2017

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Touchpoints of Chestnut
171 Main Street
East Windsor, CT 06088
M:

Signature of FLIS Staff

Lori Griffin

Licensure Category:

CCNH

Licensed Bed Capacity: _____

Census: _____

Date(s) of onsite inspection: Desk Audit 6/23/17

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. See attached violation letter dated _____

[X] Desk Audit 6/23/17 [ ] 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: _____ **DATE OF REPORT:** _____

[X] Approval for issuance of license granted by: Lori Griffin **DATE:** 6/23/17
Supervisor/Title

LICENSING INSPECTION NARRATIVE REPORT:

A desk audit was conducted on 4/23/17 for the purpose of reviewing the plan of correction for the violation letter dated 4/26/17. Violations 1 and 2 were identified as corrected

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***

Touchpoints @ Chestnut — P Knapton
171 Main St
East Windsor, CT 06088
M:

Licensure Category:

CCNH

Licensed Bed Bassinet Capacity: 60

Census: 52

Date(s) of onsite inspection: 4/12/17, 4/13/17

Date(s) additional information obtained: ___

Personnel contacted: Donna Grant (DNS) Blair Quasnitschka (Acting 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 # 21521, 21407

[✓] 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 4-26-17

[ ] 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: P Knapton **DATE OF REPORT:** 4/18/17

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

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 26, 2017

Mr. John Kolenda, Administrator
Touchpoints At Chestnut
171 Main Street
East Windsor, CT 06088

Dear Mr. Kolenda:

Unannounced visits were made to Touchpoints At Chestnut on April 12 and 13, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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 May 10, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

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

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.

Respectfully,

Karen Gworek RN SNC

Karen Gworek, RN, SNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb
Complaint #21521, 21407

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: April 12 and 13, 2017

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

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

1. Based on clinical record reviews, review of facility documentation and interviews for one sampled resident (Resident #1) who had a change in condition, the facility failed to conduct a comprehensive assessment of an extremity to set an initial baseline to determine if there was a decline. The findings include:
   a. Resident #1's diagnoses included dementia, chronic left leg pain, anxiety, diabetes mellitus, stasis dermatitis, bilateral lower extremity cellulitis, thrombophlebitis and obesity. The quarterly Minimum Data Set assessment dated 1/2/17 identified that Resident #1 had no cognitive deficits, required extensive two person assistance with dressing, bed mobility, dressing and toilet use, utilized a wheelchair for mobility and had no impairment of the upper and lower extremities. The Reportable Event Form dated 4/5/17 at 10:00 AM identified Resident #1 was noted to have left lower extremity bruise and swelling and the Advanced Practice Registered Nurse (APRN) was notified at 11:00 AM. The nurse's note dated 4/5/17 at 2:27 PM identified a hematoma and erythema was noted at the inner aspect of the left mid shin. Vital signs were obtained, temperature 98.2, pulse 76, respirations 18 and blood pressure 128/76. The note failed to reflect documentation that the circumference of the left leg at the site of the hematoma had been measured. The APRN progress note dated 4/5/17 identified Resident #1 was seen to evaluate a "bump" on the left shin that measured 1 by 1 inch. The resident had stated the injury was sustained when transferred from the bed to the wheelchair. The assessment and plan directed to apply an ice pack every shift for twenty-four (24) to forty-eight (48) hours, monitor the left leg every shift for increased edema, infection, bleeding and erythema, to check the left leg and foot Circulation, Motor, Sensation (CMS) every shift, will order a venous Doppler to rule out Deep Vein Thrombosis (DVT), the resident has a history of DVT and hematomas in the past and is receiving Eliquis, an anticoagulant medication and if the condition worsens notify the physician and/or APRN. The diagnostic report dated 4/5/17 at 3:57 PM identified there was a subcutaneous hematoma noted in the anterior aspect of the left lower extremity that measured approximately three (3) centimeters in maximum diameter and there was no evidence of DVT. The physician was notified of the results and there were no new orders. The nurse's note dated 4/6/17 at 12:19 AM identified on 4/5/17 at 5:00 PM Resident #1 was medicated for bilateral lower extremity pain with effect. The note identified the resident was observed to have a hematoma on the anterior left lower extremity, the skin surrounding the hematoma was warm to touch and had increased swelling. The note indicated the resident refused the ice pack. The note identified a family requested the resident be transferred to the hospital for an evaluation. The resident was transferred at 8:00 PM. The note failed to reflect documentation of the measurement of the left lower extremity and/or hematoma. Review of the facility investigation dated 4/5/17 identified that when the family member requested the resident be transferred to the hospital the left shin hematoma had grown four (4) times the original size. The hospital history and physical dated 4/5/17 identified the resident presented to the Emergency Department (ED) with a left leg

