Section 3

2019

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Leeway
40 Albert St
New Haven, CT

M:

FLIS Staff

Leah Clark
Paul Briand
Kenneth Flemming
Joseph Kingston

Licensure Category: ~~DEH~~ CCNH

Licensed Bed Bassinet Capacity: 30

Census: 28

Date(s) of onsite inspection: 8-12-19, 8-13-19, 8-14-19, 8-15-19

Date(s) additional information obtained: 8-16-19

Personnel contacted: Administrator's Assistant Elizabeth Daugherty

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 8-30-19

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[X] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: _____ **DATE OF REPORT:** _____

[✓] Approval for issuance of license granted by: Cheri Michaud RN **DATE:** 8.30.19
Supervisor/Title

INTRAVENOUS THERAPY PROGRAM REVIEW

IN ACCORDANCE WITH THE PUBLIC HEALTH CODE OF THE STATE OF CONNECTICUT
SECTION 19-13-D8u

Facility: Leeway	Address: 40 Albert St. New Haven, CT 06511
Inspected by: 21622	Date: 8/14/19

Area of review	MET	NOT MET	N/A
1. IV therapy prohibited unless ordered by a physician or other provider with prescriptive authority.	✓		
2. Written policies and procedures are developed that ensure safe care for all patients including:	✓		
a. Objectives/Goals/Scope	✓		
b. Names/Titles/Duties/Responsibilities	✓		
c. Education/Training/Supervision/Competencies	✓		
d. Physician Orders	✓		
e. Safe administration/monitoring/documentation and termination of therapy	✓		
f. Preparation, labeling, and handling of IV admixtures	✓		
g. Procurement, maintenance and storage of equipment and solutions	✓		
h. Recognition of signs and symptoms of complications including sepsis	✓		
i. Infection control, surveillance, review and prevention of infections	✓		
j. Quality management, review, safety and effectiveness	✓		
k. Only physician/extender and/or credentialed R.N. may remove central vein access	✓		
l. Prohibit blood draws, IV push, without waiver	✓		
3. IV Therapy Nurse based on physician order may; a. Initiate venipuncture in a peripheral vein and administer IV fluids and/or admixture into vein	✓		
b. Deliver IV fluid and/or admixture into central vein access.	✓		
4. Licensed nurses deliver IV fluids, admixtures, monitor, care for site, terminate procedure and record events and observations.	✓		
5. IV log is maintained including outcome of therapy and any complications.	✓		
6. IV supplies are maintained in accordance with policy minimums.	✓		

Done

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

August 30, 2019

Jay Katz, Administrator
Leeway, Inc
40 Albert Street
New Haven, CT 06511

Dear Dr. Katz:

Unannounced visits were made to Leeway, Inc which concluded on August 15, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure and a certification investigations.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

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 ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website 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 9, 2019.

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 9, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Cher Michaud RN BSN

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM:mb

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

1. Based on review of medical record, review of facility documentation, and interviews, for one of twelve Residents reviewed for advanced directives, (Resident #11) the facility failed to ensure a resident's wishes for Advanced Directives were accurately identified in the clinical record. The findings include:
   a. Resident #11 was admitted on 8/4/16 with diagnoses which included Hypertensive Encephalopathy, Type 2 Diabetes, difficulty walking, Adjustment Disorder, Dementia with behavioral disturbances, and Schizoaffective Disorder.
   An Advanced Directive form dated 2/19/16, signed by Resident #11, identified Resident #11 wished to be a Full Code with administration of cardiopulmonary resuscitation (CPR), Nutrition via tube feeding, and Hydration via intravenous line.
   The medical record also contained a Health Care Instructions form dated 12/13/16 for Resident #11 which identified Resident #11 wished to have staff withhold cardiopulmonary resuscitation (CPR), artificial respiration, and artificial means of providing nutrition and hydration, signed by the assigned Health Care Representative. The quarterly Minimum Data Set (MDS) dated 5/31/19 identified Resident #11 had mild cognitive impairment and was independent with Activities of Daily Living (ADL's).
   The Care Plan for Resident #11 dated 5/31/19 identified Resident #11 as a full code.
   Review of medical record identified SW #1's narrative note dated 7/17/19 at 19:28, which identified the meeting with Resident #11 and the conservator for purpose of discussion of future plans for Resident. Both the Resident and the conservator signed an advanced directive form.
   An Advanced Directive Statement, provided by the facility as it was not in the record, dated 7/17/19 signed by Resident #11 identified that Resident #11's wishes included to be provided CPR and hydration through an intravenous line, however chose not to have a tube feeding or intubation provided. The form failed to reflect the signature of the Physician.
   Review of physician's orders dated 7/19/16 and reviewed on 6/8/19 directed full code, attempt CPR.
   An interview on 8/12/2019 at 3:30 PM with the Administrator and Social Worker (SW) #1, identified that SW #1 had a meeting on 7/17/19, with Resident #11 and his/her conservator, in which the Advanced Directive form was signed by Resident #11 and the conservator for cardiopulmonary Resuscitation, (CPR), administration via intravenous, but no tubing feeding and no intubation. SW #1 identified that he/she did not call the physician and notify the physician of the change in the Advanced Directive nor did the SW notify the nursing staff, but placed the Advanced Directive sheet which was signed by Resident # 11 and the Conservator on 7/17/19 in the Red Book at the central nursing station, to be signed by the physician. The medical record did not have a copy of the Advanced Directive signed on 7/17/19.
   SW #1 identified that the Advanced Directive which was signed on 7/17/19 should have been placed in the Resident's medical record and that he/she should have notified the physician of the newly signed Advanced Directive.
   Subsequent to surveyor inquiry, the facility obtained a physician's signature on the

