated that the electronic record needed to be updated to ensure that the staff can document the education topic and/or areas that needed to be addressed.

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

2. Based on clinical record review and interview, for one reviewed for positioning (Resident #23), the facility failed to ensure that a resident was re-positioned per the facility's policy/practice and/or the resident's care plan and/or for 1 of 2 residents in survey sample reviewed for abuse (Resident #176) the facility failed to follow physician's direction to obtain a psychiatric evaluation after resident verbalized self harm. The findings include:
   a. Resident #23's diagnoses included a right hip fracture and dementia.

      The Minimum Data Set (MDS) dated 10/3/17 reflected that Resident #23 was severely cognitively impaired and that he/she needed 1-2 nursing home staff to provide extensive physical assistance with activities of daily living (ADLs).

      The care plan dated 10/3/17 identified that Resident #23 had self-care deficits. Interventions included assist of 1 with bed mobility and turn and reposition every 2-3 hours.

      Review of an orthopedic consult dated 10/2017 directed the staff to ensure that Resident #23 wore an abductor pillow at night to prevent internal rotation of the right hip.

      Review of the nursing notes dated 11/3/17 indicated that Resident #23 internally rotated his/her right hip. Review of the facility's investigation indicated that Resident #23 slept overnight without concerns but when he/she was assisted in the AM on 11/3/17 Resident #23 complained of pain to the right hip. Review of the investigation indicated that the staff's visual assessment on 11/3/17 identified that the right hip was internally dislocated. An x-ray done later that morning (11/3/17) confirmed the rotation of the hip.

      Review of the facility's investigation and interview with (Nurse Aide) NA #6 on 2/28/18 at 1:40 PM indicated that the resident was non-compliant with the hip abductor pillow on the 3 PM-11 PM shift. NA #6 indicated that he/she reported the resident's noncompliance to the 11 PM -7 AM staff.

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

An attempt to interview Registered Nurse (RN) #6 was made but was not successful.

Interview with NA #5 on 3/1/18 at 9:00 AM indicated that he/she assisted Resident #23 on 11/2/17-11/3/17 (11-7 shift). NA #5 indicated that Resident #23 slept the whole shift. NA #5 indicated that Resident #23 usually called for help if he/she needed assistance with toileting however on that night Resident #23 did not call for anything. NA #5 indicated that Resident #23 appeared comfortable. NA #5 indicated Resident #23 was not checked for placement of the abductor pillow and/or hip. NA #5 indicated that as he/she walked by the resident's room he/she (NA #5) could determine proper placement by looking at the resident's sheets and the configure of the resident's body. NA #5 indicated that he//she did not observe the resident's hip and/or correct positioning of the abductor pillow until 11/3/17 at 5:00 AM when the NA attempted to assist Resident #23 out of bed to obtain the resident's weight. NA #5 indicated that he/she did not reposition the resident during the night because Resident #23 had the abductor for an order and could not be placed on his/her sides.

Interview with the Director of Rehabilitation on 3/1/18 at 11:20 AM indicated that residents with abductor pillows should be repositioned by raising the head of the bed and/or adjusting the upper body position.

A review of the facility's policy and interview with the Director of Nurses (DNS) on 3/1/18 at 12:40 PM indicated that Resident #23 should have been repositioned every 2 hours as per the resident's care plan and the facility's policy.

b. Resident #176 was admitted to facility on 06/02/2017 with diagnoses that included dementia, systemic lupus erythematosus (SLE) and cytomegalovirus (CMV) colitis (inflammatory bowel disease).

Hospital discharge summary dated 06/02/2017 identified Resident #176 had a history of chronic gastrointestinal disease (GI) bleeds with history of disseminated Histoplasmosis. It identified that in the presence of cerebral volume loss and white matter disease, although the resident experienced waxing and waning mental status with persistent paranoid delusions about people doing things to her in the hospital, his/her mental status improved though he/she remained paranoid.