hematoma. In the ED, the hematoma enlarged rapidly, encompassing the entire lower aspect of the left lower extremity on the medial side. The leg was tense, very tender on palpation, pain with passive range of motion. The resident was admitted on 4/5/17 for left lower extremity expanding hematoma on anticoagulation and an exploration of the extremity, evacuation of the hematoma, fasciotomy, was performed on 4/5/17. Resident #1 was discharged on 4/10/17 to another long term care facility. Interview with the 3-11PM Nursing Supervisor, Registered Nurse (RN) #2 on 4/12/17 at 2:40 PM identified she saw the resident at approximately 4:15 PM, the resident was in bed with the leg elevated, and she conducted an assessment that included CMS, pulses and the hematoma was about the size of a half dollar. RN #2 identified the family member had requested the resident be sent to the hospital for an evaluation and a non-urgent ambulance was called. RN #2 stated that around 6:45 PM she reassessed the hematoma and the area was noted to have doubled in size. RN #2 identified she recalled for the ambulance and at 8:00 PM Resident #1 was transferred to the hospital. In an interview on 4/12/17 at 3:00 PM, the 7-3 Nursing Supervisor, Registered Nurse (RN) #3, identified he was informed by the Acting Director of Nursing that Resident #1 had leg swelling and bruises. RN #3 identified he went into the resident's room with other staff, noted a hematoma half way down the resident's shin and that the resident was complaining of pain. RN #3 stated the resident had been medicated with Oxycodone 5 mg for pain approximately thirty minutes earlier. RN #3 stated he returned to assess the resident between 11:00 AM and 3:00 PM, believed the area was a little bigger and applied ice to the area. RN #3 identified he wrote a brief nurse's note dated on 4/5/17. Review of the nurse's note failed to reflect documentation that the leg was measured when the area was noted to be "a little bigger".

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and professional services (1).

2. Based on clinical record reviews, review of facility documentation and interviews for one of three sampled residents (Resident #2) who was a new admission, the facility failed to ensure the resident was seen by the physician within forty-eight (48) hours of admission in accordance with the Public Health Code. The findings include:
   a. Resident #2 was admitted on 2/3/17 with diagnoses that included cellulitis of right lower leg. Review of the physician's history and physical, progress note and physician's order sheets identified the resident was assessed by the attending physician, MD #1, on 2/7/17, four days after admission. In an interview on 4/13/17 at 10:25 AM, the Social Worker identified she notified the physician's office of Resident #2's admission on the morning of 2/3/17 which was the normal process for a new admission and assumed the resident would be seen the next day. The Social Worker identified on the morning of 2/6/17 she was informed that the resident had not been seen by the physician.

DATES OF VISIT: April 12 and 13, 2017

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

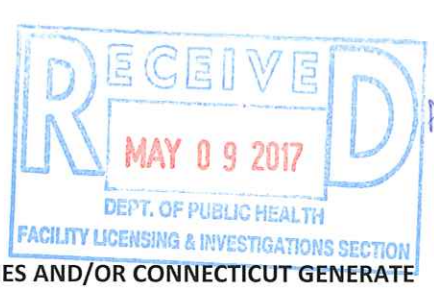
The Social Worker identified she called the physician's office to notify him again of the resident's admission and was told he would be updated. In an interview on 4/13/17 at 12:15PM, MD #1 identified he was typically informed when a new admission was arriving but could not recall being told of Resident #2's admission on 2/3/17. MD #1 identified he was told of the resident's admission on 2/6/17 and saw the resident on 2/7/17.

TOUCHPOINTS AT CHESTNUT

VIOLATIONS PLAN OF CORRECTION

MAY 4, 2017

State POC



Approved 5-11-17 KEG

THE FOLLOWING VIOLATIONS OF THE REGULTIONS OF CONNECITUCT STATE AGENCIES AND/OR CONNECTICUT GENERATE STATUTES WERE IDENTIFIED.

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

1. **Based on clinical record reviews, review of facility documentation and interviews for one sampled resident (Resident #1) who had a change of condition, the facility failed to conduct a comprehensive assessment of an extremity to set an initial baseline determine if there was a decline.**

Resident #1 no longer resides in the facility

Residents who have a hematoma to the leg have the potential to be affected by these alleged deficient practice.

RN supervisors will be educated to complete a baseline comprehensive assessment on residents with hematomas to determine if there was a decline in the residents condition.

