STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

August 24, 2022

Tina Yeitz, Person-in-Charge
Eliza Huntington Memorial Home of Norwich, Inc.
99 Washington Street
Norwich, CT 06360

Dear Ms Yeitz:

An unannounced visit was made to Eliza Huntington Memorial Home of Norwich Inc on August 10, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than fourteen days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by September 7, 2022.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by September 7, 2022 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

Respectfully,

Karen Gworek, RN
Karen Gworek, RN, BSN
Supervising Nurse Consultant
Facility Licensing & Investigations Section

KEG:lst

c. Mairead Painter, LTC Ombudsman Program

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4).

1. Based on review of facility documentation and interview, the facility failed to ensure annual employee performance evaluations were completed. The findings include:
   a. Interview and review of three (3) employee personnel files with the office manager on 8/10/22 at 12:00 PM identified annual employee performance evaluations had not been completed within the last few years.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Service and/or Section 19-13-B42 Sanitation.

2. Based on observations and interview, the facility failed to ensure the ice machine was cleaned and sanitized on a regular basis. The findings include:
   a. Interview with the office manager on 8/10/22 at 10:30 AM identified the ice machine was cleaned and sanitized every two (2) months and documented on the ice machine cleaning schedule log located on the top of the ice machine. Review of the 2022 ice machine cleaning schedule log on 8/11/22 at 10:30 AM identified the last cleaning was completed 4/4/22.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Service and/or Section 19-13-B42 Sanitation.

3. Based on observations and interviews, the facility failed to consistently monitor and document refrigerator and freezer temperatures. The findings include:

   Based on observations and interview, the facility failed to monitor and document the refrigerator and freezer temperature daily. The findings include:
   a. Observations and interview with dietary aide on 8/10/22 identified although she will occasionally check the refrigerator and freezer temperatures to make sure they are maintaining an appropriate temperature range, she does not document the temperatures anywhere. The dietary aide was unaware refrigerator and freezers temperatures needed to be monitored and documented daily.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (E)(ii)(VI).

4. Based on review of facility documentation, and interview the facility failed to ensure documentation was completed when a resident refused a medication. The findings include:
   a. Review of Resident #1's Medication Administration Record (MAR) on 8/10/22 at 11:30 AM identified a physician's order directing Tylenol 650 milligrams (mg) by mouth every six (6)

hours, 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. Upon further review, the MAR noted Resident #1 refused the 12:00 AM dose of Tylenol twelve (12) times from 7/30/22 through 8/10/22 and the MAR failed to reflect documentation on the back of the including the date, hour, initials of the staff, the medication, dose, and the reason the resident refused the medication. Interview with PCA #1 on 8/10/22 at 11:30 AM identified any resident that refuses a medication staff should be documenting on the back of the MAR the date, time, initials, the medications and the reason for the refusal. The facility administration of medications policy directs any resident who is reluctant to take any drug should be encouraged to do so. However, refusal to take a drug is to be documented with reason, dated, and initials of the staff member.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

5. Based on review of facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include:
   a. Representatives of the Division of Health Systems Regulation, Building and Fire Safety Unit, conducted an unannounced inspection of the facility for the purpose of assurance of compliance with all applicable codes, standards, and regulations that would apply to the use group of the facility. On 8/10/22 at 9:00 A.M., during a tour of the facility and while accompanied by the facility representative, the following observations were identified:
   b. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year obstruction test was done on the internal piping of the sprinkler system. Records indicate the last test was done in 2016.
   c. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., The gauges on the sprinkler system were dated 2016 and exceed the five (5) year limit of the code.
   d. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year test of the Fire Department Connection piping was done. Records indicate the last test was done in 2016.
   e. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year test of the Fire Department Connection check valve was done. Records indicate the last test was done in 2016.
   f. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a three (3) year air loss test was done on the sprinkler system. Records indicate the last test was done in 2016.
   g. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a ten (10) year destructive test was done on the heads of the sprinkler

system. Records indicate the last test was done in 2011.

h. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a twenty (20) year destructive test was done on the quick response heads of the sprinkler system. Records indicate the last test was done in 2001.
i. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any third shift fire drills were completed in the first quarter of 2022.
j. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any third shift fire drills were completed in the second quarter of 2022.
k. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any third shift fire drills were completed in the third quarter of 2022.
l. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any third shift fire drills were completed in the fourth quarter of 2021.
m. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any second shift fire drills were completed in the second quarter of 2022.
n. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any second shift fire drills were completed in the third quarter of 2022.
o. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any second shift fire drills were completed in the fourth quarter of 2021.
p. Documentation was not provided to the surveyor from the facility to indicate that the generator was being serviced two times a year (1 major and 1 Minor service) as required by NFPA 110. i.e., No minor generator service was completed in the last twelve (12) months.
q. During document review the surveyor observed that the facilities generator has not been operational and in need of repairs since 6/22/22. No repairs had been completed nor were any repairs scheduled to be completed at the time of survey. Facilities are required to have a working generator by section 19-13-D6(b)(O). of the CT Public Health Code.
r. During a tour while accompanied by a facility representative the surveyor observed there were no exit signs in the basement. A sign on the elevator said not to use the elevator in the case of fire but there was no signage as to where the egress stairs were located.
s. During a tour while accompanied by a facility representative the surveyor observed there was an excessive buildup of combustible material behind the dryer in the Main Floor Laundry Room.
t. During a tour while accompanied by a facility representative the surveyor observed the closet inside the Medication Room was missing hardware on the inside of the door. If the closet door closed on someone, they would have no way to open the door to get out.
u. During a tour while accompanied by a facility representative the surveyor observed combustibles being stored within 3 feet of and on top of electrical panels in the Generator Room.
v. During a tour while accompanied by a facility representative the surveyor observed carboard boxes being stored on the floor in the kitchen near the walk-in coolers.