Advanced Directive form dated 7/19/19.
The facility Advanced Directive policy identified that the facility will protect and promote the resident's right to determine his/her care including the Resident's Advance Directives.
The facility failed to ensure Resident #11's wishes for Advanced Directives were accurately identified in the clinical record.

Plan of Correction for Violation #1:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

2. Based on clinical record review, interviews, and review of facilty documentation, for one sampled resident reviewed for abuse, (Resident #18), the facility failed report an allegation of abuse to the state agency in a timely manner. The findings include:
   a. Resident #18 was admitted to the facility on 3/29/18. Diagnoses included bipolar disorder and alcohol and nicotine dependence, urinary incontinence, and prediabetes.
   The quarterly Minimum Data Set (MDS) dated 1/6/19 identified Resident #18 had intact cognition, was independent in toilet use, and required supervision of one staff for personal hygeine.
   The Care Plan dated 2/4/19 identified Resident #18 had an Activities of Daily Living (ADL) self care deficit related to activity intolerance. Interventions included participation of one staff person for toilet use.
   A Reportable Event Form with a date of report of 2/14/19, and a date of event of 2/14/19 identified that Resident #18 reported an overnight Nurse Aide (NA) stuck his/her hand down the Resident's brief to check if the brief was wet twice and reported that the NA was rude. The Reportable Event Form identified that the police were notified.
   Review of Facility investigation documentation follow up letter dated 2/14/19, related to a Reportable Event Form dated 2/14/19 reporting an allegation of abuse, identified in the resolution, that the Care Plan for Resident #18 was updated, Resident #18 would have two staff for care on the overnight shift, and per Resident request, Resident #18 will be checked for incontinence care on last rounds to be allowed to sleep uninterupted.
   Staff investigation statements were dated 2/14/10 and 2/15/19. One investigation statement identified the incident as occuring on 2/13/19, other statements identified the date of the incident as 2/14/19.
   A police report dated 2/15/19 identified the time reported as 2:24 PM and further identified that on 2/15/19 at approximately 3:30 PM the officer was dispatched to the facility in regards to a sexual assault complaint. The report further identified that the alleged perpetrator worked the night of 2/13/19 into 2/14/19, 11:00 PM to 7:00 AM.
   A Social Services note dated 2/15/19 at 4:34 PM identified Resident #18 had come to the

Social Worker to report an accusation regarding staff and identified that the Director of Nurses (DNS) was updated.
A nurse's note dated 2/15/19 at 5:31 PM identified that the Licensed Practical Nurse (LPN) writer and the Registered Nurse (RN) supervisor conducted a body audit with the Resident's permission.
The State Agency Electronic Reportable Event Form identified that the initial submission from the facility to report the incident was dated 2/18/19 at 12:00 AM.
An interview and record review with the DNS on 8/14/19 at 2:00 PM identified that he/she became aware of the incident in the morning maybe between 10:00 AM and 11:00 AM. The DNS identified that he/she was informed by the Social Worker. The DNS identified that he/she called the Advanced Practice Registered Nurse (APRN) at 1:00 PM, and that he/she called the state agency prior to calling the APRN. The DNS identified that the letter dated 2/14/19 to the state agency was written by the DNS. The DNS identified he/she did not remember when the incident occurred and when he/she sent out documentation. The DNS identified the discrepancy in the dates noted in the record and does not know why there are discrepancies. The DNS identified that there is a two hour window to report abuse/allegations.
Interview and review of the State Agency Electronic Reportable Event Form with the Administrator on 8/15/19 at 9:40 AM identified that the incident was not reported in a timely manner and should have reported this within two hours. The Administrator further identified that subsequent to surveyor inquiry, the facility has updated the facility policy to include the current reporting requirements.
The facility failed to ensure the allegation was reported in a timely manner.