Random weekly audits will be conducted to ensure compliance. Results will be reviewed by the Quality Assurance Committee.

The Director of Nursing is responsible for this plan of correction.

Target date of compliance is May 25, 2017.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (1).

2. **Based on clinical record reviews, review of facility documentation and interviews for one of three sampled residents (Resident #2) who was a new admission, the facility failed to ensure the resident was seen by the physician within forty-eight (48) hours of admission in accordance with the Public Health Code.**

Resident #2 no longer resides in the facility.

Any new admission to the facility has the potential to be affected by these alleged deficient practice.

MD #1 will be educated that new admissions need to be seen by the physician within 48 hours of admission in accordance with the public health code.

Random weekly audits will be conducted to ensure compliance. Results will be reviewed by the Quality Assurance Improvement Committee.

The Director of Nurses is responsible for this plan of correction.

Target date of compliance is May 25, 2017

Please feel free to contact me if there are any further questions, 860.292.5394.

Respectfully Submitted,

Blair Quasnitschka, LNHA, FACHCA

Touchpoints at Chestnut – Interim Administrator


RECEIVED
MAY 09 2017
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

OFFICE CONFERENCE
ATTENDANCE
RECORD

Facility Name: Touchpoints @ Chestnut

Address: 171 Main St. East Windsor, CT. 06088

Date: 4/10/2017

Time: 10 AM

Place: DPH.

Present: Names and Titles (Please Print Clearly)

Maria M LaRocco SW, _____,

Henrietta Simmons NC, _____,

Blair Quasnitschka, Director of OPS - ICARE, _____,

Robert Burke LCSW - iCare, _____,

_____, _____,

_____, _____,

FACILITY NAME: Touchpoints at Chestnut

REASON (S) FOR OFFICE CONFERENCE:

An office conference was held on April 10, 2017 per facility request to dispute violations (1)(a), (2)(a, (3)(a) and (5)(a)).

NARRATIVE REPORT:

(1)(a) Affirmed - Review of facility policy defines verbal abuse as any use of oral, written or gestured language that includes derogatory or disparaging terms to the resident or family. Additionally, verbal abuse was "willful' and was overheard by the resident's roommate. The nurse aide threw a Hoyer pad on the floor with a sneaker, hurting the resident's leg by being too rough during care.
(2)(a) Affirmed - Only 2 care planning conferences (2/03, 11/02/16) were held during the time the resident was at the facility and no resident signature was noted on the signature page. No additional information was provided by the facility indicating care conferences were held on 5/04/16, 8/03/16 as per interview with RN#2.
(3)(a) Affirmed - A physician's order dated 1/03/2017 directed 8 ounces of milk at each meal, a care plan dated 1/03/2017 identified to provide resident with 8 ounces of milk at each meal and a level 11 PASRR recommended 8 ounces of milk at each meal. The facility failed to provide the resident with 8 ounces of milk at each meal.
(5)(a) Affirmed - The East wing laundry room door leading to a stairwell was unlocked and interview with LPN#1 identified demented residents were identified as frequenting the area. Interview with the Administrator identified the door should have been locked at all times.

SUMMARY AND ACTION IF INDICATED:
See above notations.

Maria M. LaRocco, RN, MPH

Maria M. LaRocco, RN, M.P.H.
Supervising Nurse Consultant

cc: Licensure File

JFM:lsl

r:forms/offconf2004_confcall.doc

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*	
Touch points at Chestnut	[signature]	Kelly Madden
171 Main St	Leah Clark	Dominique Bruno
East Windsor, CT 06088	Melissa Brooks	[signature] RS, LTC
M:	Ellin Ferreri LNC	Susan Ofiell

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 60

Census: 45

Date(s) of onsite inspection: 1/23, 1/24, 1/25, 1/26 2017

Date(s) additional information obtained: ______

Personnel contacted: John V. Kolenda, Administrator, Donna Grant - 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 20963B CT 20745

[✓] 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 2/14/17

[ ] 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 Madden **DATE OF REPORT:** 1/30/17

[✓] Approval for issuance of license granted by: Aimee Schub **DATE:** 2/8/17
Supervisor/Title

s:flis\hsr\FACESHEETS
Revised 12/2016

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

February 14, 2017

John Kolenda, Administrator
Touchpoints At Chestnut
171 Main Street
East Windsor, CT 06088

Dear Mr. Kolenda:

Unannounced visits were made to Touchpoints At Chestnut on January 23, 24, 25 and 26, 2017 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure and certification inspection.

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by February 28, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

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

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.

