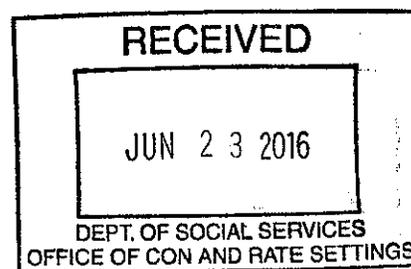


Paradigm Healthcare Center of South Windsor, LLC
Certificate of Need Application
Nursing Facility Closure



June 21, 2016

Paradigm Healthcare Center of South Windsor, LLC
Certificate of Need Application

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State of Connecticut - Department of Social Services

Office of CON & Rate Setting

55 Farmington Avenue

Hartford, CT 06106-5033

APPLICATION FOR CERTIFICATE OF NEED

AFFIDAVIT

APPLICANT: Paradigm Healthcare Center of South Windsor, LLC

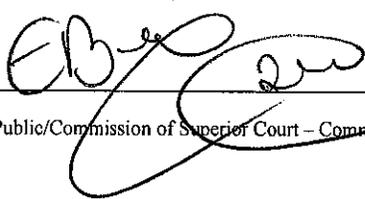
PROJECT TITLE: Nursing Facility Closure

I, Scott Ziskin, Member, of Paradigm Management, LLC being duly sworn, deposes and states that the information in this Certificate of Need Application Entitled, "Nursing Facility Renovation" is accurate and correct to the best of my knowledge.

Signature:  _____

Title: Member

Subscribed and sworn to before me on 6/23/2016
Date



My Commission Expires
January 31, 2019
Notary Public/Commission of Superior Court - Commission expires

Department of Social Services - Certificate of Need Application

1. Please include a copy of your Letter of Intent for a Certificate of Need.

A copy of the Letter of Intent is included in Attachment I.

2. Please complete Attachment II - Certificate of Need General Information.

The completed Certificate of Need General Information form is designated as Attachment II.

3. Provide a narrative summary of the reasons for your request to reduce licensed beds and the termination of all nursing facility services (facility closure).

Paradigm Healthcare Center of South Windsor, LLC (South Windsor) is seeking closure based on the fact that excess bed capacity in the market has and will continue to limit its ability to achieve a sufficient census necessary to maintain operations. As indicated below, the average census at South Windsor has been below 90% for the past four out of five years with a gradual decrease in the last three years. Generally, facility occupancy below 90% results in inefficiencies in operations.

<u>Cost Year</u>	<u>Average Census</u>	<u>Occupancy Percentage</u>
2012	87	87%
2013	91	91%
2014	87	87%
2015	79	79%
2016*	64	64%

**Based on internal census for May 2016 (Attachment VIII)*

Based on a nursing facility occupancy survey conducted by the Department of Social Services (DSS) during February 2016, identified an occupancy rate of 86.88% and 239 vacancies in the twelve facilities located within the immediate service area of Paradigm Healthcare Center of South Windsor, LLC (See attachment IV).

DSS Occupancy Survey (Attachment IV)

<u>No. of Facilities</u>	<u>Beds</u>	<u>Filled</u>	<u>Vacant</u>	<u>% Occupied</u>
12	1,821	1,582	239	86.88%

Paradigm Healthcare of South Windsor has incurred significant financial losses over the past several years due to low census and high Medicaid utilization. As of May 31, 2016, the facility only had an occupancy of 64% and an actual census of 64 residents. This calculates to more than 30% of the facilities beds not being utilized.

Additionally, the facility is significantly dependent on Medicaid per-diem revenue. The over simplified analysis below illustrates an under payment of \$481.68 PPD between the estimated allowable costs and Medicaid reimbursement rate. The Medicaid rate currently represents over 82% of the facility's revenue.

Estimated Allowable Costs PPD vs. Current Medicaid Rate

Estimated Allowable Costs	\$706.27
Current Medicaid Rate	<u>224.59</u>
Blended Amount PPD	<u>\$481.68</u>

- 4. Describe any relationship between this request and the facility's historical, current and future utilization statistics. Describe the current and projected payer mix of patients (% private, % Medicaid, % Medicare, etc.) at the facility. Identify facility bed configuration by floor pre and post project including the number of rooms and type of room (private, semi-private, etc.).**

As indicated in our response to question #2, the occupancy rate at Paradigm Healthcare Center of South Windsor has been below 90% for the past four of five years. This section includes summary information relating to payor mix for the periods between 2012 and 2015. Closure of the facility is expected to take place on September 30, 2016.

According to the statistics below, Paradigm Healthcare Center of South Windsor, LLC continually has an increasing Medicaid payor mix from 2012 to 2014. Cost year 2015 displays a decrease which is due to the overall occupancy dropping 8% from 2014 to 2015.

Payer Mix Percentages*

<u>Payer</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>
Medicaid	80.4%	82.3%	84.5%	83.8%
Medicare	13.2%	12.2%	11.7%	11.4%
Private	6.4%	5.5%	3.0%	4.0%
Other	0.0%	0.0%	0.8%	0.8%

**Per applicable Medicaid cost report filing*

Facility Bed Configuration

	<u>Private Rooms</u>	<u>Semi-Private</u>	<u>Triple</u>	<u>Total Beds</u>
Current	12	88	0	100
Project Completion	0	0	0	0

- 5. Quantify the current financial condition of the facility including the impact, if any, of this request on the Facility's rates (please provide support).**

The current financial condition of Paradigm Healthcare Center of South Windsor, LLC is poor. The facility had a loss of \$492,500 for the year ended September 30, 2015. The current payor mix and occupancy contributes to their loss. Their projected loss for the time period during the closing period of May 26 through September 30, 2016 is calculated to be \$1,540,262 (See attachment V). This does not include the loss from the period of October 1, 2015 through May 25, 2016.

Paradigm Healthcare Center of South Windsor's Financial Results

<u>Cost Year</u>	<u>Profit/(Loss)</u>
2012	(\$200,665)
2013	(\$46,069)
2014	(\$249,185)
2015	(\$492,500)
Est. 2016*	(\$1,540,262)

**Loss only covers 5/26/2016 – 9/30/2016*

Facility Closing Rate Analysis

During the closing period it is essential for Paradigm Healthcare Center of South Windsor, LLC to receive a close down rate of approximately \$706.27 per day (See attachment VI). This rate will help avoid any further deterioration of the financial condition of the facility that may adversely affect resident care and continued operations of the facility.

Close Down Rate Calculation

Total Allowable Expenses	\$1,760,917
Resident Days	<u>2,655</u>
Blended Amount PPD	\$ 663.25
Est. Fair Rent PPD	<u>43.02</u>
Requested Closure Rate	\$ 706.27*

**The above requested rate was calculated assuming waivers of all caps and waiver of minimum census*

- 6. Explain how this proposal will impact the quality, cost effectiveness, and accessibility of health care delivery in the area. Document the public need or lack of need for this request.**

The closure of Paradigm Healthcare Center of South Windsor, LLC will reduce the nursing facility service options available to individuals residing in the area. Due to the adequate availability of nursing facility beds in the immediate service area (See attachment IV), individuals requiring rehabilitation or long-term care will continue to have access to these necessary services and will meet the needs of the surrounding area.

- 7. Provide a synopsis, including dates, of major facility building renovations, new construction and physical plant/capital improvements.**

N/A – This is a facility closure CON.

- 8. Provide any available estimates of the cost to renovate the facility to current codes.**

N/A – This is a facility closure CON.

9. Describe the changes required to each department or functional area to comply with current health and safety requirements including the condition of electrical and mechanical systems including changes in fire alarm systems, nurse call systems, air conditioning, lighting, furnishings and wall, floor and ceiling finishes.

N/A – This is a facility closure CON.

10. Provide evidence of the cost and required changes including securing necessary financing at reasonable costs to meet capital costs and operating expenses.

N/A – This is a facility closure CON.

11. Specifically address current compliance with codes governing handicapped accessibility including ADA and improvements that will be made to comply with ADA requirements.

N/A – This is a facility closure CON.

12. Please describe the effect of this proposed change on the facility's current residents.

The effect of the facility closure on the current residents would require the remaining resident population to relocate to another nursing facility or find a care alternative to what Paradigm Healthcare Center of South Windsor is currently providing. Based upon available bed capacity within the surrounding communities, we believe this not to be an issue.

13. Is there a clear public need for this request? Provide the following information:

- a. The areas to be served (preferably by town),

The main area to be served are towns within Hartford County. The main towns that are to be served are the following; East Hartford, East Windsor, Manchester, Vernon and Windsor. See attachment IV.

- b. The incidence and prevalence of the medical conditions to be treated within the areas to be served,

Please refer to questions #3.

- c. The number of individuals within the service areas that need the service(s) proposed and the length of time that they will need such services,

The number of individuals requiring care within the service area will remain consistent and while being able to be serviced by the remaining providers. The

average length of stay as of September 30, 2015 for short-term and long-term rehabilitation approximates 302.37 days.

- d. **All other providers within the service areas providing the type of services being proposed and statistics on the utilization of such services compared to the capacity of such services,**

See Attachment IV that includes a listing of nursing facilities in the service area and occupancy data received from DSS as of February 2016.

