2018

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Autumn Health Care of Norwalk
34 Midrocks Road
Norwalk, CT. 06851
M:

FLIS Staff

Kathleen Bleasdale
Marie Mathieu
Jeannie Overbye
Deborah Orzell
Carol Briand

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 150

Census: 135

Date(s) of onsite inspection: 4/10/18, 4/11/18, 4/12/18, 4/16/18, 4/17/18

Date(s) additional information obtained: ___

Personnel contacted: Joshua Schechter Adm, Michelle Morrison DNS

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[X] See Complaint Investigation # 22937

[ ] 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 5/1/18

[ ] 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: Kathleen Bleasdale **DATE OF REPORT:** 4/18/18

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

May 1, 2018

Joshua Schechter, Administrator
Autumn Lake Healthcare At Norwalk
34 Midrocks Drive
Norwalk, CT 06851

Dear Mr. Schechter:

Unannounced visits were made to Autumn Lake Healthcare At Norwalk on April 10, 11, 12, 16 and 17, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and a licensing and certification 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 visits.

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 May 15, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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 to the Department in response to the items of noncompliance identified in such notice. 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.

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

Connecticut Department of Public Health

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

DATES OF VISIT: April 10, 11, 12, 16 and 17, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Kim Hriceniak, R.N., C., B.S.N.
Public Health Services Manager
Facility Licensing and Investigations Section

KH:lst

CT #22937

DATES OF VISIT: April 10, 11, 12, 16 and 17, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

1. Based on review of the clinical record, interviews, and review of facility documentation for the only sampled resident reviewed for dignity (Resident #118), the facility failed to ensure the resident was treated in a dignified manner. The findings include:
   a. Resident #118 was admitted to the facility on 3/16/18 with diagnoses that included status post right hip fracture. The admission MDS assessment dated 3/23/18 identified intact cognition, able to make h/her needs known, no behaviors exhibited, required extensive assistance for bed mobility, transfers, and toilet use. The RCP dated 4/1/18 identified an ADL self-care deficit. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction, and staff to adjust the amount of support provided with physical function as resident functional status/participation changes, and as behaviors allow. Interview with Resident #118 on 4/11/18 at 9:24 AM identified h/she had an issue with NA #1 from the previous evening. Resident#118 identified on 4/10/18 during the 3:00PM-11:00PM shift h/she rang the call bell for assistance. NA #1 came into h/her room and when Resident #118 asked for assistance NA #1 spoke to h/her in a rude manner. Additionally, when Resident #118 asked for assistance to reach for an item that dropped on the floor NA #1 rudely told Resident #118 to use h/her reacher. NA #1 then walked out of the room and slammed the door behind h/her. Resident #118 identified although h/she couldn't recall the name of the nurse, h/she reported it to the nurse on duty that evening.

      Review of the facility investigation noted that although Resident #118 was unable to recall the exact date of the incident h/she reported to the SW on 4/17/18 that NA #1 slammed the door when h/she requested assistance, and said NA #1 seemed angry at that time.

      Interview with DNS on 4/16/18 at 10:30 AM identified she was not aware of the allegations, however felt the concern was a customer service issue and h/she would initiate an investigation into Resident #118's concerns. The DNS further identified it is the responsibility of the licensed staff to ensure all allegations of mistreatment are reported to the DNS for further investigation.

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, and staff interview for one of five residents reviewed for PASRR (Resident #111), the facility failed to code the MDS assessment correctly related to PASARR. The findings include:
   a. Resident #111's diagnoses included Schizoaffective Disorder.
      Review of the PASRR summary of findings dated 6/6/17 identified R #111 met the PASRR assessment requirements and may continue to reside in the nursing home with

recommendations to meet h/her needs. The significant change in status MDS assessment dated 9/27/18 under the Preadmission Screening and Resident Review (PASRR) section was noted to be coded as a zero indicating the resident is not currently considered by the state level II PASRR process to have a serious mental illness. The RCP dated 9/27/17 identified the resident uses psychotropic medications related to the diagnoses of Schizophrenia. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness. Interview and review of the clinical record with the Social Worker on 4/12/18 at 11:15 AM identified Resident #111 had a positive PASRR level II and the MDS should reflect this. Subsequent to surveyor inquiry a modification to the MDS assessment dated 9/27/18 was completed on 4/12/18.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) .