Respectfully,

Norma Schuberth, R.N., B.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

NS:lsl

CT #'s 20745, 20963

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: January 23, 24, 25 and 26, 2017

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

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

1. Based on review of the clinical record, review of facility documentation and interviews for one of three sampled residents (Resident #43) reviewed for alleged abuse, the facility failed to ensure the resident was free from verbal abuse. The findings include:
   a. Resident #43's diagnoses included neuropathy, anxiety, over active bladder, and dementia with behavioral disturbance.

      The admission MDS dated 7/8/16 identified the resident had intact cognition, required extensive assistance of two staff with bed mobility, toilet use and personal hygiene. Additionally, the resident required total assistance for transfers and was always incontinent of bowel and bladder.

      The care plan dated 7/16/16 directed the staff to provide preventative skin care, which included incontinent care.

      The accident/incident report dated 10/4/16 at 8:00 PM identified the resident reported to RN #5 that NA#3 was rude, made an inappropriate statement by saying "that this is what happens when you piss yourself" because the resident was incontinent and also hurt the resident's right leg.

      A statement provided by RN #5 dated 10/4/16 at 8:00 PM identified Resident #43 reported that NA #3 was mean and said "that's what happens when you piss yourself". Additionally, the resident reported that NA #3 hurt his/her leg. RN #5's statement identified that NA#3 was interviewed and denied the allegation. NA #3 indicated when he/she went to provide care to the resident, the resident got upset but NA #3 did not know why. NA #3 was removed from the facility and an investigation was initiated.

      A statement provided by the social worker dated 10/5/16 identified Resident #43 indicated that on 10/4/16, he/she was incontinent of a large amount of urine when in the wheelchair. The resident told NA #3 that he/she was ready to go to bed and NA #3 called the resident a pissy woman/man. The social worker documented the resident was very upset and did not want NA #3 to provide care again.

      In a statement provided by RN #1 dated 10/5/16 at 9:30 AM identified Resident #43 reported that NA #3 called him/her a pissy woman/man, and indicated the resident was always pissing him/herself. Additionally, the resident reported NA #3 threw his/her Hoyer pad and sneakers on the floor and hurt the resident's right leg by being too rough during care.

DATES OF VISIT: January 23, 24, 25 and 26, 2017

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

The facility's investigation identified Resident #10; the resident's roommate heard the interaction between Resident #43 and NA #3. Resident #10 heard NA #3 comment, in an inappropriate manor, that the resident does a lot of pissing.

Social Service progress notes dated 10/5/16 and 10/10/16 identified the resident had no signs of depression or ill effects related to the incident that occurred on 10/4/16.

A behavioral health note dated 10/7/16 identified the resident was seen at the request of staff due to an insensitive comment made by a nurse aide. The resident indicated that a nurse aide called him/her a pissy woman/man. The resident was noted to be irritable and refused to get out of bed. The resident denied injury, denied fear but indicated he/she was mad.

Interview on 1/26/17 at 10:30 AM with Resident #43 identified the resident was able to recall the incident and stated that NA #3 called her a pissy old woman/man.

Attempts to contact for an interview NA #3 were unsuccessful.

Interview, review of the clinical record and the facility's investigation with the DNS on 1/26/17 at 11:00 AM identified the resident's statement regarding the interaction with NA #3 never changed and subsequently, NA #3 was terminated for resident mistreatment.

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

2. Based on review of the clinical record, facility policy and procedure and interview, for one sampled resident (Resident #61) reviewed for care planning, the facility failed to facilitate the inclusion of the resident and/or family representative in the care plan process. The findings include:
   a. Resident #61's diagnoses included major depressive disorder, anxiety and history of falling.

   The quarterly MDS dated 10/24/16 identified the resident was cognitively intact and was independent with all care.

   Interview with Resident #61 on 1/23/17 at 11:30 AM identified that he/she had not been invited to attend care conferences during the past year.

   Review of the care plan signature sheet for 2016 indicated that a care plan conference was held only twice, (2/3/16 and 11/2/16). Additionally, although there was a check mark in a box that indicated the resident had been invited, the care plan signature sheet dated 2/3/16 indicated a recreation staff member and RN #2 attended the meeting. The care plan signature sheet dated 11/2/16 indicated only RN #2 attended meeting. Furthermore, no other documentation was provided to indicate that any other care plan conferences were held.