- e. **Alternative less costly means of meeting the service needs of the population to be served.**

The monies received from these residents will follow them to other facilities in the service area which have an adequate number of vacant beds. Furthermore, the community home care waiver programs are designed to provide lower cost alternatives to nursing facility care.

14. Identify any other factor that the Department should consider in determining whether this request will be granted, modified or denied. Provide supporting documentation.

As stated previously, the occupancy percentages of the contiguous nursing facilities and Paradigm Healthcare Center of South Windsor, LLC are on average below 90% (See Attachment IV). The closure of this facility will prevent future increasing financial loss to the facility, while increasing occupancy for contiguous nursing facilities. Please see the attached current survey (See Attachment VII) from the Department of Health and Human Services.

Attachment I

HEATHER OVERHOLSER BERCHEM
203.772.7728 DIRECT TELEPHONE
860.240.5728 DIRECT FACSIMILE
HBERCHEM@MURTHALAW.COM

May 26, 2016

VIA FIRST CLASS MAIL

Roderick L. Bremby
Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Re: Letter of Intent to Close Paradigm Healthcare Center of South Windsor

Dear Commissioner Bremby:

Pursuant to the provisions of Conn. Gen. Stat. 17b-352, this Letter of Intent is filed on behalf of Paradigm Healthcare Center of South Windsor ("South Windsor"). South Windsor hereby requests permission to terminate services at this 100 bed facility located at 1060 Main Street, South Windsor, Connecticut. There are no capital costs associated with this request.

As you are aware, South Windsor, which is owned by Paradigm Healthcare Development, LLC ("Paradigm") has sustained consistent operating losses for a prolonged period of time. These losses have created large vendor and lender debt obligations that the facility is unable to satisfy given its current operating performance. Although licensed for 100 beds, the current occupancy is only 65 residents with no expectation that this number will increase to any significant degree. South Windsor is further burdened by the recent transfer of Paradigm's other five facilities which has created additional strain on its existing vendor relationships. Compounding these financial and operational issues, South Windsor has significant physical plant and structural issues that will require substantial renovations to bring it into compliance with applicable nursing home regulations. These factors, combined with the high Medicaid population and the significant increase in the Medicaid rate that would be required for financial viability, all indicate that closing the facility at this time is both appropriate and necessary. All of these factors indicate that closing the facility at this time is in the best interest of our residents and their families. According to the Department of Social Services, there is more than adequate bed capacity in surrounding communities to assure the availability of ongoing care for South Windsor's current residents.

7053444v1

Roderick L. Bremby
Commissioner
May 26, 2016
Page 2

Please forward at your earliest convenience CON application forms and instructions to my attention. South Windsor will cease admissions of residents to the facility immediately upon filing of this letter. Involuntary Discharge planning and involuntary discharges will not begin until a Certificate of Need to terminate services is issued by the Department.

If you have any questions or if you require any additional information, please call me at (203) 772-7728.

Sincerely,



Heather Overholser Berchem

cc: Christopher LaVigne, Director CON and Rate Setting, DSS (via email)
Kathy Shaughnessey, DSS (via email)
Nancy B. Shaffer, Long Term Care Ombudsman
Barbara Cass, Section Chief, FLIS, DPH (via email and mail)

Attachment II

General Information

I. General Information

A. Identification of Applicant

1. Specify the Name and Address of the Applicant

Applicant Name:	Paradigm Healthcare Center of South Windsor, LLC
Address 1:	1060 Main Street
Address 2:	
City, State, Zip Code:	South Windsor, CT 06074

2. Specify the Name, Title, Address and Telephone Number of the Contact Person for this Application. The contact person shall be the person to whom all communications are directed.

Name:	Scott L. Ziskin
Title:	Member
Business Address:	130 South Main Street, Suite 203
City, State, Zip Code:	Thomaston, CT 06787
Telephone Number:	(860) 335-6475
Email Address:	sziskin@paradigmhd.com
Fax Number:	N/A

3. Specify the Name, Title, Address and Telephone Number of another person who may be contacted regarding this application, in the event that the contact person specified above is not available.

Name:	Matthew S. Bovolack
Title:	Principal
Business Address:	555 Long Wharf Drive
City, State, Zip Code:	New Haven, CT 06511
Telephone Number:	(203) 781-9600
Email Address:	matthew.bovolack@marcumllp.com
Fax Number:	(203) 781-9601

4. Specify existing (E) and/or proposed (P), Department of Health Services licensure categories.

If the applicant is an existing facility, provide the following information where appropriate:

- Number of licensed beds, by licensure category:
- Primary service area (specify basis for derivation and identify geographic area encompassed, by town.

(Select all that Apply)

"X"	Facility Type/Licensing Category	(E) and/or (P)	Licensed Beds	Service Area
	Home for the Aged			
	Rest Home with Nursing Supervision (RHNS)			
X	Chronic and Convalescent Nursing Home (CCNH)	(E)	100	Hartford County
	Other, specify:			
	Other, specify:			

B. Type of Application

1. Specify if a new or additional function(s) or service(s), and/or a termination of a function or service and/or a capital expenditure exceeding statutory thresholds for review, is being proposed: **CCNH Closure/Bed Reduction Authorization**

"X"	Type of Application	Filing Fee Required
	New or Additional Function(s) or Service(s) Including staff expansion proposed by coordination, assessment, and monitoring ("CAM") agencies.	No
	Termination of Service(s);	No
	Capital Expenditures: (*see definition)	
	Major Medical Equipment, exceed statutory thresholds;	Yes
	Other Capital Expenditure, exceeding statutory thresholds	Yes
	Imaging Equipment, exceeding statutory thresholds;	Yes
X	Facility Licensed Bed Reduction from <u>100</u> to <u>0</u> Licensed Beds	No
X	Other, specify: Facility Closure	No

NOTE - Conversion to different licensure categories should be reported as a termination of service and also as an introduction of an additional function or service.

2. Specify the total amount of capital expenditures proposed:

<i>Proposed Capital Expenditures:</i> *	N/A – Closure CON	**
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* Capital Expenditures: The total of all expenditures or proposed expenditures for the acquisition, installation and initial operation of items which at the time of acquisition, have an estimated useful life of at least three years and a purchase price of at least \$500 for groups of related items, which are capitalized under generally accepted accounting principles. Such items shall include but not be limited to the following.

**Should agree with page 5, Total Proposed Capital Expenditures.

- a. Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto.
- b. The total cost of all studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquisition, improvement, expansion or replacement of physical plant or equipment or both in question, when such total costs in aggregate exceed \$50,000.
- c. Lease assets. Purchase price for leased assets, including equipment, land and/or building(s), shall be the fair market value at lease inception.
- d. Maintenance expenditures capitalized in accordance with generally accepted accounting principles.
- e. Donated assets: Donations of property and equipment which under generally accepted accounting principles, are capitalized at the fair market value at the date of contribution.

C. Proposed Capital Expenditures and Funding Sources – N/A to a Closure CON

1. Itemize all anticipated capital expenditures related to the proposal, as follows:

	Itemized Capital Expenditure Category	Amount
A	Total Building Work Costs	\$ 0
B	Total Site Work Costs	\$ 0
C	Total Off-Site Works Costs	\$ 0
D	Total Construction Costs	\$ 0
E	Fixed Equipment	\$ 0
F	Movable Equipment	\$ 0
G	Architectural & Engineering Costs	\$ 0
H	Land (use fair market value, if leased)	\$ 0
I	Building(s)(use fair market value, if leased)	\$ 0
J	Contingency Costs	\$ 0
K	CON Application Preparation	\$ 0
L	Other Costs (specify)	\$ 0

	Total Proposed Capital Expenditures:	\$ 0
M	Financing Fees (specify)	\$ 0
N	Construction Period Interest	\$ 0
O	<i>Total Capitalized Financing Costs</i>	\$ 0
	Total Proposed Capital Expenditures, which include Capitalized Financing Costs	\$ 0
	Total Renovation/New Construction Square Feet	0 / 0
	Cost Per Square Foot Renovation/New Construction	\$ 0 / \$ 0
	Cost Per Bed	\$0
	Year Facility was Built	N/A

* Include an itemized listing of equipment acquisitions identifying the amount of the proposed capital expenditure for each item. Major medical equipment acquisitions exceeding statutory thresholds, as well as any capital expenditures regardless of amount which result in a new or expanded service, should be listed separately and identified with a new or expanded service, where appropriate.

2. Itemize the anticipated proposed funding sources to be used in order to finance the proposed capital expenditures:

<i>Anticipated Funding Source</i>	Amount
Equity Contribution	\$ 0
Debt Financing – 100%	\$ 0
Lease Financing	\$ 0
Other (Specify):	\$ 0
<i>Total Proposed Funding Sources</i>	\$ 0

D. Ownership

For new facilities complete the following items. For existing facilities, submit the most recent copy of the Disclosure Statement of Ownership and Operation, Part I, and complete pertinent sections of 1 through 5d if required information is not included in the Disclosure Statement. All applicants must submit a Certificate of Incorporation or a Certificate of Partnership.

