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

SEP 25 2007

IN RE: Connecticut Healthcare Inc. d/b/a
Seacrest Retirement Center
588 Ocean Avenue
West Haven, CT 06516

CONSENT AGREEMENT

WHEREAS, Connecticut Healthcare Inc. (hereinafter the "Licensee"), has been issued License No. 1794RCH to operate a Residential Care Home known as Seacrest Retirement Center, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on October 16, 2006 and concluding on November 9, 2006 and

WHEREAS, the Department, during the course of the aforementioned inspections violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies were identified in an amended violation letter dated January 30, 2007 (Exhibit A – copy attached); and

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

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Lewis Bower its Owner/President hereby stipulate and agree as follows:

1. Within thirty (30) days of the execution of this Consent Agreement the Person In Charge shall develop and/or review and revise, as necessary, policies and procedures related to care of the residents, communication mechanisms between staff and other health care entities providing services to residents, medication administration, including but not limited to self administration, resident rights and dignity, staff job descriptions, special diets, basic incontinent care, infection control procedures, resident transfers,

physician orders, including but not limited to implementation of physician orders, and recording of necessary resident information.

2. Within ten (10) business days of completion of the review and revision to the aforementioned policies and procedures all Facility staff shall be in-serviced to the policies and procedures identified in paragraph number one (1).
3. Effective upon the execution of this Consent Agreement, the Licensee, shall ensure substantial compliance with the following:
    a. Sufficient personnel are available to meet the needs of the residents;
    b. Residents are maintained, clean, comfortable and well groomed;
    c. Medications are administered as prescribed by the physician and by appropriately credentialed personnel;
    d. Physician orders for administration of PRN (as necessary) medication shall include but not be limited to specific instructions for the behavior and/or symptom targeted regarding PRN medication;
    e. Attendant assignments accurately reflect resident needs;
    f. The personal physician or covering physician is notified in a timely manner of any significant changes in resident condition;
    g. Necessary supervision and assistance to procure assistive devices when necessary; as directed by a practitioner with applicable statutory authority shall be provided to prevent accidents;
    h. A mechanism for communication is developed and implemented to ensure all necessary information is conveyed to meet the needs of the residents;
    i. Job descriptions and duties are reviewed and revised as appropriate and reviewed with each staff member to ensure that staff are providing the necessary care and services to the residents and within their scope of duties;
    j. Medications and necessary care items are obtained in a timely manner;
    k. Side rails or other devices that may be restraints shall not be used to keep a resident from voluntarily getting out of bed;
    l. Treatments and procedures including, but not limited to, blood glucose monitoring, pulse oximetry, and assessments are performed by appropriately credentialed personnel;
    m. Residents receive appropriate diets;
    n. Known resident allergies are documented, and communicated as necessary; and

o. Development of an orientation program for all new staff.

4. The Licensee shall establish a staff development program with in-service programs scheduled at least four (4) times a year.
5. The Licensee shall make provisions for all applicable staff that participate in medication administration, to complete a medication administration course in accordance with applicable state regulations.
6. The Licensee shall ensure that should the resident experience an episode resulting in acute care needs, such care will be provided by a licensed home health agency and/or any other appropriate service provider, as deemed appropriate by the resident's physician.
7. The Licensee shall notify the Department of any changes in personnel with regards to the Person In Charge.
8. Prior to the Licensee providing services to residents through an entity in which the Licensee has a financial interest, the resident and/or responsible party shall be provided the attached written "Notice to Clients, Families, and/or Responsible Parties Regarding Additional Services at Seacrest Retirement Center."
9. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department within said timeframe.
10. Within seven (7) business days of the execution of this Consent Agreement, the Licensee shall submit the name of the physician it proposes to engage to evaluate current residents. The Licensee shall engage the physician within seven (7) days of obtaining approval from the Department, and such physician shall evaluate each current resident to determine if the resident is appropriate for continued residence in the residential care home. An attestation statement (Appendix A – copy attached) shall be signed by the physician identifying the resident's current medications, an assessment of activities of daily living, ability to self-administer medications and additional physical and psychosocial needs. The physician shall identify that the resident is appropriate to reside in a residential care home.
11. The Licensee shall immediately issue discharge notices to current residents who are deemed by the physician to require care and services beyond those provided within the residential care home setting.

