2019

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Orange Health Care Center
225 Boston Post Rd.
Orange, CT 06477
M: 07-5434

FLIS Staff

Carla Larocque
Jeannie Ourlay
Maria Elena Legardi

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 60

Census: 58

Date(s) of onsite inspection: 3/10/19, 3/11/19, 3/12/19, + 3/13/19

Date(s) additional information obtained: ___

Personnel contacted: Andree Acampora Administrator. Denise Mancuso, 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 # ___

[√] 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 3.18.19

[ ] 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: Carla Larocque **DATE OF REPORT:** 3-14-19

[ ] 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

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

March 18, 2019

Ms. Andree Acampora, Administrator
Orange Health Care Center
225 Boston Post Rd
Orange, CT 06477

Dear Ms. Acampora:

Unannounced visits were made to Orange Health Care Center which concluded on March 10, 11, 12 and 13, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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

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 March 28, 2019 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 through the ePOC website 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.

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 BSN

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

CEM:mb

The following is a violation of the Connecticut General Statutes Section 19a-550 and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

1. Based on clinical record review, review of facility documentations, and review of facility policy, for one of two sampled residents (Resident #31), reviewed for advanced directives, the facility failed to ensure physician's orders for code status and/or care plan reflected the resident's choices. The findings include:
   a. Resident #31 was admitted to facility on 5/1/17 with diagnoses that included end stage renal disease, hemodialysis, and stage 3 colorectal carcinoma. Review of the face sheet identified that Resident #31 was responsible for him/herself.
   The quarterly Minimum Data Set (MDS) assessment dated 2/1/19 identified Resident #31 was without cognitive impairment and required assist of one for bed mobility, transfers, and activities of daily living.
   A physician's order dated 2/4/19 for Resident #31 directed Do Not Resuscitate (DNR), Registered Nurse may pronounce.
   The Resident Care Plan dated 2/8/19 identified Resident #31's advance directive as full code status with interventions to discuss advance directives with resident and/or family on admission and review quarterly.
   Review of clinical documents on 3/10/19 at 1:45 PM identified an advanced directive dated and signed on 5/2/17 for Resident #31 as a full code (administer cardiopulmonary resuscitation).
   Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 3/10/19 at 1:50 PM failed to reflect documentation that Resident # 31 had a new advance directive form indicating he/she was a DNR reflecting the physician's order. LPN #1 further indicated the advance directives are updated by the nurses.
   Review of facility Advance Directive Policy identified that the resident will be assessed periodically for decision-making ability capacity and for changes in resident preferences and choices.
   Subsequent to surveyor's inquiry a new physician's orders for code status and advance directive were updated on 3/10/19 to reflect resident's wishes of full code.

Plan of Correction for Violation #1:

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

2. Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident (Resident #35) reviewed for positioning/mobility, the facility failed to identify, monitor, and/or treat an upper extremity contracture. The findings include:
   a. Resident #35 was admitted on 5/4/16 with diagnoses that included dementia without behavioral disturbance, Parkinson's, and an inoperable dislocated shoulder.
   The quarterly Minimum Data Set (MDS) assessment dated 2/4/19 identified Resident #35 was severely cognitively impaired and required the extensive assistance of one staff with bed mobility, was totally dependent on two staff for transfers, and dependant on one staff for eating, and toileting. Additionally, the resident had a limited range of motion on one side of the upper extremity.
   The Resident Care Plan (RCP) dated 2/14/19 identified dependence on staff for bathing, dressing, toileting, hygiene, feeding, and oral care.
   Interventions directed to observe/document/report to nurse/therapy any noted potential for improvement or declines in self-care and Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP) screen and treatment as indicated.
   The Nurse Aide (NA) care plan card (undated) failed to identify the provision of range of motion.
   The nurse's notes were reviewed from 4/14/17 through 3/13/19 and did not reflect documentation that the resident had contractures.
   The interdisciplinary rehabilitation screen dated 2/22/19 identified dressing, feeding and swallowing but failed to address the section referring to range of motion.
   A physician's order dated 3/1/19 directed to provide OT evaluation and treatment as indicated.
   Observation on 03/10/19 at 12:55 PM identified that Resident #35's left hand appeared contracted without the benefit of a splint, and a questionable right hand/elbow/shoulder contracture.
   Observation on 03/12/19 at 09:33 AM identified that the left hand appeared contracted without the benefit of a splint as well as right hand/elbow/shoulder contracture.
   Interview, observation, and review of facility documentation with OT #1 on 3/12/19 at 10:20 AM identified that he/she had been here for a year. OT #1 identified that he/she had not seen the resident since March, 2018 when the resident attended the wheelchair clinic. OT #1 identified that he/she had wanted to pick up the resident on case load and to assess the resident for pain, but was told by PT #1 not to touch the resident. OT #1 attempted to extend the resident's right arm (shoulder and elbow) but was unable. Additionally, OT #1 attempted to open Resident #35's left hand but was unable to. OT #1 identified that the resident looked no different than when he/she had observed the resident at the wheelchair clinic in March of 2018. OT #1 identified that the resident had contractures to the right shoulder and elbow and the left hand.
   Interview and review of facility documentation on 03/12/19 at 10:29 AM with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) identified that the resident was admitted with contractures, he/she came in with a dislocated shoulder from the hospital and