A nursing admission assessment dated 06/02/17 identified the presence of a gastric tube (PEG-Tube) and a rectal tube. It further identified that the resident expressed non-specific slight pain and that the buttocks area was reddened and excoriated.

Physician's admission orders dated 06/02/2017 included direction for a stool management system rectal tube and the application of Laniseptic (barrier) cream to buttocks every shift.

Resident care plan (RCP) dated 06/02/17 identified a problem with altered skin integrity as evidenced by excoriation areas located on the resident's buttock. Interventions included

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

provision of physician directed treatment, protective skin care and to monitor skin during care. An additional problem dated 06/05/17 identified a problem with abdominal pain. Interventions included pain assessments and monitor effectiveness of treatment.

An admission (MDS) assessment dated 06/08/2017 identified that Resident #176 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). It identified that Resident #176 was always incontinent of bowel/bladder, had a history of urinary tract infection in last thirty (30) days, had left lower quadrant pain, and had diarrhea. The assessment further identified provision of skin treatments that included pressure reducing devices for chair/bed and applications of ointments/medications.

Nurse's note dated 06/05/17 timed at 1:30 AM identified that Resident #176 was experiencing increased confusion, was difficult to re-direct, and was attempting to get out of bed. It further identified that Resident #176 will be monitored closely. An addendum timed at 2:00 AM identified that every fifteen (15) minute checks was initiated.

Nurse note timed at 4:00 AM identified that Resident #176 was confused, yelling, and complaining of right abdominal pain.

Nurse note timed at 5:30 AM identified that Resident #176 stated "why don't you let me go to the hospital I will cut myself in tiny pieces so you will have to send me". The note identified that the supervisor was made aware and that every 15 minute checks continued.

Nurse note dated 06/05/17 timed at 6:00 AM identified that Resident #176 indicated having a 11/10 on the pain scale and that "on the issue of cutting his/herself" resident stated "it was just to make the nurse know how much I am hurting". The note indicated that the MD's office was called and staff was awaiting a return call.

Interview with Physician (MD) #1 on 03/01/2018 at 10:20 AM indicated he/she was aware of the incident and directed a psychiatric evaluation for Resident #176 at the time.

During an interview and review of Resident #176's clinical record with the Director of Nursing on 03/01/18 at 11:18 AM identified that although the 6/5//17 6:00 A.M. nurses note indicated awaiting call back from MD, he/she could not provide documentation that the physician returned the call and/or was unable to provide documentation that 15 minute checks were conducted and/or an assessment indicating that every 15 minute checks was no longer required and/or that a psychiatric evaluation was obtained for Resident #176 as directed.

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

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

3. Based on clinical record review and interview, for one resident in the survey sample (Resident #175) the facility failed to provide ancillary (podiatry) services as identified in the care plan. The findings include:
   a. Resident #175 was admitted to facility on 09/04/17 with diagnoses that included Alzheimer's disease, dementia with behaviors, depressive disorder, anxiety disorder, and hallucinations.

      Nursing admission assessment dated 09/04/17 identified upon admission the presence of an (old) skin tear located on the left arm that measured 0.5 x 0.5 cm and no other impaired skin.

      Resident care plan (RCP) dated 09/04/17 identified a potential problem with skin and fragile skin secondary to a history of skin tears and impaired circulation. Interventions included to monitor skin during provision of care and provide pressure reducing mattress.

      Nurse's note dated 09/11/17 timed at 2:30 PM identified the presence of a blister located on Resident #175's left second toe and that notifications were made and a treatment in place.

      The RCP was revised on 09/11/17 with interventions that included provision of a podiatry consult.

      Review of treatment administration record (TAR) dated 09/11/17 identified the application of skin prep to left second toe and to "hold shoes".

