	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S	
		075201	B. WING			С
NAME OF F	ROVIDER OR SUPPLIER	4		TREET ADDRESS OF A STATE OF THE	01/0	06/2012
PARADIO	SM HEALTHCARE CI	ENTER OF WEST HAVEN, LLC		REET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516		
. (X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 000	INITIAL COMMEN	TS	F 000			
	Abbreviations which document include	ch may be used throughout this the following:				,
	ADL ('s) - activities ADNS - Assistant [ APRN - Advanced	of daily living Director of Nursing Practice Registered Nurse				,
	BID two times per BUN - Blood Urea	day Nitrogen				
	DNS/DON - Directo	pstructive pulmonary disease ular accident (stroke) or of Nursing				
	DM- diabetes melli DRR- drug regimer GI - gastrointestina	n review I			:	
}	IV - Intravenous LPN - Licensed Pra	utput monitoring/measuring				
	MD   Medical Docto	or ata Set (interdisciplinary				777
	MI - myocardial infa MRSA - Methicillin I Aureus	rction (heart attack) Resistant Staphylococcus				
	MDRO - Multi Drug NA - Nurse Aide	Resistant Organisms	-			
	OOB- out of bed OT - Occupational 1 PO- orally	·				
1.	PT - Physical Thera RCP - resident care RE- reportable even	plan				
	RN - Registered Nu ROM - range of mot SW - Social Worker	ion		Please note the filing of this plan of correcti not constitute any admission as to the alleg deficiencies. The plan of correction is filed	ed oc	
F 161	√RE - Vancomycin F	Resistant Enterococcus Y BOND - SECURITY OF	F 161	evidence of the facilities continued complian applicable laws.	ice with	
	+T//J			1.	1210	PUC
Z, (	THE CITY SOR PROVIDE	RISUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITILE_	May X	X6) DATE
a -					, ,	

01:59:14 p.m.

02-27-2012

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ORM 6445-2567(02-99) Previous Versions Obsolete

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Event tD: 9EQQ11

Facility iD: CT0019

If continuation sheet Page 1 of 32

01:59:40 p.m. 02-27-2012

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

PRINTED: 02/23/20 FORM APPROVE

		·		OMB NO	0.0938-03
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ		(X3) DATE SURVEY COMPLETED	
075201		B. WING			С
	NTER OF WEST HAVEN, LLC	S.	310 TERRACE AVE		06/2012
SUMMA DV ST	Select and the selection of the selectio		WEST HAVEN, CT 06516		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	EACH CORRECTIVE ACTION S	HOULD 8F	(X5) COMPLETIC DATE
The facility must pu otherwise provide a Secretary, to assure	irchase a surety bond, or issurance satisfactory to the ethe security of all personal	F 16	F161 483.10(c)(7) SURETY BOND-SE PERSONAL FUNDS  Residents who reside at the facility have be affected by the deficient practice.	the potential to	
This REQUIREMENT by: Based on review or staff interviews, the surety bond to provito the resident's per findings include:	NT is not met as evidenced  f facility documentation and facility failed to obtain a ide coverage against any loss sonnel funds accounts. The		security of all personal funds of residents with the facility.  Administrator and/or designee will have	deposited	
that the total amount funds account as \$2 the facility's insurant to reflect that a sure of the policy to provipersonal funds accounting a surety bond 483.10(n) RESIDEN DRUGS IF DEEMED An individual resident the interdisciplinary \$483.20(d)(2)(ii), has practice is safe.  This REQUIREMENT by:	t in the resident's personal 19,235.00. However, review of the policy dated 1/3/12 failed ty bond was included as part de coverage for the resident's bunt. Subsequent to surveyor di was obtained by the facility. IT SELF-ADMINISTER DISAFE and may self-administer drugs if the team, as defined by a determined that this	F 176	Resident number 5 has a completed self-a of medication assessment to determine ab administer medications.  Residents who reside at the facility have the affected by the deficient practice.  Staff will be in-serviced on the importance completing this assessment on admission and trends will be conducted weekly months or until substantial compliance is a and trends will be reported to the QA Compadditional recommendations as necessary, designee will have the responsibility for conducting the process of the commendation of the commendations as necessary, designee will have the responsibility for conducting the commendations as necessary.	dministration ility to self- he potential to e of and quarterly. for three (3) met. Findings mittee with	
	PROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY  REGULATORY OR L  Continued From pa  The facility must purotherwise provide a Secretary, to assurfunds of residents of the resident's per findings include:  Interview and review of staff interviews, the surety bond to provide to the resident's per findings include:  Interview and review funds accounts on that the total amount funds account as \$4 the facility's insurance to reflect that a sure of the policy to providersonal funds account as \$4 the facility's insurance to reflect that a sure of the policy to providersonal funds account as \$4 the facility's insurance to reflect that a sure of the policy to providersonal funds account as \$4 the facility's insurance to reflect that a sure of the policy to providersonal funds account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility's insurance to reflect that a sure of the policy to provide account as \$4 the facility in the policy to provide account and the p	PROVIDER OR SUPPLIER  IGM HEALTHCARE CENTER OF WEST HAVEN, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 personnal 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. 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by \$483.20(d)(2)(ii), has determined that this practice is safe.	OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULD  (X3) MULD  (X4) MULD  (X5) MULD  (X6) MURD  (X6) MURD  (X7) MUST  (X7) MUST  (X6) MURD  (X7) MUST  (X7) MUST  (X6) MUST  (X7) MUST  (X8) MURD  (X8) MURD  (X8) MURD  (X8) MURD  (X8) MURD  (X9) MURD  (X9) MURD  (X9) MURD  (X9) MURD  (X1) MURD  (X2) MURD  (X6) MURD  (X6) MURD  (X7) MURD  (X7) MURD  (X8) MURD  (X2) MURD  (X8) MURD	A BUILDING  OF CORRECTION  (X1) PROVIDER OR SUPPLIER  OF CORRECTION  OF SO11  DEPTIFICATION NUMBER:  OF SO12  DEPTIFICATION NUMBER:  OF SO12  DEPTIFICATION NUMBER:  OF SO12  DEPTIFICATION NUMBER:  OF SO12  STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516  SUMMARY STATEBERY OF DEFICIENCIES  (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 falled to obtain a surety bond to provide coverage against any loss to 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 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 obtained by the facility.  An individual resident may self-administer 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:  Safed will be inserviced on the importance completing this assessment on admission.  Residents who reside at the facility have the affected by the deficient practice.  F176 482.10(a) RESIDENT SELF-ADM DRUGS IF DEEMED SAFE  F176 483.20(d)(2)(iii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by:  Administrator and/or designee will have responsibility for completing this assessment on admission.  Residents who reside at the facility have the affected by the deficient practice.  Safeth will be in serviced on the importance completing this aspessment on admission.  Residents who reside at the facility have	TO PERFORMENTS OF CORRECTION  (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMPL (X4) CASH CASH COMPL (X4) CASH CASH COMPL (X4) CASH CASH COMPLIANCE (X5) DATE COMPLIANCE (X

