PW accepted 4/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075317	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILTON MEADOWS HEALTH CARE CEN	439 DANBURY RD RT 7 WILTON CT 06897

RECEIVED
MAR 19 2012
FACILITY LICENSING & INVESTIGATIONS SECTION
DEPT. OF PUBLIC HEALTH

(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 BIMS- Brief Interview for Mental Status BUN - Blood Urea Nitrogen COPD - chronic obstructive pulmonary disease CVA - cerebrovascular accident (stroke) DNS/DON - Director of Nursing 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 OT - Occupational Therapist PT - Physical Therapist RCP - resident care plan RN - Registered Nurse SW - Social Worker VRE - Vancomycin Resistant Enterococcus	F 000	Please note the filing of this plan of correction does not constitute any admissions as to any of the alleged deficiencies set forth on this statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable laws. F221 Assuming for the moment that the findings and the determination of deficiency is accurate, without admitting or denying that they are, our proposal for corrective action is as follows:	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Andrew Krochko

TITLE Andrew S. Krochko Administrator

(X6) DATE 3/13/2012

Any 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 221	Continued From page 2 the restraint, and/or that the seat belt was the least restrictive device necessary to treat a medical symptoms, and/or that alternatives to restraints were attempted, and/or that attempts at reduction/elimination had been made since the restraint was applied in November 2011. The facility restraint policy directed that the nurse implementing the restraint must complete, in part, a physician order, a physical restraint form, a care plan and consent. 2. Resident #170's diagnoses included Alzheimer's dementia. The MDS dated 1/29/12 identified impaired cognition, required extensive assistance of two staff for transfers, bed mobility and toilet use, impaired balance and the use of a trunk restraint. A nurse's note dated 1/21/12 at 2:50PM identified the resident had slid out of the wheelchair onto the floor. An alarmed seatbelt was applied after family consent was obtained. Physician orders dated 1/23/12 directed to apply a seatbelt to the wheelchair at the "family request". A fall risk evaluation dated 1/23/12 identified the resident was at high risk to fall. A therapy assessment dated 2/15/12 identified the resident was provided with Dycem due to sliding down in the wheelchair causing the seatbelt to unclip. Review of the clinical record on 2/27/12 at 10:30 AM with RN#3 failed to provide documentation that an interdisciplinary assessment for the use of a restraint had been completed prior to initiating the restraint, and/or that the seat belt was the least restrictive device necessary to treat a	F 221	Completion Date: April 5, 2012	

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F 250	Continued From page 4 A social service note dated 7/25/11 indicated that the social worker would keep the resident updated on discharge planning and continue visits 2-3 times a week for the next 2 weeks to build trust. On 10/13/11, social services noted that R#108's family expressed the desire for R#108 to return to assisted living and that the social worker would continue weekly visits over the next 90 days. The social service note dated 1/10/12 identified a visit to say a "quick hi" was made with no mention of discharge plans. On 1/23/12, a social service note indicated visits to continue 2-3 times weekly but failed to identify any discharge planning or discussion. Interview with the resident on 2/23/12 at 2 PM noted that R#108 had no recollection of visits with the social worker to review placement status, stating " I don't remember anyone coming in to talk to me about my stay here, I would like to go back to the (assisted living)". Review of clinical record & interview with SW#1 on 2/24/12 at 9:45 AM identified although social service would make regular visits, there was no documentation to indicate that they had occurred stating " I must have not written them down, I usually do" and that R #108's placement status remained short term. SW#1 indicated being aware of the resident's desire to return to assisted living, with an evaluation to determine appropriateness for return to take place this week, although she had not informed the resident.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 6 Admission Social Service notes dated 12/9/11 identified the resident was admitted to the facility for short term rehabilitation and that discharge planning "will be discussed with resident and family." Social Service notes dated 12/14/11 identified that the Social Worker will keep resident and family updated on discharge plans, and will continue to visit resident 2-3 times a week for the next 3 weeks to build trust. Review of the care plan on 2/27/12 at 9:40 AM with Social Worker #1 failed to identify the care plan was comprehensive to include discharge planning. Further interview with SW#1 noted that she does not initiate a care plan in the care plan section of the clinical record record regarding discharge planning, but does include planning in the social service notes. Review of the Social Worker notes at that time noted that no discharge planning notes had been completed since 12/14/11 (and the resident remained in the facility).	F 279		
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, observation and	F 282		