      During an interview and review of Resident #175's clinical record with the Director of Nursing on 2/28/18 at 10:03 AM he/she indicated that although the process of referring and scheduling resident's for podiatry services was recently revised he/she was unable to provide documentation that Resident #175 had seen a podiatrist before the resident's discharge in November 2017.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

4. Based on clinical record review and interview for one resident in survey sample (Resident #176) the facility lacked documentation of the implementation of interventions to monitor the resident's safety. The findings include:
   a. Resident #176 was admitted to facility on 06/02/2017 with diagnoses that included dementia, systemic lupus erythematosus (SLE) and cytomegalovirus (CMV) colitis (inflammatory bowel disease).

      Hospital discharge summary dated 06/02/2017 identified Resident #176 had a history of

chronic gastrointestinal disease (GI) bleeds with history of disseminated Histoplasmosis. It identified that in the presence of cerebral volume loss and white matter disease, although the resident experienced waxing and waning mental status with persistent paranoid delusions about people doing things to her in the hospital, his/her mental status improved though he/she remained paranoid.

A nursing admission assessment dated 06/02/17 identified the presence of a gastric tube (PEG-Tube) and a rectal tube. It further identified that the resident expressed non-specific slight pain and that the buttocks area was reddened and excoriated.

Resident care plan (RCP) dated 06/02/17 identified a problem with altered skin integrity as evidenced by excoriation areas located on the resident's buttock. Interventions included provision of physician directed treatment, protective skin care and to monitor skin during care. An additional problem dated 06/05/17 identified a problem with abdominal pain. Interventions included pain assessments and monitor effectiveness of treatment.

An admission (MDS) assessment dated 06/08/2017 identified that Resident #176 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). It identified that Resident #176 had left lower quadrant pain.

Nurse's note dated 06/05/17 timed at 1:30 AM identified that Resident #176 was experiencing increased confusion, was difficult to re-direct, and was attempting to get out of bed. It further identified that Resident #176 will be monitored closely. An addendum timed at 2:00 AM identified that every fifteen (15) minute checks was initiated.

Nurse note timed at 4:00 AM identified that Resident #176 was confused, yelling, and complaining of right abdominal pain.

Nurse note timed at 5:30 AM identified that Resident #176 stated "why don't you let me go to the hospital I will cut myself in tiny pieces so you will have to send me". The note identified that the supervisor was made aware and that every 15 minute checks continued.

Nurse note dated 06/05/17 timed at 6:00 AM identified that Resident #176 indicated having a 11/10 on the pain scale and that "on the issue of cutting his/herself" resident stated "it was just to make the nurse know how much I am hurting". The note indicated that the MD's office was called and staff was awaiting a return call.

Interview with Physician (MD) #1 on 03/01/2018 at 10:20 AM indicated he/she was aware of the incident and directed a psychiatric evaluation for Resident #176 at the time.

During an interview and review of Resident #176's clinical record with the Director of Nursing on 03/01/18 at 11:18 AM identified that although the 6/5//17 6:00 A.M. nurses note

indicated awaiting call back from MD, he/she could not provide documentation that the physician returned the call and/or was unable to provide documentation that 15 minute checks were conducted and/or an assessment indicating that every 15 minute checks was no longer required.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (1).

5. Based on clinical record review and interview, for one of three residents in survey sample reviewed for abuse (Resident #176) facility failed to appropriately document a change in skin condition and/or physician notification. The findings include:
   a. Resident #176 was admitted to facility on 06/02/2017 with diagnoses that included dementia, systemic lupus erythematosus (SLE) and cytomegalovirus (CMV) colitis (inflammatory bowel disease).

      Hospital discharge summary dated 06/02/2017 identified Resident #176 had a history of chronic gastrointestinal disease (GI) bleeds with history of disseminated Histoplasmosis. It identified that in the presence of cerebral volume loss and white matter disease, although the resident experienced waxing and waning mental status with persistent paranoid delusions about people doing things to her in the hospital, his/her mental status improved though he/she remained paranoid. The discharge physical exam identified that the percutaneous endoscopic gastrostomy (PEG) tube was draining green fluid and that a rectal tube was in place with loose watery stools in the rectal tube bag.