12. The Licensee shall obtain certification from each prospective resident's personal physician to verify that the physician has evaluated the prospective resident and determined that he or she is appropriate to reside in a residential care home.
13. The Licensee shall provide each current and prospective resident with an attestation statement (Appendix B - copy attached), which clearly identifies the services that are provided by a residential care home and the criteria for discharging from the facility.
14. The Licensee shall not provide services beyond the scope of a residential care home as defined in Section 19-13-D6.
15. The Licensee shall pay a monetary penalty to the Department in the amount of four thousand dollars ($4,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The money penalty and any reports required by this document shall be directed to:

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

16. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
17. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

18. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
19. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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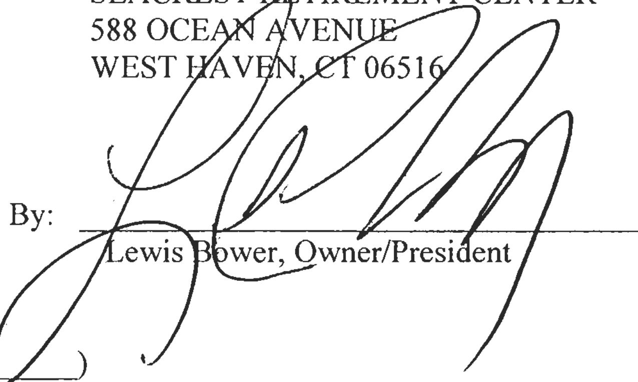
WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

CONNECTICUT HEALTHCARE, INC. d/b/a
SEACREST RETIREMENT CENTER
588 OCEAN AVENUE
WEST HAVEN, CT 06516



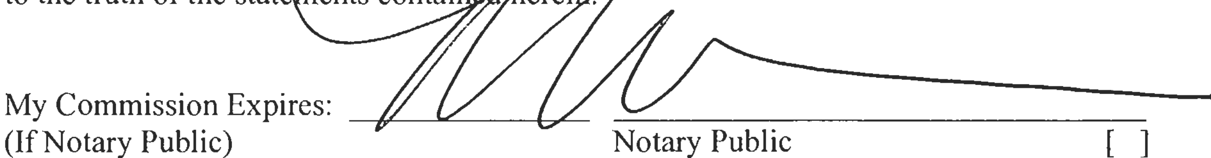
9/25/07
Date

By: ______________________
Lewis Bower, Owner/President

STATE OF Connecticut)

County of Hartford) ss Sept. 25, 2007

Personally appeared the above named Lewis Bower and made oath to the truth of the statements contained herein.

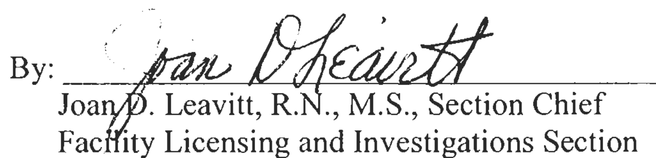


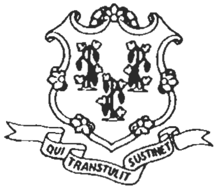
My Commission Expires: ______________
(If Notary Public)

Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [X]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

9/27/07
Date

By: 
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 9

Amended

January 30, 2007

Lewis Bower
Connecticut Health Care, Inc
588 Ocean Avenue
West Haven, CT 06516

Dear Mr. Bower:

This is an amended version of the violation letter dated December 6, 2006.

Unannounced visits were made to Seacrest Retirement Center on October 16, 25 and 30 and November 2 and 9, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting 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.

An office conference has been scheduled for December 7, 2006 at 1:30 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

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

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

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

CM

c: licensure file
CT5885, CT6099

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (a)Definitions(17) and/or (c) Administration (1) and/or (d) Medical supervision and/or (c)Administration(5).