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/23/201 FORM APPROVE <u>39</u>

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
•		A. BUILDING  B. WING	COMPLETED
NAME OF PROPERTY OF STREET	075201	D. VVIIVO	01/06/2012
NAME OF PROVIDER OR SUPPLIER  PARADIGM HEALTHCARE OF	MITED OF WEST HAVEN ALO	STREET ADDRESS, CITY, STATE, ZIP CODE	

		0/5201	-/:::://		01/06/2012	
	PROVIDER OR SUPPLIER SM HEALTHCARE CE	NTER OF WEST HAVEN, LLC	s	TREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516	· · · · · · · · · · · · · · · · · · ·	
. (X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPRINCE OF	JLD BE COMPLETION	
	observed during macility failed to condetermine the resident medications. The finger resident medications. The finger resident medications. The finger resident medication of the final medication of the final medication. Interview of the final medication. Interview of the final medications. Interview of final medications. Interview of final medications. Interview with LPN# indicated that reside locked drawer and the final medication of the final medications. Interview with LPN# indicated that reside locked drawer and the final medication a self-admedication a s	ne of ten sampled residents edication pass (R#5), the iplete an assessment to ent's ability to self-administer	F 17	6		

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		a MEDICAID SERVICES				OMB NO	D. <u>09</u> 38-039
STATEMENT OF DEFICIENCIES (X1) PAND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		075201	B, WIN	G		01/	C 06/2012
NAME OF PROVIDER OR SUPPLIER  PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC			310	ET ADDRESS, CITY, STATE, ZIP CODE TERRACE AVE		: · <u>    - · · · · · · · · · · · · · · · · · </u>	
	·	<u> </u>		WE	EST HAVEN, CT 06516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	. PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 223	she administered A because the reside LPN#1 indicated the and NA#2 hold the resident was attempted the catheter insertion resident was yelling names. LPN#1 indicated the proced never made the required that at no time did solar or cover the residentified that he work pM-11:00 PM shift), approximately 12:30 documentation he resuppose to replace When LPN#2 went the Foley catheter, time. LPN #2 indicated when he to that she could not diassistance with the he assisted LPN#1, the (indicated when he to that she could not diassistance with the he assisted LPN#1 while NA #1 and NA LPN #1 then cathering resident was heard the procedure. LPN# did he observe any sersident's mouth or suppose the resident with NA #1 interview with NA #1	tivan 0.25 mg by mouth int had been yelling that day, at she requested that NA#1 resident's arms, because the oting to push her away during on. LPN#1 indicated the and calling the staff foul cated that she would have ure, however the resident uest. LPN #1 also indicated the witness any staff member sident's mouth.  #2 on 1/05/12 at 4:30 PM orked on 11/10/11 (3:00  LPN#2 indicated that at 0 PM while completing his emembered that he was R #108's Foley catheter, into R#108's room to change the resident refused at that ted that he notified the (11 ervisor who instructed him to 11 PM-7 AM) nurse. LPN#2 old LPN #1, LPN #1 indicated to it herself and requested procedure. LPN#2 indicated to it herself and requested procedure. LPN#2 indicated to y spreading R#108's legs #2 held the resident's hands, zed the resident while the yelling and swearing during #2 indicated that at no time staff member cover the slap the resident.	F 2	23			
	identified that on 11/	o hold R#108's hand while		-			

02:01:39 p.m.