Plan of Correction for Violation #2:

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

3. Based on review of the clinical record, interviews, and review of facility policy, for three of four Residents reviewed for Hospitalization, (Resident #13, Resident #27, and Resident #28) the facility failed to ensure written notification regarding a hospitalization was provided to the Resident and the Resident's Representative, and/or failed to ensure notification of hospitalizations was sent to the ombudsman in a timely manner. The findings include:
   a. Resident #13 was admitted on 3/11/10. Diagnoses included urinary tract infection and hemiplegia.
   The annual Minimum Data Set (MDS) dated 2/26/19 identified Resident #13 had intact cognition.
   A nurse's note dated 5/20/19 identified Resident #13 was noted to have change in condition

and was sent to the hospital.
A nurse's note dated 5/29/19 at 12:05 AM identified Resident #13 was readmitted to the facility that evening from the hospital.
Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.
Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.

b. Resident #27 was admitted on 7/25/19 with diagnoses of cerebral infarction and end stage renal disease.
The admission MDS assessment dated 8/25/19 identified Resident #27 with intact cognition and requiring extensive to total assistance of one to two staff for Activities of Daily Living (ADLs).
A nurse's note dated 8/8/19 identified Resident #27 was sent to the hospital directly from dialysis.
Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.
Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.

c. Resident #28 was admitted on 4/22/19 with diagnoses which included diabetes, pulmonary edema, renal failure, anemia, and depression.
The admission MDS dated 5/5/19 identified Resident #28 had intact cognition and required limited assistance for transfers.
Review of the clinical record identified Resident #28 was admitted to the hospital on 6/25/19 and returned to the facility on 7/9/19; and Resident #28 was admitted to the hospital on 7/30/19 and discharged back to facility on 8/1/19.
Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.
Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.

Plan of Correction for Violation #3:

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

4. Based on review of the clinical record, interviews, and review of facility policy for three of four Residents reviewed for Hospitalization, (Resident #13, Resident #27, and Resident #28) the facility failed to ensure written notification regarding the facility bed hold policy was provided to the Resident and/or the Resident's Representative when the Resident was hospitalized. The findings include:
   a. Resident #13 was admitted on 3/11/10. Diagnoses included urinary tract infection and hemiplegia.
      The annual Minimum Data Set (MDS) dated 2/26/19 identified Resident # 13 had intact cognition.
      A nurse's note dated 5/20/19 identified Resident #13 was noted to have change in condition and was sent to the hospital.
      A nurse's note dated 5/29/19 at 12:05 AM identified Resident #13 was readmitted to the facility that evening from the hospital.
      Facility documentation failed to reflect any bed hold notification to the Resident and/or Resident's representative when the Resident was hospitalized.
      Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.
   b. Resident #27 was admitted on 7/25/19 with diagnoses of cerebral infarction and end stage renal disease.
      The admission MDS assessment dated 8/25/19 identified Resident #27 with intact cognition and requiring extensive to total assistance of one to two staff for Activities of Daily Living (ADLs).
      A nurse's note dated 8/8/19 identified Resident #27 was sent to the hospital directly from dialysis.
      Facility documentation failed to reflect written notification to the Resident and/or Resident's representative of the facility's bed hold policy when the Resident was hospitalized.
      Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.
   c. Resident #28 was admitted on 4/22/19 with diagnoses which included diabetes, pulmonary edema, renal failure, anemia, and depression.
      The admission MDS dated 5/5/19 identified Resident #28 had intact cognition and required limited assistance for transfers.
      Review of the clinical record identified Resident #28 was admitted to the hospital on 6/25/19 and returned to the facility on 7/9/19; and Resident #28 was admitted to the hospital on 7/30/19 and discharged back to facility on 8/1/19.
      Facility documentation failed to reflect written notification to the Resident and/or Resident Representative, of the facility bed hold policy when the Resident was hospitalized.
      Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.

The facility policy for Bed Hold identified the facilty will provide notice of the facility's bed hold policy upon admission and notice will also be given upon any transfer to the hospital or therapeutic leave.