1a: Ownership- (Existing Facility)

Name of Facility:	Paradigm Healthcare Center of South Windsor, LLC
Doing Business As:	
Address 1:	1060 Main Street
Address 2:	
City, State, Zip Code:	South Windsor, CT 06074
Contact Person:	Scott L. Ziskin

Title:	Member
Telephone Number:	(860) 335-6475
Fax Number:	N/A

2a: Type of Facility/Bed Configuration/Payer Mix/Utilization Statistics

Type of Facility	Licensed Bed Capacity	Census	Date of Census
Chronic and Convalescent Nursing Home	100	64	5/31/2016
Rest Home with Nursing Supervision			
Home for the Aged-Licensed Bed Capacity			
Chronic Disease Hospital-Licensed Capacity			
Bed Configuration	Private	Semi Private	3 bedrooms
Current Number of Rooms / Beds	12 / 12	44 / 88	0 / 0
Proposed Number of Rooms / Beds	00 / 00	00 / 00	0 / 0
Payer Mix	Medicaid %	Medicare %	Private %
Current (May 31, 2016)	83%	8%	9%
Anticipated	0%	0%	0%
Utilization Statistics	9/30/2015	5/31/2016	Anticipated
Occupancy Percentage	78.7%	64.0%	00.0%

2b. Form of Ownership (Choose One)

"X"	<i>Ownership Type</i>	"X"	Ownership Type
	Sole Proprietorship		Profit Corporation
	General Partnership		Professional Corporation
	Limited Partnership		Non-Profit Corporation
	Municipality		Joint Venture
	Other (Specify):	X	Limited Liability Corporation (LLC)

2c. Owner(s) of Facility - Please list in descending order ownership share. Also include associates, incorporators, directors and sponsors.

Name & Address	Business Phone	Ownership Phone
Stephen LeGault	(860) 335-6858	(860) 335-6858
Scott L. Ziskin	(860) 335-6475	(860) 335-6475
Charles D. Bizilj	(860) 335-0588	(860) 335-0588

2d. If an above owner is a corporation or partnership or if the facility is operated by a corporation or partnership under a contract, identify the following related to owners or beneficial owners of ten percent (10%) or more of the stock of that corporation or for each general or limited partner of that partnership.

Name & Address	Business Phone	Ownership % *	Type **
Scott L.Ziskin***	(860) 335-6475	33.33%	General
Stephen LeGault	(860) 335-6858	33.33%	General
Charles D. Bizilj	(860) 335-0588	33.33%	General

*List in descending order by ownership share

**Indicate general or limited

***Please contact ONLY Scott Ziskin with any questions about the closure CON

3a. Administrator of Facility - Individuals and/or contracted management company.

Name & Address	Title	Business Phone
Tracy B. Newport 1060 Main Street, South Windsor, CT 06074	Administrator	(860) 913-7911

3b. If a management company has been contracted to manage the day-to-day operations, identify them and specify their responsibilities in relation to those of the owner(s) and/or operators. **The facility utilizes Paradigm Management, LLC as their management company providing administrative and back office support.**

4a. Land Information

Identify who holds the record title of the land on which the facility is located

Land Title Holder Name:	Continuing Care of South Windsor, Inc.
Address 1:	13 Riverwalk
Address 2:	
City, State, Zip Code:	Branford, CT 06405

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the landowner in the facility and the policy-making responsibilities as related to the facility's owners. **Paradigm Healthcare Center of South Windsor, LLC rents the building from a non-related party.**

4b. Building Information

Identify who holds the record title of the building in which the facility is located.

Building Title Holder Name:	Continuing Care of South Windsor, Inc.
Address 1:	13 Riverwalk
Address 2:	
City, State, Zip Code:	Branford, CT 06405

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners. **Paradigm Healthcare Center of South Windsor, LLC rents the building from a non-related party.**

4c. Equipment Information

Note: Complete separate page for each owner of the Facility's equipment. Identify who holds title to the equipment of the facility.

Equipment Title Holder Name:	Paradigm Healthcare Center of South Windsor, LLC
Address 1:	1060 Main Street
Address 2:	
City, State, Zip Code:	South Windsor, CT 06074

List all the equipment to which the owner holds title. If the facility or specified owner holds title to all equipment, indicate "All".

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners. **Paradigm Healthcare Center of South Windsor, LLC owns the equipment inside the building.**

5a. Submit the organization chart and a chart of legal corporate structure which identifies any relationship or affiliation with any parent or hold company, subsidiary of the facility and subsidiary of a parent or holding company.

See Attachment III.

5b. For each entity identified in 5a, above, identify:

Entity 1: **Not Applicable**

Name & Address:	
Form of Ownership:	

Ownership Interest in Facility:	
Type of Business Activity:	
Ownership Type:	

Entity 2: Not Applicable

Name & Address:	
Form of Ownership:	
Ownership Interest in Facility:	
Type of Business Activity:	
Ownership Type:	

Also indicate profit or non-for-profit.

II. Project Description

A. Summary

Provide a summary or overview of the project that includes the principal reason why the application should be approved.

See responses to CON Questions 1 through 14. (Applicant Pages 4-9)

B. Linkages

Where the proposed service is intended as a regional resource or where other providers of care are integral to ensure an effective continuum of care, provide evidence of existing or proposed agreements/understandings with these providers.

Not applicable to a Closure CON

Attachment III

Attachment IV

**Contiguous Towns
Occupancy & Available Capacity**

<u>Facility</u>	<u>License Type</u>	<u>Bed Capacity</u>	<u>Town</u>	<u>Count</u>	<u>Hold</u>	<u>Total</u>	<u>Date</u>	<u>Open Beds</u>	<u>Occup. Rate</u>
Greensprings Healthcare and Rehabilitation LLC	Nurs Fac-CCH	145	East Hartford	90	-	90	1/26/2016	55	62.07%
Riverside Health and Rehabilitation Center	Nurs Fac-CCH	345	East Hartford	305	-	305	1/18/2016	40	88.41%
Kettle Brook Care Center, LLC	Nurs Fac-CCH	140	East Windsor	138	-	138	2/23/2016	2	98.57%
Touchpoints at Chestnut	Nurs Fac-CCH	59	East Windsor	55	-	55	2/23/2016	4	93.22%
Crestfield Rehab Cur & Fenwood Manor	Nurs Fac-CCH	95	Manchester	91	-	91	3/2/2016	4	95.79%
Crestfield Rehab Ctr & Fenwood Manor	Nurs Fac-RHNS	60	Manchester	39	-	39	3/2/2016	21	65.00%
Manchester Manor, Inc.	Nurs Fac-CCH	126	Manchester	115	1	116	2/3/2016	10	92.06%
Touchpoints at Manchester	Nurs Fac-CCH	131	Manchester	126	2	128	2/23/2016	3	97.71%
Westside Care Center	Nurs Fac-CCH	162	Manchester	156	1	157	2/23/2016	5	96.91%
Vernon Manor Health Care Center	Nurs Fac-CCH	120	Vernon	117	1	118	2/5/2016	2	98.33%
Kimberly Hall North	Nurs Fac-CCH	150	Windsor	142	-	142	2/23/2016	8	94.67%
Kimberly Hall South Center	Nurs Fac-CCH	180	Windsor	107	-	107	2/23/2016	73	59.44%
Kindred Transitional Care and Rehab. - Windsor	Nurs Fac-CCH	108	Windsor	94	2	96	2/23/2016	12	88.89%
Available Beds		1,821		1,575	7	1,582		239	86.88%

Attachment V

Paradigm Healthcare
South Windsor Closing Analysis
May 26 - September 30

	May 26-31	Jun-16	Jul-16	Aug-16	Sep-16	Total
	\$	\$	\$	\$	\$	Closing
Rev. Revenues						
Patient Service Revenues						
Private	\$ 2,369	\$ 11,843	\$ -	\$ -	\$ -	\$ 14,211
Medicaid	73,910	291,609	151,180	36,059	-	552,758
Medicare	22,050	31,500	12,075	-	-	65,625
Other Insurance	2,490	4,980	3,320	-	-	10,790
Medicare Part B	3,000	15,000	4,000	1,000	-	23,000
Subtotal-Patient care revenue	\$ 103,819	\$ 354,931	\$ 170,575	\$ 37,059	\$ -	\$ 666,384
Exp. Expenses						
Operating salaries and wages	\$ 69,829	\$ 308,400	\$ 257,242	\$ 219,550	\$ 103,296	\$ 958,316
Ancillary salaries and wages	4,457	23,029	19,209	12,000	-	58,694
Employee benefits	23,966	143,761	162,656	133,380	68,611	532,374
Nursing supplies and expenses	1,560	5,374	3,013	1,171	608	11,726
Ancillary supplies and services	4,182	20,910	10,390	5,917	3,500	44,899
Dietary	2,730	8,963	4,563	1,156	-	17,412
Activities/Patient recreation	50	451	226	51	-	778
Housekeeping	350	1,213	607	138	-	2,308
Laundry	250	1,058	530	121	-	1,959
Repairs/maintenance and utilities	1,500	19,743	17,083	14,933	10,067	63,326
General administration	3,200	19,341	14,484	13,043	14,800	64,868
Management Fee	2,496	9,126	4,589	1,047	-	17,258
Taxes and insurance	1,848	9,238	9,238	9,238	9,238	38,800
Provider tax	5,675	28,377	14,357	3,384	-	51,793
Total Operating Expenses	\$ 122,093	\$ 598,983	\$ 518,186	\$ 415,128	\$ 210,120	\$ 1,864,511
Income (Loss) Before Loan Paymen	\$ (18,274)	\$ (244,052)	\$ (347,612)	\$ (378,069)	\$ (210,120)	\$ (1,198,127)
Rent/SL Rent/Contingent Exp.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Secured Lender Payments	13,800	64,470	134,925	64,470	64,470	342,135
Non Operating Expenses						
	\$ (32,074)	\$ (308,522)	\$ (482,537)	\$ (442,539)	\$ (274,590)	\$ (1,540,262)