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

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075201		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		B. WING		C		
NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC				REET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516	01/0	06/2012
(X4) ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP  DEFICIENCY)	OURDRE	(X5) COMPLETIO DATE
SS=D	LPN #2 catheterize that she held one in NA#1 indicated she because the reside # 2 who was cather indicated the reside and stated, "I am gishe or any other stand/or covering the Interview with NA# identified that on 1" AM she was asked catheterized the rewas on one side of on the other side, was yelling and usi indicated that she is because the reside with his/her hands/no time did she obscover the residents 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negleand misappropriation. This REQUIREMENT by:  Based on clinical repolicy, review of RE of 4 sampled reside R#80), the facility fa	ed the resident. NA#1 indicated hand and NA#2 held the other. e held R#108's hand loosely ent attempted to swing at LPN derizing the resident. NA#1 ent was yelling and swearing roing to get you." At no time did aff member observe hitting e resident's mouth.  12 on 1/06/12 at 6:20 AM 1/11/11 at approximately 1:00 to calm R#108 while LPN #2 sident. NA#2 indicated she the resident and NA #1 was NA#2 indicated that R#108 ing curse words. NA#2 neld the resident's hand int was trying to get at LPN #2 arms. NA#2 indicated that at serve any staff slap and/or mouth.  12 P/IMPLMENT  13 ETC POLICIES	F 226	F226 483.13(c) DEVELOP/IMPLEMENT	potential to  three (3)  Findings  ittee with	

02-27-2012

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

PRINTED: 02/23/20 FORM APPROVE,

		WEDIOAD OFFICES	<del>-</del>			OMB NO	D0938 <b>-</b> 03!
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-		075201	B. Wil	۱Ġ _		01/	C 06/2012
	PROVIDER OR SUPPLIER  GM HEALTHCARE CE	NTER OF WEST HAVEN, LLC	- · · · · · · · · · · · · · · · · · · ·		TREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516		06/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETIO DATE
1	policy. The findings  1. Resident #23 on 11/9/11 with diagon rheumatoid arthritists MDS dated 11/16/1 severely cognitively total assistance with frequent pain, the won the pain scale. Find 12/20/11 identified to transferred to the hot that the resident premultiple rib fractures.  Review of the RE in total assistance with required bed baths, documentation faile completed a thoroughthe DNS on 1/05/12 facility concluded the fractures during the and as a result a national line and as a result a national line and as a result and assessed to be one hospitalization on 12 fractures were definablegedly sustained of MD #2 on 1/6/11 at owere old.	s include:  B was admitted to the facility gnoses that included and dementia. An admission 1 identified the resident as impaired cognition, required a ADL and experienced forst pain was identified as a 6 deview of a RE report dated that when R#23 was ospital, the hospital reported, esented to the hospital with s.  dicated that R#23 required a care, was bed bound and Further review of the dot reflect that the facility gh investigation. Interview with at 2:00 PM identified that the at R#23 sustained the hospitalization on 12/20/11 arrative note was completed.  If on 1/6/12 at 11:50 AM are of the fracture was or two weeks prior to 12/20/11 and indicated that the itely older than injuries on 12/20/11. Interview with 12:25 PM noted the fractures	F 2		5		
	they determined the hospital. Review of a	on reflected a narrative that fracture occurred in the the facility Abuse Prevention t, the facility will ensure that					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES GENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/201; FORM APPROVE(

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STATEMENT OF DEFICIENCIES	(X1) PROV
AND PLAN OF CORRECTION	IDE UT

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

075201

B. WING\_

С 01/06/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE

## PARADIGM HEALTHCARE CENTER OF WEST HAVEN LLO

PARADI	GM HEALTHCARE CENTER OF WEST HAVEN, LLC			810 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 PREFI TAG	— х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.	F 2	<del></del> -	CROSS-REFERENCED TO THE APPROPRIATE	DATE
	Review of the facility's investigation related to this njury of unknown origin included only 3 statements from staff, 2 statements were unsigned and could not be determined who made				
avi UMS-2567	7(02-99) Previous Versions Obsolute				1

