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

POC accepted mmc 2/8/12

PRINTED: 01/17/2012
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 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1/30/12

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 17, 2012. 14	
F 176 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations	F 176		

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F 176	Continued From page 3 that the resident is capable of administering the medication correctly. The DNS further indicated that the self-administration assessment was not completed. Review of the facility policy indicated that if a resident wishes to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate, by completing a self-administration of medication assessment and assessment of compliance and safety will be documented on a weekly basis in the resident's medical record.	F 176		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on review of clinical records, review of RE, and interviews for one of four sampled residents reviewed with allegations of abuse (R#108), the facility failed to ensure the resident was free from mistreatment. The findings include: Resident # 108's diagnoses included left hydronephrosis, sacral decubiti, dementia, delirium, hypothyroidism, and anemia. An MDS dated 10/06/11 identified the resident as alert, with short and long-term memory problems, no	F 223	**F223 483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECULSION** Resident number 108 currently resides in the facility; the resident has made no further statements regarding individualized and dignified care. Residents who reside at the facility have the potential to be affected by the deficient practice. The staff was in-serviced on abuse, neglect and resident rights with emphasis on the importance of prompt care to the individual resident needs. Random audits will be conducted to ensure compliance. 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.	

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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 1/05/12 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		

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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		

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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 D 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.	

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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		

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F 281	Continued From page 13 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 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	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	

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F 309	Continued From page 15 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) 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	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	

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F 309	Continued From page 17 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 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.	F 309		

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F 309	Continued From page 19 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 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	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 17, 2012.	

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	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

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility investigation, RE and staff interview, for 2 of 4 sampled residents reviewed for accidents, (R#23, 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: 1. Resident #23 was admitted to the facility on 11/09/11 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, experienced frequent pain, with the worst pain identified as a 6 on the pain scale(rated 1-10 least to worst). Review of a RE dated 12/20/11 identified that the resident presented to the hospital with multiple rib fractures. Review of the facility documentation/investigation identified that R#23 required total assistance with care, was bed bound and required bed baths. Interview with the DNS on 1/05/12 at 2:00 PM identified that the resident sustained the fractures during hospitalization on 12/20/11. Interview with MD #1 on 1/06/12 at 11:50 AM identified that the age of the fractures were	F 323	**F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** 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. 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 17, 2012. 14	

F323 #1- deleted due to the 02/07/12 IDR

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PARADIGM HEALTHCARE CENTER D = WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

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F 323	Continued From page 23 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 11/09/11 identified the resident was not at high risk for dehydration. Review of the dietary	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.	

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PARADIGM HEALTHCARE CENTER OF WEST HAVEN, LLC	310 TERRACE AVE WEST HAVEN, CT 06516

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F 329	Continued From page 25 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: Resident # 28's diagnoses included	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.	

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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

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F 332	Continued From page 27 mellitus, Vascular Dementia and hypertension. A physician order dated 12/28/11 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 nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 29 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 17, 2012. 14	

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F 492	Continued From page 31 Based on review of facility personnel files and interviews the facility failed to complete annual employee evaluations as per Section 19-13-D8Dt (j)(2)(k) of the Public Health Code. The findings include: Review for NA #1, NA #2, LPN #1, and LPN #2 employee files failed to reflect that employee evaluations were completed for the year 2010 and 2011. Interview with the Administrator on 1/6/12 at 10:30 AM identified she was aware that annual evaluations were not completed for the year 2010 and 2011.	F 492	**F492 483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD** Evaluations have been completed for NA#1 and NA#2, LPN#1 and LPN#2 no longer are employed by the facility. A system has been developed whereby all employees will be evaluated annually according to their initial hire date. 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 17, 2012. 14	
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 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	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 17, 2012. 14	