3. Based on clinical record review, interview, and review of facility policy and procedure for the only sampled resident reviewed for self-administration of medications, (Resident #118) the facility failed to ensure self- medication administration practices were completed in accordance with facility policy and procedure. The findings include:
   a. Resident #118 was admitted to the facility on 3/16/18 with diagnoses which included status post right hip fracture. The admission MDS assessment dated 3/23/18 identified intact cognition, able to make h/her needs known, no behaviors exhibited, required extensive assistance for bed mobility, transfers, and toilet use. The self-administration of medication assessment dated 3/23/18 identified RN #2 assessed Resident #118's ability to self-administer medications and granted approval to self-administer medications. Although the RCP dated 3/27/18 identified resident self-administers supplements. The care plan failed to reflect where and/or how these supplements were to be securely stored and/or how they are provided to the resident and/or who was responsible for documenting that supplements were taken.

      Physician orders dated 4/1/18 directed Bone strength Vit may self-administer, Bromelain 833 mg may self-administer, Co-enzyme B may self-administer, COQ 10-100mg may self-administer, herbal complex may self-administer, joint supplement may self-administer, lysine olive leaf may self-administer, methylsulfanylmethane may self-administer, Probiotic 15-35 may self-administer, turmeric may self-administer, Vitamin C /Calcium 500mg may self-administer, and Zyflamed Rosemary may self-administer.

      Observation and interview with Resident #118 on 4/11/18 at 9:30 AM identified ten containers of over the counter (OTC) medications on the bed. The ten supplements were Mega EFA 1200mg, Ester-C 500mg, Turmeric extract, MSM-(methylsulfonylmethane), Wellness formula-immune booster, Bone strength, Bromelain, Zyfamend, Multivitamin, and Co-enzyme B. R #118 proceeded to open each container of OTC's and remove two tablets from each bottle and swallow. Once completed Resident #118 placed all of the bottles in the

top drawer of h/her bedside table without the benefit of locking the drawer.

Review of the MAR dated 4/1/18 through 4/17/18 directed to administer Folic Acid 1mg daily, Multi-vitamin with minerals daily, Thiamine 100mg daily, and Vitamin C 250mg daily.

Observation of Resident #118's bedside unit and interview with RN #2 on 4/17/18 at 10:05 AM noted two bedside tables both with a top drawer key lock. Inside the locked right sided bedside table were 14 bottles of OTC medications/supplements, in the unlocked left sided bedside table were 14 bottles of OTC medications/supplements. RN #2 was able to lock the drawer of the right sided table but was unable to lock the left sided bedside table with the same key. Although RN #2 completed the self-administration assessment h/she was unable to explain who was responsible for documenting when the OTC medications/supplements were taken and/or for ensuring the medications/supplements were stored in a safe and secure manner. Interview with Resident #118 on 4/17/18 at 10:10 AM identified the two bedside tables are utilized for the storage of all h/her OTC medications/supplements, the right sided table is used just for the extra bottles and is always locked, and the left sided table is utilized for the current opened bottles which h/she has never locked as h/she did not a key that fit the lock.

Interview with the DNS on 4/17/18 at 10:30AM identified that all medications should be stored according to facility policy. The DNS was not able to explain who was responsible to ensure documentation of medication administration was completed.

Facility policy and procedure for self-administration of medications identified residents have the right to self -administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The staff and practitioner will assess each resident's mental and physical abilities, to determine whether self-administering medications is clinically appropriate for the resident. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken and to ensure the medications are stored in a safe and secure place, which is not accessible by other residents. Additionally nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the MAR kept at the nursing station, appropriately noting that the doses were self- administered.

DATES OF VISIT: April 10, 11, 12, 16 and 17, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(D).