Plan of Correction for Violation #4:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

5. Based on clinical record review and interview, for one of two Residents reviewed for Pre-Admission Screening and Resident Review, (PASRR), (Resident #4), the facility failed to notify the state-designated agency with a change in mental status or diagnosis. The findings include:
   a. Resident #4 was originally admitted on 7/28/06 with diagnoses which included depression and additional diagnoses of dementia added in 2009 and bipolar disorder added in 2016.
   Preadmission MI/MR identification sheet dated 7/12/06 identified diagnosis of depressive disorder but did not identify bipolar and/or other disorders.
   The annual Minimum Data Set (MDS) assessment dated 2/6/19 identified Resident #4 with intact cognition, requiring extensive assistance of one staff with Activities of Daily Living (ADLs), no level II PASRR, and receiving antipsychotic, antianxiety, and antidepressant medications.
   The resident care plan indicated Resident #4 had a potential behavior problem related to encephalopathy, dementia, depression, manic episodes, and bipolar disorder.
   The most recent psychiatric evaluation and consultation documented dated 7/29/19 identified Resident #4 with history of bipolar disorder, depression, insomnia, and dementia without behavioral disturbances.
   Interview with Licensed Practical Nurse (LPN) #1 on 8/15/19 at 11:00 AM indicated Resident #4 was evaluated and admitted prior to the required assessments and LPN #1 was not aware the resident now has the additional diagnoses of dementia and bipolar disorder. LPN #1 further indicated that, after speaking with a representative for the PASRR review process, if a new psychiatric diagnosis is added, the facility must submit a request for a Level I review and indicate status change for new diagnoses. LPN #1 further indicated the previous behavioral health group did not share resident diagnosis information with the MDS coordinator, and Resident #4 will be evaluated by the consultant psychiatric group and this evaluation will be sent with the status change request.

Plan of Correction for Violation #5:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

6. Based on clinical record review, interviews, and review of facility documentation, for one sampled Resident reviewed for abuse, (Resident #18), the facility failed to revise the plan of care related to a change in Resident care needs. The findings include:
   a. Resident #18 was admitted to the facility on 3/29/18. Diagnoses included bipolar disorder and alcohol and nicotine dependence, urinary incontinence and prediabetes.
   The quarterly Minimum Data Set (MDS) dated 1/6/19 identified Resident #18 had intact cognition, was independent in toilet use and required supervision of one staff for personal hygeine.
   A Reportable Event Form with a date of report of 2/14/19, identified that Resident #18 reported an overnight Nurse Aide (NA) stuck his/her hand down the Resident's brief to check if the brief was wet twice and reported that the NA was rude.
   Review of facility investigation documentation related to a Reportable Event Form dated 2/14/19 reporting an allegation of abuse, identified in the resolution, that the Care Plan for Resident #18 was updated, Resident #18 would have two staff for care on the overnight shift, and per Resident request, Resident #18 will be checked for incontinence care on last rounds to be allowed to sleep uninterupted.
   The current Care Plan identified Resident #18 had an Activities of Daily Living (ADL) self care deficit related to activity intolerance. Interventions included participation of one staff for toilet use.
   In an interview with the Director of Nurses (DNS) on 8/14/2019 at 2:00 PM, identified the Care Plan for Resident #18 did not reflect that there would be two staff persons for care of Resident #18 at night, nor that the Resident's sleep would not be interrupted during the night but would be checked for incontinence on the last rounds of the shift.
   An interview and review of the care card and care plan with Registered Nurse (RN) #1 on 8/15/19 at 9:30 AM identified that he/she was responsible to revise the Care Plan for Resident #18. RN #1 thought it had been revised, did not know why this was not done.
   The facility Care Plan Policy identified that the care plan will reflect the specific problems of the Resident, measurable and attainable goals and approach(es) that specifically address the needs/problems identified. The policy further identified that the Care Plan will be updated on an ongoing basis by members of the Interdisciplinary Team.

Plan of Correction for Violation #6:

VPOC CEN 9.10.19

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renee D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan
Bysiecwicz
Lt. Governor

Healthcare Quality And Safety Branch
IMPORTANT NOTICE-PLEASE READ CAREFULLY

August 30, 2019

Jay Katz, Administrator
Leeway, Inc
40 Albert Street
New Haven, CT 06511

Dear Dr. Katz:

Unannounced visits were made to Leeway, Inc which concluded on August 15, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure and a certification investigations.

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The plan of correction is to be submitted to the Department by September 9, 2019.

The plan of correction shall include:

(I) 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 lo 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 9, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be

Connecticul Department
of Public lle lth

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.0. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov /dph

deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter lo the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM:mb

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j)) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

I. Based on review of medical record, review of facility documentation, and interviews, for one of twelve Residents reviewed for advanced directives, (Resident #11) the facility failed to ensure a resident's wishes for Advanced Directives were accurately identified in the clinical record. The findings include:

a. Resident #11 was admitted on 8/4/16 with diagnoses which included Hypertensive Encephalopathy, Type 2 Diabetes, difficulty walking, Adjustment Disorder, Dementia with behavioral disturbances, and Schizoaffective Disorder.

An Advanced Directive form dated 2/19/16, signed by Resident #11, identified Resident #11 wished to be a Full Code with administration of cardiopulmonary resuscitation (CPR), Nutrition via tube feeding, and Hydration via intravenous line.