Attachment VI

**PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR
FACILITY CLOSING ANALYSIS**

May 26 - September 30

<u>Description</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>September</u>	<u>Total</u>
Total Expenses	\$ 135,893	\$ 663,453	\$ 653,111	\$ 479,598	\$ 274,590	\$ 2,206,646
<u>(Less) NonAllowable Expenses</u>						
Ancillary salaries and wages	(4,457)	(23,029)	(19,209)	(12,000)	-	(58,694)
Ancillary supplies and services	(4,182)	(20,910)	(10,390)	(5,917)	(3,500)	(44,899)
Secured Lender Expenses	(13,800)	(64,470)	(134,925)	(64,470)	(64,470)	(342,135)
Estimated Total Allowable Expenses	\$ 113,453	\$ 555,045	\$ 488,588	\$ 397,211	\$ 206,620	\$ 1,760,917
Resident Days						<u>2,655</u>
Blended Amount Per Patient Day						\$ 663.25
Estimated Minimum Fair Rent PPD						43.02
Requested Closure Interm Rate*						<u><u>\$ 706.27</u></u>

*Assumes waivers of all caps, waivers of census and fair rental reimbursement at the minimum fair rent.

Attachment VII

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

IMPORTANT NOTICE - PLEASE READ CAREFULLY

March 16, 2016

Tracy Haddad, Administrator
Paradigm Healthcare Center Of South Windsor
1060 Main St
South Windsor, CT 06074

Dear Ms Haddad:

On March 10, 2016 a survey and investigation were concluded at your facility by the State of Connecticut, Department of Public Health, Facility Licensing & Investigations Section to determine if your facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found the most serious deficiency(ies) in your facility to be:

Widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

An Enforcement Cycle has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Your Enforcement Cycle began with the March 10, 2016 survey. All surveys conducted after March 10, 2016 with deficiencies at a "D" level or greater become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle. Facilities are expected to achieve and maintain continuous substantial compliance.

A Plan of Correction (PoC) for the deficiencies must be submitted by the 10th day after the facility receives its Statement of Deficiencies (Form CMS-2567). Your PoC serves as your written allegation of compliance.



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

Tracy Haddad

Paradigm Healthcare Center Of South Windsor

Page 3

If you do not achieve substantial compliance within 3 months after the last day of the survey identifying noncompliance, the CMS Regional Office and the State of Connecticut Department of Social Services must deny payments for new admissions.

We are also recommending to the CMS Regional Office and State of Connecticut Department of Social Services that your provider agreement be terminated on 09/06/2016 if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with separate formal notification of that determination.

Allegation of Compliance

The Plan of Correction serves as your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State of Connecticut Department of Social Services will impose the previously recommended remedy(ies) at that time.

Upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office and the State of Connecticut Department of Social Services beginning on **March 10, 2016** and to continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State of Connecticut Department of Social Services may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for ~~deficiencies which resulted in a finding of Substandard Quality of Care (SQC) or immediate jeopardy.~~ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy), to this office. This request must be sent during the same 10 day period you have for submitting a PoC for the cited deficiencies. Informal dispute resolution may be accomplished by telephone, review of submitted documentation or a meeting held at the Department. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for informal dispute resolution. You will be advised in writing of the decision related to the informal dispute process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2016
FORM APPROVED
OMB NO. 0938-039

ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2016
NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR		STREET ADDRESS, CITY, STATE ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

Unannounced visits were made to the facility on 3/07, 3/08, 3/09, and 3/10/2016 by representatives of the Facility Licensing & Investigations Section for the purpose of conducting multiple investigations, a licensure inspection, and a certification survey.

Abbreviations which may be used throughout this document include the following:

- ADL (s) - activities of daily living
- ADNS/ADON - Assistant Director of Nursing
- APRN - Advanced Practice Registered Nurse
- BIMS- Brief Interview for Mental Status
- BUN - Blood Urea Nitrogen
- C-Diff - Clostridium Difficile (Colitis)
- COPD - chronic obstructive pulmonary disease
- CVA - cerebrovascular accident (stroke)
- DNS/DON - Director of Nursing
- DTI - deep tissue injury (pressure related)
- ED/ER - emergency department of acute care hospital
- ESBL - Extended spectrum beta-lactamase
- ESRD - End Stage Renal Disease
- FSS/FSD - Food Service Director/ Food Service Supervisor
- GI - gastrointestinal
- I&O - intake and output monitoring/measuring
- IV - intravenous
- LPN - Licensed Practical Nurse
- MD - Medical Doctor
- MDS - Minimum Data Set (interdisciplinary assessment tool)
- MI - myocardial infarction (heart attack)
- MRSA - Methicillin Resistant Staphylococcus Aureus
- MDRO - Multi Drug Resistant Organisms

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued participation

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2016
FORM APPROVED
OMB NO. 0938-0391

IDENTIFICATION OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

075422

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

C

03/10/2016

NAME OF PROVIDER OR SUPPLIER

PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR

STREET ADDRESS, CITY, STATE, ZIP CODE

1060 MAIN ST

SOUTH WINDSOR, CT 06074

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 000 Continued From page 1

F 000

NA - Nurse Aide

OT - Occupational Therapist

PT - Physical Therapist

RCP - resident care plan

RN - Registered Nurse

SW - Social Worker

VRE - Vancomycin Resistant Enterococcus

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

Resident #61's care card has been updated to reflect the use of floor mats at the bedside. All nurses and care plan coordinator have been educated on the policy for updating and revising care cards and care plans as needed. Audits will be conducted weekly for four weeks and then monthly for two months to ensure care plans and care cards are in agreement and properly updated.

All residents have the potential risk to be affected by this alleged deficient practice.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The care plan coordinator and DNS will be responsible for monitoring this plan. The facility will be in compliance by April 19, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074	
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(X5) COMPLETION DATE			

F 280 Continued From page 2

F 280

This REQUIREMENT is not met as evidenced by:

Based on clinical record review, review of facility documentation, observations and interviews and for 1 of 4 sampled residents reviewed for accidents (R#61) the facility failed to review and revise the care card to include floor mats at bedside. The findings include:

Resident # 61's diagnoses included dementia. A quarterly MDS assessment dated 12/16/15 identified the resident as moderately cognitively impaired and required total assistance of 1 person for ADL's. A resident care plan dated 12/22/16 identified the resident at risk for further falls. Interventions included to apply a floor mat at the bedside. Review of the resident's nurse aide care card dated 3/07/16 failed to reflect that the resident required a mat at the bedside. Observations with the DNS on 3/09/16 at 2:30 PM identified that the resident lying in bed without benefit of a mat. The DNS identified that the resident required a mat at his/her bedside, and indicated that the information should have been noted on the resident's care card.

32 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER

075422

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

03/10/2016

NAME OF PROVIDER OR SUPPLIER

PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR

STREET ADDRESS, CITY, STATE, ZIP CODE

1060 MAIN ST
SOUTH WINDSOR, CT 06074

(X4) ID
PREFIX
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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

F 282 Continued From page 3

F 282

Resident #61's care card has been updated to include the use of floor mats at the bedside. All Certified Nursing Assistants have been educated on the need to review care cards prior to providing care to a resident. Audits (Interviews) with Certified Nursing Assistants to ensure care cards are being reviewed prior to providing care to residents will be conducted weekly for four weeks and then monthly for two months.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The care plan coordinator and DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review, review of facility documentation, observations and interviews and for 1 of 4 sampled residents reviewed for accidents (R#61) the facility failed to implement the plan of care for a resident with a history of falls. The findings include:

Resident # 61's diagnoses included dementia. A quarterly MDS assessment dated 12/16/15 identified the resident as moderately cognitively impaired and required total assistance of 1 person for ADL's. A resident care plan dated 12/22/16 identified the resident at risk for further falls. Interventions included to apply a floor mat at the bedside. Review of the resident care card dated 3/07/16 failed to reflect that the resident required a mat at the bedside. Observations with the DNS on 3/09/16 at 2:30 PM identified that the resident lying in bed without benefit of a mat. The DNS identified that the resident required a mat at his/her bedside, and indicated that the information should have been noted on the resident's care card.

483.25(j) MAINTAIN NUTRITION STATUS

F 325

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074	
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			IXS, COMPLETION DATE

F 325 Continued From page 4
SS=D UNLESS UNAVOIDABLE

F 325

Based on a resident's comprehensive assessment, the facility must ensure that a resident -

- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
- (2) Receives a therapeutic diet when there is a nutritional problem.