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

Interview with RN #2 on 1/25/17 at 1:00 PM identified that he/she was responsible for scheduling the care plan conferences which include nursing (charge nurse and certified nursing assistant), dietary, recreation and social services. Additionally, RN #2 indicated that Resident #61's care conferences for 2016 were held on 2/3/16, 5/4/16, 8/3/16 and 11/2/16. Although RN #2 indicated that nurses, nurse assistants, recreation, social services and dietary usually attend the meetings, he/she could not explain the lack of staff signatures on the care plan signature sheets. RN #2 also identified that it had not been his/her responsibility to invite residents and/or family members until just recently. Prior to January 2017, the Social Worker was responsible for inviting the residents and the family.

An interview with the Social Worker on 1/25/17 at 2:00PM identified that during 2016 he/she was responsible for inviting residents and families to the care plan conferences. The Social Worker believed Resident #61 had been invited to all the scheduled care conferences, however, could not locate documentation of the invitation.

Review of the facility's care plan policy identified that the care planning process will facilitate the inclusion of the resident/representative. Additionally, that the care plan is developed by the interdisciplinary team which consists of representatives from nursing (charge nurse and a certified nursing assistant with responsibility for the resident), social services, behavioral health, dietary, rehabilitation, activities, the resident or resident representative and any other staff or professionals in disciplines as requested by the resident.

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

3. Based on observation, clinical record review, review of facility documentation, review of facility policy and interviews for the only sampled resident reviewed for PASRR (Resident #41), the facility failed to provide the appropriate services as recommended. The findings include:
   a. Resident #41's diagnoses included Trisomy 21, cervical compression, diabetes mellitus, suprapubic tube and Hiatal Hernia.

      A PASRR Level II assessment dated 8/11/16 identified the resident had an intellectual disability and required total care. The Level II assessment identified the resident had a physician order for 8 ounces of milk at each meal.

      The annual MDS dated 1/2/17 identified the resident was severely cognitively impaired and required extensive assistance with all care including eating.

      The care plan dated 1/3/17 identified the resident was at risk for alteration in nutritional status with interventions that included to provide the diet as ordered, honor meal preferences

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

and provide 8oz of milk with each meal.

Physicians orders dated 1/3/17 directed 8oz of milk be provided with each meal.

Interview on 1/24/17 at 2:22PM with NA #1, identified the resident did not receive milk at breakfast or lunch and that milk had not been offered during those meals.

Interview on 1/25/17 9:41AM with Dietary Manager identified that milk and juice were served on the trays by dietary staff, that menu stated that milk would be provided to all residents at mealtimes and that Resident #41 had specific dietary needs listed on his/her meal ticket.

Resident #41's individual meal ticket identified that honey thickened milk was to be provided with each meal.

Observation on 1/25/17 at 12:45 PM during lunch identified that the resident was served 16 oz of juice and 4oz of yogurt. The observation identified that the resident did not receive milk.

Interview with NA #2 on 1/25/17 at 12:45PM identified that the resident does not always receive milk at mealtimes.

Interview with Dietary Staff #1 on 01/25/2017 12:48:09 PM identified that he/she refers to resident meal ticket to determine any specific dietary need and that he/she is responsible for providing the fluids on resident meal trays.

Facility policy identified that dietary staff were responsible for placing milk and juice on meal trays.

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

4. Based on review of the clinical record, review of facility documentation, and interview for one sampled resident reviewed for care and services (Resident #33), the facility failed to ensure eye drops were administered and/or a pacemaker check was conducted in accordance with the physician's orders. The findings include:
   a. Resident #33's diagnoses included encephalopathy, hypothyroid, trigeminal neuralgia, a pacemaker, and dementia.

      The MDS dated 5/16/16 identified the resident had severe cognitive impairment and required extensive assistance with all care.

DATES OF VISIT: January 23, 24, 25 and 26, 2017

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

The care plan dated 5/23/16 identified a problem with vision related to Blepharitis. Interventions included to offer warm soaks to the eyes and eye drops as ordered.

Physician's order dated 6/7/16 directed to administer Refresh 1.4/0.6 drops, 1 drop in both eyes, two times a day.

The MAR for June 2016 identified the resident did not receive the Refresh eye drops on 4 occasions; 6/11/16 at 3:30 PM, 6/12/16 at 3:30 PM, 6/13/16 9:30 AM and 3:30 PM.

Interview and review of the clinical record on 1/24/17 at 10:45 AM with the DNS identified although Refresh eye drops are over the counter medication and are usually stocked in the facility, they were not available for administration on the 6/11/16, 6/12/16 and 6/13/16.

The Pacemaker status report dated 2/25/16 identified a pacemaker check was conducted and the report identified the resident required another pacemaker check on 7/12/16.

The MDS dated 11/25/16 identified the resident had severe cognitive impairment and required extensive assistance with all care.