4. Based on observations, review of facility policy, and interviews the facility failed to handle food in a sanitary manner. The findings include:
   a. Observation with the Food Service Director on 4/16/18 at 7:50AM identified Dietary Staff #1 repeatedly handled French toast with a gloved hand and then opened the warmer door using the same gloved hand. Interview with Dietary Staff #1at the time identified he used a gloved hand to handle the French toast for ease of securing when cutting in half with the alternate hand without first removing the soiled gloves and performing hand hygiene. Interview with the Food Service Director (FSD) at that time identified it is the responsibility of the dietary staff to handle food items in a way that prevents risk of cross contamination. The FSD further indicated that dietary staff #1 should be removing his gloves and performing hand hygiene between such tasks to prevent cross contamination. Subsequent to surveyor inquiry, Dietary Staff #1 handled and cut food using tongs and a knife.

      The facility policy for food preparation directs that al foods are prepared in accordance with guidelines of the USDA Food code. The policy further directs that all staff will use serving utensils appropriately to prevent cross contamination.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

5. Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 sampled residents (Resident # 333) reviewed for non- pressure related wounds, the facility failed to maintain appropriate infection control practices during a dressing change. The findings include:
   a. Resident # 333 diagnoses included osteomyelitis, abscess of the left ankle bursa, COPD and GERD.

      The physician ' s orders dated 4/12/18 directed to cleanse the left ankle wound with normal saline followed by Silvadene 1% twice daily

      The admission MDS assessment dated 4/13/18 identified Resident #333 was moderately cognitively impaired and required supervision with personal care.

      The April 2018 care plan identified a skin infection of the left ankle surgical wound with interventions which included to administer treatments as ordered and monitor for signs of infection.

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The admission MDS assessment dated 4/13/18 identified Resident #333 had mild cognitive impairment, supervision with personal care and did not have a pressure ulcer.

An observation of wound care on 4/12/18 at 11: 50 AM identified that although performed hand hygiene prior to beginning the treatment and after removing Resident # 333's soiled dressing, LPN #1 failed to perform hand hygiene after cleansing the surgical wound site and before applying the Silvadene 1% ointment during a dressing change. Further observation identified that although LPN #1 removed her gloves following the completion of the wound dressing change, she handled the garbage, medication keys and the drawer to the treatment cart without first performing hand hygiene.

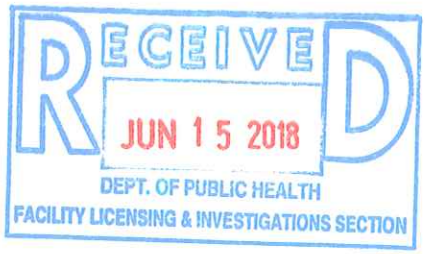
Interview with LPN #1 on 4/12/18 at 12:05 PM identified she thought she had performed hand hygiene after cleansing the wound and following wound care according to facility policy.

Interview with RN #1 on 4/17/18 at 9:08 AM identified it is the responsibility of the licensed staff to perform hand hygiene after the cleansing of a wound and before the application of a wound treatment to reduce cross-contamination.

The facility policy for hand hygiene directs that all personnel follow hand hygiene procedures to help prevent the spread of infections. The policy further directs that hand hygiene be performed before handling clean or soiled gauze pads or dressings and after removing gloves.

AUTUMN LAKE
HEALTHCARE
at Norwalk

6/18/18 approved CT



June, 11 2018

Kim Hriceniak, R.N., C., B.S.N.
Public Health Manager
Facility Licensing & Investigations Section
State of CT, Department of Public Health
410 Capitol Avenue – MS#12HSR

Dear Mrs. Hriceniak,

Attached you will find the amended plan of correction for Autumn Lake Health Care at Norwalk for the April 17, 2018 annual survey.

Nota Bene: The filing of this Plan of Correction does not constitute an admission as to any violations of Connecticut State Agencies and/or General Statutes of Connecticut set forth in this statement of violations. The Plan of Corrections is filed as evidence of this facility's continues commitment to compliance with all applicable laws.

Please contact me with any additional questions.

Sincerely,

Joshua Schechter
Administrator

1. **Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1)**
   a. The Administrator or designee will reeducate the MDS coordinators and social workers on ensuring that MDS assessments related to PASARR are coded correctly.
   b. Effective date: 5/18/18
   c. Random weekly audits of MDS's for patients with positive Level II PASARR will be conducted by the social workers or designee to ensure that MDS assessments are coded correctly related to PASARR.
   d. The Administrator will oversee this POC and report findings to monthly QAPI meetings x90 days or until the facility reaches compliance.

