2018

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Evergreen Woods
88 Notch Hill Rd
North Branford, CT
M: 010471

FLIS Staff

Amy McNeil
[illegible]
Jeannie Overbye

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 50

Census: 41

Date(s) of onsite inspection: 5/30, 5/31, 6/1 2018

Date(s) additional information obtained: ___

Personnel contacted: Ronald Miller, Admin; Cynthia DeLaney DN

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 # ___

[X] 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 6/12/18

[ ] 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: Amy McNeil **DATE OF REPORT:** 6/4/18

[ ] Approval for issuance of license granted by: Maria R Fabrucci **DATE:** 6/12/18
Supervisor/Title

s:flis\hsr\FACESHEETS
Revised 2/2018

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

June 12, 2018

Ms. Jaclyn Martinelli, Administrator
Evergreen Woods
88 Notch Hill Road
North Branford, CT 06471

Dear Ms. Martinelli:

Unannounced visits were made to Evergreen Woods on May 30, 31 and June 1, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, a licensure and a 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 June 26, 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: May 30, 31 and June 1, 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,

Maria M LaRocco, RN

Maria M. LaRocco, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

MML:mb

DATES OF VISIT: May 30, 31 and June 1, 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 (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (r) Therapeutic Recreation (1).

1. Based on observations, clinical record review, review of facility documentation, and interviews for one of one sampled resident reviewed for activities (Resident #22) the facility failed to ensure the resident's dignity was met during an activity. The findings include:
   a. Physician ' s order dated 12/13/17 directed to keep the resident NPO.
   Resident #22 ' s diagnoses included cerebral infarction due to embolism, vascular dementia with behavioral disturbance and osteoarthritis. An annual MDS assessment dated 1/09/18 identified Resident #22 as severely cognitively impaired and totally dependent on staff for transfers, eating and personal hygiene. Additionally, the staff assessment for activity preference identified that it was important for the resident to be around animals, do things with groups of people, participate in favorite activities, and spend time outdoors.
   The Resident Care Plan (RCP) dated 1/18/18 identified the resident is NPO (nothing by mouth) due to dysphagia and requires a feeding via PEG tube, and would benefit from diversional activities for cognitive stimulation, social interaction due to dementia, and aphasia. Appears to enjoy watching TV, sometimes interacts in a 1:1 setting but is not consistent.
   Interventions included to administer tube feeding per orders and move to a safe quiet space if over stimulated, provide 1:1 bedside visits and activities if unable to attend out of room events, and escort to activity functions.
   Observation on 05/30/18 at 10:17 AM identified the resident sitting in a Broda chair in the hall in front of the nurses desk, leaning back, looking up at the ceiling.
   Observation on 5/30/18 at 11:19 AM identified the resident sitting in the hall next to the fish tank, looking up at the ceiling.
   Interview and review of the clinical record with the Recreational Director on 5/31/18 at 8:55 AM identified that the resident's goal was to accept two one to one visits for social/cognitive stimulation per week. The Recreation Director identified that although he/she asks everyone to attend all the activities, he/she could not identify why the resident did not attend most of the monthly group activities.
   Review of Resident #22's activity logs identified in January the resident attended 7 activities, 6 of which were 1:1 and 1 in a group and did not attend 6 additional activities noted as n/a. In February the resident attended 7 activities, 6 of which were 1:1 and 1 in a group with no documented n/a's. In March the resident attended 13 activities 5 were facility scheduled activities in a group and 8 were 1:1 with 1 documented n/a. In April the resident attended 11 activities 6 of which were facility scheduled activities in a group and 5 were 1:1 with 2 documented n/a's.
   Subsequent to surveyor inquiry the May activity log was provided, the resident attended 11 activities, 3 were facility group activities and 8 were 1:1 visits with 10 documented n/a.
   A second interview and review of the clinical record with the Recreation Director on 5/31/18 at 3:15 PM identified that the resident's attendance to the glazed donut and coffee

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

social on January 12, 2018 , the attendance to the poetry and pie activity on March 21, 2018, the attendance to the animal cracker fun (which was a discussion of animal crackers without the crackers) on April 18, 2018, and the attendance to the root beer float social on April 25, 2018 were appropriate for the resident because the resident was able to benefit from the socialization aspect, despite not being able to participate in eating due to his/her being fed via a PEG tube only and not allowed to take any food by mouth. The Recreation Director identified that the Resident observed what was happening and that just because he/she was unable to eat it didn't mean he/she did not enjoy being in the setting or the environment. Interview with the Administrator on 5/31/18 at 3:30 PM identified that the Recreation Director should be documenting the specific recreational activity that was provided to the resident and that a food program for a tube fed resident is appropriate if it includes other consecutive activities.

Review of the Dignity Policy identified, in part, that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality and that treated with dignity means the resident will be assisted in maintaining and enhancing his/her self esteem and self-worth.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(1).