w. Documentation was not provided to the surveyor from the facility to indicate that the temporary generator was recently serviced before installation as required by NFPA 110. i.e., During survey it was found that the facilities required standby generator was not operational. The facility was required to install a temporary rental generator immediately and after several requests for documentation over the period of a week none was provided.

x. Documentation was not provided to the surveyor from the facility to indicate that the temporary generator was load bank tested in the past year before installation as required by NFPA 110. i.e., During survey it was found that the facilities required standby generator was not operational. The facility was required to install a temporary rental generator immediately and after several requests for documentation over the period of a week none was provided.

September 7, 2022

Approved 9/15/22 KEG

Facility Licensing & Investigations Section
410 Capitol Avenue P.O. Box 340308
Hartford Ct. 06134-0308

Below you will find our plan of correction for the unannounced visit to The Eliza Huntington Memorial Home of Norwich, Inc. on August 10, 2022.

1) **Violation: Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4)**
All employee evaluations have been completed up to the performance year of 10/1/2021 – 10/1/2022, which will be completed in the next 90 days. All previous evaluations will be filed accordingly in the appropriate employee files. In addition to this, an annual audit will be implemented and performed in January by the Office Manager to ensure that all annual reviews have been completed and filed accordingly.

2) **Violation: Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Service and/or Section 19-13-B42 Sanitation**
The bimonthly cleaning of the ice machine will now be the responsibility of the Dietary Department to ensure that the cleaning is completed in a timely fashion. In addition to this there will be a quarterly facility review being implemented and completed by the Administrator to ensure all regular tasks related the facility operations are being completed.

3) **Violation: Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Service and/or Section 19-13-B42 Sanitation**
Documentation of the refrigerator and freezer temperatures will be documented and logged by the 3rd shift PCA. Currently they are responsible for monitoring and documenting the temperatures in the Med Fridge and will add these temperatures to the nightly check. Part of the quarterly facility review process will be to spot check the temperature logs to ensure proper completion.

4) **Violation: Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (E) (ii)(VI)**
All Med Certified PCA's have been reminded that any refusals need to be documented on the back of the MAR. The Administrator or Director of Resident Care shall monitor the MAR logs periodically during the week to ensure that this is being completed.

5) **Violation: Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5):**

(B through H)
These violations regarding the sprinkler system have all been addressed with the company that we have maintaining our sprinkler system and a quote has been received and approved and the work will be completed with 5-7 business days. In addition to this we are setting up and ongoing service contract with an automatic scheduling option to ensure that required maintenance does not get overlooked in the future. This maintenance schedule will be incorporated into the quarterly facility review to ensure that the scheduled maintenance is completed.

(I through O)
The Administrator will set up a 6 - month schedule for the fire drills to ensure that they are being completed at times that cover all three shifts in each quarter. During each quarter, the Office Manager will be responsible for reviewing the fire drill records and ensuring that all shifts are being represented in the schedule and completion of the drills.

(P, Q)
The generator parts have been ordered and the temporary generator is still on site At the facility. We are also exploring the possibility of replacing the generator in it's entirety with one that will cover a larger area of the building. The Office Manager and/or the Administrator will follow up with the vendor bi-weekly for updates on when the work will be completed.

(R)
New wall signs were purchased indicating the use of the stairs in the event of a fire and a directional sign was posted in the basement to direct individuals to the staircase through the basement door. Each quarter the Administrator will be completing a facility checklist to ensure that these signs are legible and still in place.

(S)
The lint was vacuumed out from behind the dryer in the housekeeping room. This has also been added as a weekly task for the housekeeping department to ensure that there is no additional opportunity to build up. This will be a task that is also added to the quarterly facility inspection to ensure that the housekeeping department is maintaining this properly.

(T)
The door knob has been replaced for this closet. The quarterly facility review being implemented and completed by the Administrator will include a section for general repairs that need to be completed.

(U)
The 3 items that are kept in the generator room are: odor kill powder, Blot-o Air, (also an odor reducer) and a can of non-flammable electric parts cleaner. There is limited storage in this room so we have moved the cans onto a bucket in the corner of the room as far away from the panels as possible. This room will be included in the quarterly facility review to be completed by the Administrator to ensure that the vendors are not storing any items in an improper manner.

(V)
All of the cardboard boxes that were in the kitchen and could not fit onto the storage shelves have been placed on risers so that they are up off the floor. The administrator will be reviewing the storage areas of the kitchen during the quarterly facility inspection going forward to ensure all storage is in the appropriate areas stored properly.

(W and X)
I have all of the email correspondence that can be provided to show that not only did I request this information from the vendor on the night of the actual review when they finished installing the temporary generator, I then followed up with them again the next day and every couple of days until the documentation was received. Should there be a need to obtain any additional records from the vendor the Administrator will be responsible for daily follow up until the documentation is received.