2. **Section 19-13-D8t (m) Nursing Staff (2)(A)**
   a. The Unit Manager or designee will educate Resident #111 on proper storage and security of her vitamins/supplement. The Unit Manager or designee will educate Resident #111 on properly documenting when taking her vitamins/supplement. The Staff Development Coordinator or designee will reeducate Licensed Nursing Staff on the facility's policy of self-administration of vitamins/supplements.
   b. Effective date: 5/18/18
   c. Random weekly audits of Resident #111's nightstands containing vitamins/supplements will be conducted by the Unit Manager or designee to ensure that they are locked when the residents is not self-administering vitamins/supplements. Random weekly audits of Resident #111's medication binder will be conducted by the Unit Manager to ensure that vitamins/supplements administration is being documented.
   d. The DNS or designee will oversee this POC and report findings to monthly QAPI meetings x90 days or until the facility reaches compliance.

3. **Section 19-13-D8t (q) Dietary Services (2)(D)**
   a. The Director of Dietary or designee will reeducate the dietary department on the proper method of handling food to prevent the risk of cross contamination.
   b. Effective date: 5/18/18
   c. The Director of Dietary or designee will be conducted a random weekly audits of the kitchen staff during meal prep time to ensure that staff are handling food properly to prevent the risk of cross contamination.

d. The Administrator will oversee this POC and report findings to monthly QAPI meetings x90 days or until the facility reaches compliance.

4. **Section 19-13-D8t (t) Infection Control (2)(A)**

a. The Staff Development Coordinator or designee will educate the nurses to ensure that they maintain appropriate infection control practices during a dressing change.

b. Effective date: 5/18/18

c. Random weekly audits of nurses providing treatments to non-pressure related wounds will be conducted by the Infection Preventionist or designee to ensure that they maintain appropriate infection control practices during a dressing change.

d. The DNS or Designee will oversee this POC and report findings to monthly QAPI meetings x90 days or until the facility reaches compliance.

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Autumn Health Care @ Norwalk
34 Midrocks Road
Norwalk, CT. 06851
M:

FLIS Staff

Kathleen Blenkiron
Marie Mathieu
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Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 150

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Date(s) of onsite inspection: 4/10/18, 4/11/18, 4/12/18, 4/16/18, 4/17/18

Date(s) additional information obtained: ___

Personnel contacted: Joshua Schechter Adm, Michelle Morrison DNS

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[X] See Complaint Investigation # 22937

[ ] 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 5/1/18

[ ] Desk Audit ___ [✓] Amended Letter: 6/5/18 Original Ltr. ___

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

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[✓] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Kathleen Blenkiron **DATE OF REPORT:** 4/18/18

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
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Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 5, 2018

Joshua Schechter, Administrator
Autumn Lake Healthcare At Norwalk
34 Midrocks Drive
Norwalk, CT 06851

Dear Mr. Schechter:

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Respectfully,

Kim Hriceniak, R.N., C., B.S.N.
Public Health Services Manager
Facility Licensing and Investigations Section

KH:lst

CT #22937

DATES OF VISIT: April 10, 11, 12, 16 and 17, 2018

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   Physician orders dated 4/1/18 directed Bone strength Vit may self-administer, Bromelain 833 mg may self-administer, Co-enzyme B may self-administer, COQ 10-100mg may self-administer, herbal complex may self-administer, joint supplement may self-administer,

lysine olive leaf may self-administer, methylsulfanylmethane may self-administer, Probiotic 15-35 may self-administer, turmeric may self-administer, Vitamin C /Calcium 500mg may self-administer, and Zyflamed Rosemary may self-administer.

Observation and interview with Resident #118 on 4/11/18 at 9:30 AM identified ten containers of over the counter (OTC) medications on the bed. The ten supplements were Mega EFA 1200mg, Ester-C 500mg, Turmeric extract, MSM-(methylsulfonylmethane), Wellness formula-immune booster, Bone strength, Bromelain, Zyfamend, Multivitamin, and Co-enzyme B. R #118 proceeded to open each container of OTC's and remove two tablets from each bottle and swallow. Once completed Resident #118 placed all of the bottles in the top drawer of h/her bedside table without the benefit of locking the drawer.