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F 282	Continued From page 8	F 282		
F 309 SS=D	1 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and clinical record review for two of six sampled residents (Resident #4, Resident # 5) reviewed for proper positioning and /or appropriate skin monitoring, the facility failed to ensure appropriate table height for self feeding and/or thorough skin assessments. The findings include: 1. Resident #4's diagnoses included dementia, diabetes, dysphagia and gastroparesis. An MDS dated 12/16/11 identified the resident was without significant cognitive impairment, required supervision for eating, limited assistance for transfers and ambulation and was on a	F 309	F309 Assuming for the moment that the findings and the determination of deficiency is accurate, without admitting or denying that they are, our proposal for corrective action is as follows: Resident # 4 currently dines at a dining table which measures 26". Resident #5 no longer resides at the facility. The facility has developed a Policy and Procedure for non-pressure wounds which includes assessment/treatment. The wound tracking sheet has been revised. Residents of the facility have the potential to be affected by the identified deficient practice. To assure that this identified deficient practice does not recur we are taking the following corrective measures: Nursing Staff will be provided in-service education on ensuring residents are properly positioned at dining table to enable self feeding and appropriate skin monitoring and assessments are completed for residents who present with skin rashes. Random audits will be conducted weekly for (2) months to ensure residents dine at tables that are the appropriate height to enable self feeding and appropriate skin monitoring/assessments are completed for residents who present with skin rashes.	

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F 309	Continued From page 10 other activities of daily living. A nursing admission skin assessment dated 9/15/11 identified multiple bruises on the back, but no open areas were identified. On 10/5/11 at 2:30 PM a nurse's note identified that the physician ordered Lotrimin to a rash between the buttocks twice daily for 10 days. Review of the clinical record including nurse's notes and skin assessment record failed to identify description of the rash, size, color, etc. On 2/27/12 at 1:00 PM, an interview with RN #2 identified that documentation in the nurse's notes should have identified the size, color and description of the rash. Review of the policy manual with RN#3 on 2/27/12 at 1:45 PM failed to document that the facility had a policy for non-pressure wounds and their assessment/treatment. Further interview with RN#3 at that time noted the facility utilizes a pressure wound sheet for non-pressure areas and just crosses out the pressure section of the assessment sheet. Review of the clinical record at that time with RN#3 failed to identify a pressure ulcer sheet had been initiated on 10/5/11 for the resident's rash.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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F 314	Continued From page 12	F 314		

cm by 0.7 cm and one to the inner buttocks/coccyx area measuring 0.8 cm by 0.2 cm. Physician orders dated 10/9/11 directed Exuderm to open areas every 72 hours for 14 days. On 10/10/11 physician orders directed to discontinue previous treatment orders to open areas and begin Calazime skin protectant paste three time daily for 14 days and apply an air mattress.

The facility weekly wound round record dated 10/9/11 measured the areas as left buttocks 2 cm by 3 cm by 0.1 cm and the coccyx area as a Stage 1 pressure ulcer measuring 5 cm by 2.0 cm by 0.0 cm.

A weekly pressure ulcer documentation flow sheet dated 10/10/11 identified the location of the wound to be "coccyx/sacral area", acquired in house, Stage 2 pressure ulcers, but lacked the date of origin. The weekly pressure ulcer flow sheet further failed to identify measurements and combined both open areas as one large area on a skeletal diagram. Measurements dated 10/17/11 identified the coccyx area resolved and the left buttocks was a Stage 2 measuring 2.0 cm by 3.0 cm by 0.1 cm.

Wound Nurses notes dated 10/17/11 identified the sacrum pressure ulcer resolved and the coccyx Stage 2 was still present.