was sent right back because the shoulder still appeared to be dislocated. Additionally, the resident previously had a dislocated shoulder at home prior to admission to the hospital. The DNS and ADNS were unable to explain why PT #1 told OT #1 that the resident could not be seen. Additionally, both the DNS and ADNS were on staff when the resident was admitted.
Interview with the Administrator on 03/12/19 at 10:57 AM failed to identify that he/she was aware that the resident could not be seen by OT.
An interview with PT #1 on 03/12/19 at 02:26 PM identified that the resident was holding a cup and moving right arm without problems a few months ago. PT #1 identified that the resident was never picked up for range of motion. PT #1 identified that he/she had talked to the orthopedic physician back in 2016 when the resident was first admitted and was told not to touch the resident. PT #1 identified that the orthopedic physician had looked at both the resident's left and right upper body sides and that the orthopedic physician "basically directed the facility not to touch" him/her. PT #1 identified that the previous OT would have documented in the clinical record, any directives from the physician. PT #1 identified that he/she did not personally have a conversation with the family but that the family did not want anything done with the resident because the resident was "basically comfort care".
An interview with PT #2 on 03/13/19 at 8:36 AM identified that the facility has documentation for other resident contractures which included ROM measurements, however, failed to provide documentation for Resident #35.
An interview with PT #2 and the DNS on 03/13/19 10:40 AM identified that the facility has documentation for other resident contractures which included ROM measurements, however, failed to provide documentation for Resident #35. PT #2 identified that the resident was seen in the wheelchair clinic and it was identified then that the resident had bilateral flexion contracture of the upper extremities, but he/she was unsure of the accuracy of this. Although the DNS identified previously that the resident was admitted with contractures, both PT #2 and the DNS identified that the resident was known to have had his/her right arm extended. During observation, PT #2 was unable to fully extend Resident #35's right arm. Additionally, PT #2 was unable to fully extend the left hand. PT #2 identified that both the right arm and the left hand had some degree of contracture.
Interview with Person #2 on 3/13/19 at 11:05 AM identified that the resident was supposed to have a sling on his/her left arm. When he/she was at the facility two weeks ago the resident was observed with the left arm hanging down by the resident's side. Person #2 identified that he/she never saw Resident #35 hold a cup with his/her right hand. Person #2 identified that the resident was able to move his/her right arm to his her side on admission, but preferred to hold the dislocated left shoulder with his/her right hand. Person #2 identified that he/she had not been approached by the facility for treatment of contractures, but had told the facility that the orthopedic physician had said never to do anything with the resident's left shoulder and that he/she did not want any internal testing performed. Person #2 identified that he/she would be willing to allow OT to evaluate the resident's contractures.
Interview and observation with NA #1 on 3/13/19 at 1:25 PM identified that he/she had been here for 5 years and the NA assignments changed every week. NA #1 identified that he/she cares for Resident #35 and that since the resident arrived, his/her right arm has become more difficult to put clothes on the resident and was more contracted. NA #1

identified that he/she puts the resident's clothes on the right arm first due to the immobility of the resident's arm. Additionally, NA #1 identified that the resident does not utilize a sling or any device for the left arm, but has a platform on the left side of the wheelchair arm to keep the arm stable. NA #1 identified that the resident is able to move his/her left arm independently.
Subsequent to surveyor inquiry, interview with OT #1 on 3/13/19 at 1:30pm identified that therapy would be picking up Resident #35 for evaluation and treatment.
The facility did not provide a contracture policy.
The facility failed to identify, monitor, and/or treat Resident #35's upper extremity contractures/limited range of motion.