The medical record also contained a Health Care Instructions form dated 12/13/16 for Resident#11 which identified Resident#11 wished to have staff withhold cardiopulmonary resuscitation (CPR), artificial respiration, and artificial means of providing nutrition and hydration, signed by the assigned Health Care Representative. The quarterly Minimum Data Set (MOS) dated 5/31/19 identified Resident #11 had mild cognitive impairment and was independent with Activities of Daily Living (ADL's).

The Care Plan for Resident #11 dated 5/31/19 identified Resident #11 as a full code.

Review of medical record identified SW #1's narrative note dated 7/17/19 at 19:28, which identified the meeting with Resident #11 and the conservator for purpose of discussion of future plans for Resident. Both the Resident and the conservator signed an advanced directive form.

An Advanced Directive Statement, provided by the facility as it was not in the record, dated 7/17/19 signed by Resident #11 identified that Resident #11's wishes included to be provided CPR and hydration through an intravenous line, however chose not to have a tube feeding or intubation provided. The form failed to reflect the signature of the Physician.

Review of physician's orders dated 7/19/16 and reviewed on 6/8/19 directed full code, attempt CPR.

An interview on 8/12/2019 at 3:30 PM with the Administrator and Social Worker (SW) #I, identified that SW #I had a meeting on 7/17/19, with Resident #11 and his/her conservator, in which the Advanced Directive form was signed by Resident #11 and the conservator for cardiopulmonary Resuscitation, (CPR), administration via intravenous, but no tubing feeding and no intubation. SW # I identified that he/she did not call the physician and notify the physician of the change in the Advanced Directive nor did the SW notify the nursing staff, but placed the Advanced Directive sheet which was signed by Resident # 11 and the Conservator on 7/17/19 in the Red Book at the central nursing station, to be signed by the physician. The medical record did not have a copy of the Advanced Directive signed on 7/17/19.

SW #1 identified that the Advanced Directive which was signed on 7/17/19 should have been placed in the Resident's medical record and that he/she should have notified the physician of the newly signed Advanced Directive.

Subsequent to surveyor inquiry, the facility obtained a physician's signature on the Advanced Directive form dated 7/19/19.

The facility Advanced Directive policy identified that the facility will protect and promote the resident's right to determine his/her care including the Resident's Advance Directives.

The facility failed to ensure Resident #11's wishes for Advanced Directives were accurately identified in the clinical record.

Plan of Correction for Violation #1:

1. Resident #11 Advanced Directives have been updated per Conservator, MD, and Resident. Resident's Advanced Directive is in the medical record and signed by the MD.
2. All Residents have the potential to be affected by this process.
3. Staff Development Nurse will in-service all Licensed and Social Service Staff on Advanced Directive Policy
4. The facility will audit all current Residents Advanced Directives 2x a week by MDS Coordinator for 3 months then 1x a week for 3 months. The results of the audits will be reviewed at the monthly QAPI meeting for further recommendations.
5. The DNS and or Administrator will monitor the process.
6. Completion Date: September 25, 2019.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-081 (f) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

2. Based on clinical record review, interviews, and review of facility documentation, for one sampled resident reviewed for abuse, (Resident#18), the facility failed report an allegation of abuse to the state agency in a timely manner. The findings include:
   a. Resident# 18 was admitted to the facility on 3/29/18. Diagnoses included bipolar disorder and alcohol and nicotine dependence, urinary incontinence, and prediabetes.
   The quarterly Minimum Data Set (MOS) dated 1/6/19 identified Resident#18 had intact cognition, was independent in toilet use, and required supervision of one staff for personal hygeine.
   The Care Plan dated 2/4/19 identified Resident #18 had an Activities of Daily Living (AOL) self-care deficit related to activity intolerance. Interventions included participation of one staff person for toilet use.
   A Reportable Event Form with a date of report of 2/14/19, and a date of event of2/14/19 identified that Resident #18 reported an overnight Nurse Aide (NA) stuck his/her hand down the Resident's brief to check if the brief was wet twice and reported that the NA was rude. The Reportable Event Form identified that the police were notified.
   Review of Facility investigation documentation follow up letter dated 2/14/19, related to a Reportable Event Form dated 2/14/19 reporting an allegation of abuse, identified in the resolution, that the Care Plan for Resident #18 was updated, Resident# 18 would have two staff for care on the overnight shift, and per Resident request, Resident #18 will be checked for incontinence care on last rounds to be allowed to sleep uninterupted.
   Staff investigation statements were dated 2/14/10 and 2/15/19. One investigation statement identified the incident as occuring on 2/13/19, other statements identified the date of the incident as 2/14/19.
   A police report dated 2/15/19 identified the time reported as 2:24 PM and further identified that on 2/15/19 at approximately 3:30 PM the officer was dispatched to the facility in

regard to a sexual assault complaint. The report further identified that the alleged perpetrator worked the night of 2/13/19 into 2/14/19, 11:00 PM to 7:00 AM.
A Social Services note dated 2/15/19 at 4:34 PM identified Resident #18 had come to the Social Worker to report an accusation regarding staff and identified that the Director of Nurses (DNS) was updated.
A nurse's note dated 2/15/19 at 5:31 PM identified that the Licensed Practical Nurse (LPN) writer and the Registered Nurse (RN) supervisor conducted a body audit with the Resident's permission.