1. Based on observation, interview and a review of facility documentation, services were being provided beyond the scope of a Residential Care Home and by staff that were were not qualified to conduct said service. The findings include:

   a. Resident #17 was treated in the Emergency Department (ED) on 10/25/06 for congestive heart failure/fluid overload. The discharge instructions identified that the resident was to be weighed daily in the morning, prior to taking his medications. For a weight under 140 pounds the resident was to receive 40 mg of furosemide. For a weight over 140 pounds the resident was to receive 80 mg of furosemide. Special instructions were for the resident to return to the ED for edema and/or shortness of breath. The Medication Administration Record (MAR) identified a physician's order dated 10/25/06, which directed the resident receive Diltiazem HCL 120 mg, by mouth daily. Instructions read hold if Blood Pressure less than 100 or Heart Rate less than 60. Observation on 11/2/06 at 8 AM identified that Resident #17 complained to Staff Member #1 that he could not breath. Staff Member #1 stated that she would call the resident's physician and proceded to weigh the resident, take a blood pressure (103/60), a pulse (94) and oxygen saturation level (94%). Staff member #1 was not qualified to carry out these functions.

   b. On 8/24/06 Resident #19 was receiving services from the visiting nurse as well as a private attendant for three hours daily. The home health nursing assessment dated 8/24/06 identified the resident had decubiti on both heels, Alzheimer's dementia, a history of aspiration pneumonia, angina, Chronic Obstructive Pulmonary Disease (COPD), myocardial infarction and hypertension. Additionally, the assessment identified Resident #19 was incontinent of bowel and bladder, experienced behavior problems at least daily, had contractures of the lower extremities, was legally blind and had functional limitation with hearing. The resident required a honey consistency thickened puree diet and was unable to feed himself. On 9/14/06 Resident #19 became unresponsive and was brought to the Emergency Department. Resident #19 was hydrated, received anti-biotic therapy and was discharged to the facility on 9/19/06. The hospital discharge summary dated 9/19/06 identified that the resident was back to his baseline physical status. Hospital documentation (W-10) identified that Resident #19 required total assistance with all activities of daily living, oxygen therapy, as needed and a puree diet. Resident #19 resumed services from the visiting nurse every three days for wound care (duoderm dressing change) to the left heel and assessment of the cardio-respiratory status. A memo of understanding between the home health agency and the facility identified that the facility was to provide 24 hour supervision, meals, room, board, assistance with feeding, administration of by mouth medications, and assistance with oxygen and nebulizer treatments. The Home Health Nurse's assessment dated 9/20/06 identified that the resident was unable to communicate. Physician orders dated 9/20/06 directed the resident to receive Duoneb 3 ml every 4 to 6 hours as needed via a nebulizer for wheezing. The MAR identified that Resident #19 received the nebulizer treatments daily on 9/19/06, 9/20/06 and 9/22/06 as well as three times on 9/24/06 for wheezing. On 9/25/06 Resident #19 was re-admitted to the hospital with the diagnosis of COPD exacerbation.

Plan of Correction | Completion date

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13 D6(c) Administration (4) and/or(a) Definitions(17) and/or (c)Administration(5). .