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Observation of Resident #118's bedside unit and interview with RN #2 on 4/17/18 at 10:05 AM noted two bedside tables both with a top drawer key lock. Inside the locked right sided bedside table were 14 bottles of OTC medications/supplements, in the unlocked left sided bedside table were 14 bottles of OTC medications/supplements. RN #2 was able to lock the drawer of the right sided table but was unable to lock the left sided bedside table with the same key. Although RN #2 completed the self-administration assessment h/she was unable to explain who was responsible for documenting when the OTC medications/supplements were taken and/or for ensuring the medications/supplements were stored in a safe and secure manner. Interview with Resident #118 on 4/17/18 at 10:10 AM identified the two bedside tables are utilized for the storage of all h/her OTC medications/supplements, the right sided table is used just for the extra bottles and is always locked, and the left sided table is utilized for the current opened bottles which h/she has never locked as h/she did not a key that fit the lock.

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Facility policy and procedure for self-administration of medications identified residents have the right to self -administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The staff and practitioner will assess each resident's mental and physical abilities, to determine whether self-administering medications is clinically appropriate for the resident. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken and to ensure the medications are stored in a safe and secure place, which is not accessible by other residents. Additionally nursing staff will

review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the MAR kept at the nursing station, appropriately noting that the doses were self- administered.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(D).

3. Based on observations, review of facility policy, and interviews the facility failed to handle food in a sanitary manner. The findings include:
   a. Observation with the Food Service Director on 4/16/18 at 7:50AM identified Dietary Staff #1 repeatedly handled French toast with a gloved hand and then opened the warmer door using the same gloved hand. Interview with Dietary Staff #1at the time identified he used a gloved hand to handle the French toast for ease of securing when cutting in half with the alternate hand without first removing the soiled gloves and performing hand hygiene. Interview with the Food Service Director (FSD) at that time identified it is the responsibility of the dietary staff to handle food items in a way that prevents risk of cross contamination. The FSD further indicated that dietary staff #1 should be removing his gloves and performing hand hygiene between such tasks to prevent cross contamination. Subsequent to surveyor inquiry, Dietary Staff #1 handled and cut food using tongs and a knife.

      The facility policy for food preparation directs that al foods are prepared in accordance with guidelines of the USDA Food code. The policy further directs that all staff will use serving utensils appropriately to prevent cross contamination.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

4. Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 sampled residents (Resident # 333) reviewed for non- pressure related wounds, the facility failed to maintain appropriate infection control practices during a dressing change. The findings include:
   a. Resident # 333 diagnoses included osteomyelitis, abscess of the left ankle bursa, COPD and GERD.

      The physician ' s orders dated 4/12/18 directed to cleanse the left ankle wound with normal saline followed by Silvadene 1% twice daily

      The admission MDS assessment dated 4/13/18 identified Resident #333 was moderately cognitively impaired and required supervision with personal care.

      The April 2018 care plan identified a skin infection of the left ankle surgical wound with

interventions which included to administer treatments as ordered and monitor for signs of infection.

The admission MDS assessment dated 4/13/18 identified Resident #333 had mild cognitive impairment, supervision with personal care and did not have a pressure ulcer.

An observation of wound care on 4/12/18 at 11: 50 AM identified that although performed hand hygiene prior to beginning the treatment and after removing Resident # 333's soiled dressing, LPN #1 failed to perform hand hygiene after cleansing the surgical wound site and before applying the Silvadene 1% ointment during a dressing change. Further observation identified that although LPN #1 removed her gloves following the completion of the wound dressing change, she handled the garbage, medication keys and the drawer to the treatment cart without first performing hand hygiene.

Interview with LPN #1 on 4/12/18 at 12:05 PM identified she thought she had performed hand hygiene after cleansing the wound and following wound care according to facility policy.

Interview with RN #1 on 4/17/18 at 9:08 AM identified it is the responsibility of the licensed staff to perform hand hygiene after the cleansing of a wound and before the application of a wound treatment to reduce cross-contamination.

The facility policy for hand hygiene directs that all personnel follow hand hygiene procedures to help prevent the spread of infections. The policy further directs that hand hygiene be performed before handling clean or soiled gauze pads or dressings and after removing gloves.