DEPARTMENT OF HEALTH AND HUMAN SERVICES (Approved 4/3/12-KMP)
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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	INITIAL COMMENTS Abbreviations which may be used throughout this document include the following: ADL ('s) - activities of daily living ADNS - Assistant Director of Nursing APRN - Advanced Practice Registered Nurse BID- two times per day BUN - Blood Urea Nitrogen COPD - chronic obstructive pulmonary disease CVA - cerebrovascular accident (stroke) DNS/DON - Director of Nursing DM- diabetes mellitus DRR- drug regimen review 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 NA - Nurse Aide OOB- out of bed OT - Occupational Therapist PO- orally PT - Physical Therapist RCP - resident care plan RE- reportable event RN - Registered Nurse ROM - range of motion SW - Social Worker VRE - Vancomycin Resistant Enterococcus	F 000	Please note the filing of this plan of correction does not constitute any admission as to the alleged deficiencies. The plan of correction is filed as evidence of the facilities continued compliance with applicable laws.	
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS	F 161		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

POC 2/27/12

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 161	Continued From page 1 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interviews, the facility failed to obtain a surety bond to provide coverage against any loss to the resident's personnel funds accounts. The findings include: Interview and review of the resident's personal funds accounts on 1/06/12 at 10:00 AM identified that the total amount in the resident's personal funds account as $49,235.00. However, review of the facility's insurance policy dated 1/3/12 failed to reflect that a surety bond was included as part of the policy to provide coverage for the resident's personal funds account. Subsequent to surveyor inquiry a surety bond was obtained by the facility.	F 161	**F161 483.10(c)(7) SURETY BOND-SECURITY OF PERSONAL FUNDS** Residents who reside at the facility have the potential to be affected by the deficient practice. The facility will provide assurance to assure the security of all personal funds of residents deposited with the facility. Administrator and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-adrninister drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations	F 176	**F176 482.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE** Resident number 5 has a completed self-administration of medication assessment to determine ability to self-administer medications. Residents who reside at the facility have the potential to be affected by the deficient practice. Staff will be in-serviced on the importance of completing this assessment on admission and quarterly. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 176	Continued From page 2 and interview for one of ten sampled residents observed during medication pass (R#5), the facility failed to complete an assessment to determine the resident's ability to self-administer medications. The findings included: Resident #5's diagnoses include chronic obstructive pulmonary disease, was oxygen dependent, and depression and anxiety. A physician order dated 1/03/11 directed in part combivent inhaler 2 puffs, by mouth four times per day, ipratropium-albuterol 0.5-3 (2.5) mg/3 comp. to duoneb 0.5 mg-3 ml, 1 unit dose, via nebulizer every 6 hour, and Ativan 1.0 mg, three times a day. Observations of medication administration on 1/05/12 at 12:30 PM identified that R#5 refused the duoneb 0.5-3 ml inhaler stating, " I took it already, I had one that was left on my table, so I set up the machine and did it myself, I did it before I layed down. " Resident # 5 then obtained the combivent inhaler from the locked drawer and self-administered the medication. Interview with LPN#4 on 1/5/12 at 12:35 PM identified that she did not administer R#5's duoneb 0.5-3 ml, could not identify a time and/or if the resident received a duoneb nebulizer treatment. LPN#4 then signed off the medication kardex to reflect that the duoneb 0.5/3 ml was administered to resident. Review of the clinical record failed to reflect that the resident was assessed for the ability to self-administered medications. Interview with LPN#4 on 1/5/12 at 12:35 PM indicated that resident keeps medications in locked drawer and usually self -administers. Review of R#5's clinical record and interview with the DNS on 1/6/12 at 1:00 PM identified that medication a self-administration assessment should be completed by the charge nurse to verify	F 176		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIOI DATE
F 223	Continued From page 5 she administered Ativan 0.25 mg by mouth because the resident had been yelling that day. LPN#1 indicated that she requested that NA#1 and NA#2 hold the resident's arms, because the resident was attempting to push her away during the catheter insertion. LPN#1 indicated the resident was yelling and calling the staff foul names. LPN#1 indicated that she would have stopped the procedure, however the resident never made the request. LPN #1 also indicated that at no time did she witness any staff member slap or cover the resident's mouth. Interview with LPN #2 on 1/05/12 at 4:30 PM identified that he worked on 11/10/11 (3:00 PM-11:00 PM shift). LPN#2 indicated that at approximately 12:30 PM while completing his documentation he remembered that he was suppose to replace R #108's Foley catheter. When LPN#2 went into R#108's room to change the Foley catheter, the resident refused at that time. LPN #2 indicated that he notified the (11 PM-7 AM shift) supervisor who instructed him to tell the LPN#1, the (11 PM-7 AM) nurse. LPN#2 indicated when he told LPN #1, LPN #1 indicated that she could not do it herself and requested assistance with the procedure. LPN#2 indicated he assisted LPN#1 by spreading R#108's legs while NA #1 and NA #2 held the resident's hands. LPN #1 then catherized the resident while the resident was heard yelling and swearing during the procedure. LPN#2 indicated that at no time did he observe any staff member cover the resident's mouth or slap the resident. Interview with NA #1 on 1/06/12 at 6:00 AM identified that on 11/11/11 at approximately 1:00 AM she was asked to hold R#108's hand while	F 223		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 223	Continued From page 6 LPN #2 catheterized the resident. NA#1 indicated that she held one hand and NA#2 held the other. NA#1 indicated she held R#108's hand loosely because the resident attempted to swing at LPN # 2 who was catheterizing the resident. NA#1 indicated the resident was yelling and swearing and stated, "I am going to get you." At no time did she or any other staff member observe hitting and/or covering the resident's mouth. Interview with NA #2 on 1/06/12 at 6:20 AM identified that on 11/11/11 at approximately 1:00 AM she was asked to calm R#108 while LPN #2 catheterized the resident. NA#2 indicated she was on one side of the resident and NA #1 was on the other side. NA#2 indicated that R#108 was yelling and using curse words. NA#2 indicated that she held the resident's hand because the resident was trying to get at LPN #2 with his/her hands/arms. NA#2 indicated that at no time did she observe any staff slap and/or cover the residents' mouth.	F 223		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility policy, review of RE and facility investigation for 2 of 4 sampled resident reviewed for abuse (R#23, R#80), the facility failed to thoroughly investigate injuries of unknown origin as per the facility	F 226	**F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICY** Resident number 23 continues to reside at the facility and has had no further incidents. Resident number 80 continues to reside at the facility and has had no further incidents. Residents who reside at the facility have the potential to be affected by the deficient practice. Licensed nursing staff will be educated on how to complete investigation of incidents . Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 226	Continued From page 7 policy. The findings include: 1. Resident #23 was admitted to the facility on 11/9/11 with diagnoses that included rheumatoid arthritis and dementia. An admission MDS dated 11/16/11 identified the resident as severely cognitively impaired cognition, required total assistance with ADL and experienced frequent pain, the worst pain was identified as a 6 on the pain scale. Review of a RE report dated 12/20/11 identified that when R#23 was transferred to the hospital, the hospital reported, that the resident presented to the hospital with multiple rib fractures. Review of the RE indicated that R#23 required total assistance with care, was bed bound and required bed baths. Further review of the documentation failed to reflect that the facility completed a thorough investigation. Interview with the DNS on 1/05/12 at 2:00 PM identified that the facility concluded that R#23 sustained the fractures during the hospitalization on 12/20/11 and as a result a narrative note was completed. Interview with MD #1 on 1/6/12 at 11:50 AM indicated that the age of the fracture was assessed to be one or two weeks prior to hospitalization on 12/20/11 and indicated that the fractures were definitely older than injuries allegedly sustained on 12/20/11. Interview with MD #2 on 1/6/11 at 12:25 PM noted the fractures were old. Facility documentation reflected a narrative that they determined the fracture occurred in the hospital. Review of the facility Abuse Prevention policy directed in part, the facility will ensure that	F 226		