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	NO FUR MEDICARE	& MEDICAID SERVICES			OMB NO	0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		075201	B. WING	<b>3</b>	04/1	C 06/2012
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		3612012
PARADIO	SM HEALTHCARE CE	ENTER OF WEST HAVEN, LLC		310 TERRACE AVE WEST HAVEN, CT 06516		
(X4) ID PREFIX TAG	! (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 226 F 281	the statements. In 1/06/12 at 11:15 AN obtain additional st	terview with the DNS on M indicated that she failed to aff interviews,	F 2:			
SS=D	PROFESSIONAL S  The services provides	RVICES PROVIDED MEET STANDARDS ded or arranged by the facility ional standards of quality.	F 21	F281 483.20(k)(3)(i) SERVICES I MEET PROFESSIONAL STAND Resident number 5 continues to resident has been assessed for self-admir medication.	DARDS de in the facility	
	by: Based on clinical nation facility policy, observed for ten sampled resistant medication administration one of three sampled control (R#23) and/resident reviewed for failed to provide set standards of quality  1. Resident #5 obstructive pulmonate dependent, depressioned attended 1/03/11 puffs by mouth four ipratropium-albutered duoneb 0.5 mg-3 mevery 6 hour, and Aday. Observations of	ecord reviews, a review of rvations and interviews for one dents observed during the stration pass (#5) and/or for ed resident reviewed for pain for for one of three sampled or hydration (R#30) the facility rvices to meet professional. The findings include: diagnoses include chronic ary disease, oxygen sion and anxiety. A physician directed combivent inhaler 2 times per day, of 0.5-3(2.5)mg/3 comp. to I, 1 unit dose via nebulizer tivan 1.0 mg, three times a of medication administration PM identified that R#5 refused		Resident number 23 continues to res and has had a pain assessment comp continues on standing dose of pain in Resident number 30 continues to res and has not exhibited any signs or sy dehydration.  Residents who reside at the facility has affected by the deficient practice.  Licensed nursing staff will be educated completing self-medication assessment and quarterly.  Licensed nursing staff will be educated completing pain assessments on admand with any new episode of pain.  Licensed nursing staff will be educated by the deficient protocol.  Random audits will be conducted we months or until substantial compliant and trends will be reported to the QA additional recommendations as necessaries.	oleted. The resident nedications.  Iside in the facility symptoms of the potential to the nedication of the nedication o	

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

designee will have the responsibility for compliance.

Compliance date, February 14, 2012.

02:03:16 p.m. 02-27-2012

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

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

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01/06/2012

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AND	PLAN	OF	COR	REC	TION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

075201

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

B. WING\_

NAME OF PROVIDER OR SUPPLIER

### PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE

WEST HAVEN OF 06546

		1	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.	F 281		
	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		· .	

02:03:39 p.m.

02-27-2012

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

PRINTED: 02/23/201; FORM APPROVEL OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

075201

B. WING

С 01/06/2012

NAME OF PROVIDER OR SUPPLIER

### PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE

PARADIGIN HEALTHCARE CENTER OF WEST HAVEN, LLC			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) OMPLETION 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.	F 2	81			
	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					

PRINTED: 02/23/201 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 075201 01/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC WEST HAVEN, CT 06516 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 281 Continued From page 12 F 281 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

17/35

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

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

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

A. BUILDING

COMPLETED

075201

B. WING

С 01/06/2012

NAME OF PROVIDER OR SUPPLIER

#### PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE

WEST HAVEN CT 06516

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(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	F 281		
F 282 SS=D	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.  483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	·	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		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.	
	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:		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.	
	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			

18 /35

02:04:46 p.m.

PRINTED: 02/23/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY NO PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 075201 01/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC WEST HAVEN, CT 06516 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 14 F 282 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. 483.25 PROVIDE CARE/SERVICES FOR F 309 F 309 HIGHEST WELL BEING SS≃G 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)

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

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

STATEMENT C	F DEFICIENCIES
AND PLAN OF	CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

075201

B. WING

С 01/06/2012

NAME OF PROVIDER OR SUPPLIER

#### PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE

PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC			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	FIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
F 309	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	F 3	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.	
	sugar before meal at 6:30 AM, 11:30 AM and 4:30		Compliance date, February 14, 2012.	

02:05:36 p.m.

02-27-2012

20 /35

PRINTED: 02/23/2012

	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE	
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NAME OF PROVIDER OR SUPPLIER  PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  310 TERRACE AVE  WEST HAVEN, CT 06516	· :
. (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (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 1/06/12 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/23/20 FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERS IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
***		075201	B. WII	NG_		04#	C 06/2012
•		ENTER OF WEST HAVEN, LLC	1	] 3	REET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516	) 01/1	36/2012
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F 309	rheumatoid arthritis MDS dated 11/16// severely cognitively assistance with AD pain, the worst pain pain scale. A RCP risk for alteration in chronic severe rhe contractures. Interpain assessment, operation on 1/0 premeditate before report ineffective patholic physician.  Observation on 1/0 morning care indicagrimacing and reported that in the nursing staff that the about pain. Intervied 12:00 PM identified medication change with APRN #1 on 1/2 that R#23's pain levilast assessment with assessment with assessment scale of indicating the worst scale.  Interview with LPN ridentified that the reapproximately 8:30 reported that the resthe issue was reported the interview with LPN ridentified that the resthe issue was reported that the resthe issue was reported the interview with LPN ridentified that the resthe issue was reported that the resthe issue	age 17 s and dementia. An admission of identified the resident as a manage in identified the resident as a manage in identified as a 6 on the dated 11/10/11 identified the accomfort related to a history of furnatoid arthritis and arthritis arthritis and arthritis arthritis arthritis and arthritis arthritis arthritis and arthritis arthritis arthritis arthritis arthritis arthritis and arthritis arthritis arthritis arthritis arthritis arthritis arthritis and arthritis and arthritis arth	F	309			

02:06:22 p.m. 02-27-2012

22 /35

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/201 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 075201 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 309 Continued From page 18 F 309 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. 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

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. 483.25(e)(2) INCREASE/PREVENT DECREASE