Plan of Correction for Violation #2:

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

3. Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident (Resident #153) reviewed for nutrition, the facility failed to weigh the resident upon admission. The findings include:
   a. Resident #153 was admitted on 3/6/19 with diagnoses that included hypoxia, diabetes, and hyperparathyroidism status post parathyroidectomy.
   Review of the hospital discharge summary dated 3/6/19 identified a discharge weight of 93.4 kg (205.48 pounds).
   The Admission Resident Care Plan (RCP) dated 3/6/19 identified a nutritional status/diet, resident will have no unavoidable weight loss. Interventions directed to weight the resident as ordered per facility protocol.
   A physician's order dated 3/6/19 directed to weigh the resident weekly on Tuesdays, 3-11 shift.
   Review of the nursing admission assessment dated 3/6/19 failed to reflect that there was an admission weight taken.
   Interview with Resident #153 on 03/10/19 at 11:28 AM identified that he/she had not been weighed since admission and was unable to answer if he/she was losing weight at the facility. Resident #153 did identify that he/she had been losing weight at the hospital.
   Interview and review of facility documentation with the Assistant Director of Nursing (ADNS) on 03/11/19 at 2:18 PM failed to identify that Resident #153 had been weighed,

according to facility policy, on the day of admission. Additionally, the ADNS identified that since he/she was the admitting nurse, he/she was responsible to ensure the resident's weight was obtained. The ADNS was unable to explain why the resident's weight had not been taken.
Review of facility Weight Policy identified that the weight of all resident shall be taken and recorded on admission.
Subsequent to surveyor inquiry the resident's weight was obtained and was noted to be 204.2 pounds.

Plan of Correction for Violation #3:

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

4. Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident, (Resident #302), reviewed for dialysis, the facility failed to have a consistent communication process in place with the Dialysis center. The findings include:
   a. Resident #302 was admitted on 9/8/17 and readmitted on 3/1/19 with diagnoses that included end stage renal renal disease, dependence on renal dialysis, and type 2 diabetes mellitus.
   A review of Resident #302's binder titled 'Dialysis communication' dated 11/1/18 through 3/12/19 failed to reflect that the facility was providing any types of communication and/or documentation regarding Resident #302 to the Dialysis center.
   A review of the nurse notes dated 11/1/18 through 3/12/19 failed to reflect that any type of communication had occurred from the facility to the Dialysis center and/or any type of documentation was provided to the Dialysis center for Resident #302.
   A physician's order dated 3/1/19 directed to send Resident #302 to the Dialysis center for hemodialysis on Monday, Wednesday, and Friday, with a pick up time of 9:30 AM.
   The nursing admission assessment dated 3/1/19 identified Resident #302 was alert, verbal, and cooperative. Resident # 302 required assistance of one with bathing, dressing, and toileting.
   The Resident Care Plan (RCP) dated 3/1/19 identified Resident # 302 had renal disease and goes to hemodialysis on Monday, Wednesday, and Friday at the dialysis center.
   Interventions directed to provide transportation arrangements, obtain vital sign, offer the

resident a meal in relationship to dialysis appointments, check bruit and thrill of right arteriovenous fistula graft every shift, adhere to dialysis scheduled as ordered, and if there any questions regarding care contact the dialysis center.
Interview with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) on 3/12/19 at 10:30 AM identified he/she would not expect to find any other documents in Resident #302's Dialysis communication binder other than the communication forms sent by the Dialysis center.
Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 3/12/19 at 11:17 AM failed to provide documentation to reflect that the facility was communicating with the Dialysis center. LPN #1 indicated he/she would call the Dialysis center if there were any major changes in Resident #302's health status.
An interview with Person #1, a staff member at the Dialysis center, on 3/13/19 at 8:40 AM. Person #1 identified he/she cared for Resident #302 at the Dialysis center he/she indicated the Dialysis center does not receive any types of documents and/or communication from the facility on the days of Resident # 302's dialysis treatments. Person #1 further indicated that he/she would expect to receive a completed communication form for Resident # 302 from the facility.
Review of the Nursing Facility Dialysis Agreement identified the Nursing facility identified emergency and non-emergency changes in a resident's medical condition will be immediately communicated by the party having primary knowledge of the change to the other party.
Review of facility policy titled Dialysis identified a Dialysis communication binder will be sent with the Resident to Dialysis and recommendations will be reported to the physician.
The facility lacked an identified and consistent form of communication to the Dialysis Center.