Resident #84 and #85 no longer reside at this facility. The facility dietician will be educated on the policy to ensure the admission nutritional assessment is completed within 14 days of admission and quarterly thereafter. Random audits will be done weekly for four weeks and monthly for two months on all new admissions and residents with quarterly assessment to ensure compliance.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interviews for two of three residents sampled reviewed for nutrition, (R#84, R#85), the facility failed to ensure Nutritional Assessments was completed in a timely manner. The findings include:

All residents have the potential risk to be affected by this alleged deficient practice. Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

1. Resident#84 was admitted from home on 4/06/15 with diagnoses which included diabetes and esophageal dismotility. A Nursing Admission assessment dated 4/06/15 identified the resident's weight as 126.8 lbs. and without oral health problems. An admission MDS assessment dated 4/13/15 identified the resident with intact cognition, independent with ADL's and no known weight gain or loss. Resident care plan dated 4/20/15 identified the resident at risk for nutritional issues related to diabetes, depression, anxiety, esophageal motility dysfunction, and lower weight for ideal body weight. Physician admission orders directed to provide consistent carbohydrate.

The DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

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NAME OF PROVIDER OR SUPPLIER <p style="text-align: center;">PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR</p>		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074		
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F 325 Continued From page 5
ground diet, and on 4/29/15 sugar free milk shakes were added with meals three times day.

F 325

Weekly and then monthly weights were as follows: 4/14/15, 126.4 lbs., 4/21/15, 124.8 lbs., 4/28/15, 125 lbs., 5/05/15, 130.5 lbs. and 6/01/15 123.1 lbs. with a reweigh to 125.5 lbs.

Review of the clinical record failed to reflect that a comprehensive admission nutritional assessment was completed until 6/03/15, (approximately 2 months after admission), when a new dietitian came to the facility and was consulted for weight loss.

Attempts to reach the previous dietitian was unsuccessful.

Interview with the DNS on 3/10/16 at 10:35 AM indicated, although not included in the Nutritional Assessment policy, the comprehensive Admission Nutritional Assessment should be completed within 14 days of admission.

2. Resident#85's diagnoses include cerebral vascular accident, seizure disorder and depression. A quarterly MDS assessment dated 5/02/15 identified the resident as severely cognitively impaired, requiring extensive to total assistance from staff with transfers, hygiene and bathing, independent with eating and weight loss. The RCP identified the resident at risk for weight loss due to a stroke, dementia and a variable intake.

Review of the Admission Nutrition Assessment dated 10/29/14 indicated the resident was on a no added salt, soft diet, weight as 180 lbs. and the resident doesn't like the texture of her diet. The

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NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074	
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			X5: COMPLETION DATE

F 328 Continued From page 7
Prostheses.

F 328

Resident #64 continues to reside at the facility. His tube feeding schedule has been reviewed with all caregivers. All staff will be educated on the necessity of assessing each resident at the beginning of the shift. This will serve to ensure all tube feedings, IVs and tracheotomies are functioning properly and all residents are receiving the care they require. Random audits will be conducted weekly for four weeks and then monthly for two months to ensure compliance.

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interview for one of one sampled resident observed for tube feedings (Resident #64), the facility failed to ensure a tube feeding was infusing. The findings include:

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

Resident #64's diagnoses included ventricular fibrillation arrest, diabetes mellitus and convulsions. A quarterly MDS dated 1/21/16 identified the resident as requiring total care of two for bed mobility and transfers. The MDS further identified the resident required total care of one with dressing, eating, toileting and personal hygiene. The resident's mental ability was not scored on the quarterly MDS.

The DNS will be responsible for monitoring this plan. The facility will be in compliance by April 19, 2016.

A care plan dated 1/27/16 identified a problem with being at a nutritional risk related to anoxic

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 OFFICE OF SURVEILLANCE AND INSPECTION
 OFFICE OF LICENSING AND REGULATION
 OFFICE OF CERTIFICATION AND COMPLIANCE
 OFFICE OF MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2016
 FORM APPROVED
 OMB NO. 0938-0391

ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2016
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NAME OF PROVIDER OR SUPPLIER RADIGM HEALTHCARE CENTER OF SOUTH WINDSOR	STREET ADDRESS CITY STATE ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074
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(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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328 Continued From page 8 F 328

encephalopathy and receiving a tube feeding for 100% of his/her nutritional needs. Interventions included to weigh per physician orders and to provide tube feedings as ordered.

A physician order dated 2/26/16 directed the resident as nothing by mouth and to administer Jevity 1.5 cal at 65 cc per hour for 22 hours (off at 4:00 PM and on at 6:00 PM) via enteral feeding of gastrostomy tube.

Observation on 3/07/16 from 8:33 AM to 9:10 AM identified R#64 's tube feeding pump was in the "off" position and not infusing. Further observation of the resident at that time identified R#64 was not able to answer questions, was non-verbal, unresponsive and had bilateral hand/elbow contractures with splints and/or hand rolls in place.

Interview with LPN#1 at that time identified that he/she was not aware the tube feeding had not been infusing and further identified that he/she did not assess the resident yet (he/she started the shift at 7:00 AM). Interview with NA#1 on 3/07/16 at 9:11 AM identified that he/she did not provide care to R#64 and had not tampered with the tube feeding pump. Interview with NA#2 on 3/07/16 at 9:11 AM identified that although R#64 was on her/his assignment, he/she had not provided care/ and or tampered with the resident 's feeding pump. Interview with the DNS on 3/9/16 at 10:00 AM identified that LPN#1 was to have assessed the resident's feeding pump for infusion at the beginning of the shift.

329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS F 329

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

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NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074
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F 329 Continued From page 9

F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Resident #57 continues to reside at the facility.

The pharmacy recommendation to check the renal function panel has been completed.

Nursing staff will be educated on the need to follow through on pharmacy recommendations at all times. All pharmacy recommendations will be copied prior to giving them to the physician for review. The copy will be retained by the DNS to ensure each recommendation is returned and completed.

Resident #56 continues to reside at the facility.

The pharmacy recommendation for monitoring orthostatic blood pressures to determine if a gradual dose reduction is appropriate, discontinue glimepiride and change rivastimine capsules to patches have been implemented. Nursing staff will be educated on the need to follow through on pharmacy recommendations at all times.

All pharmacy recommendations will be copied prior to giving them to the physician for review.

The copy will be retained by the DNS to ensure each recommendation is returned and completed.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review, review of facility documentation and interviews for 2 of 5 sampled residents reviewed for unnecessary medications (R#57, R#86) the facility failed to implement recommendations made by the pharmacy. The findings include:

1. Resident # 57's diagnoses included

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dehydration. A quarterly MDS dated 8/22/15 identified that the resident as severely cognitively impaired and requiring total care with ADL's.

A RCP dated 8/26/15 identified that the resident at risk for dehydration. Interventions included to monitor for dehydration.

Physician's orders dated 10/28/15 direct to administer Lasix (a diuretic) 40 milligrams once daily and Klor-Con (a potassium supplement) 20 milli-equivalents once daily.

A pharmacy consult dated 11/01/15 through 11/30/15 recommended review of the continued use of potassium due to interactions with another medication could cause gastrointestinal toxicities.

MD#2 signed the recommendation, agreed with the pharmacy recommendations and on 11/12/15 directed to continue the Lasix, continue the potassium and to repeat renal function panel as soon as possible.

Review of the clinical record failed to reflect that the renal function panel was completed as directed by the physician.

F 329

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The facility will be in compliance by April 19, 2016.

Interview with the DNS on 3/10/16 at 1:30 PM identified that he/she was unable to determine if the renal function tests were completed. The DNS indicated that the lab comes to the facility on Monday's, Wednesday's and Friday's and the labs should have been drawn on the next scheduled lab day if the physician had ordered it "as soon as possible".

2. Resident # 86's diagnoses included Alzheimer's dementia. A quarterly MDS dated

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10/20/15 identified the resident as cognitively impaired and required limited assistance with ADL'S, unsteady while walking, but able to stabilize without staff assistance.

A resident care plan dated 11/29/15 identified that the resident at risk for falls, had fallen in the hallway on 11/29/15 and with an intervention dated 12/01/15 that included a pharmacy medication review.

Review of a Pharmacy Consultation Report dated 12/01/15 identified that R#86 had been experiencing a new onset or worsening of falls and a medication regime review was completed at the request of the facility. The physician signed in agreement to the recommendations on 12/14/15. The pharmacy recommendations included:

- a) To monitor for orthostatic hypotension, and if orthostatic blood pressures due at the end of the month were considered orthostatic, considering tapering of the antipsychotic or blood pressure medication may be appropriate.

Review of the December, 2015 and January, 2016 MAR's identified that although there was a spot marked off for the orthostatic blood pressure to be obtained on 12/19/15 and 1/19/16, there was no blood pressure or initials in the marked off areas. Interview with the DNS on 3/09/16 at 2:30 PM identified that he/she could not locate any orthostatic blood pressures that had been completed in December, 2015 and/or January, 2016.