Based on the comprehensive assessment of a

identified the resident's pain was more than

F 318

ORM CMS-2567(02-99) Previous Versions Obsolete

IN RANGE OF MOTION

F 318

SS=D

Event ID: 9EQQ11

Facility ID; CT0019

If continuation sheet Page 19 of 32

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE : OMB NO. 0938-03! STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 075201 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) Continued From page 19 F 318 resident, the facility must ensure that a resident with a limited range of motion receives F318 483.25(e)(2) INCREASE/PREVENT appropriate treatment and services to increase DECREASE IN RANGE OF MOTION range of motion and/or to prevent further 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. This REQUIREMENT is not met as evidenced Residents who reside at the facility have the potential to be affected by the deficient practice. Based on clinical record review, observation and interviews for one of three sampled residents Nursing staff will be in-serviced on following the reviewed for ROM (R#13) the facility failed to individualized plan of care for each resident. ensure that the resident's splint and/or hand roll Random audits will be conducted weekly for three (3) were applied to prevent a decline. The findings months or until substantial compliance is met. Findings included: and trends will be reported to the QA Committee with additional recommendations as necessary. DNS and/or Resident #13's diagnoses included CVA, designee will have the responsibility for compliance. osteoarthritis and arthritis. An MDS dated Compliance date, February 14, 2012. 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

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

wheelchair, on 1/04/12 and 1/06/12 from 9:45 AM to 11:30 AM identified the resident without benefit

splint/brace to the left wrist and elbow,

comfy roll on per resident tolerance.

Observation of the resident OOB in the

02:07:10 p.m.

24/35

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/201 FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-039 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING  $\mathbf{C}$ B. WING 075201 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 318 Continued From page 20 · F 318 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 323 483.25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES SS≃G F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident Resident number 80 continues to reside at the facility environment remains as free of accident hazards and has had no further incidents. The resident has had as is possible; and each resident receives the side rails removed from her bed. adequate supervision and assistance devices to Residents who reside at the facility have the potential to prevent accidents. 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.

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This REQUIREMENT is not met as evidenced

Compliance date, February 14, 2012.

02:07:34 p.m. 02-27-2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/23/20

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	M APPROVI 0. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION NG	(X3) DATE : COMPL	SURVEY
	075201				01/	C 06/2012
NAME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		
PARADIO	SM HEALTHCARE CE	NTER OF WEST HAVEN, LLC	- 1	310 TERRACE AVE WEST HAVEN, CT 06516		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 323	_ =	•	F 323	3		
	investigation, RE a sampled residents the facility failed to environment remai and/or the resident supervision to previnclude:  Resident # 80 anxiety, urosepsis, dementia. An MDS the resident had diffusorganized thinking assistance for all A Review of the RCP resident at risk for fatatus, dementia ar Interventions including assistance of 2	diagnoses included PVD, hypoglycemia, diabetes and dated 9/28/11 identified that ficulty focusing, had				
	A review of the facil 12/1/11 indicated th resident was noted right knee with "limp pain on movement.	lity's investigation dated lat on 11/30/11 at 5:40 AM the to have a reddened swollen loness", to the right leg and A radiology exam dated a spiral fracture to the distal				