2. Based on reviews of the record, facility documentation and interview, the facility failed to ensure that sufficient and/or capable personnel provided care for the residents. The findings include:
a. Resident #3 was admitted to the facility on 5/8/04 with diagnoses that included diabetes, coronary artery disease, Alzheimer's Dementia, and joint pain. Resident #3 received services from a home health nurse several times a week for care to a stage two pressure area on her left buttocks. Observation on 10/30/06 identified the resident wearing incontinent briefs and the resident to be sitting on a foam ring. Further observations identified the right buttocks was discolored with pinpoint open areas on the left upper quadrant. On10/18/06, Person #2 stated that because Resident #3 was incontinent of urine and required incontinent care and the staff members were " very busy", Person #2 hired an "aide" to provide incontinent care. Facility documentation dated 10/18/06 identified, in part, that attendants were " to assist residents with dressing and toileting as needed." Facility documentation identified that Resident #3 received care twice daily, for 1/2 hour sessions from a private attendant with the cost incurred by the resident.
b. Resident #5 was admitted to the facility on 11/1/05 with diagnoses which included osteoarthritis. On 10/12/06 Resident #5 began receiving services from a home health nurse several times a week to care for a pressure area on her left buttocks. On 10/23/06 Person #5 stated that because Resident #5 was incontinent and used the call bell frequently for help with toileting and meals, the facility suggested that the family provide the resident with extra help. A private attendant provided care, four times a day for thirty-minute intervals. Interview with facility staff members identified that when a private attendant was not in place, Resident #5 received assistance with toileting every two hours. Observation on 10/25/06 at 12:20 PM identified Resident #5 to be in a wheel chair. Subsequent observations on 10/30/06 identified Resident #5 with multiple complaints of left buttocks pain. Resident #5 on 10/30/06 at 8:17 AM was observed to have a pressure sore on the buttocks, the right ankle and had reddened, boggy heels. On the left buttocks was an open area with drainage and black eschar measuring approximately 2.5 cm by 2.5 cm and 1 cm in depth. The right outer ankle was noted with an open area measuring approximately .8 cm by .8 cm surrounded by a golf ball size reddened area. Subsequently on 10/30/06 Resident #5 was admitted to the hospital for treatment of decubitus ulcer requiring debridement.
c. On 10/18/06 Attendant #4 identified that attendants were to assist residents with dressing and toileting. Observation on 11/2/06 at 6:35 AM identified Resident #10 sitting in a wheel chair wearing only a shirt and an incontinent brief. Resident #10 was disoriented to time and place. The staff moved the resident from his room and placed him in the hallway while they completed other tasks.
d. Facility documentation identified that Resident #10 was to have liquids thickened to honey consistency. On 11/2/06 at 8 AM in the dining room, Resident #10 was observed to be drinking coffee without the benefit of it being thickened. Attendant # 4 identified on 11 /2/06 that facility staff were expected to thicken Resident 10's liquids with premeasured packets of Thick-It.
e. Observation on 11/2/06 identified that Resident #11 was wheelchair bound and required total assistance for activities of daily living. Although Attendant #1 was Resident #11's private attendant on 11/2/06 from 7:30 AM to 8:30 AM, Attendant #1 was observed on 11/2/06 at 8:15 AM in the basement dining room feeding both Resident #11 and Resident #15. Attendant #1 stated on 11/2/06

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

that because the dining room sometimes became hectic, she "helped".

f. Observation on 11/2/06 at 7:40 AM identified Resident #11 to be totally dependant on staff for care with an indwelling urinary catheter in place. On 11/2/06 at 7:40 AM the drainage bag was noted to be resting on the floor. Attendant #1 was observed to empty urine from the bag holding the clamp and contaminating the bag. Subsequent observations on 11/2/06 identified, two attendants were observed to pull the resident from a supine to a sitting position by pulling his wrists. Resident #11 was non-weight bearing. The staff members were observed to lift the resident from the bed to the chair from under his arms and the back of his trousers. Subsequent to the transfer, Resident #11's urinary drainage bag was attached to the wheelchair in a position above the bladder.

g. Observation during a tour on 11/2/06 identified Resident #10 and #16 to have oxygen at their bedside. Resident #10 and #16's nasal cannulas were noted to be on the floor.

Plan of Correction | Completion date

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4) (A) and/or (c)Administration(5).

3. Based on observation, interview and a review of facility documentation, the facility failed to provide documentation that care attendants were informed of their duties and responsibilities. The findings include:

   a. A review of personnel files failed to identify a written job description for care attendants. In a written statement Care Manager #1 identified that although the facility did not have a written job description, during orientation the manager reviews the job responsibilities with each care attendant. The duties, in part, included to direct residents to meals and activities, assist with

dressing and toileting, make resident beds, provide towels and soap, follow posted shower schedules, and report any changes in residents' condition to the Care Coordinator immediately. Observations on 10/16, 10/25, 10/30 and 11/2/06 identified multiple residents who were disoriented to time, place and person, were non-ambulatory and dependant on staff members for activities of daily living. There was no mechanism in place to communicate the resident's needs to the staff.