Interview and review of the clinical record on 1/24/17 at 10:45 AM with the DNS identified that although pacemaker checks were conducted in the facility by licensed staff, the clinical record failed to provide documentation the pacemaker check was conducted on 7/12/16. The DNS could not identify why the pacemaker check was missed on 7/12/16. Further review of the clinical record with the DNS identified that a pacemaker check was conducted on 1/13/17 and subsequent to cardiology notification; an order for pacemaker checks every 90 days was obtained.

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

5. Based on observation, review of facility documentation and interviews, the facility failed to ensure that the resident environment remained free from potential hazards. The findings include:
   a. Observation on 1/23/17 at 9:30 AM identified a laundry door, that opened up to a stairwell in East wing was unlocked and without the benefit of an alarm system.

      Interview with the Administrator on 1/23/17 at 12:13 PM identified the door should be locked at all times. Additionally, the Administrator indicated that an auto locking door lock will be used to replace the current lock.

      Interview with LPN #1 on 1/24/17 11:58 AM identified that residents with a diagnosis of dementia reside on the unit and walk in the hallway.

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

Interview with the Director of Operations on 1/24/17 at 1:13 PM identified that the facility did not currently have a policy for accident prevention, specifically to securing hazardous areas.

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

6. Based on clinical record reviews and interviews for two of five sampled residents (Residents # 1 and # 24) reviewed for unnecessary medications, the facility failed to consistently monitor orthostatic blood pressures according to the physician orders. The findings include:
   a. Resident #1's diagnoses included schizophrenia and depression.

      The care plan dated 1/7/16 through 11/30/16 identified Resident #1 received psychotropic medications related to a diagnosis of schizophrenia. Interventions included to observe for side effects and record and/or report any concerns and/or changes to the physician.

      The quarterly MDS dated 2/22/16 identified the resident had intact cognition, required limited one person assistance with bed mobility, transfer, walking and locomotion on/off unit, and received antipsychotic medications.

      Physician orders dated February 2016 through August 4, 2016 directed to administer Abilify 5 mg daily. The physician's order dated 8/4/16 directed to administer Abilify 5 mg daily at bedtime.

      Monthly physician's orders from February 2016 through January 2017 directed to monitor orthostatic blood pressures every month on the 17th.

      A psychiatric behavioral health note dated 11/3/16 identified the resident was calmer on current medications and the treatment plan directed to obtain orthostatic blood pressures every month.

      Review of the resident's vitals summary and MAR identified that orthostatic blood pressures were not completed in 2/2016, 3/2016, 4/2016, 5/2016, 6/2015, 7/2016, 8/2016, 10/2016, 11/2016, 12/2016 or 1/2017.

      Interview with RN #4 on 1/25/17 at 1:50 PM failed to reflect that orthostatic blood pressures were consistently obtained and/or documented per the physician's order. Additionally, RN #4 indicated that it was the responsibility of the charge nurse to obtain and document orthostatic blood pressures on the MAR each month.

      Interview with MD #1 on 1/26/17 at 10:00 AM identified that secondary to Resident #1

receiving antipsychotic medications that may cause orthostatic hypotension, the residents orthostatic blood pressure monitoring should have been completed and evaluated as ordered.

b. Resident # 24's diagnoses included depression with psychotic features.
The physician's order dated 10/28/16 directed to administer Seroquel 100mg daily at bedtime.

The physician's order dated 12/1/16 (original date 8/29/12) direct to obtain orthostatic blood pressure every month on the 19th.

The quarterly MDS dated 12/14/16 identified the resident with had intact cognition, was independent with all care and walking.

The care plan dated 12/14/16 identified the use of psychotropic medication with interventions that included to observe for medication side effects. Additionally, the care plan identified the resident was independent with transfers and ambulated with a rolling walker.

Physician's orders dated 1/5/17 directed to decrease the Seroquel to 75 mg daily at bedtime.

Interview and review of the clinical record with RN#3 on 1/25/17 at 11:45 AM identified that orthostatic blood pressures were not obtained in 10/2016, 11/2016 or 12/2016.

Interview and record review with RN #3 on 1/25/2017 at 12:22 PM identified that nursing, the interdisciplinary team and pharmacy are responsible to ensure the completeness of the MAR and ensuring orthostatic blood pressures are monitored as per physician's orders.

Interview with MD #1 on 1/26/17 at 10:11 AM identified that he/she was not aware the orthostatic blood pressures were not being obtained as per the physician order. MD #1 indicated that monthly checks for signs of orthostatic hypotension should be done for several months and then discontinued if there are no issues.