- b) To consider discontinuation of Glimpiride (a medication used to decrease blood sugar in

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	<p>diabetics). If the medication is discontinued to increase the fingerstick monitoring for 3-4 days.</p>			
	<p>Interview with the DNS on 3/9/16 at 2:30 PM and review of the clinical record identified that although the Glimepiride had been discontinued on 12/15/15, he/she could not find that the increase in fingerstick monitoring had been completed.</p>			
	<p>c) Consider using Rivastigmine patches instead of capsules. Interview and review of the medical record with the DNS on 3/9/16 at 2.30 PM identified that he/she was unable to find that the change had been made from capsules to patches.</p>			
	<p>Interview with the Consulting Pharmacist on 3/09/16 at 4:30 PM identified that he/she had recommended to increase the fingerstick monitoring to ensure the blood sugars did not increase or decrease after the Glimiperide was discontinued. He/she recommended that the rivastigmine be changed from capsules to the patch because the patch has less side effects of vertigo and gives more of a steady release of medication therefore decreasing the potential for side effects.</p>			
	<p>Interview with the DNS on 3/09/15 at 2:30 PM identified that the pharmacy representative gives the recommendations to him/her and he/she will read them and anything that needs physician's attention will go into the physicians folder, once the physician reviews the recommendation and signs that he/she agrees with the recommendation, the recommendations should then be implemented by the nursing staff.</p>			

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F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF
SS=D PER CARE PLANS

F 353

F 353

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty

Resident #32 continues to reside at the facility. Our staffing has been reviewed. NA #5 has been educated on the importance of serving food at an appropriate temperature. Random audits will be done weekly for four weeks and the monthly for two months to ensure all residents are served food that is hot. If a meal is served later, it will be heated by staff prior to serving.

Resident #64 continues to reside at the facility. His tube feeding schedule has been reviewed with all caregivers. All staff will be educated on the necessity of assessing each resident at the beginning of the shift. This will serve to ensure all tube feedings, IVs and tracheotomies are functioning properly and all residents are receiving the care they require. Random audits will be conducted weekly for four weeks and then monthly for two months to ensure compliance.

This REQUIREMENT is not met as evidenced by:

Based on observation and interviews for one sampled resident observed during the breakfast meal (R#32) and/or for one of one sampled resident observed for tube feedings (R#64), the facility failed to maintain adequate staffing to

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meet the needs of the residents. The findings
include:

F 353

All residents have the potential risk to be affected
by this alleged deficient practice.

Findings will be reviewed by the Quality
Assurance Improvement Committee
(QAPI) with recommendations as needed.

The DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

1. A Dietitian annual review dated 1/18/16 identified R#32 had swallowing difficulties related to the development of motor issues secondary to dementia. Dietary recommendations included to continue the current diet consistency per the speech therapy (SPL) recommendations, which consisted of a pureed diet, continue to monitor the percentage of daily meal intake, monitor weights, continue extra fluids and notify the Registered Dietitian (RD) of any changes in the resident's intake. The resident's goal was to consume 50-100% of meals and adequate fluids to prevent dehydration.

An annual Minimum Data Set (MDS) dated 1/19/16 identified R#32 as severely cognitively impaired and was completely staff dependent with transfers, bed mobility, toileting and eating. The Nursing Care Plan dated 1/20/16 identified R#32 with a self-care deficit related to dementia and required total assistance with personal care tasks, including eating. The Resident had impaired communication, was alert, disoriented and non-verbal. Resident #32 was identified as a nutritional risk related to his/her diagnosis of dementia and a history of dehydration.

A SPL progress note dated 1/27/16 identified the resident was on aspiration precautions, should be upright for all meals, take small bites and sips, and alternate solids and liquids. Physician's orders dated 2/21/16 directed the administration of Trazodone and Colace, and a diet order for pureed consistency and nectar thick liquids. Resident #32 diagnoses included dementia, anxiety disorder, and depression.

Observation on 3/07/16 at 8:15 AM identified the breakfast food cart arrived on the unit at 8:15 AM.

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At 9:23AM (one (1) hour and eight (8) minutes later) the breakfast tray was removed from the food cart and brought to Resident #32. At that time, as NA #5 began feeding the Resident, the Food Service Director (FSD) took the temperature of the food on the Resident 's plate. The food, which consisted of pureed waffles, recorded a temperature of 99 degrees. Interview with the FSD at 10:04 AM identified that 99 degrees is considered too cold to serve hot food. The FSD further identified that the pureed waffles had a temperature of 181 degrees upon leaving the kitchen and he/she would expect the breakfast trays to be served to the residents within 15 minutes of arrival onto the unit. Interview with NA #5 on 03/07/2016 at 10:24 AM identified that he/she had to first bring breakfast trays to the residents who chose to eat on the Unit Dining Room, then he/she had to deliver food trays to the residents who chose to eat in their rooms, after that he/she could begin to work with the residents who required assistance with eating. NA #5 further identified that he/she had five residents to feed in the morning and Resident #32 was last one. NA #5 continued to identify that there were three nursing assistants for two wings and he/she could not have assisted Resident #32 with breakfast sooner. NA #5 acknowledged that he/she would have microwave the food if it felt cold, but the plate felt warm to him/her so it wasn't reheated. According to food industry service standards, hot food should be served at a minimum temperature of 135 degrees.

2. Resident #64's diagnoses included ventricular fibrillation arrest, diabetes mellitus and convulsions. A quarterly MDS dated 1/21/16 identified the resident as requiring total care of

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(X2) MULTIPLE CONSTRUCTION

A BUILDING _____

B WING _____

(X3) DATE SURVEY
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PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR

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two for bed mobility and transfers. The MDS further identified the resident required total care of one with dressing, eating, toileting and personal hygiene. The resident's mental ability was not scored on the quarterly MDS.

A care plan dated 1/27/16 identified a problem with being at a nutritional risk related to anoxic encephalopathy and receiving a tube feeding for 100% of his/her nutritional needs. Interventions included to weigh per physician orders and to provide tube feedings as ordered.

A physician order dated 2/26/16 directed the resident as nothing by mouth and to administer Jevity 1.5 cal at 65 cc per hour for 22 hours (off at 4:00 PM and on at 6:00 PM) via enteral feeding of gastrostomy tube.

Observation on 3/07/16 from 8:33 AM to 9:10 AM identified R#64's tube feeding pump was in the "off" position and not infusing. Further observation of the resident at that time identified R#64 was not able to answer questions, was non-verbal, unresponsive and had bilateral hand/elbow contractures with splints and/or hand rolls in place.

Interview with LPN#1 at that time identified that he/she was not aware the tube feeding had not been infusing and further identified that he/she did not assess the resident yet (he/she started the shift at 7:00 AM). Interview with NA#1 on 3/07/16 at 9:11 AM identified that he/she did not provide care to R#64 and had not tampered with the tube feeding pump. Interview with NA#2 on 3/07/16 at 9:11 AM identified that although R#64 was on her/his assignment, he/she had not provided care/ and or tampered with the resident

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s feeding pump. Interview with the DNS on 3/9/16 at 10:00 AM identified that LPN#1 was to have assessed the resident's feeding pump for infusion at the beginning of the shift.

F 360 483.35 PROVIDED DIET MEETS NEEDS OF SS=E EACH RESIDENT

F 360

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Residents #7, #11, #13, #23, #60 and #70 continue to reside at the facility. These residents currently receive Lactaid for breakfast and lunch as ordered. The Food Service Director has been educated on the necessity of following the prescribed diet. Additionally the FSD has been educated on the proper procedure for making management aware of any food items that are not available. Weekly audits will be conducted for four weeks and monthly for two months.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The Administrator and DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, review of facility documentation, observations and interviews for 6 of 6 sampled residents receiving a dairy alternative (R # 7, #11, #13, #23, #60 and #70) the facility failed to ensure that the dietary alternative was provided and/or available for the residents. The findings include:

1. Resident # 7's diagnoses included Dementia. Observations on 3/09/16 and review of the dietary slip dated 3/09/16 identified that the resident should receive 8 oz of Lactaid milk at breakfast and 4 oz of Lactaid milk at lunch.

2. Resident # 11's diagnoses included Dementia. Observation and review of R # 11's dietary slip for breakfast and lunch dated 3/09/16 identified that the resident should receive 8 oz of Lactaid for breakfast and 4 oz of Lactaid for lunch.

3. Resident # 13's diagnoses included

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<p>Dementia. Observation and review of R # 13's dietary slip identified that the resident should not have milk, the dietary slip dated 3/09/16 for breakfast and lunch identified that the resident should receive Lactaid 8 oz at breakfast and 4 oz for lunch.</p> <p>4. Resident # 23's diagnoses included Dementia. Review of a diet order dated 12/31/15 identified that the resident is lactose restricted. Observation and review of a dietary slip dated 3/09/16 identified that the resident was on a low lactose diet and should receive 8 oz of Lactaid at breakfast.</p> <p>5. Resident # 60's diagnoses included Diabetes Mellitus. A diet order dated 2/29/16 identified that the resident is lactose restricted. Observation and review of a dietary slip dated 3/09/15 identified that the resident is on a low lactose diet and should have 8 oz of Lactaid at breakfast and 4 oz of Lactaid at lunch.</p> <p>6. Resident # 70's diagnoses included Dementia. A diet order dated 12/31/15 identified that the resident is lactose restricted. Observation and review of the dietary slip dated 3/09/16 identified that the resident is on a low lactose diet and should have 8 oz of Lactaid at breakfast and 4 oz of Lactaid at lunch.</p> <p>Interview with the FSD on 3/09/16 at 3:00 PM identified that he/she had run out of Lactaid and that there were 6 residents in house who did not receive their Lactaid for breakfast or lunch on 3/09/16. The FSD identified that he/she had run out of Lactaid because he/she did not have a milk vendor to deliver to the facility. Additionally the FSD did not inform anyone that the facility had</p>			

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run out of Lactaid and/or did not add any other fluids or equivalent to the affected resident's trays.