Plan of Correction | Completion date

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5) and/or (c)Administration(5).

4. Based on interviews and reviews of facility and hospital documentation, the facility failed to ensure a safe environment by providing appropriate supervision. The findings include:
   a. Resident #1 was admitted to the facility on 6/9/06 and had diagnoses of dementia with behavioral disturbances and hearing loss. On 8/5/06, subsequent to aggressive behaviors i.e. hair pulling, wandering into other resident's rooms and multiple elopement attempts, Resident #1 was sent to the Emergency Department for evaluation. It was determined that the resident did not require hospitalization and was not a threat to herself and/or others. Resident #1's medications were adjusted and the resident returned to the facility on 8/9/06 at 10:30 am. Psychiatrist #1 identified on 10/18/06 that she had conversations with Person #2 and the facility staff regarding Resident #1's requirement for a higher level of care. Psychiatrist #1 identified that Person #2 refused placement elsewhere and agreed that the resident would remain at the facility with a twenty-four hour private attendant and a wander guard. On 8/9/06 at 3 PM, the resident left the building and walked into the parking lot. Facility documentation and interview identified that the door did not malfunction rather the client leaned on the emergency egress function and the door properly released as it was designed to do. Although Psychiatrist #1 identified the resident could remain at the facility with a 24 hour a day private attendant, evidence was lacking that a 24 hour attendant was provided.

Plan of Correction | Completion date

EXHIBIT A

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m)Administration of Medications(2)(D)(i) and/or (ii)(IX) and/or (c)Administration(5).

5. Based on interview, observation and a review of facility documentation, the facility failed to ensure that medication was administered as directed by the physician, and/or failed to ensure that specific instructions regarding how the medication was to be given was identified. The findings include:
   a. On 6/09/06 Resident #1's Medication Administration Record (MAR) had a physician's order that read: Risperdal 2 mg tablet one table by mouth every six hours as needed for agitation, part of 2.5 mg dose and Risperdal 0.5 mg tablet one tablet by mouth every six hours as needed for agitation, part of 2.5 mg dose. An additional order identified the resident was to receive Haloperidol 0.5 mg by mouth every six hours as needed for agitation. The orders did not clearly identify clear and specific parameters for either medication to be administered. The MAR identified that from 7/5/06 through 7/10/06 Resident #1 did not receive Risperdal as directed. The MAR identified that Resident #1 received Risperdal 2 mg. on 7/6/06 at 4 PM, on 7/6/06 at 10: 30 PM, and on 7/7/06 at 3 PM and 9:30 PM. On 7/10/06 at 12 midnight Resident #1 received only 0.5 mg of Risperdal. During interviews, staff were unable to identify why the medication was administered as it was.
   b. Facility documentation dated 7/26/06 identified a physician's order for Resident #1 to receive Seroquel 25 mg one tablet by mouth as needed. Although the order failed to specify the time interval and/or targeted behavior, Seroquel was administered for wandering and/or pacing on 7/26/06 at 8 PM, 7/27/06 at 8 am, 7/27/06 at 8 PM and on 7/28/06 at 10 am.
   c. Resident #7 had a physician order dated 10/20/06 which directed the resident receive Risperdal 0.5 mg every four hours as needed for wandering. A review of the Medication Administration Record (MAR) identified that from 10/20/06 through 10/24/06 Resident #7 received Risperdal 0.5 mg on eight occasions for behaviors other the wandering, i.e. agitation.
   d. Resident #8 had a physician's order dated 8/23/06, which directed the resident receive Zyprexa 5mg as needed every four hours. The orders did not address targeted behaviors. Subsequently, on 10/18/06 at 5 PM Resident #8 received Zyprexa 5 mg for wandering.
   e. Resident #9 had physician's orders, which directed the resident receive Alprazolam 25 mg one tablet by mouth every four hours and/or daily as needed. The physician's order did not specify a time frame and/or a targeted behavior and subsequently from 10/01/06 through 10/24/06, Resident #9 received the medication for "anxiety" and/or "nerves" on six occasions.