Plan of Correction for Violation #4:

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

5. Based on review of facility documentation, review of facility policy, and interviews, for a review of the Infection Prevention program, the facility failed to follow its policy regarding infection rates and/or surveillance criteria, and data collection. The findings include:
   a. Interview and review of facility documentation with the Director of Nurses (DNS) and

Assistant Director of Nurses (ADNS) on 03/11/19 at 10:45 AM identified that although the facility policy identified the need for infection resolutions rates, quarterly infection rates, and/or surveillance criteria data documentation, they were unable to provide documentation of such. The DNS and ADNS identified that they were unaware of the need for the documentation.

Plan of Correction for Violation #5:

JPC CEM 4.24.19

The following is a violation of the Connecticut General Statutes Section 19a-550 and/or Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

1. Based on clinical record review, review of facility documentations, and review of facility policy, for one of two sampled residents (Resident #31), reviewed for advanced directives, the facility failed to ensure physician's orders for code status and/or care plan reflected the resident's choices. The findings include:
   a. Resident #31 was admitted to facility on 5/1/17 with diagnoses that included end stage renal disease, hemodialysis, and stage 3 colorectal carcinoma. Review of the face sheet identified that Resident #31 was responsible for him/herself.
   The quarterly Minimum Data Set (MDS) assessment dated 2/1/19 identified Resident #31 was without cognitive impairment and required assist of one for bed mobility, transfers, and activities of daily living.
   A physician's order dated 2/4/19 for Resident #31 directed Do Not Resuscitate (DNR), Registered Nurse may pronounce.
   The Resident Care Plan dated 2/8/19 identified Resident #31's advance directive as full code status with interventions to discuss advance directives with resident and/or family on admission and review quarterly.
   Review of clinical documents on 3/10/19 at 1:45 PM identified an advanced directive dated and signed on 5/2/17 for Resident #31 as a full code (administer cardiopulmonary resuscitation).
   Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 3/10/19 at 1:50 PM failed to reflect documentation that Resident # 31 had a new advance directive form indicating he/she was a DNR reflecting the physician's order. LPN #1 further indicated the advance directives are updated by the nurses.
   Review of facility Advance Directive Policy identified that the resident will be assessed periodically for decision-making ability capacity and for changes in resident preferences and choices.
   Subsequent to surveyor's inquiry a new physician's orders for code status and advance directive were updated on 3/10/19 to reflect resident's wishes of full code.

Plan of Correction for Violation #1:

Resident # 31 has had her code status and advanced directives updated on 3/10/2019 to reflect her wishes to be a full code.

All residents code status will be reviewed to ensure they are properly reflect each resident's current wishes by 4/5/19.

Going forward the Social Worker or Supervising Nurse will meet with all newly admitted residents or responsible parties to give them an opportunity to formulate advanced directives if they have not already provided them to the facility. Once the resident's wishes are determined the physician will be notified and an order will be obtained. The residents wish will then be care planned. The Social Services Director or designee will conduct random weekly audits of newly admitted residents to ensure advanced directives have corresponding physician orders and a care plan. The Director of Nurses or designee will conduct random audits to ensure compliance in this area.

To prevent a reoccurrence, resident's code status will be reviewed on admission and again quarterly during resident care plan meetings or during resident change of condition meetings. A space will be added to the care plan meeting sign-in sheet indicating that the resident's code status orders has been confirmed with the residents wishes.

In addition to this process an in-service will be provided for all MD's and APRN's on the importance of checking for any changes in code status wishes or advanced directives prior to writing orders.