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

PRINTED: 02/23/201;
FORM APPROVEI
OMB NO. 0938-039·

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 226	Continued From page 8 all alleged violations are thoroughly investigated and appropriate corrective action taken. The investigation includes written statements. 2. Resident # 80 diagnoses included PVD, anxiety, urosepsis, hypoglycemia, diabetes and dementia.. An MDS dated 9/28/11 identified that the resident had difficulty focusing, had disorganized thinking, and required total dependence for all ADL's. A RCP dated 10/04/11 identified the resident at risk for falls related to non- ambulatory status, history of dementia and anxiety. Interventions included to transfer the resident with the assistance of 2 staff members using a Marissa lift, and 2 half side rails up when the resident is in bed. A review of a RE dated 12/01/11 identified that on 11/30/11 at 5:40 AM, R#80 was observed with a reddened swollen right knee with "limpness" to the right leg and pain on movement. A radiology exam dated 11/30/11 identified a spiral fracture to the distal right femur. Interview with the DNS on 1/05/12 at 1:00 PM identified that based on her investigation she could not determine how the resident sustained the fracture. A review of the facility's policy related to Accident/Incident reporting, all injury of unknown origin will have written statements from all staff members caring for the resident the previous 24 to 48 hours to the discovery of the injury. Review of the facility's investigation related to this injury of unknown origin included only 3 statements from staff, 2 statements were unsigned and could not be determined who made	F 226		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 226	Continued From page 9 the statements. Interview with the DNS on 1/06/12 at 11:15 AM indicated that she failed to obtain additional staff interviews.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews,a review of facility policy, observations and interviews for one of ten sampled residents observed during the medication administration pass (#5) and/or for one of three sampled resident reviewed for pain control (R#23) and/or for one of three sampled resident reviewed for hydration (R#30) the facility failed to provide services to meet professional standards of quality. The findings include: 1. Resident #5 diagnoses include chronic obstructive pulmonary disease, oxygen dependent, depression and anxiety. A physician order dated 1/03/11 directed combivent inhaler 2 puffs by mouth four times per day, ipratropium-albuterol 0.5-3(2.5)mg/3 comp. to duoneb 0.5 mg-3 ml, 1 unit dose via nebulizer every 6 hour, and Ativan 1.0 mg, three times a day. Observations of medication administration on 1/5/12 at 12:30 PM identified that R#5 refused the duoneb 0.5-3 ml inhaler stating, " I took it already, I had one that was left on my table, so I set up the machine and did it myself, I did it before I layed down. " Resident # 5 then proceeded to take combivent inhaler from the locked drawer and self-administered the	F 281	**F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** Resident number 5 continues to reside in the facility and has been assessed for self-administration of medication. Resident number 23 continues to reside in the facility and has had a pain assessment completed. The resident continues on standing dose of pain medications. Resident number 30 continues to reside in the facility and has not exhibited any signs or symptoms of dehydration. Residents who reside at the facility have the potential to be affected by the deficient practice. Licensed nursing staff will be educated with regard to completing self-medication assessments on admission and quarterly. Licensed nursing staff will be educated with regard to completing pain assessments on admission, quarterly, and with any new episode of pain. Licensed nursing staff will be educated with regard to hydration protocol. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 281	Continued From page 10 medication. Interview with LPN#4 on 1/5/12 at 12:35 PM identified that she did not give R#5 the duoneb 0.5-3 ml and could not identify a time and/or if the resident had a duoneb nebulizer treatment. LPN#4 then proceeded to sign off the medication kardex indicating that the duoneb 0.5/3 ml was administered to resident. Review of facility policy indicated that the individual who administer the medication dose record the administration on the resident MAR directly after the medication is given. 2. Resident #23 was admitted to the facility on 11/9/11 with diagnoses that included rheumatoid arthritis and dementia. An admission MDS dated 11/16/11 identified the resident as severely cognitively impaired, required total assistance with ADL's and frequent pain, the worst pain identified as a 6 on the pain scale. A RCP dated 11/10/11 identified the resident at risk for alteration in comfort related to a history of chronic severe rheumatoid arthritis and contractures. Interventions included to complete a pain assessment on the pain scale 1-10, premedicate before treatment, and bathing and to report ineffective pain medication to the physician. Observation on 1/5/11 at 11:45 AM during morning care identified R#23 with facial grimacing and reported to be in pain. Person # 1 indicated that she had informed the nursing staff, all morning, regarding the resident's complaints of pain. Interview with LPN #6 on 1/5/112 at 12:00 PM identified that he had requested medication changes from the APRN. Interview with APRN #1 on 1/05/12 at 12:59 PM identified that R#23's pain level had changed from the last assessment	F 281		

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 281	Continued From page 11 that was completed three days prior. The interview also identified that pain assessments were lacking and the pain scale rating was at a 10, the worst pain. In addition review of the clinical record identified that pain assessment was lacking. Interview with LPN #4 on 1/05/12 at 1:05 PM identified that R#23 was medicated at around 8:30 AM and that when Person #1 reported that the resident had pain she reported the issue to the unit supervisor, LPN#6. Interview with the DNS on 1/5/12 at 2:00 PM identified that LPN #6 should have collected the data and then reported to the RN. Additionally, observation on 1/5/12 at 12:00 PM indicated that LPN#6 identified himself as the nursing supervisor. The LPN#4 reported that she had reported R#23's pain to LPN#6 however, LPN #6 did not report the resident's concerns the RN, and as a result R#23 was observed to be in pain for a period of time. Additionally, a family member also reported the resident's pain to LPN#4 and LPN #6. Interview with DNS on 1/05/12 at 12:00 PM identified that LPN #6 can evaluate the resident. Interview with the Administrator on 1/06/12 identified that that it is the expectation that the LPN report issues to a RN. According to the Declaratory Ruling, issues by the Board for Nursing in January 1989; The LPN is allowed to contribute to the nursing assessment by collecting, reporting, and recording objective data in an accurate and timely manner. Data collection includes observation about the condition or change in the condition of the client	F 281		