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

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING

OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

SUMMARY STATACH DEFICIENCY GULATORY OR LS  ued From pagent had 2 full range with the DI ed that she co	ils up while he/she was in	ID PREFD TAG	310 WE:	TADDRESS, CITY, STATE, ZIP CODE TERRACE AVE ST HAVEN, CT 06516  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION	6/2012 (X5) COMPLETIC DATE
SUMMARY STATACH DEFICIENCY GULATORY OR LS  ued From pagent had 2 full range with the DI ed that she co	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. C IDENTIFYING INFORMATION)  Je 22  Ils up while he/she was in	ID PREFIX TAG	310 WE:	TERRACE AVE ST HAVEN, CT 06516  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF T	unar l	COMPLETIC DATE
ued From pagent had 2 full ra	MUST BE PRECEDED BY FULL. C IDENTIFYING INFORMATION)  HE 22  ils up while he/she was in	PREFD TAG	_	CROSS-REFERENCED TO THE APPRO	unar l	COMPLÉTIO DATE
nt had 2 full ra www.ith the Di ed that she co	ils up while he/she was in	F 3:	23			
(j) SUFFICIE! ATION cility must pro	vild not determine how the se fracture.  NT FLUID TO MAINTAIN  vide each resident with to maintain proper hydration	F 32	F. M. R. ar ph ou	AAINTAIN HYDRATION  desident number 23 continues to reside at the and is currently on comfort measures and has a hysician's order to no longer monitor intake autput.	a and	
on clinical red documentation d residents re lity failed to co that fluid goals dings include: esident #23 w with diagnose tion. and dem 1/16/11 identifiely impaired a L's. A RCP da I for dehydrations in terventions in lor, and muco	rord reviews, review of and interviews for 1 of 3 viewed for hydration (R#23), ensistently monitor I&O's to swere met and new ented in a timely manner.  The state of the facility on a state included UTI, entia. An admission MDS ed the resident as severely and required total assistance ted 11/29/11 identified the on related to failure to cluded to monitor I&O's, us membrane.		Li ac Ra me an ad des	icensed nursing staff will be educated with recurate and proper documentation of intake as andom audits will be conducted weekly for it onths or until substantial compliance is met. It is not trends will be reported to the QA Committed the commendations as necessary. Designee will have the responsibility for committing the commendations as necessary.	ree (3) Findings ee with	
citing all a control of the control	ity must prove fluid intake th.  QUIREMENT or clinical recommentation residents recommentation residents recommentation in clinical second fluid goals ons implements include:  sident #23 with diagnose on, and dem 16/11 identifity impaired at a RCP data for dehydratic erventions in r, and mucon in r, and mucon in the side of the	ity must provide each resident with the fluid intake to maintain proper hydration th.  QUIREMENT is not met as evidenced in clinical record reviews, review of recumentation and interviews for 1 of 3 residents reviewed for hydration (R#23), y failed to consistently monitor I&O's to leat fluid goals were met and new ons implemented in a timely mapper.	ity must provide each resident with the fluid intake to maintain proper hydration th.  QUIREMENT is not met as evidenced in clinical record reviews, review of recumentation and interviews for 1 of 3 residents reviewed for hydration (R#23), y failed to consistently monitor I&O's to real fluid goals were met and new ons implemented in a timely manner. The ings include:  sident #23 was admitted to the facility on ith diagnoses that included UTI, on, and dementia. An admission MDS 16/11 identified the resident as severely y impaired and required total assistance is A RCP dated 11/29/11 identified the for dehydration related to failure to reventions included to monitor I&O's, r, and mucous membrane.	ity must provide each resident with the fluid intake to maintain proper hydration th.  QUIREMENT is not met as evidenced  In clinical record reviews, review of recumentation and interviews for 1 of 3 residents reviewed for hydration (R#23), y failed to consistently monitor I&O's to reat fluid goals were met and new rons implemented in a timely manner. The single include:  Sident #23 was admitted to the facility on ith diagnoses that included UTI, ron, and dementia. An admission MDS 16/11 identified the resident as severely y impaired and required total assistance as A RCP dated 11/29/11 identified the for dehydration related to failure to reventions included to monitor I&O's, r, and mucous membrane.	ity must provide each resident with a fluid intake to maintain proper hydration th.  PUIREMENT is not met as evidenced an clinical record reviews, review of procumentation and interviews for 1 of 3 residents reviewed for hydration (R#23), yfailed to consistently monitor I&O's to at fluid goals were met and new ons implemented in a timely manner. The include:  Sident #23 was admitted to the facility on the diagnoses that included UTI, on, and dementia. An admission MDS 16/11 identified the resident as severely yfurnal methods as severely yfurnal methods are severely the included to monitor I&O's, read mucous membrane.  F327 483.25(j) SUFFIEICENT FLUID TO MAINTAIN HYDRATION  Resident number 23 continues to reside at the and is currently on comfort measures and has a physician's order to no longer monitor intake and proper documentation of intake and trends will be reported to the QA Committed additional recommendations as necessary. DN designee will have the responsibility for complication of the diagnoses that included UTI, on, and dementia. An admission MDS 16/11 identified the resident as severely yfurnal methods and required total assistance is A RCP dated 11/29/11 identified the or dehydration related to failure to preventions included to monitor I&O's, r, and mucous membrane.	ity must provide each resident with the fluid intake to maintain proper hydration th.  POUIREMENT is not met as evidenced in clinical record reviews, review of recumentation and interviews for 1 of 3 residents reviewed for hydration (R#23), y failed to consistently monitor I&O's to last fluid goals were met and new ons implemented in a timely manner. In and dementia. An admission MDS 16/11 identified the resident as severely y impaired and required total assistance is ARCP dated 11/29/11 identified the for dehydration related to failure to perventions included to monitor I&O's, r, and mucous membrane.

02:08:19 p.m. 02-27-2012

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROV OMB NO. 0938-03 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING

		075201	B. Wil	NG_			C
NAME OF F	ROVIDER OR SUPPLIER		_ <del></del>	- CT	COEET ADDOCCO OUT OT THE		//06/2012
PARADIO	· _ ·	NTER OF WEST HAVEN, LLC	•		FREET ADDRESS, CITY, STATE, ZIP 310 TERRACE AVE WEST HAVEN, CT 06516	CODE	
(X4) ID PREF(X TAG	LEACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	īX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 327	C					· · · · · · · · · · · · · · · · · · ·	<del></del>
F 32/	Continued From pag		F:	327	7		
	risk for dehydration. assessment dated 1	e resident was not at high Review of the dietary 1/9/11 identified the resident's 1/50 cc to 1375. Review of					
	baseline BUN of 38	ted 11/14/11 identified a mg/dl (normal 7-25 mg/dl) mg/dl (normal 0.63 to 1.22					
}	nursing report, identi 11/25/11 the total into 1620 cc, on 11/29/11 lacking, on 12/6/11, 5 on 12/14/11, 540 cc, 12/17/11, 600 cc, on 12/19/11, 1320 cc. Hi record failed to reflect	tained from the 24-hour fied the following: on ake was 980 cc, on 11/26/11, 660 cc, on 12/13/11, 1020 cc, and on 12/16/11, 780 cc, on 12/18/11, 720 cc and on owever review of the clinical tany new interventions were see resident's estimated fluid					
	OF 54 mg/drand crea	ted 12/19 identified a BUN tinine of 1.95 mg/dl. Nurse's dentified the resident was pital for hydration.					
i i f	nospital due to abnornable to abnornable the residentified the residentified the DN: dentified the residentified the residentified the residentified the facility's Hydration Managers are response tetermine if fluid requ	I discharge summary dated 23 was admitted to the mal laboratory findings sident as mildly dehydrated. Son 1/6/12 at 1:30 PM s I&O were not consistently o facility policy. Review of Protocol identified that Unit sible for reviewing I&O's to irements have been met. If we not been met, then the nitiated.					
/ CMS-2567	(02-99) Previous Versions Obs	colete Event ID: 9EQQ11					
		Event to, aEQQ33		raci	Hity ID: CT0019	continuation sheet	Page 24 of 32