Interview with RN # 3 on 3/09/16 at 3:30 PM identified that if he/she had known the facility was out of Lactaid, the facility would have gone out to the store and purchased some.

Interview with the Dietician on 3/10/16 at 8:50 AM identified that he/she was unaware that the facility had run out of Lactaid, and since there is nothing that can be used to replace Lactaid, she would have suggested that someone go out and buy it.

SS=F 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:

Based on review of the Dietary menus, observation, interview and, the facility failed to follow the scheduled dietary menu for 26 out of 54 meals. The findings include:

Observation of the breakfast menu on 3/07/16 at 8:23 AM included 4 oz juice, 6 oz of oatmeal, 1 cup cold cereal, 2 pancakes with syrup and 2 slices of bacon. Breakfast for Resident #32 consisted of scrambled eggs and pureed waffles.

F 363 The facility currently adheres to the planned menu. The Food Service Director has been educated on the process for making changes to the preplanned menu. Audits will be conducted weekly for four weeks and then monthly for two months to ensure compliance.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The Administrator and DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

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Interview on 3/09/16 at 11:37 AM with the FSD regarding the changes in the printed menu identified that he/she had been experiencing delays and cancellations of food orders in the past few weeks due to vendors requiring cash on delivery for purchases, and because of this, he/she has had to make multiple changes, switches and substitutions to the menu. He/she further identified that he/she was able to make equally nutritive changes.

Interview on 3/09/16 at 12:15 PM with the facility Administrator identified that he/she acknowledged that there have been menu corrections, but only since the middle of the previous week. Prior to that, there have been no issues. He/she further explained that the facility was part of a corporate restructure and they had been in the process of setting up new vendor accounts.

A review of the Dietary Menu dated from Sunday, February 21, 2016 through Wednesday, March 9, 2016 with the Dietary Director on 3/9/16 at 12:50 PM identified 26 changes out of 54 meals.

171 483.35(i) FOOD PROCURE,
=F STORE/PREPARE/SERVE - SANITARY

F 371

- The facility must -
- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
 - (2) Store, prepare, distribute and serve food under sanitary conditions

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			(X5) COMPLETION DATE

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F 371

This REQUIREMENT is not met as evidenced by:
 Based on observation, interview and review of facility documentation, the facility failed to separate dented cans from useable stock. The findings include:

Observation on 3/07/16 at 6:40 AM identified three out of seven dented cans, two containing marinara sauce and one containing sauerkraut. Interview with the FSD at 10:04 AM identified that canned goods are unpacked by the cooks and inspected for dents when removed from the case. If the cans are dented, they are put aside to be returned to the vendor. FSD further identified that the three cans identified as dented should have been removed from the stock and put aside for return.

Observation on 3/09/16 at 11:37 AM identified a dented can of marinara sauce in the usable stock. Interview with the FSD at that time identified that food delivery had not occurred since 3/07/16 and the dented can of marinara sauce was put back in to the useable stock to ensure there was enough food in stock to feed facility residents. FSD further identified that, at that point, there was only enough food in the building to serve breakfast on 3/10/16, but not enough to serve lunch and dinner.

Interview with the Administrator on 3/09/16 at 12:15 PM identified that an order for food was placed at 10:30 AM and the delivery was expected later that day to cover a week's worth of meals. The facility Administrator indicated that the facility was in the process of switching to

The facility has an established area for non-usable food items. All cans received as defective will be returned to the vendor. Should food items become dented once in stock, they will be removed and placed in the area for non-usable items. The kitchen staff has been educated on the process for removing dented cans from the rack for usable food items. Weekly audits will be conducted for four weeks and then monthly for two months.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The Director of Food Services and DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

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AND PLAN OF CORRECTION

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IDENTIFICATION NUMBER:

075422

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

03/10/2016

NAME OF PROVIDER OR SUPPLIER

PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR

STREET ADDRESS, CITY, STATE, ZIP CODE

1060 MAIN ST
SOUTH WINDSOR, CT 06074

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY)

(X5)
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new food vendor.

F 371

The facility's policy on Food and Supply Storage Procedures identified a designated area will be maintained for items that are damaged (such as dented cans) that are to be returned for credit. Post a sign so items will not be used.

F 373 483.35(h) FEEDING ASST -
SS=D TRAINING/SUPERVISION/RESIDENT

F 373

A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law.

A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

Resident #22 continues to reside in this facility. She is currently being fed by nursing staff only. The volunteer policy has been reviewed with staff and the volunteer in question. There will be weekly audits for four weeks and then monthly for two months to ensure compliance.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The Administrator and DNS will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

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F 373

NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:

- o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
 - Feeding techniques.
 - Assistance with feeding and hydration.
 - Communication and interpersonal skills.
 - Appropriate responses to resident behavior.
 - Safety and emergency procedures, including the Heimlich maneuver.
 - Infection control.
 - Resident rights.
 - Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

This REQUIREMENT is not met as evidenced by:
Based on review of facility documentation, observations and interviews for one of one sampled resident reviewed for feeding (R#22) the facility failed to ensure a resident with feeding problems was fed by qualified and trained personnel. The findings include:

A quarterly MDS dated 2/10/16 identified R#22 as severely cognitively impaired, required a

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F 373 Continued From page 24

F 373

two person total assist for transfers and bed mobility and completely dependent on staff assistance to eat.

A Speech Therapy evaluation dated 2/10/16 identified Resident #22 should be upright for all meals, allow sufficient time for all intake, and alternate solids and liquids. Feeding instructions directed staff assistance with meals and utilize adaptive equipment as ordered.

The nursing care plan dated 2/13/16 identified the resident with impaired cognitive skills and a nutritional risk related to a diagnosis of dementia. In addition, the nursing care plan further identified that Resident #22 had difficulty with feeding his/herself secondary to dementia. Interventions included to have nursing staff or nursing assistants provide assistance during meals.

Physician's Orders dated 2/21/16 directed a House, Dysphagia, Ground consistency, and thin liquids. The Resident was ordered to be upright for all meals, allowed sufficient time for all intake, alternate liquids and solids, feed with an assist of one and adaptive equipment divided high sided plate. ~~Diagnoses included anxiety, depression,~~ acute organic brain syndrome, and dementia with behavioral psychological syndrome.

Interview with a facility Volunteer #1 on 3/8/16 at 2:50 PM identified that he/she has been coming to the facility daily for the past few years. Volunteer #1 indicated that the Unit had several residents requiring feeding assistance and when he/she officially became a volunteer and completed the orientation he/she was allowed to assist with feeding R#22. Volunteer #1 explained that he/she was friendly with R#22 and their

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F 373 Continued From page 25

F 373

family and had permission to assist with feeding. Volunteer #1 further explained that he/she had not had any training on feeding residents but as a LPN in the past he/she understood the procedure.

Interview with NA #4 on 03/09/2016 at 1:57 PM identified that the Volunteer #1 assists with feeding Resident #22 all the time, and does not assist with feeding anyone else. NA #4 further identified that Volunteer #1 was not feeding Resident #22 prior to becoming a volunteer.

Interview with the DNS on 03/09/2016 at 2:04 PM identified that Volunteer #1 was allowed to assist with feeding residents because he/she was an LPN in the past and the Unit dining room had a lot of people requiring assistance with feeding. The DNS further identified that he/she, as well as other staff, were always in the Unit dining room supervising and was confident that Volunteer #1 would alert someone if there was a problem.

The volunteer orientation/training guidelines signed by Volunteer #1 on 3/01/15 identified item number thirteen under the general rules; "Volunteers are not allowed to feed the Residents."

Interview with the Recreation Director/Volunteer Coordinator on 03/09/2016 at 3:29 PM identified he/she began working at the facility in April of 2015 and was informed by the previous Recreation Director that the paperwork and orientation for Volunteer #1 was completed. The Recreation Director identified that volunteers should not be feeding residents and was unaware that this practice was going on.

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F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS

F 431
F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Residents #4, #5, #15, #24, #37, #39, #48, #60, and #67 continue to reside at the facility. Resident # 79 has discharged to home. All insulin pens and vials that were not labeled with the resident name and date opened were discarded and replacements were ordered. All insulin pens and vials are currently labeled with the appropriate pharmacy label and date opened. Nursing staff has received education on proper labeling of insulin and the need to date when opened. Additionally, nursing staff has been educated on the length of time insulin may be used after opening. Random audits will be conducted weekly for four weeks and monthly for two months to ensure compliance.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The DNS and Supervisors will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

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F 431

This REQUIREMENT is not met as evidenced by:

Based on clinical record review, review of facility documentation, observations and interviews for 10 of 13 sampled residents residents reviewed for medication storage (R #4, R#5, R#15, R#24, R#37, R#39, R#48, R#60, R#67, R#79), the facility failed to ensure opened insulin vials and/or single use insulin pens were with the benefit of open date labeling, and/or outdated insulin were discarded as per manufacturers' recommendations, and/or failed to discard an insulin pen that was without the benefit of a prescription reference label. The findings include:

On 3/08/16 at 9:20 AM interview with RN #2 indicated he/she had just completed the insulin administration pass for one of the two facility resident units. Inspection of insulin with RN #2 identified four multi - use vials of insulin and 19 insulin flex pens with concerns related to labeling. Three of four multi - dose vials of insulin were identified for R#37 (Novolog) and R#67 (Lantus and Humalog) were without the benefit of open date label. R#79's Lantus insulin vial of was labeled with an open date of 1/31/16 (recommended open vial discard date was 10 days overdue).