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

PRINTED: 02/23/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIOI DATE
F 281	Continued From page 12 and signs and symptoms of deviation from the normal health status. 3. Resident #30's diagnoses diagnoses included DM, PVD, DM foot ulcer, renal insufficiency and CAD. An MDS dated 9/11/11 identified the resident with modified independence with cognitive skills for decision-making and totally dependent for eating with one person physical assist. Review of laboratory results dated 9/12/11 identified a BUN of 41 mg/dl (normal 7-25) and creatinine 1.10 mg/dl (normal .67-1.54 mg/dl). A RCP 9/20/11 identified the resident with a history of diabetes mellitus and the potential for complications related to insulin dependence and diabetic status. Interventions included to report appetite and hydration intake problems to the physician. Physician's orders dated 10/11 directed Lasix 40 mg BID. Review of the nurse's notes date from 10/29/11 through 10/31/11 identified the resident with mental status changes, slurred speech and decreased oral intake. The resident was transferred to the hospital on 10/31/11. A discharge summary dated 11/4/11 identified the resident's diagnoses as acute renal failure, acute mental status changes and a BUN of 82 mg/dl on admission to the hospital A review of the resident's clinical record with the Director of Nursing on 1/6/12 at 11:20 AM failed to reflect that a dehydration assessment was completed as per facility policy. Interview with the DNS on 1/6/12 at 11:20 AM indicated that she would have initiated a dehydration assessment with the onset of the mental status changes on	F 281		

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 281	Continued From page 13 10/29/11. Review of facility's Hydration Protocol policy identified that a dehydration risk assessment should be completed quarterly and with a significant change in condition. Risk factors included are the elderly, renal disease, use of diuretics, impaired functional ability, residents dependence on staff for the provision of fluid intake and residents with poor fluid intake.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility policy, observations and interviews one of two sampled residents observed during the smoke break (R#3) the facility failed to implement the plan of care. The findings include: Resident #3's MDS dated 9/29/11 identified the resident as moderately cognitively impaired and required no assistance with eating. A smoking assessment dated 9/27/11 identified the resident as a supervised smoker, uses oxygen and staff to provide reminders not to use oxygen while smoking. The RCP dated 10/04/11	F 282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Resident number 3 currently resides in the facility; the resident has had her smoking apron with her each time she has been in the smoking area. Residents who reside at the facility have the potential to be affected by the deficient practice. Nursing staff will be in-serviced on following the individualized plan of care for each resident. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 282	Continued From page 14 identified the resident as a supervised smoker with intervention that included to provide a smoke bib. Observation on 1/05/12 at 1:30 PM in the smoke area identified the resident without benefit of a smoking apron. Interview with R#3 and NA#6 at the time of observation identified that the reason the resident required a smoking apron was due to hand tremors and the resident's history of dropping ashes on his/her clothing. NA#6 indicated that the resident's smoke apron was in the laundry and she had no replacements. Interview with the LPN# 4 at 1:45 PM identified that she located a smoke bib and the bib was not in the laundry.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, review of facility policy, observations and interviews for three of ten sampled residents reviewed during medication administration (R#5, R#30, R#81)	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 309	Continued From page 15 and/or for one of three sampled residents reviewed for pain control (R#23, R#80) the facility failed to provide necessary care and services as per physician orders and/or to attain and maintain the highest practical well-being. The findings included: 1. Resident #5 diagnoses include chronic obstructive pulmonary disease, oxygen dependent, depression and anxiety. A physician order dated 1/03/11 directed combivent inhaler 2 puffs by mouth four times per day, ipratropium-albuterol 0.5-3(2.5)mg/3 comp. to duoneb 0.5 mg-3 ml, 1 unit dose via nebulizer every 6 hour, and Ativan 1.0 mg, three times a day. Observations of medication administration on 1/5/12 at 12:30 PM identified that R#5 refused the duoneb 0.5-3 ml inhaler stating, " I took it already, I had one that was left on my table, so I set up the machine and did it myself, I did it before I layed down. " Resident # 5 then proceeded to take combivent inhaler from the locked drawer and self-administered the medication. Interview with LPN#4 on 1/5/12 at 12:35 PM identified that she did not give R#5 the duoneb 0.5-3 ml and could not identify a time and/or if the resident had a duoneb nebulizer treatment. LPN#4 then