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/23/201 FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING\_ 075201 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 483.25(I) DRUG REGIMEN IS FREE FROM F 329 F 329 SS≃D UNNECESSARY DRUGS F329 483.25(I) DRUG REGIMEN IS FREE FROM Each resident's drug regimen must be free from UNNECESSARY DRUGS unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including Resident number 28 continues to reside at the facility. She has had no incidence of seizure. Most recent duplicate therapy); or for excessive duration; or dilantin level obtained on 1/23/12 was 15.1 mg/L, without adequate monitoring, or without adequate reference range 10 to 20, indications for its use; or in the presence of adverse consequences which indicate the dose Residents who reside at the facility have the potential to be affected by the deficient practice. should be reduced or discontinued; or any combinations of the reasons above. All pharmacy recommendations will be addressed in a timely manner with the APRN or physician of record, Based on a comprehensive assessment of a resident, the facility must ensure that residents Random audits will be conducted weekly for three (3) months or until substantial compliance is met. Findings who have not used antipsychotic drugs are not and trends will be reported to the QA Committee with given these drugs unless antipsychotic drug additional recommendations as necessary. DNS and/or therapy is necessary to treat a specific condition designee will have the responsibility for compliance. as diagnosed and documented in the clinical Compliance date, February 14, 2012. 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

findings include:

for one of ten sampled residents review for unnecessary drugs (R#28) the facility failed to obtain blood work in a timely manner. The

02:09:05 p.m. 02-27-2012

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

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

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
075201			B. WING _		C 01/06/2012	
	ROVIDER OR SUPPLIER	ENTER OF WEST HAVEN, LLC	;	REET ADDRESS, CITY, STATE, ZIP CODE 810 TERRACE AVE WEST HAVEN, CT 06516		70,2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 332 SS=E	malignant brain les hypothyroidism. A pthrough 1/12 direct ER, 100 mg, two tir Regimen Review of pharmacy recommelevel. Review of lab subsequent call to 1/06/12 at 11:15 AN Dilantin level was of 19.8 mg/dl (normal with RN#2 on 1/6/1 he was unsure as the drawn for resident. Interview with the Didentified that she is blood work is obtain recommendations 483.25(m)(1) FREE RATES OF 5% OR	s diagnoses included ion, seizure and ohysician order dated 9/11 ed in part Phenytoin Sodium, mes a day. Review of the Drug ated 11/22/11 identified a endation to obtain a Dilantin foratory results and the laboratory by RN#2 on M indicated that the last frawn on 6/29/11 with a level of level 10-20 mg/dl). Interview 2 at 11:25 AM indicated that to why a Dilantin level was not Review of the facility der was obtained and/or that a on was completed. DNS on 1/06/12 at 12:30 PM is responsible to ensure that ned according to pharmacy	F 329	F332 483.25(m) (1) FREE OF MEDICATERROR RATES OF 5% OR MORE  Resident number 13 continues to reside at the and has no ill effects from the day the medical late.	ne facility cation was	
	by: Based on observat of ten sampled resident medications admini	stration (R#13) the facility the medication as ordered by		Residents who reside at the facility have the be affected by the deficient practice.  Medication times have been adjusted to faci medications being administered in a timely Nursing staff will be educated that medicationly be administered within the acceptable of the secondary o	litate manner. ons may time frames, r three (3) et. Findings nittee with DNS and/or	

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01/06/2012

DEPARTMENT OF HEALT	H AND HUMAN SERVICES		PRi <u>l</u>
	E & MEDICAID SERVICES		a AMO
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		Oivit
		1/Y2\ MIII TIDI E CONSTRUCTION	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE		PRINTED: 02/23/20 FORM APPROV	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	OMB NO. 0938-05 (X3) DATE SURVEY COMPLETED
	075201	B. WING	С

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	F 222			
	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 HCI 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.	F 332			
F 428 SS=D	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.  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			

02:09:52 p.m.