The facility was unable to provide a policy for the monitoring of orthostatic blood pressures for residents prescribed antipsychotic medications.

DATES OF VISIT: January 23, 24, 25 and 26, 2017

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8v (b)(2)(B)(i).

7. Based on clinical record review, review of facility documentation, and interviews for two of five sampled residents (Resident # 1 and 24) reviewed for unnecessary medications, the pharmacist failed to report the lack of orthostatic blood pressure monitoring for two residents who were prescribed antipsychotic medications. The findings include
   a. Resident #1's diagnoses included schizophrenia and depression.

      The care plan dated 1/7/16 through 11/30/16 identified Resident #1 received psychotropic medications related to a diagnosis of schizophrenia. Interventions included to observe for side effects and record and/or report any concerns and/or changes to the physician.

      The quarterly MDS dated 2/22/16 identified the resident had intact cognition, required limited one person assistance with bed mobility, transfer, walking and locomotion on/off unit, and received antipsychotic medications.
      Physician orders dated February 2016 through August 4, 2016 directed to administer Abilify 5 mg daily. The physician's order dated 8/4/16 directed to administer Abilify 5 mg daily at bedtime.

      Monthly physician's orders from February 2016 through January 2017 directed to monitor orthostatic blood pressures every month on the 17th.

      A psychiatric behavioral health note dated 11/3/16 identified the resident was calmer on current medications and the treatment plan directed to obtain orthostatic blood pressures every month.

      Review of the resident's vitals summary and MAR identified that orthostatic blood pressures were not completed in 2/2016, 3/2016, 4/2016, 5/2016, 6/2015, 7/2016, 8/2016, 10/2016, 11/2016, 12/2016 or 1/2017.

      Interview with RN #4 on 1/25/17 at 1:50 PM failed to reflect that orthostatic blood pressures were consistently obtained and/or documented per the physician's order. Additionally, RN #4 indicated that it was the responsibility of the charge nurse to obtain and document orthostatic blood pressures on the MAR each month.

      Interview with MD #1 on 1/26/17 at 10:00 AM identified that secondary to Resident #1 receiving antipsychotic medications that may cause orthostatic hypotension, the residents orthostatic blood pressure monitoring should have been completed and

evaluated as ordered.

Review of the medication regimen (pharmacy consultant monthly report) and interview with the DNS on 1/26/17 at 10:30 AM identified the report failed to reflect that orthostatic blood pressures had not been completed according to the physician orders.

Interview with the Pharmacy Consultant on 1/25/17 at 1:40 PM indicated that residents who receive antipsychotic medications should have orthostatic blood pressures monitored.

b. Resident # 24's diagnoses included depression with psychotic features.
The physician's order dated 10/28/16 directed to administer Seroquel 100mg daily at bedtime.

The physician's order dated 12/1/16 (original date 8/29/12) direct to obtain orthostatic blood pressure every month on the 19th.

The quarterly MDS dated 12/14/16 identified the resident with had intact cognition, was independent with all care and walking.

The care plan dated 12/14/16 identified the use of psychotropic medication with interventions that included to observe for medication side effects. Additionally, the care plan identified the resident was independent with transfers and ambulated with a rolling walker.

Physician's orders dated 1/5/17 directed to decrease the Seroquel to 75 mg daily at bedtime.

Interview and review of the clinical record with RN#3 on 1/25/17 at 11:45 AM identified that orthostatic blood pressures were not obtained in 10/2016, 11/2016 or 12/2016.

Interview and record review with RN #3 on 1/25/2017 at 12:22 PM identified that nursing, the interdisciplinary team and pharmacy are responsible to ensure the completeness of the MAR and ensuring orthostatic blood pressures are monitored as per physician's orders.

Interview with MD #1 on 1/26/17 at 10:11 AM identified that he/she was not aware the orthostatic blood pressures were not being obtained as per the physician order. MD #1 indicated that monthly checks for signs of orthostatic hypotension should be done for several months and then discontinued if there are no issues.

DATES OF VISIT: January 23, 24, 25 and 26, 2017

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

The facility was unable to provide a policy for the monitoring of orthostatic blood pressures for residents prescribed antipsychotic medications.

The medication regimen reviews dated 11/29/16, 12/26/16 and 1/26/17 failed to address the absence of orthostatic blood pressures monitoring.

Touchpoints
at Chestnut

State POC

February 23, 2017

Norma Schuberth, RN., B.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue, MS # 12HSR
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Schuberth:

Enclosed please find the Touchpoints at Chestnut Plan of Correction for the alleged violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut cited during our survey, which was concluded on January 26, 2017.