proceeded to sign off the medication kardex indicating that the duoneb 0.5/3 ml was administered to resident. Review of facility's medication administration policy identified to ensure that medications are administered as prescribed only by persons legally authorized to do so. 2. Resident #30 diagnoses include CVA and insulin dependent diabetes mellitus. A physician's order dated 12/6/11 directed, finger stick for blood sugar before meal at 6:30 AM, 11:30 AM and 4:30	F 309	**F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Resident number 5 continues to reside in the facility and has been assessed for self-administration of medication. Resident number 30 continues to reside in the facility and has not exhibited any signs or symptoms of hyper or hypoglycemia. Resident number 81 continues to reside in the facility and has not exhibited any signs or symptoms of hyper or hypoglycemia. Resident number 23 continues to reside in the facility and has had a pain assessment completed. The resident continues on standing dose of pain medications. Resident number 80 continues to reside at the facility and has had a pain assessment competed. The resident continues to receive pain medication as needed. Residents who reside at the facility have the potential to be affected by the deficient practice. Licensed nursing staff will be educated with regard to completing self-medication assessments on admission and quarterly. Licensed nursing staff will be educated with regard to proper times of checking residents' blood sugars and insulin administration. Licensed nursing staff will be educated with regard to completing pain assessments on admission, quarterly, and with any new episode of pain. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 309	Continued From page 16 PM, Insulin as part of pre-meal dosing 2 units, 0-10 minutes before meal, if PO intake doubtful, may give insulin immediately after finishing meal. Observations on 1/5/12 at 12:45 PM identified LPN#4 checked the resident's blood sugar and then administered the insulin. Prior to blood sugar check, R#30 indicated that he had already eaten his/her lunch although lunch tray was not present in room. LPN#4 also confirmed that R#30 had eaten his lunch and that she was falling behind. Interview with the DNS on 1/06/12 at 12:30 PM identified that it is the expectation that the charge nurse monitor blood sugar and administer medication according to physician's order. 3. Resident #81 diagnoses included coronary artery disease, congestive heart failure and diabetes. A physician's order directed fingerstick for blood sugar, before meal and at bedtime at 6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM and coverage with regular insulin as per sliding scale. Observation on 1/05/12 at 1:15 PM identified LPN#4 checked R#81's blood sugar then administered 4 units of regular insulin per sliding scale (one hour and 45 minutes after scheduled time per physician order). Resident #81 blood sugar at that time was 205 mg/dl. Prior to the blood sugar check, R#81 indicated that he had already eaten lunch in the dining room. Interview with LPN#4 on 1/05/12 at 1:20 PM indicated that she usually checks the residents blood sugar after lunch because R#81 has lunch in the dining room, and lunch is served at 11:30 AM. Review of facility policy indicated that medications are administered within 60 minutes of the scheduled time, except before or after meal orders, which are administered based on meal times. 4. Resident #23 was admitted to the facility on 11/9/11 with diagnoses that included	F 309		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 309	Continued From page 17 rheumatoid arthritis and dementia. An admission MDS dated 11/16/11 identified the resident as severely cognitively impaired, required total assistance with ADL and experienced frequent pain, the worst pain was identified as a 6 on the pain scale. A RCP dated 11/10/11 identified the risk for alteration in comfort related to a history of chronic severe rheumatoid arthritis and contractures. Interventions included to complete a pain assessment, on the pain scale 1-10, premeditate before treatment, and bathing and to report ineffective pain medication to the physician. Observation on 1/05/11 at 11:45 AM during morning care indicated Resident #23 with facial grimacing and reports of a lot of pain. Person # 1 reported that in the morning she had informed nursing staff that the resident was complaining about pain. Interview with LPN #6 on 1/05/12 at 12:00 PM identified that he had requested a medication change from the APRN. Interview with APRN #1 on 1/5/12 at 12:59 PM identified that R#23's pain level had changed from the the last assessment which had been completed three days prior. The interview also indicated that pain assessments were lacking and the pain assessment scale on 1/05/12 was at a 10, indicating the worst pain experience on the pain scale. Interview with LPN #4 1/05/12 at 1:05 PM identified that the resident was medicated at approximately 8:30 AM and that when Person #1 reported that the resident was experiencing pain, the issue was reported to the unit supervisor, LPN#6. Interview with the DNS on 1/05/12 at 2:00 PM identified that it is the expectation that	F 309		