The results of the audits will be brought to the QAPI/QA program along with the results of the care plan meeting notes to monitor the effectiveness of this plan for 3 months or as long as needed. Monitored by the DNS. 4/15/2019

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

2. Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident (Resident #35) reviewed for positioning/mobility, the facility failed to identify, monitor, and/or treat an upper extremity contracture. The findings include:
   a. Resident #35 was admitted on 5/4/16 with diagnoses that included dementia without behavioral disturbance, Parkinson's, and an inoperable dislocated shoulder.
   The quarterly Minimum Data Set (MDS) assessment dated 2/4/19 identified Resident #35 was severely cognitively impaired and required the extensive assistance of one staff with bed mobility, was totally dependent on two staff for transfers, and dependant on one staff for eating, and toileting. Additionally, the resident had a limited range of motion on one side of the upper extremity.
   The Resident Care Plan (RCP) dated 2/14/19 identified dependence on staff for bathing, dressing, toileting, hygiene, feeding, and oral care.
   Interventions directed to observe/document/report to nurse/therapy any noted potential for improvement or declines in self-care and Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP) screen and treatment as indicated.
   The Nurse Aide (NA) care plan card (undated) failed to identify the provision of range of motion.
   The nurse's notes were reviewed from 4/14/17 through 3/13/19 and did not reflect documentation that the resident had contractures.
   The interdisciplinary rehabilitation screen dated 2/22/19 identified dressing, feeding and swallowing but failed to address the section referring to range of motion.

A physician's order dated 3/1/19 directed to provide OT evaluation and treatment as indicated.
Observation on 03/10/19 at 12:55 PM identified that Resident #35's left hand appeared contracted without the benefit of a splint, and a questionable right hand/elbow/shoulder contracture.
Observation on 03/12/19 at 09:33 AM identified that the left hand appeared contracted without the benefit of a splint as well as right hand/elbow/shoulder contracture.
Interview, observation, and review of facility documentation with OT #1 on 3/12/19 at 10:20 AM identified that he/she had been here for a year. OT #1 identified that he/she had not seen the resident since March, 2018 when the resident attended the wheelchair clinic. OT #1 identified that he/she had wanted to pick up the resident on case load and to assess the resident for pain, but was told by PT #1 not to touch the resident. OT #1 attempted to extend the resident's right arm (shoulder and elbow) but was unable. Additionally, OT #1 attempted to open Resident #35's left hand but was unable to. OT #1 identified that the resident looked no different than when he/she had observed the resident at the wheelchair clinic in March of 2018. OT #1 identified that the resident had contractures to the right shoulder and elbow and the left hand.
Interview and review of facility documentation on 03/12/19 at 10:29 AM with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) identified that the resident was admitted with contractures, he/she came in with a dislocated shoulder from the hospital and was sent right back because the shoulder still appeared to be dislocated. Additionally, the resident previously had a dislocated shoulder at home prior to admission to the hospital. The DNS and ADNS were unable to explain why PT #1 told OT #1 that the resident could not be seen. Additionally, both the DNS and ADNS were on staff when the resident was admitted.
Interview with the Administrator on 03/12/19 at 10:57 AM failed to identify that he/she was aware that the resident could not be seen by OT.
An interview with PT #1 on 03/12/19 at 02:26 PM identified that the resident was holding a cup and moving right arm without problems a few months ago. PT #1 identified that the resident was never picked up for range of motion. PT #1 identified that he/she had talked to the orthopedic physician back in 2016 when the resident was first admitted and was told not to touch the resident. PT #1 identified that the orthopedic physician had looked at both the resident's left and right upper body sides and that the orthopedic physician "basically directed the facility not to touch" him/her. PT #1 identified that the previous OT would have documented in the clinical record, any directives from the physician. PT #1 identified that he/she did not personally have a conversation with the family but that the family did not want anything done with the resident because the resident was "basically comfort care".
An interview with PT #2 on 03/13/19 at 8:36 AM identified that the facility has documentation for other resident contractures which included ROM measurements, however, failed to provide documentation for Resident #35.
An interview with PT #2 and the DNS on 03/13/19 10:40 AM identified that the facility has documentation for other resident contractures which included ROM measurements, however, failed to provide documentation for Resident #35. PT #2 identified that the resident was seen in the wheelchair clinic and it was identified then that the resident had bilateral flexion contracture of the upper extremities, but he/she was unsure of the accuracy of this. Although the DNS identified previously that the resident was admitted with contractures, both PT #2 and the DNS identified that the resident was known to have had