      A nursing admission assessment dated 06/02/17 identified the presence of a gastric tube (PEG-Tube) and a rectal tube. It further identified that the resident expressed non-specific slight pain and that the buttocks area was reddened and excoriated.

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      Resident care plan (RCP) dated 06/02/17 identified a problem with altered skin integrity as evidenced by excoriation areas located on the resident's buttock. Interventions included provision of physician directed treatment, protective skin care and to monitor skin during care. An additional problem dated 06/05/17 identified a problem with abdominal pain. Interventions included pain assessments and monitor effectiveness of treatment.

      An admission (MDS) assessment dated 06/08/2017 identified that Resident #176 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). It identified that Resident #176 was always incontinent of bowel/bladder, had a history of urinary tract infection in last thirty (30) days, had left lower quadrant pain, and

had diarrhea. The assessment further identified provision of skin treatments that included pressure reducing devices for chair/bed and applications of ointments/medications.

Nurses note dated 6/17/17 timed at 8:45 PM noted blood in brief, cleaned no trace of blood on rectum and that Resident #176 had excoriation to bilateral groin and vaginal labia's had denuded skin.

In an interview with RN #8 on 03/1/18 at 1:32 PM he/she indicated that denuded meant that the outer layer of skin was not intact. RN #8 further indicated that he/she was not aware that the denuded skin was a change in condition and that he/she would only document the communication with the physician if the physician gives orders.

During an interview and review of Resident #176's clinical record with the Director of Nursing on 03/01/18 at 1:46 PM, he/she indicated that although the physician was notified of the change in Resident #176's skin (denuded labia's) as indicated by the twenty four hour report, he/she was unable to provide documentation in the clinical record that the physician was specifically notified about denuded skin and/or what direction for treatment if any was given.

POC CEN 3/27/18

RegencyHouse
Nursing & Rehabilitation Center

March 26, 2018

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

Email address: Cher.Michaud@ct.gov Sent via email and regular mail

Re: Plan of correction from State Survey ending 3/1/18

Dear Ms. Michaud:

Attached is our plan of correction for the State Violations noted during the State Survey that ended on 3/1/18.

Please let me know if you need anything

Respectfully,

David Bond, Administrator

Regency House Nursing and Rehabilitation provides the plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.

Section 19-13-D8t(j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A):

Resident #276 is no longer in the facility.
All residents have the potential to be affected. Education will be provided to Licensed staff regarding the documentation of specific education provided to the resident and will be reflected in the plan of care. Audits will be conducted on all new admissions weekly x 4 weeks and then monthly x 3. The Nursing Director will be responsible for monitoring compliance. Findings will be updated at all QAPI meetings. Date for completion is 4/6/18.

Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or Nursing staff (2)(A):

Resident #23 was found not to have been repositioned per policy. Turn and positioning has since been added to the care plan, CNA Kardex and the resident is being turned. Resident #176 is no longer in the facility. All residents have the potential to be affected. Education will be provided for licensed nursing staff regarding obtaining a psych evaluation as directed by M.D. order. Education will be provided to C.N.A staff regarding turning and repositioning. Audits will be conducted weekly x 4 and then monthly x 3. The Nursing Director will be responsible for monitoring compliance. Finding will be updated at all QAPI meetings. Date for completion is 4/6/18.

Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or Nursing staff (2)(A:

Resident #175 is no longer in the facility. All residents have the potential to be affected. Education will be provided to Licensed nursing staff regarding obtaining Podiatry Services in a timely manner. Audits will be conducted on all long term residents weekly x 4 and then monthly x 3.The Assistant Director of Nursing will be responsible for monitoring compliance. Findings will be updated at all QAPI meetings.

Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or Nursing staff (2)(C):

Resident #175 is no longer in the facility. All residents have the potential to be affected. Education will be provided to Licensed nursing staff regarding documentation of physicians interventions for safety an documentation of 15-minute checks. Audits will be conducted weekly x 4 and then monthly x 3.The Director of Nursing will be responsible for monitoring compliance. Findings will be updated at all QAPI meetings. Date for completion is 4/6/18.

Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or Nursing staff (2)(A) and/or (o) Medical Records (1):

Resident #176 is no longer in the facility. All residents have the potential to be affected. Education will be provided to licensed Nursing staff regarding documentation of notification to M.D. regarding changes in condition of residents skin. Audits will be conducted at random weekly x 4 and then monthly x 3. The Director of Nursing will be responsible for monitoring compliance. Findings will be updated at all QAPI meetings. Date for completion is 4/6/18.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 10, 2018

Mr. David Bond, Administrator
Regency House Nursing And Rehabilitation Center
181 E Main Street
Wallingford, CT 06492

Dear Mr. Bond:

This is an amended letter to violation letter dated March 19, 2018.

Unannounced visits were made to Regency House Nursing And Rehabilitation Center concluding on March 1, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a licensure inspection.

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

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 April 2, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

We do not anticipate making any practitioner referrals at this time.

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

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

DATES OF VISIT: February 26, 27, 28 and March 1, 2018

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

Respectfully,

Cher Michaud/MSL

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CM/JM:jf

Complaints #21847 and #22556

DATES OF VISIT: February 26, 27, 28 and March 1, 2018

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

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

1. Based on clinical record review, observation, and interview, for one resident reviewed for edema, (Resident #276), the facility failed to ensure that the resident's care plan identified the resident's edema and/or that the resident was being provided comprehensive education to ensure readiness for discharge. The findings include:
   a. Resident #276 was admitted on 2/19/18 with diagnoses that included Coronary Artery Disease (CAD), status post open heart surgery, and obesity. The admission nursing assessment dated 2/19/18 reflected that Resident #276 was admitted to the facility for short term rehab related to Coronary Artery Bypass Graft (CABG) and Gastro-intestinal (GI) bleed.

      The care plan dated 2/20/18 identified that Resident #276 had cardiovascular alteration. Interventions included assess for shortness of breath and cyanosis, monitor vital signs and notify the MD with any changes, and monitor and report any changes with lung sounds and/or edema and/or weight changes.
      Review of the physician's orders dated 2/19/18 directed the staff to document under cardiac protocol, incentive spirometer every hour each shift.

      Observation on 2/26/18 and 2/27/18 identified Resident #276 out of bed in the chair with bilateral upper extremities and bilateral lower extremities noted to be edematous. The lower extremities were in a dependent position with some drainage noted to the compression stockings. Interview with Resident #276 indicated that he/she was comfortable and that he/she elevated his/her feet at times when in bed.

      A review of the Physician's (MD) orders indicated that at the time of admission (2/19/18) the staff was directed to administer furosemide 40mg daily orally for fluid overload. Further review of the MD orders dated 2/28/18 directed the staff to increased the dose of furosemide to 80mg daily. Additional review of the MD orders dated 2/28/18 directed the staff to increase the furosemide to 160mg daily.

      Review of the nursing notes and laboratory findings dated 2/23/18 reflected that Resident #276's chest xray identified a lower lobe left infiltrate. Further review of the nursing notes indicated that Resident #276 continued to have +2 to +3 edema to the upper and lower bilateral extremities. Review of the nursing notes indicated that Resident #276 was compliant with care.

      A review of Resident #276's care plan, cardiac pathway education flow sheets, and nursing notes failed to reflect that Resident #276 was being educated on elevating the dependent limbs, incentive spirometer, and/or medications.

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

Interview with LPN #2 on 3/1/18 at 10:15AM indicated that nursing education is documented via electronic records, however a review of the record only reflected that Resident #276 was educated however the record did not reflect what the education was regarding.

Interview with the Director of Nurses and the Corporate Nurse on 3/1/18 11:40 indicated that the electronic record needed to be updated to ensure that the staff can document the education topic and/or areas that needed to be addressed.