On 2/27/12 at 1:30 PM, interview with RN#2 noted that at that time the Unit Manager assessed the wounds weekly. She further noted that both open areas were not be to be combined on the wound flow sheet, the date of origin was to be identified and was she was unable to ascertain

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F 323	Continued From page 14 included bed/chair alarm and seatbelt alarm. An interdisciplinary referral form dated 1/14/11 identified the resident required a seatbelt for pelvic positioning in the wheelchair due to sitting position and occasional leaning to right especially when tired. Observation on 2/24/12 at 11:05 AM identified the resident in the wheelchair and the seat belt loosely draped across thighs near knees. Interview with the DNS on 2/24/12 at 2:00 PM identified the seatbelt should not be loose. Subsequent to surveyor inquiry, staff was reeducated on the use of seatbelts. 2. Resident #170's diagnoses included Alzheimer's dementia. The MDS dated 1/29/12 identified the resident had impaired cognition, required extensive assistance of two staff for transfers, bed mobility and toilet use, had impaired balance and utilized a trunk restraint. The care plan dated 12/2/11 identified the resident was at risk for falls due to impaired cognition and a history of falls. A physician order dated 1/23/12 to utilize an alarming seatbelt in the wheelchair for safety. A nurse's note dated 1/21/12 at 2:50PM identified the resident had slid out of the wheelchair onto the floor. Additionally, an alarmed seatbelt was applied after family consent. A fall risk evaluation dated 1/23/12 identified the resident was at high risk to fall. A facility report dated 2/2/12 at 2:50 PM identified the resident was found on the floor in the toilet	F 323	The results of the audits will be reported to the Quality Assurance Assessment Committee, which will recommend any further corrective measures, indicated. The Director of Nursing is responsible for implementing this plan of correction. Complete Date: April 5, 2012	

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F 327	Continued From page 16 signs and symptoms of fluid deficit include skin turgor, mucous membranes and level of consciousness, assess edema, encourage fluids, hydration assessment as needed and update physician, I&O as ordered and as needed. Physician Admission Orders dated 9/9/11 directed the administration of Lasix 60 mg 1 tab every day. The Nutrition Risk and Medical Nutrition Therapy assessment dated 9/12/11 identified the resident's estimated fluid needs were 2000-2400 cc daily. Review of lab work dated 7/30/11, prior to skilled nursing facility admission, identified a Blood Urea Nitrogen (BUN) of 27 (normal 7-25) and a creatinine 1.28 (normal 0.67-1.54). Review of laboratory results dated 10/17/11 identified a BUN of 40 and a creatinine of 1.45. Review of the Intake and output documentation dated 11/12/11 through 11/19/11 identified the resident failed to meet fluid needs with the 8 day average being 1575 ml. Nurse's notes dated 11/20/11 identified that the resident was restless and had an oxygen saturation of 74%. The resident was transferred to the hospital. Review of the hospital history and physical dated 11/20/11 identified R#139's daughter had visited the day prior to admission and found the resident very lethargic. The daughter indicated that the resident had been declining over the previous week, had behavioral issues and was not able to	F 327	Licensed Staff will be provided in-service education on the Hydration Policy and Procedure with the focus on identifying residents who do not meet their fluid expectations and the procedure to follow for assessing the resident. As well as revising the care plan with appropriate interventions to prevent dehydration. The Intake and Output monitoring flow records will be reviewed during 24 hour am report meetings. Random audits will be conducted weekly for (2) months to ensure residents who do not meet fluid expectations are assessed appropriately for signs and symptoms of dehydration and interventions are initiated in the resident's plan of care to prevent dehydration. The results of the audits will be reported to the Quality Assurance Assessment Committee, which will recommend any further corrective measures, indicated.	