his/her right arm extended. During observation, PT #2 was unable to fully extend Resident #35's right arm. Additionally, PT #2 was unable to fully extend the left hand. PT #2 identified that both the right arm and the left hand had some degree of contracture.
Interview with Person #2 on 3/13/19 at 11:05 AM identified that the resident was supposed to have a sling on his/her left arm. When he/she was at the facility two weeks ago the resident was observed with the left arm hanging down by the resident's side. Person #2 identified that he/she never saw Resident #35 hold a cup with his/her right hand. Person #2 identified that the resident was able to move his/her right arm to his her side on admission, but preferred to hold the dislocated left shoulder with his/her right hand. Person #2 identified that he/she had not been approached by the facility for treatment of contractures, but had told the facility that the orthopedic physician had said never to do anything with the resident's left shoulder and that he/she did not want any internal testing performed. Person #2 identified that he/she would be willing to allow OT to evaluate the resident's contractures.
Interview and observation with NA #1 on 3/13/19 at 1:25 PM identified that he/she had been here for 5 years and the NA assignments changed every week. NA #1 identified that he/she cares for Resident #35 and that since the resident arrived, his/her right arm has become more difficult to put clothes on the resident and was more contracted. NA #1 identified that he/she puts the resident's clothes on the right arm first due to the immobility of the resident's arm. Additionally, NA #1 identified that the resident does not utilize a sling or any device for the left arm, but has a platform on the left side of the wheelchair arm to keep the arm stable. NA #1 identified that the resident is able to move his/her left arm independently.
Subsequent to surveyor inquiry, interview with OT #1 on 3/13/19 at 1:30pm identified that therapy would be picking up Resident #35 for evaluation and treatment.
The facility did not provide a contracture policy.
The facility failed to identify, monitor, and/or treat Resident #35's upper extremity contractures/limited range of motion.

Plan of Correction for Violation #2:

Resident #35 has had an OT evaluation for her right arm completed on 3/13/2019. Res #35 is currently being treated by OT. The evaluation has determined that splinting would not be beneficial at this time as resident currently has ROM and moves her arm from her lap to her left shoulder which remains her position of comfort. Splinting her arm has been determined to be contraindicated in this case.

For all current residents, a Contraction Monitoring Program has been instituted. This will consist of a Contracture Monitoring Binder (CMB) that therapy will use to track residents from admission then then quarterly for decreases in ROM or changes in ADL's contributable to contractures.

An inservice given by therapy, beginning 4/2/19 and ongoing, is being conducted for nursing staff to teach how to identify a possible contracture, how to report a contracture, how to fill out a screen request form and what may happen after a screen form is completed.

To prevent reoccurrence, all new admissions will be screened for contractures and again quarterly for any reductions in ADL's related to contractures or a reduction in ROM's and their evaluations

and treatment plans kept in the CMB. Also all residents care plans will be updated as needed. The current forms can be seen attached to the Federal EPOC.

In addition to this Contracture Monitoring will be added to our weekly Risk Management meetings and discussed with our interdisciplinary team for further input and weekly auditing.

In order to monitor the effectiveness of this program the results of the weekly Risk management meetings as well as the CMB book will be reviewed by the interdisciplinary team at our QAPI/QA program for 3 months or as long as necessary. Monitored by our Assistant director of Therapy. 4/15/2019

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

3. Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident (Resident #153) reviewed for nutrition, the facility failed to weigh the resident upon admission. The findings include:
   a. Resident #153 was admitted on 3/6/19 with diagnoses that included hypoxia, diabetes, and hyperparathyroidism status post parathyroidectomy.
   Review of the hospital discharge summary dated 3/6/19 identified a discharge weight of 93.4 kg (205.48 pounds).
   The Admission Resident Care Plan (RCP) dated 3/6/19 identified a nutritional status/diet, resident will have no unavoidable weight loss. Interventions directed to weight the resident as ordered per facility protocol.
   A physician's order dated 3/6/19 directed to weigh the resident weekly on Tuesdays, 3-11 shift.
   Review of the nursing admission assessment dated 3/6/19 failed to reflect that there was an admission weight taken.
   Interview with Resident #153 on 03/10/19 at 11:28 AM identified that he/she had not been weighed since admission and was unable to answer if he/she was losing weight at the facility. Resident #153 did identify that he/she had been losing weight at the hospital.
   Interview and review of facility documentation with the Assistant Director of Nursing (ADNS) on 03/11/19 at 2:18 PM failed to identify that Resident #153 had been weighed, according to facility policy, on the day of admission. Additionally, the ADNS identified that since he/she was the admitting nurse, he/she was responsible to ensure the resident's weight was obtained. The ADNS was unable to explain why the resident's weight had not been taken.
   Review of facility Weight Policy identified that the weight of all resident shall be taken and recorded on admission.