The State Agency Electronic Reportable Event Form identified that the initial submission from the facility to report the incident was dated 2/18/19 at 12:00 AM. An interview and record review with the DNS on 8/14/19 at 2:00 PM identified that he/she became aware of the incident in the morning maybe between 10:00 AM and 11:00 AM. The DNS identified that he/she was informed by the Social Worker. The DNS identified that he/she called the Advanced Practice Registered Nurse (APRN) at 1:00 PM, and that
he/she called the state agency prior to calling the APRN. The DNS identified that the letter dated 2/14/19 to the state agency was written by the DNS. The DNS identified he/she did not remember when the incident occurred and when he/she sent out documentation. The DNS identified the discrepancy in the dates noted in the record and does not know why there are discrepancies. The DNS identified that there is a two-hour window to report abuse/allegations.
Interview and review of the State Agency Electronic Reportable Event Form with the Administrator on 8/15/19 at 9:40 AM identified that the incident was not reported in a timely manner and should have reported this within two hours. The Administrator further identified that subsequent to surveyor inquiry, the facility has updated the facility policy to include the current reporting requirements.
The facility failed to ensure the allegation was reported in a timely manner.

Plan of Correction for Violation #2:

1. Resident #18 Care Plan and Care Card has been updated to reflect assist of 2 for personal care. No other incidents have occurred with Resident #18.
2. All Resident's at this facility have the potential to be affected by this process.
3. Licensed Staff will be in-serviced by the Staff Development Nurse on the Abuse Allegation Policy and Abuse Investigation Policy.
4. The facility will monitor this plan with audits 2x weekly. The results of the audits will be reviewed at the monthly QAPI meeting for further recommendations.
5. The Administrator will monitor this process.
6. Completion date: September 25, 2019.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor *(1).*

3. Based on review of the clinical record, interviews, and review of facility policy, for three of four Residents reviewed for Hospitalization, (Resident #13, Resident #27, and Resident #28) the facility failed to ensure written notification regarding a hospitalization was provided to the Resident and the Resident's Representative, and/or failed to ensure notification of hospitalizations was sent to the ombudsman in a timely manner. The findings include:
   a. Resident #13 was admitted on 3/11/10. Diagnoses included urinary tract infection and hemiplegia.
      The annual Minimum Data Set (MOS) dated 2/26/19 identified Resident# 13 had intact cognition.
      A nurse's note dated 5/20/19 identified Resident #13 was noted to have change in condition and was sent to the hospital.
      A nurse's note dated 5/29/19 at 12:05 AM identified Resident#13 was readmitted to the facility that evening from the hospital.
      Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.
      Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.

   b. Resident #27 was admitted on 7/25/19 with diagnoses of cerebral infarction and end stage renal disease.
      The admission MOS assessment dated 8/25/19 identified Resident #27 with intact cognition and requiring extensive to total assistance of one to two staff for Activities of Daily Living (ADLs).
      A nurse's note dated 8/8/19 identified Resident #27 was sent to the hospital directly from dialysis.
      Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.
      Interview with the Administrator on 8/14/19 at 12:IO PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.
   c. Resident #28 was admitted on 4/22/19 with diagnoses which included diabetes, pulmonary edema, renal failure, anemia, and depression.
      The admission MOS dated 5/5/19 identified Resident #28 had intact cognition and required limited assistance for transfers.
      Review of the clinical record identified Resident #28 was admitted to the hospital on 6/25/19 and returned to the facility on 7/9/19; and Resident #28 was admitted to the hospital on 7/30/19 and discharged back to facility on 8/1/19.
      Facility documentation failed to reflect written notifications of the hospitalization to the Resident or ombudsman.

Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility has not implemented any written notification of hospitalization to the Resident and the Resident's Representative, or to the ombusdsman, and has no related policy, as the facility was not aware of the requirements.