   f. Resident #20 was admitted to the facility on 10/25/06 with diagnoses that included urosepsis, urinary tract infection and chronic dementia. The resident was described as alert but confused and continent of bowel and bladder. Interviews with facility staff identified that from 10/25/06 through 11/04/06 Resident #20 had escalating aggressive behaviors, (i.e. attempting to stab an employee, hitting, spitting). On 10/26/06 a physician's order directed Risperdal 0.5mg every four hours as needed for screaming, not to exceed three doses daily. From 10/25/06 through 10/31/06 Resident #20 was assessed by facility staff to present with screaming behaviors and received Risperdal 0.5mg on ten occasions. The Medication Administration Record (MAR) listed assessments performed by facility staff that the medication was ineffective. Person #5 identified that while visiting on Monday 10/30/06 he noted Resident #20 to be extremely lethargic, only opening her eyes briefly in response to his questions and be incontinent of stool. Subsequently ,the Psychiatist (MD #2) was contacted. MD #2 identified that on 10/31/06,the resident was noted to be lethargic and the Risperdal dose was decreased to 0.25 mg twice a day. However, these directions were not clearly

conveyed to the facility. Subsequently on 10/31/06 at 1pm and 7 pm Resident #20 received Risperdal 0.5 mg for screaming behaviors as well as Risperdal 0.25 mg at 7 AM and 5 PM. The physician's order did not clearly identify specific instructions for administering the medication. A physician's order dated 11/2/06 directed to hold the Risperdal. On 11/04/06 the resident was admitted to the hospital due to increased lethargy.

Plan of Correction Completion date

The following is a violation of the Connecticut General Statues Sec 19a-550 (b) (8) and/or (c)Administration(5).

6. Based on observation and interview, the facility utilized physical restaints. The findings include:
   a. Observation on 11/2/06 from 5:45 AM through 7 AM identified Resident #15 to occupy a bed that was against a wall and with the outer side rail in place. Observation of Resident #15 during breakfast identified the resident to be confused and required assistance with his meal. Attendant #1 stated that residents routinely used side rails. An interview with the Attendant#1 on 11/3/06 failed to identify a physician's order and/or an assessment for the use of a side rail. She stated that the use of side rails was a resident preference and used to maintain resident safety.

Plan of Correction Completion date

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of medications (2) and/or (c)Administration(5).

7. Based on observation and review of facility documentation, the facility failed to ensure that medications were administered by qualified individuals. The findings include:
   a. Resident #18's diagnoses included diabetes. Resident #18 received services from a home

health agency every two weeks to prepare insulin syringes. The home health nursing assessment dated 9/29/06 identified the resident was incontinent, had a memory deficit and impaired decision making and required assistance with dressing and bathing. Interview on 11/2/06 at 6:53 AM with Resident #18 identified she was unable to orient to the time or place. Resident #18 identified Attendant #3 as her "nurse". The Medication Administration Record (MAR) identified a physician's order dated 9/21/06 which directed " Novolin N 100/ml unit, 12 units subcutaneously every morning, rotate sites, may self-administer". Observation on 11/2/06 at 6:53 AM identified Attendant #3 provided Resident #18 with assistance in monitoring her blood glucose levels by placing her hands over the resident's hand to accomplish the procedure. Resident #18's blood glucose reading was 36. Attendant #3 asked the resident how she was feeling. The resident replied " yea, ok". Attendant #3 stated that sometimes because the blood sample was not of sufficient quantity, the readings were not accurate. Attendant #3 then assisted the resident to retake the blood glucose. The repeated reading was 144. Resident #18's hand was visibly shaking and required two attempts to pierce the skin. Although Resident #18 made several attempts, Resident #18 was unable to depress the plunger to administer the medication. Attendant #3 was observed to place her finger over Resident #18's finger, which was on the plunger, and push, administering the insulin. On 10/30/06 posted in the medication room was a memo which stated "3rd shift staff will still do blood sugar testing and give insulin from 5:30 AM-6 AM ". The memo listed residents requiring insulin and blood glucose testing inclusive of Resident #18.

Plan of Correction | Completion date

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(E)(ii)(V) and/or (VI) and/or (c)Administration(5).