Subsequent to surveyor inquiry the resident's weight was obtained and was noted to be 204.2 pounds.

Plan of Correction for Violation #3:

Resident #153 Weight was obtained on 3/11/2019 and documented as 204.2lbs.

A review of all current resident's charts will be completed to ensure that all residents have an accurate and current weight documented. A review of our past 4 admissions, since survey ended, all have admissions weights properly charted.

The following 3 step process is in place to ensure sustainability of solution:

1) CNA assigned to admitting patient's room is responsible for obtaining resident's vitals, obtaining resident's admission weight and assisting nursing with resident's body audit and other admission protocol. Check one.
2) Admitting Nurse is responsible for transferring residents' vitals and weight from CNA paperwork to chart. Check two.
3) Following mornings charge nurse or ADNS audits new admits chart for completeness including admission weight. Check three.

To prevent this from reoccurring, an in-service will be conducted for all nursing staff on the importance of obtaining an admission weight on admission and the proper procedure for doing so. Within 24 hours post admission an audit will be conducted to ensure that the weight had been obtained and properly documented in the chart.

This will be added to our QAPI/QA program and monitored for 3 months or as long as necessary to ensure compliance. Monitored by our ADNS. 4/15/2019

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

4. Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for one sampled resident, (Resident #302), reviewed for dialysis, the facility failed to have a consistent communication process in place with the Dialysis center. The findings include:
   a. Resident #302 was admitted on 9/8/17 and readmitted on 3/1/19 with diagnoses that included end stage renal renal disease, dependence on renal dialysis, and type 2 diabetes mellitus.
   A review of Resident #302's binder titled 'Dialysis communication' dated 11/1/18 through

3/12/19 failed to reflect that the facility was providing any types of communication and/or documentation regarding Resident #302 to the Dialysis center.
A review of the nurse notes dated 11/1/18 through 3/12/19 failed to reflect that any type of communication had occurred from the facility to the Dialysis center and/or any type of documentation was provided to the Dialysis center for Resident #302.
A physician's order dated 3/1/19 directed to send Resident #302 to the Dialysis center for hemodialysis on Monday, Wednesday, and Friday, with a pick up time of 9:30 AM.
The nursing admission assessment dated 3/1/19 identified Resident #302 was alert, verbal, and cooperative. Resident # 302 required assistance of one with bathing, dressing, and toileting.
The Resident Care Plan (RCP) dated 3/1/19 identified Resident # 302 had renal disease and goes to hemodialysis on Monday, Wednesday, and Friday at the dialysis center.
Interventions directed to provide transportation arrangements, obtain vital sign, offer the resident a meal in relationship to dialysis appointments, check bruit and thrill of right arteriovenous fistula graft every shift, adhere to dialysis scheduled as ordered, and if there any questions regarding care contact the dialysis center.
Interview with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) on 3/12/19 at 10:30 AM identified he/she would not expect to find any other documents in Resident #302's Dialysis communication binder other than the communication forms sent by the Dialysis center.
Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 3/12/19 at 11:17 AM failed to provide documentation to reflect that the facility was communicating with the Dialysis center. LPN #1 indicated he/she would call the Dialysis center if there were any major changes in Resident #302's health status.
An interview with Person #1, a staff member at the Dialysis center, on 3/13/19 at 8:40 AM. Person #1 identified he/she cared for Resident #302 at the Dialysis center he/she indicated the Dialysis center does not receive any types of documents and/or communication from the facility on the days of Resident # 302's dialysis treatments. Person #1 further indicated that he/she would expect to receive a completed communication form for Resident # 302 from the facility.
Review of the Nursing Facility Dialysis Agreement identified the Nursing facility identified emergency and non-emergency changes in a resident's medical condition will be immediately communicated by the party having primary knowledge of the change to the other party.
Review of facility policy titled Dialysis identified a Dialysis communication binder will be sent with the Resident to Dialysis and recommendations will be reported to the physician.
The facility lacked an identified and consistent form of communication to the Dialysis Center.