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

PRINTED: 02/23/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 309	Continued From page 18 LPN #6 would have reported the concerns to the RN. Interview with the Recreational Director on 1/06/12 at 1/6/12 at 9:54 AM noted that the resident is usually in pain/or discomfort and often refuses to attend recreational activity as a result. 5. Resident #80's MDS dated 4/1/11 identified the resident as severely cognitively impaired, inattentive, and with disorganized thinking. A nurse's note dated 11/30/11 identified that at 5:45 AM the resident was noted as having pain to the right lower limb with movement. Additional review of the nurse's note dated 11/30/11 indicated at 12:30 PM the resident had noted discomfort while radiology exams were initiated. Review of the nurse aide flow sheet dated 11/30/11 identified that R#80 was repositioned at least 3 times for incontinent care. Review of a pain assessment dated 11/30/11 identified the resident ' s pain was more than moderate, approximately an 8, based on nonverbal indicators. Additionally, an initial fracture assessment dated 11/30/11 directed nursing staff to treat the limb as if there was a fracture. Review of the MAR for 11/30/11 failed to identify that the resident's pain was addressed and did not received any pain medication until 5:00 PM (almost 12 hours after onset) as he/she was being transported to the hospital. Interview with the DNS on 1/6/12 at 11:00 AM indicated that the resident was observed sleeping on and off during the day and should have received pain medication when repositioned.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 318	Continued From page 19 resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interviews for one of three sampled residents reviewed for ROM (R#13) the facility failed to ensure that the resident's splint and/or hand roll were applied to prevent a decline. The findings included; Resident #13's diagnoses included CVA, osteoarthritis and arthritis. An MDS dated 11/19/11 identified the resident with memory problems and totally dependent on staff for all ADL's. A RCP dated 11/23/11 identified the resident requires a splint/brace to maintain ROM motion and to support upper extremity, secondary to weakness. Interventions included to apply a splint/brace to the left wrist and elbow, monitor/report skin problems, and consult with therapy when changes or problems occur. A physician's order dated 12/26/11 directed in part, left hand splint "on" at bedtime when in bed and remove in the morning with morning care, apply left elbow splint when OOB only, left hand comfy roll on per resident tolerance. Observation of the resident OOB in the wheelchair, on 1/04/12 and 1/06/12 from 9:45 AM to 11:30 AM identified the resident without benefit	F 318	**F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION** Resident number 13 continues to reside in the facility. The resident has been evaluated by therapy and the degree of the contractures remains unchanged from prior assessments. The resident currently has the hand roll and splint applied per MD orders. Residents who reside at the facility have the potential to be affected by the deficient practice. Nursing staff will be in-serviced on following the individualized plan of care for each resident. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 318	Continued From page 20 of a resting hand splint and/or hand roll. Interview with NA#3 on 1/6/12 at 11:30 AM identified that although she was assigned to provide care to the resident she did no apply the splint because the charge nurse usually applies it. Interview with LPN #3 and review of clinical record on 1/06/12 identified that it is the responsibility of the nurses aide to apply the splint and/or hand roll. Review of the nurses aide assignment on 1/6/12 at 11:45 AM with NA#3 identified that nurse aide assignment included the the application of the splint. Subsequent to surveyor's inquiry the elbow splint was applied, however the hand roll was not available. Interview with OT#1 on 1/06/11 at 12:30 PM identified that she was not aware that the resident's hand roll was missing and indicated that the nurse aides will receive inservice education regarding splint application.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** Resident number 80 continues to reside at the facility and has had no further incidents. The resident has had the side rails removed from her bed. Residents who reside at the facility have the potential to be affected by the deficient practice. Residents who require assistance for transfers will be screened by the therapy department to ensure the most appropriate transfer technique is correct. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 323	Continued From page 21 Based on clinical record review, review of facility investigation, RE and staff interview, for 1 of 4 sampled residents reviewed for accidents, (R#80) the facility failed to ensure that the resident environment remained free of accident hazards and/or the resident received adequate supervision to prevent an accident. The findings include: Resident # 80 diagnoses included PVD, anxiety, urosepsis, hypoglycemia, diabetes and dementia. An MDS dated 9/28/11 identified that the resident had difficulty focusing, had disorganized thinking, and required total assistance for all ADL's. Review of the RCP dated 10/04/11 identified the resident at risk for falls related to non-ambulatory status, dementia and history of anxiety. Interventions included to transfer the resident with the assistance of 2 staff, using a Marissa lift, and 2 half-side rails up when the resident is in in bed. A review of the facility's investigation dated 12/1/11 indicated that on 11/30/11 at 5:40 AM the resident was noted to have a reddened swollen right knee with "limpness", to the right leg and pain on movement. A radiology exam dated 11/30/11 identified a spiral fracture to the distal right femur. Interview with the MD #2 on 1/05/12 at 12:30 PM identified that the spiral fracture diagnosed on 11/30/11 could have only be caused by a fall or a twisting of the limb. Interview with NA #5 on 1/5/12 at 1:30 PM indicated that the resident was resistive of care at times and that prior to the resident's fractured femur on 11/30/11, the	F 323		

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

PRINTED: 02/23/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIO DATE
F 323	Continued From page 22 resident had 2 full rails up while he/she was in bed. Interview with the DNS on 1/5/12 at 1:00 PM identified that she could not determine how the resident sustained the fracture.	F 323		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, review of facility documentation and interviews for 1 of 3 sampled residents reviewed for hydration (R#23), the facility failed to consistently monitor I&O's to ensure that fluid goals were met and new interventions implemented in a timely manner. The findings include: Resident #23 was admitted to the facility on 11/9/11 with diagnoses that included UTI, dehydration. and dementia. An admission MDS dated 11/16/11 identified the resident as severely cognitively impaired and required total assistance with ADL's. A RCP dated 11/29/11 identified the potential for dehydration related to failure to thrive. Interventions included to monitor I&O's, skin turgor, and mucous membrane. Review of a dehydration assessment dated	F 327	**F327 483.25(j) SUFFIEICENT FLUID TO MAINTAIN HYDRATION** Resident number 23 continues to reside at the facility and is currently on comfort measures and has a physician's order to no longer monitor intake and output. Residents who reside at the facility have the potential to be affected by the deficient practice. Licensed nursing staff will be educated with regard to accurate and proper documentation of intake and output Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2C
FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIC DATE
F 327	Continued From page 23 11/09/11 identified the resident was not at high risk for dehydration. Review of the dietary assessment dated 11/9/11 identified the resident's fluid goals between 1150 cc to 1375. Review of laboratory results dated 11/14/11 identified a baseline BUN of 38 mg/dl (normal 7-25 mg/dl) and creatinine as 1.4 mg/dl (normal 0.63 to 1.22 mg/dl). Review of I&O's obtained from the 24-hour nursing report, identified the following: on 11/25/11 the total intake was 980 cc, on 11/26/11 1620 cc, on 11/29/11, 660 cc, on 11/30 data was lacking, on 12/6/11, 500 cc, on 12/13/11, 1020 cc, on 12/14/11, 540 cc, and on 12/16/11, 780 cc, on 12/17/11, 600 cc, on 12/18/11, 720 cc and on 12/19/11, 1320 cc. However review of the clinical record failed to reflect any new interventions were implemented when the resident's estimated fluid goals were not met. Laboratory results dated 12/19 identified a BUN of 54 mg/dl and creatinine of 1.95 mg/dl. Nurse's note dated 12/20/11 identified the resident was transferred to the hospital for hydration. Review of the hospital discharge summary dated 12/23/11 identified R#23 was admitted to the hospital due to abnormal laboratory findings which identified the resident as mildly dehydrated. Interview with the DNS on 1/6/12 at 1:30 PM identified the resident's I&O were not consistently monitored according to facility policy. Review of the facility's Hydration Protocol identified that Unit Managers are responsible for reviewing I&O's to determine if fluid requirements have been met. If fluid requirements have not been met, then the hydration protocol is initiated.	F 327		