Plan of Correction for Violation #3:

1. All Residents and Conservators will be given written notice of the bed hold policy when discharged to the hospital. The State Ombudsman will receive a copy of all notices once monthly.
2. All Residents have the potential to be affected by this process.
3. Licensed Staff will be in-serviced on the Bed Hold Policy paperwork.
4. The DNS will conduct weekly audits to assure bed hold policy is being followed. The results of the audits will be reviewed at the monthly QAPI meetings for further recommendations.
5. The Administrator will monitor this process.
6. Completion date: September 25, 2019.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

4. Based on review of the clinical record, interviews, and review of facility policy for three of four Residents reviewed for Hospitalization,(Resident #13, Resident #27, and Resident #28) the facility failed to ensure written notification regarding the facility bed hold policy was provided to the Resident and/or the Resident's Representative when the Resident was hospitalized. The findings include:
   a. Resident #13 was admitted on 3/11/10. Diagnoses included urinary tract infection and hemiplegia.

      The annual Minimum Data Set (MOS) dated 2/26/19 identified Resident# 13 had intact cognition.

      A nurse's note dated 5/20/19 identified Resident #13 was noted to have change in condition and was sent to the hospital.

      A nurse's note dated 5/29/19 at 12:05 AM identified Resident #13 was readmitted to the facility that evening from the hospital.

      Facility documentation failed to reflect any bed hold notification to the Resident and/or Resident's representative when the Resident was hospitalized.

      Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.
   b. Resident #27 was admitted on 7/25/19 with diagnoses of cerebral infarction and end stage renal disease.

      The admission MOS assessment dated 8/25/19 identified Resident #27 with intact cognition and requiring extensive to total assistance of one to two staff for Activities of Daily Living (ADLs).

      A nurse's note dated 8/8/19 identified Resident #27 was sent to the hospital directly from dialysis.

      Facility documentation failed to reflect written notification to the Resident and/or Resident's representative of the facility's bed hold policy when the Resident was hospitalized.

Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.

c. Resident #28 was admitted on 4/22/19 with diagnoses which included diabetes, pulmonary edema, renal failure, anemia, and depression.
The admission MOS dated 5/5/19 identified Resident #28 had intact cognition and required limited assistance for transfers.
Review of the clinical record identified Resident #28 was admitted to the hospital on 6/25/19 and returned to the facility on 7/9/19; and Resident #28 was admitted to the hospital on 7/30/19 and discharged back to facility on 8/1/19.
Facility documentation failed to reflect written notification to the Resident and/or Resident Representative, of the facility bed hold policy when the Resident was hospitalized.
Interview with the Administrator on 8/14/19 at 12:10 PM identified that the facility does have a policy for bed hold notification, however, in 2014 this practice stopped occurring and they are now reinstituting this, it is unknown why this practice stopped.
The facility policy for Bed Hold identified the facilty will provide notice of the facility's bed hold policy upon admission and notice will also be given upon any transfer to the hospital or therapeutic leave.

Plan of Correction for Violation #4:

1. All Residents and Conservators will be given written notice of the bed hold policy when a Resident is discharged to the hospital. The state Ombudsman will receive a copy of all notices monthly.
2. All Residents have the potential to be affected by this process.
3. Licensed Staff will be in-serviced on Bed Hold Policy and educated on the Bed Hold Policy paperwork.
4. The DNS will conduct weekly audits to assure Bed Hold Policy is being followed. The results of the audits will be reviewed at the monthly QAPI meeting for further recommendations.
5. The Administrator will monitor this process.
6. Completion date: September 25, 2019.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j)
Director of Nurses (2) and/or (k) Nurse Supervisor *(1).*

5. Based on clinical record review and interview, for one of two Residents reviewed for Pre-Admission Screening and Resident Review, (PASRR), (Resident #4), the facility failed to notify the state-designated agency with a change in mental status or diagnosis. The findings include:
   a. Resident #4 was originally admitted on 7/28/06 with diagnoses which included depression and additional diagnoses of dementia added in 2009 and bipolar disorder added in 2016. Preadmission MI/MR identification sheet dated 7/12/06 identified diagnosis of depressive disorder but did not identify bipolar and/or other disorders.
   The annual Minimum Data Set (MOS) assessment dated 2/6/19 identified Resident #4 with intact cognition, requiring extensive assistance of one staff with Activities of Daily Living (ADLs), no level II PASRR, and receiving antipsychotic, antianxiety, and antidepressant medications.
   The resident care plan indicated Resident #4 had a potential behavior problem related to encephalopathy, dementia, depression, manic episodes, and bipolar disorder.
   The most recent psychiatric evaluation and consultation documented dated 7/29/19 identified Resident #4 with history of bipolar disorder, depression, insomnia, and dementia without behavioral disturbances.
   Interview with Licensed Practical Nurse (LPN) #1 on 8/15/19 at I 1:00 AM indicated Resident #4 was evaluated and admitted prior to the required assessments and LPN #1 was not aware the resident now has the additional diagnoses of dementia and bipolar disorder. LPN #1 further indicated that, after speaking with a representative for the PASRR review process, if a new psychiatric diagnosis is added, the facility must submit a request for a Level I review and indicate status change for new diagnoses. LPN #1 further indicated the previous behavioral health group did not share resident diagnosis information with the MOS coordinator, and Resident #4 will be evaluated by the consultant psychiatric group and this evaluation will be sent with the status change request.