Plan of Correction for Violation #4:

Resident #302 has had a new hemodialysis communication record added to his dialysis book which travels routinely with him to and from dialysis. This form has been attached to the Federal POC for your review.

This new form will be added to all appropriate dialysis resident's communication books to prevent any

future noncompliance. This form has also been shared with our local dialysis center.

An in-service will be held for all nursing staff on the proper procedure for completion of these forms and weekly audits will be conducted to ensure compliance until we can be assured systematic changes are in place.

This will be added to our QAPI/QA program and monitored by the DNS . 4/15/2019

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

5. Based on review of facility documentation, review of facility policy, and interviews, for a review of the Infection Prevention program, the facility failed to follow its policy regarding infection rates and/or surveillance criteria, and data collection. The findings include:
   a. Interview and review of facility documentation with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) on 03/11/19 at 10:45 AM identified that although the facility policy identified the need for infection resolutions rates, quarterly infection rates, and/or surveillance criteria data documentation, they were unable to provide documentation of such. The DNS and ADNS identified that they were unaware of the need for the documentation.

Plan of Correction for Violation #5:

The facility policy for Infection Prevention & Control was reviewed. The ADNS has reviewed and revised the Infection Line List beginning April 2019. Each listing has a corresponding review against the McGeer's criteria. All data is tracked, trended and an analysis conducted to determine infection rates using the following equation; Number of Residents with Infections in the month divided by total resident days for the month multiplied by 1000. This equation will be utilized to determine the infection rate for each infection as well as the overall infection rate on a monthly basis.

We will also calculate the infection resolution rates and the infection rates for both community and facility acquired infections quarterly instead of monthly as we had been doing. This program will be headed by our facility Infection Preventionist by 11/28/2019.

The Director of Nurses or designee will review the infection Prevention & Control line list, McGeer's criteria and analysis monthly to ensure that the rate of infections is determined. The Director of Nurses or designee will conduct random audits to ensure compliance in this area.

Nursing staff will be educated on the Infection Prevention & Control policy beginning on 4/15/19 and will be ongoing.

Data from the audits including Infection data, rates of infection and analysis will be reviewed in QAPI for three months or until the committee determines resolution. It will also be reviewed in Medical Staff meetings.

This will be monitored by our ADNS. 4/15/2019

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Orange Rehab
225 Boston Post Rd
Orange CT 06477
M:

FLIS Staff

JDaley

Licensure Category:

CCNH

Licensed Bed
Bassinet Capacity: 60

Census: 49

Date(s) of onsite inspection: 10/16/19

Date(s) additional information obtained: _____

Personnel contacted: Andree Acompora Adm, Denise Mancuso DON

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[X] See Complaint Investigation # 26193

[ ] 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: JDaley RN, MSN **DATE OF REPORT:** 10/16/19

[ ] 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
Orange Health Care Center
225 Boston Post Road
Orange, CT 06477
M:

FLIS Staff
Marie Mahl

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 60

Census: 52

Date(s) of onsite inspection: 4/23/19

Date(s) additional information obtained: 4/23/19

Personnel contacted: DNS → Denise Mancuso
ADNS → Michael Tolokan

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

[X] Visit **OR** Revisit for the purpose of Reviewing the Plan of Correction for the violation letter dated 3/18/19 and 3/13/19

[ ] 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 _____

[ ] 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.

[X] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Marie Mahl **DATE OF REPORT:** 4/24/19

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

STRIKE MONITORING SUPPLEMENT TO LICENSING INSPECTION REPORT

LICENSING INSPECTION NARRATIVE REPORT:

Entity: Orange Health Care Center
Date of Visit: 4/23/19

An unannounced visit was made by a representative of the Facility Licensing and Investigation section of 4/23/19 for the purpose of reviewing the Plan of Correction for the violation letter dated 3/18/19 and 3/13/19

Staffing was reviewed for the period of 4/7/19 through 4/30/19 and met the minimum requirements of the regulations of the state agency.

Based on a tour of the facility, review of facility documentations and plan of correction education, inservices, audits, clinical record review and interviews violations number 1a, 2a, 3a, 4a, 5a. And 1a, 1b, 2 were identified as corrected.

As a result of this visit, No violations were issued.

+ Life Safety Code violations were corrected/KMP –

Marie Mathieu RN/NC