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F 327	Continued From page 18 fluid needs. 2. Resident #227's diagnoses included status post pacemaker insertion, bradycardia and seizure disorder. An admission assessment dated 2/16/12 identified the resident had impaired cognition, required extensive assistance for eating and was frequently incontinent of bladder. The care plan dated 2/10/12 identified a potential for fluid volume deficit. Interventions included to assess for signs of dehydration. The dietitian's assessment dated 2/14/12 noted a fluid goal of 2000-2400 cc per 24 hrs. Review of the intake and output records for the period of 2/9 through 2/21/12 identified the fluid goal was not being met . The fluid intake was as follows: 2/10 960 cc 2/11 1060 cc 2/12 1440 cc 2/13 840 cc 2/14 900 cc 2/15 660 cc 2/16 820 cc 2/17 1920 cc 2/18 1220 cc 2/19 1620 cc 2/20 960 cc 2/21 780 cc Interview and clinical record review with the DNS on 2/27/12 at 10:45 am identified there should have been hydration assessments completed	F 327		

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F 329	Continued From page 20 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 clinical record review and interview for one of ten residents reviewed for unnecessary medications (R#149), the facility failed to ensure that behavior monitoring was conducted related to the use of an anti-psychotic medication. The findings include: Resident #149's diagnoses included dementia, alcohol encephalopathy and diabetic neuropathy. Psychiatry notes dated 1/12/12 identified the resident was verbally abusive to staff and other residents, mildly paranoid (thinking the food is contaminated), anxious and irritable at times with recommendations to add a low dose neuroleptic medication. Physician's order dated 1/12/12 directed to initiate Risperdal 0.5 mg twice a day. Review of the behavior monitoring flow record with RN#1 and LPN#4 on 2/23/12 at 2:39 PM indicated that behavior monitoring was conducted	F 329	Residents of the facility who receive Antipsychotic Medication have the potential to be affected by the identified deficient practice. To assure that this identified deficient practice does not recur we are taking the following corrective measures: Licensed staff will be provided in-service education on the procedure to follow to ensure that behavioral monitoring is conducted related to the use of an Anti-psychotic Medication and that the correct target behaviors are being monitored. Random audits will be conducted weekly for (2) months to ensure behavioral monitoring is conducted related to the use of Anti-Psychotic medications and the correct target behaviors are being monitored. The results of the audits will be reported to the Quality Assurance Assessment Committee, which will recommend any further corrective measures, indicated. The Director of Nursing is responsible for implementing this plan of correction. Complete Date: April 5, 2012	

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F 428	Continued From page 22 A pharmacy consultation report dated 1/6/2012 identified a recommendation to initiate Folic Acid 1 mg daily. Further review of the clinical record indicated that the although the physician visited the resident and reviewed the orders on 1/22/12, the recommendations were not acted upon. Interview with RN#1 on 2/23/12 at 2:03 PM identified that pharmacy recommendations are usually handled by the APRN who comes almost on a daily basis and she could not explain why the recommendations were not reviewed. Upon surveyor inquiry, the physician was called and directed to start folic acid 1 mg daily. Interview with the Pharmacist on 2/27/12 at 12:20pm identified that folic acid can decrease the gastrointestinal symptoms associated with methotrexate use.	F 428	Random audits will be conducted weekly for (2) months to ensure residents Pharmacy recommendations are acted on timely. The results of the audits will be reported to the Quality Assurance Assessment Committee, which will recommend any further corrective measures, indicated. The Director of Nursing is responsible for implementing this plan of correction. Complete Date: April 5, 2012	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F 441 Assuming for the moment that the findings and the determination of deficiency is accurate, without admitting or denying that they are, our proposal for corrective action is as follows: LPN #5 has received appropriate counseling and in-service education on the Policy and Procedure for hand washing. Residents of the facility have the potential to be affected by the identified deficient practice.	

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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 441	Continued From page 24 placed on the meal cart and failure to wash hands afterward. Further observation at 9:20 am identified the application of hearing aides without gloves and exited the resident's room without washing hands. Subsequent to surveyor inquiry, LPN #5 then washed hands. LPN #5 stated he/she usually washes hands in between medication administration and prior to performing each task but " forgot" to do so; stating did not use hand sanitizer because it was " too sticky and bother's my hands." Interview with the DNS on 2/24/12 at 10 am identified the expectation and standard practice is to wash hands in between residents and anytime prior and after completion of tasks.	F 441		
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:	F 514	F514 Assuming for the moment that the findings and the determination of deficiency is accurate, without admitting or denying that they are, our proposal for corrective action is as follows: Resident #102 no longer resides at the facility. Residents admitted to the facility for short term placement have the potential to be affected by the identified deficient practice.	