The facility has achieved substantial compliance with all requirements as of the completion date specified and the plan of correction of these violations. Therefore, the facility requests that this plan of correction serve as its allegation of compliance with all requirements. Please note, "the filing of this plan of correction does not constitute an admission of any fact or that the alleged violations did in fact exist. This plan of correction is filed as evidence of the facility's commitment to comply with the legal requirements and to continue to provide high quality resident care".

If you have any questions, please do not hesitate to contact me.

Sincerely,

John Kolenda
Administrator

171 Main Street, East Windsor, CT 06088
Tel: 860-292-5394 Fax: 860-627-2858

P.O.C accepted 3/3/17 JES

FACILITY: Touchpoints at Chestnut

DATES OF VISIT: January 23, 24, 25 and 26, of 2017

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

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

Note: The Filing of this Plan of Correction does not constitute any admissions as to any of the alleged violations set forth in this statement of deficiencies. The Plan of Correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#43 suffered no ill effects from the incident and is receiving care in a dignified manner. Residents who require incontinent care have the potential to be affected by this alleged deficient practice. NA#3's employment was terminated. Random weekly audits will be completed to ensure that residents are free from verbal abuse. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/9/17.

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

Note: The Filing of this Plan of Correction does not constitute any admissions as to any of the alleged violations set forth in this statement of deficiencies. The Plan of Correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#61 is invited to her care plan meetings. Residents who have care conferences have the potential to be affected by this alleged deficient practice. RN#2 and Social Worker have been inserviced on the need to invite residents and/or family representatives to care plan conferences, to document the invitation and to ensure that the interdisciplinary team members sign the attendance sheet. Random weekly audits will be completed that ensure compliance. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/9/17.

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

Note: The filing of this Plan of Correction does not constitute any admission as to any of the alleged deficiencies set forth in this statement of deficiencies.

This Plan of correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#41 is receiving milk at meals per the care plan. Residents who have a PASRR recommendation for milk at meals have the potential to be affected by this alleged deficient practice. Nursing staff and dietary staff have been inserviced on the need to follow the care plan and/or meal ticket regarding care plan interventions for fluids. Random weekly audits will be completed that ensure compliance. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/9/17

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

Note: The filing of this Plan of Correction does not constitute any admission as to any of the alleged deficiencies set forth in this statement of deficiencies.

This Plan of correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#33 is receiving saline eye drops per MD order and pacemaker was checked on 1/13/17. Residents who receive saline eye drops and/or require pacemaker checks have the potential to be affected by this alleged deficient practice. Licensed nursing staff have been reinserviced on the procedure to follow for ordering OTC meds, procedure for when meds are not available for administration and the need to follow up on recommendations for pacemaker checks. Random weekly audits will be completed that ensure compliance. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/9/17.

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

Note: The filing of this Plan of Correction does not constitute any admission as to any of the alleged deficiencies set forth in this statement of deficiencies.

This Plan of correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

No residents suffered any ill effects. Ambulatory residents with a diagnosis of dementia have the potential to be affected by this alleged deficient practice. An "auto locking" lock was installed on the door. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Maintenance is responsible. Compliance date: 3/9/17.

RECEIVED
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-d8t (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

Note: The filing of this Plan of Correction does not constitute any admission as to any of the alleged deficiencies set forth in this statement of deficiencies.

This Plan of correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#1 and R#24 Blood Pressures are being monitored MD orders. Residents receiving psychotropic medications with an MD order for orthostatic blood pressure monitoring have the potential to be affected by this alleged deficient practice. Licensed Staff will be re-inserviced on the importance of monitoring orthostatic blood pressures per MD orders. Random weekly audits will be completed that ensure compliance. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/9/17

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-d8v (b)(2)(B)(i).

Note: The filing of this Plan of Correction does not constitute any admission as to any of the alleged deficiencies set forth in this statement of deficiencies.

This Plan of correction is being filed as evidence of the facilities continued compliance with all applicable laws and the facility's desire to continue to provide quality service.

R#1 and R#24 Blood Pressures are being monitored per MD orders. Residents receiving psychotropic medications with an MD order for orthostatic blood pressure monitoring have the potential to be affected by this alleged deficient practice. Pharmacy Consultant will be inserviced on the need to monitor compliance to orthostatic blood pressure monitoring as part of the monthly drug regimen review. Random weekly audits will be completed to ensure compliance. Results will be reviewed by the Quality Assessment/Improvement Committee. Director of Nursing is responsible. Compliance date: 3/7/17.