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

2. Based on clinical record review and interview, for one reviewed for positioning (Resident #23), the facility failed to ensure that a resident was re-positioned per the facility's policy/practice and/or the resident's care plan and/or for 1 of 2 residents in survey sample reviewed for abuse (Resident #176) the facility failed to follow physician's direction to obtain a psychiatric evaluation after resident verbalized self harm. The findings include:
   a. Resident #23's diagnoses included a right hip fracture and dementia.

      The Minimum Data Set (MDS) dated 10/3/17 reflected that Resident #23 was severely cognitively impaired and that he/she needed 1-2 nursing home staff to provide extensive physical assistance with activities of daily living (ADLs).

      The care plan dated 10/3/17 identified that Resident #23 had self-care deficits. Interventions included assist of 1 with bed mobility and turn and reposition every 2-3 hours.

      Review of an orthopedic consult dated 10/2017 directed the staff to ensure that Resident #23 wore an abductor pillow at night to prevent internal rotation of the right hip.

      Review of the nursing notes dated 11/3/17 indicated that Resident #23 internally rotated his/her right hip. Review of the facility's investigation indicated that Resident #23 slept overnight without concerns but when he/she was assisted in the AM on 11/3/17 Resident #23 complained of pain to the right hip. Review of the investigation indicated that the staff's visual assessment on 11/3/17 identified that the right hip was internally dislocated. An x-ray done later that morning (11/3/17) confirmed the rotation of the hip.

      Review of the facility's investigation and interview with (Nurse Aide) NA #6 on 2/28/18 at 1:40 PM indicated that the resident was non-compliant with the hip abductor pillow on the 3 PM-11 PM shift. NA #6 indicated that he/she reported the resident's noncompliance to the 11 PM -7 AM staff.

An attempt to interview Registered Nurse (RN) #6 was made but was not successful.

Interview with NA #5 on 3/1/18 at 9:00 AM indicated that he/she assisted Resident #23 on 11/2/17-11/3/17 (11-7 shift). NA #5 indicated that Resident #23 slept the whole shift. NA #5 indicated that Resident #23 usually called for help if he/she needed assistance with toileting however on that night Resident #23 did not call for anything. NA #5 indicated that Resident #23 appeared comfortable. NA #5 indicated Resident #23 was not checked for placement of the abductor pillow and/or hip. NA #5 indicated that as he/she walked by the resident's room he/she (NA #5) could determine proper placement by looking at the resident's sheets and the configure of the resident's body. NA #5 indicated that he//she did not observe the resident's hip and/or correct positioning of the abductor pillow until 11/3/17 at 5:00 AM when the NA attempted to assist Resident #23 out of bed to obtain the resident's weight. NA #5 indicated that he/she did not reposition the resident during the night because Resident #23 had the abductor for an order and could not be placed on his/her sides.

Interview with the Director of Rehabilitation on 3/1/18 at 11:20 AM indicated that residents with abductor pillows should be repositioned by raising the head of the bed and/or adjusting the upper body position.

A review of the facility's policy and interview with the Director of Nurses (DNS) on 3/1/18 at 12:40 PM indicated that Resident #23 should have been repositioned every 2 hours as per the resident's care plan and the facility's policy.

b. Resident #176 was admitted to facility on 06/02/2017 with diagnoses that included dementia, systemic lupus erythematosus (SLE) and cytomegalovirus (CMV) colitis (inflammatory bowel disease).

Hospital discharge summary dated 06/02/2017 identified Resident #176 had a history of chronic gastrointestinal disease (GI) bleeds with history of disseminated Histoplasmosis. It identified that in the presence of cerebral volume loss and white matter disease, although the resident experienced waxing and waning mental status with persistent paranoid delusions about people doing things to her in the hospital, his/her mental status improved though he/she remained paranoid.

A nursing admission assessment dated 06/02/17 identified the presence of a gastric tube (PEG-Tube) and a rectal tube. It further identified that the resident expressed non-specific slight pain and that the buttocks area was reddened and excoriated.

Physician's admission orders dated 06/02/2017 included direction for a stool management system rectal tube and the application of Laniseptic (barrier) cream to buttocks every shift.