Fourteen of the nineteen opened insulin pens

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<p>431 Continued From page 28</p>	<p>F 431</p> <p>were identified without the benefit of open date labels for R#4 (Novolog and Lantus), R#5 (Levemire and Novolog), R#15 (Levemire and Novolog), R#24 (Levemire and Novolog), R#39 (Levemire and Novolog), R#48 (Levemire and Novolog) and R#60 (Humalog & Levemire). One insulin pen was identified without a prescription reference label that failed to include the resident's name for identification. Interview with RN#2 indicated it is facility policy to date the insulin when opened and that it is the responsibility of the nurse who opens the insulin to complete the label dating process. Furthermore RN#2 indicated the insulin pen that lacked a prescription label was not used during the insulin administration pass that had just been completed.</p> <p>Interview and review of facility policy with the DNS on 3/08/16 at 11:30 AM identified that insulin should be dated when first opened and discarded according to manufactures' recommendations. The nurse who opens the insulin vial is responsible for completing the open date labeling process. The manufactures' recommendation for vials of Novolog, humalog and Lantus was to discard after 28 days. The Novolog, humalog and Lantus insulin pens recommended discard date is 28 days after opening where as the Levemire pen has a discard date of 42 days. The unidentified insulin pen had a partial label covering written information below. The label was removed by the DNS to identify an open date of 2/13/16 and a potential resident's last name The pharmacy was contacted and with information from the removed partial label the pen was identified as prescribed to R#48. The Novolog pre-filled cartridge capacity for the identified Novolog pen was 250 units with approximately 170 units of insulin remaining. Additional, review</p>			
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 OFFICE OF SURVEILLANCE AND ENFORCEMENT
 DIVISION OF DEFICIENCIES AND PLAN OF CORRECTION

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431 441 3S=D	Continued From page 29 of the facility policy indicated that nursing staff should not remove any labels applied to insulin pens. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 431 F 441		
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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and

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transport linens so as to prevent the spread of
infection.

F 441

Resident #56 continues to reside at the facility . She continues to require a foley catheter for urinary retention. The foley bag has been secured in such a way that it no longer touches the floor. The facility currently has a total of four residents with catheters. The nursing staff has been educated on the infection control issues as related to catheters being on the floor. Weekly audits will be conducted for four weeks and then monthly for two months to ensure that all catheters are not on the floor.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The DNS and Supervisors will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, review of facility documentation, observations and interviews and for 1 of 1 sampled resident reviewed for Foley catheter care (R #56) the facility failed to ensure the Foley drainage bag was maintained in accordance with infection control guidelines. The findings include:

Resident # 56's diagnoses included urinary retention. An Annual MDS dated 2/15/16 identified that the resident as cognitively intact, required total care for ADL's, and required an indwelling catheter.

Physician's orders dated 2/01/16 directed a Foley

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catheter # 16 Fr with a 5-10 milliliter balloon.

A resident care plan dated 2/23/16 identified that the resident was experiencing urinary retention and required a Foley catheter.

Observation with LPN # 4 on 3/08/16 at 3:30 PM identified R # 56 sitting by his/her bed in a recliner with the Foley drainage bag on the floor. LPN # 4 identified that the Foley drainage bag should not be on the floor, but hung on the bed frame.

Observation with LPN # 2 on 3/10/16 at 11:35 AM identified R # 56 sitting by his/her bed in a recliner with the Foley drainage bag on the floor to the right of the resident. LPN # 2 identified that the Foley drainage bag should not be on the floor, but hung on the bed frame.

Interview with RN#3 on 3/10/15 at 12:30 PM identified that although the facility did not have a Foley catheter policy, the facility should follow infection control guidelines and keep the Foley drainage bag off of the floor.

465 483.70(h)
S=D SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

F 441

F 465

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

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NAME OF PROVIDER OR SUPPLIER ADIGM HEALTHCARE CENTER OF SOUTH WINDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074
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ID FIX G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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492 Continued From page 33
 such a facility.

This REQUIREMENT is not met as evidenced by:
 Based on observation and interview, the facility failed to maintain a three - day emergency supply of staple food items at all times as per the Public Health Code (q)(3)(H). The findings include:

Observation on 3/09/16 at 11:30 AM identified multiple menu items missing from the required three - day emergency supply of food. Items missing from the inventory included: applesauce, peaches, pudding, powdered milk and beef ravioli.

Interview with the FSD on 3/09/16 at 11:40 AM identified the three - day emergency supply of staple items was used on 3/05/16 and 3/06/16 to supplement the daily menu. FSD further identified that food had been ordered, but delivery was unreliable due to the facility's failure to have an account with their vendors and the vendors requiring cash on delivery (COD) for pick up and wire funds for delivery.

Interview with the facility Administrator on 3/09/16 at 12:15 PM identified that a delivery was due that afternoon to replenish the three - day emergency supply. The Administrator was unsure as to why food was taken out of the emergency supply stock and used for the daily menu.

514 483.75(l)(1) RES
 S=E RECORDS-COMPLETE/ACCURATE/ACCESSIB
 LE

F 492 The three day emergency food supply has been replenished as mandated by Federal, State, and local laws. The facility is receiving food deliveries weekly without issue. Weekly audits will be conducted for four weeks and then monthly for two months to ensure compliance.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The DNS and Director of Maintenance will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

F 514

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

Applicant Page 67
 PRINTED: 03/10/2016
 FORM APPROVED
 OMB NO. 0938-0391

NUMBER OF DEFICIENCIES AND/OR CORRECTION 	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">075422</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">C 03/10/2016</p>
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NAME OF PROVIDER OR SUPPLIER ADIGM HEALTHCARE CENTER OF SOUTH WINDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1080 MAIN ST SOUTH WINDSOR, CT 06074
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ID PREFIX TAG 3	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
 Based on clinical record review and interviews for two of three residents reviewed for nutrition, (R#84 R#85), the facility failed to maintain a complete medical record. The findings include:

Resident#84 was admitted on 4/06/15 and Resident#85 was admitted on 10/23/14. During review of the clinical record for potential weight loss, it was identified that the percentage of snack and dietary intake on the residents clinical record was incomplete.

Interview with Unit Secretary#1 on 3/7/16 at 12:20 PM indicated meal intakes are not recorded in each resident's clinical record but rather on the nourishment record, by unit which identifies all the

Residents #84 and #85 no longer reside at the facility. Snack and meal intake is currently documented in the clinical record on the CAN flow sheets. Nursing assistants have been educated on the need to record this information in the record as it is part of the permanent record. The unit secretary has been educated not discard the flow sheets. Weekly audits will be conducted for four weeks and then monthly for two months to ensure compliance.

All residents have the potential risk to be affected by this alleged deficient practice.

Findings will be reviewed by the Quality Assurance Improvement Committee (QAPI) with recommendations as needed.

The DNS and Director of Maintenance will be responsible for monitoring this plan.

The facility will be in compliance by April 19, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2016
NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF SOUTH WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 MAIN ST SOUTH WINDSOR, CT 06074	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

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residents on the unit. The secretary further indicated the nourishment record is not part of the clinical record but rather the sheets are kept separately by the Unit Secretary. Upon further review, sheets before 6/07/15 were noted to be missing. Further interview with the Unit Secretary indicated that the secretary discarded the sheets prior to 6/07/15 after the previous state survey was completed because she felt they were no longer needed.

Interview with the DNS on 3/10/16 at 10:35 AM indicated snack and dietary intake amounts should be documented in and is part of the clinical record.

Attachment VIII

**Paradigm Healthcare Center of South Windsor, LLC
 Census Report Summary
 May 2016**

{a} →

<u>Summary by Payor</u>	<u>Total Days</u>	<u>Occupancy as of 5/31/16</u>		
Managed Medicare RUGs (MMR)	16		1	
Managed Care with Levels (MCL)	31		1	
Medicaid (MCD)	1,423		46	
Medicaid Pending (MP)	31		1	
Hospice Medicaid (HM)	178		6	
Medicare A (MCA)	198		5	
Hospice Inpatient (HIP)	5		-	
Private Pay (PP)	121		4	
Total	2,003		64	
# of Beds	100		100	
Days in Month	31		1	
Available Bed Days in Month/Day	3,100		100	
Occupancy Percentage	64.61%		64.00%	
<u>Resident Day Breakout</u>				
Medicare	198	9.9%	5	7.8%
Medicaid	1,632	81.5%	53	82.8%
Other	173	8.6%	6	9.4%
Total Days	2,003	100.0%	64	100.0%

Tickmarks

{a} Data was taken from internal census for the month of May 2016.