02-27-2012

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DEPAR	I MENT OF HEALTH	AND HUMAN SERVICES			PRINTEC	D: 02/23/2
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		075201	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	0/5201			01/0	06/2012
PARADI	GM HEALTHCARE CE	NTER OF WEST HAVEN, LLC	ļ	FREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516		, .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETI DATE
F 428		ge 27 reports must be acted upon.	F 428	3		
	by; Based on clinical refor one of ten samplunnecessary drugs ensure that pharmacacted upon. The find Resident # 28's malignant brain lesichypothyroidism. A phthrough 1/12 directems two times a day. dated 11/22/11 identification for laboratory results an laboratory by RN#2 clindicated that the las 6/29/11 with a level c-20 mg/l). Interview vAM identified he was	diagnoses included on, seizure and onysician's order dated 9/11 d phenytoin sodium, ER 100 Review of the DRR raview.		F428 483.60(c) DRUG REGIME REVIER REPORT IRREGULAR, ACT ON  Resident number 28 continues to reside at She has had no incidence of seizure. Most Dilantin level obtained on 1/23/12 was 15. reference range 10 to 20.  Residents who reside at the facility have the be affected by the deficient practice.  All pharmacy recommendations will be additimely manner with the APRN or physician Random audits will be conducted weekly for months or until substantial compliance is mand trends will be reported to the QA Commadditional recommendations as necessary, designee will have the responsibility for con Compliance date, February 14, 2012.	the facility, recent I mg/L, e potential to ressed in a of record. r three (3) et. Findings ittee with	

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

02:10:18 p.m.

02-27-2012

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

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
075201	B. WING_		_	С		
NAME OF PROVIDER OR SUPPLIER PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	·   3	STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
recommendations are acted upon by the facility staff and or the prescriber.  F 431 SS=D  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		have the potential to e.  the policy of expired destroyed.  weekly for three (3) ance is met. Findings (A Committee with essary. DNS and/or			

02:10:42 p.m. 02-27-2012

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

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

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) DATE SURVEY COMPLETED	
		075201	B. WIN	G	01/06/2012	
	ROVIDER OR SUPPLIER	ENTER OF WEST HAVEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 310 TERRACE AVE WEST HAVEN, CT 06516		
(X4) ID PREFIX TAG	) (EACH DEFICIEN)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLÉ	
F 431	Continued From p	age 29	F 4	31		
	by: Based on observation of medications accorpractice. The finding observation in area on 1/04/12 at nurse identified (2). Hyfiber liquid fiber Interview with the opened medication days and it is nurse and discard the mindicated that the process of the medication	the medication room storage 12:45 PM with the medication one quart bottles of opened dated 3/29/11 and 5/11/11.  unit supervisor identified that as should be discarded after 30 ings responsibility to monitor edication. The supervisor charmacist consultant had just efore and did not know how. Review of facility policy on an and storage ing is responsible for ation storage and preparation e and sanitary manner.  PLETE/ACCURATE/ACCESSIB raintain clinical records on each ance with accepted professional ctices that are complete; and	F 5	F514 483.75(I)(i) RECORDS-COMPLETE/ACCURATE/ACCESSII  Resident number 23 continues to reside a and is currently on comfort measures and physician's order to no longer monitor in output.  Residents who reside at the facility have be affected by the deficient practice.  Licensed nursing staff will be educated waccurate and proper documentation of int Random audits will be conducted weekly months or until substantial compliance is and trends will be reported to the QA Co additional recommendations as necessary Administrator and/or designee will have responsibility for compliance. Complian February 14, 2012.	t the facility has a ttake and the potential to with regard to ake and output for three (3) met. Findings mmittee with the	

02:11:07 p.m. 02-27-2012

02-27-2012 34/35

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					PRINTE	): 02/23/2 MAPPRO\
Į STATEMĖN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE	E CONSTRUCTION	<del>-</del>	OMB NO	<u>). 0938-0:</u>
<b>.</b>		075201	A. BUII				COMPI	ETED
NAME OF I	PROVIDER OR SUPPLIER	0.0201	<del>_</del>		-		01/	06/2012
PARADI	GM HEALTHCARE CE	NTER OF WEST HAVEN, LLC		310	TADDRESS, CITY, STATERRACE AVE ST HAVEN, CT 06:			
(X4) ID PREFIX TAG	1 TEACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI.		PROVIDER'S P (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTIVE ACTION SHO	שמת תוור	(X5) COMPLETI DATE
F 514	This REQUIREMEN by: Based on clinical re interviews for one or reviewed for hydratic maintain a complete findings include:  1. Resident:	he results of any ning conducted by the State;  IT is not met as evidenced ecord record review and f three sampled resident on (R#23) the facility failed to medical record. The	F 5	14	DE	FICIENCY)		
	MDS dated 11/16/11 severely cognitively assistance with ADL identified the potentifailure to thrive. Inter I&O's, skin turgor, a Review of a dehydra 11/09/11 identified thrisk for dehydration. assessment dated 1 fluid goals between 1 Review of I&O's obthursing report, identif 11/25/11 the total inta 1620 cc, on 11/29/11, acking, on 12/6/11, 5 on 12/14/11, 540 cc.	ained from the 24-hour						

02:11:27 p.m.

02-27-2012

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/23/2( APPROV : 0938-03
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		075201	B. WING		į.	C 6/2012
		NTER OF WEST HAVEN, LLC	3-	EET ADDRESS, CITY, STATE, ZIP CODE 10 TERRACE AVE /EST HAVEN, CT 06516	1 0170	6/2012
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	(X5) COMPLETIC DATE
F 514	1/6/11 at 2:00 PM id	Interview with the DNS on dentified that the information on the 24 hour nursing report	F 514			
ORM CMS-256	7(02-99) Previous Versions C	Phoolate				