Resident care plan (RCP) dated 06/02/17 identified a problem with altered skin integrity as evidenced by excoriation areas located on the resident's buttock. Interventions included

provision of physician directed treatment, protective skin care and to monitor skin during care. An additional problem dated 06/05/17 identified a problem with abdominal pain. Interventions included pain assessments and monitor effectiveness of treatment.

An admission (MDS) assessment dated 06/08/2017 identified that Resident #176 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). It identified that Resident #176 was always incontinent of bowel/bladder, had a history of urinary tract infection in last thirty (30) days, had left lower quadrant pain, and had diarrhea. The assessment further identified provision of skin treatments that included pressure reducing devices for chair/bed and applications of ointments/medications.

Nurse's note dated 06/05/17 timed at 1:30 AM identified that Resident #176 was experiencing increased confusion, was difficult to re-direct, and was attempting to get out of bed. It further identified that Resident #176 will be monitored closely. An addendum timed at 2:00 AM identified that every fifteen (15) minute checks was initiated.

Nurse note timed at 4:00 AM identified that Resident #176 was confused, yelling, and complaining of right abdominal pain.

Nurse note timed at 5:30 AM identified that Resident #176 stated "why don't you let me go to the hospital I will cut myself in tiny pieces so you will have to send me". The note identified that the supervisor was made aware and that every 15 minute checks continued.

Nurse note dated 06/05/17 timed at 6:00 AM identified that Resident #176 indicated having a 11/10 on the pain scale and that "on the issue of cutting his/herself" resident stated "it was just to make the nurse know how much I am hurting". The note indicated that the MD's office was called and staff was awaiting a return call.

Interview with Physician (MD) #1 on 03/01/2018 at 10:20 AM indicated he/she was aware of the incident and directed a psychiatric evaluation for Resident #176 at the time.

During an interview and review of Resident #176's clinical record with the Director of Nursing on 03/01/18 at 11:18 AM identified that although the 6/5//17 6:00 A.M. nurses note indicated awaiting call back from MD, he/she could not provide documentation that the physician returned the call and/or was unable to provide documentation that 15 minute checks were conducted and/or an assessment indicating that every 15 minute checks was no longer required and/or that a psychiatric evaluation was obtained for Resident #176 as directed.

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

3. Based on clinical record review and interview for one resident in survey sample (Resident #176) the facility lacked documentation of the implementation of interventions to monitor the resident's safety. The findings include:
   a. Resident #176 was admitted to facility on 06/02/2017 with diagnoses that included dementia, systemic lupus erythematosus (SLE) and cytomegalovirus (CMV) colitis (inflammatory bowel disease).

      Hospital discharge summary dated 06/02/2017 identified Resident #176 had a history of chronic gastrointestinal disease (GI) bleeds with history of disseminated Histoplasmosis. It identified that in the presence of cerebral volume loss and white matter disease, although the resident experienced waxing and waning mental status with persistent paranoid delusions about people doing things to her in the hospital, his/her mental status improved though he/she remained paranoid.

      A nursing admission assessment dated 06/02/17 identified the presence of a gastric tube (PEG-Tube) and a rectal tube. It further identified that the resident expressed non-specific slight pain and that the buttocks area was reddened and excoriated.

      Resident care plan (RCP) dated 06/02/17 identified a problem with altered skin integrity as evidenced by excoriation areas located on the resident's buttock. Interventions included provision of physician directed treatment, protective skin care and to monitor skin during care. An additional problem dated 06/05/17 identified a problem with abdominal pain. Interventions included pain assessments and monitor effectiveness of treatment.

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IPOC CEN 32710

RegencyHouse
Nursing & Rehabilitation Center

March 26, 2018

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

Email address: Cher.Michaud@ct.gov Sent via email and regular mail

Re: Plan of correction from State Survey ending 3/1/18

Dear Ms. Michaud:

Attached is our plan of correction for the State Violations noted during the State Survey that ended on 3/1/18.

Please let me know if you need anything

Respectfully,

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