Plan of Correction for Violation #5:

1. Resident #4 new Level 1 was submitted and waiting for approval.
2. All Residents may be affected by the process.
3. Staff Development Nurse will educate Licensed Staff, Admissions, and Social Services on the PASSR process.
4. Staff Development Nurse conduct chart audits 2x weekly for new psych diagnosis. The results of the audits will be discussed at the monthly QAPI meeting for further

recommendation.

5. The DNS will monitor this process.
6. Completion date: September 25, 2019

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

6. Based on clinical record review, interviews, and review of facility documentation, for one sampled Resident reviewed for abuse, (Resident #**18**), the facility failed to revise the plan of care related to a change in Resident care needs. The findings include:
   a. Resident #18 was admitted to the facility on 3/29/18. Diagnoses included bipolar disorder and alcohol and nicotine dependence, urinary incontinence and prediabetes. The quarterly Minimum Data Set (MDS) dated l/6/19 identified Resident# 18 had intact cognition, was independent in toilet use and required supervision of one staff for personal hygeine.

A Reportable Event Form with a date of report of 2/14/19, identified that Resident #18 reported an overnight Nurse Aide (NA) stuck his/her hand down the Resident's brief to check if the brief was wet twice and reported that the NA was rude.

Review of facility investigation documentation related to a Reportable Event Form dated 2/14/19 reporting an allegation of abuse, identified in the resolution, that the Care Plan for Resident #18 was updated, Resident #18 would have two staff for care on the overnight shift, and per Resident request, Resident #18 will be checked for incontinence care on last rounds to be allowed to sleep uninterrupted.

The current Care Plan identified Resident #18 had an Activities of Daily Living (AOL) self-care deficit related to activity intolerance. Interventions included participation of one staff for toilet use.

In an interview with the Director of Nurses (DNS) on 8/14/2019 at 2:00 PM, identified the Care Plan for Resident #18 did not reflect that there would be two staff persons for care of Resident #18 at night, nor that the Resident's sleep would not be interrupted during the night but would be checked for incontinence on the last rounds of the shift.

An interview and review of the care card and care plan with Registered Nurse (RN) #1 on 8/15/19 at 9:30 AM identified that he/she was responsible to revise the Care Plan for Resident #18. RN #1 thought it had been revised, did not know why this was not done.

The facility Care Plan Policy identified that the care plan will reflect the specific problems

of the Resident, measurable and attainable goals and approach(es) that specifically address the needs/problems identified. The policy further identified that the Care Plan will be updated on an ongoing basis by members of the Interdisciplinary Team.

Plan of Correction for Violation #6:

1. Resident #18 Care Plan and Care Card have been updated to reflect a change in care, she is now an assist of 2.
2. All Residents have the potential to be affected.
3. Licensed Staff will be educated on the process of updating care plans and care cards.
4. MDS Coordinator will audit 2x weekly to assure care plans and care cards are updated. The results of these audits will be reviewed at the monthly QAPI meeting for recommendation.

5. The DNS will monitor this process.
6. Completion date: September 25, 2019.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Leeway INC
40 Albert Street
New Haven, CT. 06511

Signature of FLIS Staff
P. Henrietta Simmons, NC

Licensure Category:
CCNH

Licensed Bed Bassinet Capacity: 30

Census: 29

Date(s) of onsite inspection: Desk Audit, on Friday, October 11, 2019
Date(s) additional information obtained: _____

Personnel contacted Administrator: **Jay Katz, Administrator. Phone # 203-865-0068**

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)
[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: _____

[**X**] Visit **OR** Revisit for the purpose of **DESK AUDIT** for **Violation Letters of August 30, 2019 and Review of POC**

[ ] See Complaint Investigation # _____

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated _____

[**X**] **Desk Audit October 11, 2019** [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[**X**] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: P. Henrietta Simmons, RN **DATE OF REPORT: October 11, 2019**

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

A desk audit was conducted for, **Leeway 40 Albert Street, New Haven, CT 06511,** on Friday, October 11, 2019, for the purpose of reviewing the plan of correction for violation letter dated on, August 30, 2019.

The POC, facility policies and procedures, review of facility documentation of in-services to staff and audits conducted were reviewed. Violations numbers #1 through 6 were identified as being corrected. As a result violations were not identified at the time of this desk audit. An Incompliance phone call was placed to the Jay Katz, Administrator.

P. Henrietta Simmons, RN, NC
DPH Nurse Consultant