8. Based on review of facility documentation, documentation was lacking that medications were administered as directed. The findings include:

   a. Resident #2 had current physician's orders, which directed the resident, receive fludrocortisone 0.1 mg by mouth on Tuesday and Thursdays. Documentation was lacking that the medication was administered on 10/05/06.

EXHIBIT A

b. Resident #3 had current physician's orders, which directed the resident receive Actonel 35 mg weekly, one tablet by mouth. Documentation was lacking that the medication was administered on 10/14/06.

c. Resident #6 had current physician's orders, which directed the resident receive Actonel 35mg weekly, one tablet by mouth. Documentation was lacking that the medication was administered on 10/14/06.

Plan of Correction | Completion date

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (m)Aministration of Medications (2)(D)(ii)(VIII) and/or (c)Administration(5).

9. Based on review of facility documentation, the physician's orders lacked a listing of the resident's allergies. The findings include:

   a. Resident #2 was readmitted to the facility on 9/9/06 with an interagency referral report, which identified the resident had drug allergies of penicillin, Benadryl and Keflex. Facility documentation (the Medication Administration Record and the admission record) only identified that the resident was allergic to penicillin.

Plan of Correction | Completion date

Provider/Representative | Title | Date

NOTICE TO CLIENTS, FAMILIES, AND/OR RESPONSIBLE PARTIES
REGARDING ADDITIONAL SERVICES AT
SEACREST RETIRMENT CENTER

Seacrest is a residential care home that provides facilities and personnel to furnish food, shelter, laundry and services of a personal nature that do not require the training or skills of a licensed nurse. Services of a personal nature covered by the daily rate include assistance with bathing and dressing, preparation of special diets, and the supervision and/or administration of medications.

A client, family member, or responsible party may, in their discretion, contract with another party, such as a care and companion agency or a home health care agency, for additional services. . These services may be obtained from any provider that maintains appropriate insurance and performs criminal background checks.

Please be aware that Medicare will cover certain services provided by a certified home health care agency in a residential care home. We recommend that you investigate the availability of those services through a Medicare certified home health agency. Those services must be ordered by a physician and would include skilled nursing visits, therapy services, and home health aides. .

If you choose to contract with Keep Me Home, a care and companion agency, please be advised that the same parties own this entity as Seacrest Retirement Center. Keep Me Home does not provide any services that would be covered under Medicare. You are absolutely under no obligation to contract with Keep Me Home.

Acknowledged:

____

Please print your name here: __________________________
(If you are signing on behalf of a resident, please state below your relationship to the resident –e.g. conservator, health care representative, attorney-in-fact or family member)

____

Date: ___________

APPENDIX "A"

I certify the following regarding: Date:_______________

____
Name of Resident

[ ] This individual must be transferred to a nursing home.

[ ] This individual can remain at Seacrest if the services are of short duration and are provided by a licensed home health care agency.

[ ] This individual can remain at Seacrest if services are not required beyond food, shelter and laundry and services of a personal nature which do not require the training or skills of a licensed nurse.

[ ] This individual must be transferred to another type of health care institution which has services necessary to monitor_________________.

Please identify the specific nursing/medical needs of the individual, if any.

Rationale for Determination____

____
(Name of Resident)

Signed____________________________________, M.D.

CT. Licensee: ______________________________

____
Address
____

____
Date

Appendix B

Scope of Practice of a Residential Care Home

A Residential Care Home is defined as "an institution that is licensed pursuant to section 19a-490(c) of the Connecticut General Statutes having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition, provide services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision of medications which are self-administered, or the administration of medications pursuant to subsection 19-13-D6 (m)(2) of the Regulations of Connecticut State Agencies."

Should a resident have an episode resulting in acute care needs or experience a change in condition requiring the services of a licensed nurse the services must be provided by a licensed home health agency. The Residential Care Home must ensure that the resident is re-assessed for residential care home level of care.

I have read and understand the above and acknowledge that at some point in time, the care and services offered in a residential care home may not be sufficient to meet my health care needs necessitating transfer to another type of healthcare facility.

____
Resident

____
Responsible Party