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

PRINTED: 02/23/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. This REQUIREMENT is not met as evidenced by: Based on review of clinical record and interviews for one of ten sampled residents review for unnecessary drugs (R#28) the facility failed to obtain blood work in a timely manner. The findings include:	F 329	**F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Resident number 28 continues to reside at the facility. She has had no incidence of seizure. Most recent dilantin level obtained on 1/23/12 was 15.1 mg/L, reference range 10 to 20. Residents who reside at the facility have the potential to be affected by the deficient practice. All pharmacy recommendations will be addressed in a timely manner with the APRN or physician of record. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2C
FORM APPROVI
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETIC DATE
F 329	Continued From page 25 Resident # 28's diagnoses included malignant brain lesion, seizure and hypothyroidism. A physician order dated 9/11 through 1/12 directed in part Phenytoin Sodium, ER, 100 mg, two times a day. Review of the Drug Regimen Review dated 11/22/11 identified a pharmacy recommendation to obtain a Dilantin level. Review of laboratory results and subsequent call to the laboratory by RN#2 on 1/06/12 at 11:15 AM indicated that the last Dilantin level was drawn on 6/29/11 with a level of 19.8 mg/dl (normal level 10-20 mg/dl). Interview with RN#2 on 1/6/12 at 11:25 AM indicated that he was unsure as to why a Dilantin level was not drawn for resident. Review of the facility laboratory book and R#28's clinical record failed to reflect that an order was obtained and/or that a laboratory requisition was completed. Interview with the DNS on 1/06/12 at 12:30 PM identified that she is responsible to ensure that blood work is obtained according to pharmacy recommendations	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one of ten sampled residents observed for medications administration (R#13) the facility failed to administer the medication as ordered by the physician. The findings include:	F 332	**F332 483.25(m) (1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE** Resident number 13 continues to reside at the facility and has no ill effects from the day the medication was late. Residents who reside at the facility have the potential to be affected by the deficient practice. Medication times have been adjusted to facilitate medications being administered in a timely manner. Nursing staff will be educated that medications may only be administered within the acceptable time frames. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2(
FORM APPROV
OMB NO. 0938-0:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETI DATE
F 332	Continued From page 26 Resident #13's diagnoses included Diabetes mellitus, Vascular Dementia and hypertension. A physician order dated 12/26/11 directed Amlodipine Besyl 10 mg, one tablet by mouth, every day, Child Aspirin 81 mg, chewable, one tablet by mouth, every day at 8 AM, Cymbalta 30 mg capsule by mouth every day at 8:00 AM, Furosemide 20 mg, one half tablet (10 mg) at 8:00 AM, Glipizide 5 mg tablet, by mouth every day at 8:00 AM, Acetaminophen 500 mg capsule, 2 capsules, by mouth every day at 8:00 AM, Multivitamin and minerals formula, one tablet by mouth every day at 8:00 AM, Phenobarbital 60 mg tablet, one tablet by mouth, twice daily at 8:00 AM and 4:00 PM, Refresh Dry Eye Therapy, instill one drop into both eyes every day at 8:00 AM, Senna 8.6 mg, 2 tablets (17.2 mg) by mouth daily at 8:00 AM, Calcium and Vitamin 600/200 mg, one tablet by mouth at 8:00 AM, and Metformin HCl 500 mg, one tablet by mouth, twice daily at 8:00 AM and 4:00 PM. The medication pass was observed at 10:44 AM on 1/06/12, 2 hours and 44 minutes after the scheduled time. Interview with LPN #3 on 1/06/12 at 10:50 PM indicated that the medications were late because he/she had stopped along the way to do treatments so the resident could get out of bed to go to therapy.	F 332		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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

PRINTED: 02/23/2
FORM APPROV
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETI DATE
F 428	Continued From page 27 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on clinical record review of and interviews for one of ten sampled residents review for unnecessary drugs (R#28) the facility failed to ensure that pharmacy recommendations were acted upon. The findings include: Resident # 28's diagnoses included malignant brain lesion, seizure and hypothyroidism. A physician's order dated 9/11 through 1/12 directed phenytoin sodium, ER 100 mg two times a day. Review of the DRR review dated 11/22/11 identified a pharmacy recommendation for a Dilantin level. Review of laboratory results and subsequent call to the laboratory by RN#2 on 1/6/12 at 11:15 AM indicated that the last Dilantin level was drawn on 6/29/11 with a level of 19.8 mg/dl (normal level 10 -20 mg/l). Interview with RN#2 on 1/6/12 at 11:25 AM identified he was unsure as to why the Dilantin level was not drawn. Review of the facility laboratory book and the clinical record failed to identify that an order was obtained and/or a laboratory requisition was completed for a Dilantin level. Interview with DNS on 1/6/12 at 12:30 PM identified that she is responsible for reviewing the pharmacy recommendations and then the unit managers are responsible to ensure pharmacy recommendations are completed. Further interview with the DNS identified that she is not sure why the pharmacy recommendations were	F 428	**F428 483.60(c) DRUG REGIME REVIEW, REPORT IRREGULAR, ACT ON** Resident number 28 continues to reside at the facility. She has had no incidence of seizure. Most recent Dilantin level obtained on 1/23/12 was 15.1 mg/L, reference range 10 to 20. Residents who reside at the facility have the potential to be affected by the deficient practice. All pharmacy recommendations will be addressed in a timely manner with the APRN or physician of record. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2(
FORM APPROV
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETI DATE
F 428	Continued From page 28 not acted upon. Review of facility policy identified that consultant pharmacy report recommendations are acted upon by the facility staff and or the prescriber.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	F 431	**F431 431.60(b) (d)(e)DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICAL** Residents who reside at the facility have the potential to be affected by the deficient practice. Nursing staff will be educated on the policy of expired medications, or medications to be destroyed. Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2
FORM APPRO\
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLET DATE
F 431	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to discard opened and unused liquid stock medications according to standards of facility practice. The findings included: Observation in the medication room storage area on 1/04/12 at 12:45 PM with the medication nurse identified (2) one quart bottles of opened Hyfiber liquid fiber dated 3/29/11 and 5/11/11. Interview with the unit supervisor identified that opened medications should be discarded after 30 days and it is nursings responsibility to monitor and discard the medication. The supervisor indicated that the pharmacist consultant had just checked the day before and did not know how they had missed it. Review of facility policy on Medication Ordering, Receiving and storage identifies that nursing is responsible for maintaining medication storage and preparation areas in clean, safe and sanitary manner.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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	F 514	**F514 483.75(l)(i) RECORDS-COMPLETE/ACCURATE/ACCESSIBILE** Resident number 23 continues to reside at the facility and is currently on comfort measures and has a physician's order to no longer monitor intake and output. Residents who reside at the facility have the potential to be affected by the deficient practice. Licensed nursing staff will be educated with regard to accurate and proper documentation of intake and output Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings and trends will be reported to the QA Committee with additional recommendations as necessary. Administrator and/or designee will have the responsibility for compliance. Compliance date, February 14, 2012.	

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

PRINTED: 02/23/2
FORM APPRO\
OMB NO. 0938-0:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETI DATE
F 514	Continued From page 30 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 record review and interviews for one of three sampled resident reviewed for hydration (R#23) the facility failed to maintain a complete medical record. The findings include: 1. Resident #23 was admitted to the facility on 11/9/11 with diagnoses that included UTI, dehydration. and dementia. An admission MDS dated 11/16/11 identified the resident as severely cognitively impaired and required total assistance with ADL's. A RCP dated 11/29/11 identified the potential for dehydration related to failure to thrive. Interventions included to monitor I&O's, skin turgor, and mucous membrane. Review of a dehydration assessment dated 11/09/11 identified the resident was not at high risk for dehydration. Review of the dietary assessment dated 11/9/11 identified the resident's fluid goals between 1150 cc to 1375 cc. Review of I&O's obtained from the 24-hour nursing report, identified the following: on 11/25/11 the total intake was 980 cc, on 11/26/11 1620 cc, on 11/29/11, 660 cc, on 11/30 data was lacking, on 12/6/11, 500 cc, on 12/13/11, 1020 cc, on 12/14/11, 540 cc, and on 12/16/11, 780 cc, on 12/17/11, 600 cc, on 12/18/11, 720 cc and on	F 514		

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

PRINTED: 02/23/2(
FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

(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) COMPLETI(DATE
F 514	Continued From page 31 12/19/11, 1320 cc. Interview with the DNS on 1/6/11 at 2:00 PM identified that the information was documented on the 24 hour nursing report, and was not part of the clinical record.	F 514		