2. Based on review of the clinical record, facility documentation, policy and/or procedures and interviews for one of two sampled residents reviewed for falls (R#2), the facility failed to review and/or revise the plan of care following a fall and/or for 1 of 3 sampled residents reviewed for pressure ulcers (Resident # 7) the facility failed to review and revise the plan of care when there was an identified change. The findings included:
   a. Resident #2 diagnoses that included Alzheimer ' s disease, dementia without behavioral disturbance, panic disorder, anxiety disorder, and age-related osteoporosis.
   An admission MDS assessment 2/14/18 identified the resident as cognitively intact, requiring extensive assistance from staff for most activities of daily living, utilizes a walker and as having an unsteady sitting balance and/or moving on and/or off the table.
   The RCP updated on 3/02/18 identified a potential for falls as a focus. Interventions included encourage appropriate footwear.
   Reportable Event (RE) and nurse ' s notes dated 4/03/18 at 8:40 P.M. and 10:26 P.M. identified in part, Resident in bathroom in his/her room at 8:50 P.M. with nurse aide for HS care. Resident was seated on the toilet, nurse aide turned to sink and turned back and resident was sitting on the floor. ROM was assessed to all extremities and resident had no pain and/or injury. Resident returned to standing position with assist of two, MD and son were notified.
   On 6/01/18 at 11:05 A.M. an interview and review of the clinical record and RE dated 4/03/18 regarding R#2 fall on 4/03/18 with RN# 2 indicated although the resident was wearing shoes at the time of the fall, RN#2 revised the care plan on 4/04/18 to reflect an intervention for utilizing non-skid socks and was unaware that this intervention was already

in place.
On 6/1/18 at 11:15 A.M. an interview and review of the clinical record and RE with the DNS indicated although the intervention had been discussed with the interdisciplinary team following the resident ' s fall, RN#2 was to have reviewed the RCP and/or the NA care card's for previously noted interventions prior to adding a new one.

b. Resident # 7 was admitted on 11/17/11 with diagnoses that included type II diabetes, rheumatoid arthritis and atrial fibrillation.
A quarterly MDS assessment dated 2/28/18 identified the resident with severe cognitive impairment and required total one person assist with personal care.
Physician orders dated 5/25/18 directed weekly skin checks, alternating pressure mattress, soft booties on while in bed and skill care boots on at all times.
A care plan dated 5/28/18 identified a potential alteration in skin integrity related to mobility, diabetes and incontinence. Interventions included soft booties on while in bed, skill care heel boots at all times, bed cradle and turn and position every two hours.
Observation of Resident #7 on 5/31/18 at 10:35 AM identified he/she was lying in bed without the benefit of heel booties. Slippers were observed on Resident #7 ' s wheelchair where he/she had been transferred from.
The CNA care card dated 5/31/18 identified skill care card identified that heel boots are to be on at all times on leg rests in the wheel chair.
Interview with the ADNS on 5/31/18 at 10:35 AM identified Resident #7 was only required to wear heel booties at night.
A second observation on 6/01/18 at 10:05 AM identified Resident #7 was in bed without the benefit of heel booties.
An interview with the ADNS and NA #1 on 6/01/18 at 10:13 AM identified that although Resident #7 ' s booties had been removed to provide care, booties are required only at night or if remaining in bed during the day.
A subsequent interview on 6/01/18 at 11:00 AM identified that although Resident #7 no longer wore booties while out of bed, she did not have the order discontinued and /or revise the care plan to reflect the change.
The facility policy on care planning indicates that the care plan will be reviewed and revised to meet the residents needs on an ongoing basis.

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).

3. Based on observations, clinical record review, review of facility documentation, review of facility policy and interviews for one of five sampled residents reviewed for unnecessary medication (R#8), the facility failed to obtain lab work as per pharmacy recommendation and/or per physician's order. The findings included:
   a. Resident #8's diagnoses included Parkinson disease, polyneuropathy and Dementia with behavioral disturbance. The annual MDS assessment dated 2/28/18 identified Resident #8 with no cognitive impairment and required extensive assistance of two persons for bed

mobility and transfer.
The pharmacy consultant report dated 11/17/17 indicated facility should consider monitoring serum creatinine on next convenient lab day and every 6 months thereafter.
A physician's order dated 12/18/17 directed in-part serum creatinine level on next lab day then every six months December and June.
Additional pharmacy consultant report dated 4/27/18 indicated resident has not had an assessment of renal function with the past six months, labs ordered in December and result not found.
Review of Resident #8's progress notes dated 12/06/17 through 5/31/18 failed to indicate that labs were obtained and/or resident refused lab drawn.
Review of facility documentation indicated a requisition was made on 12/20/17 to obtain creatinine level, however the facility was unable to provide documentation indicating labs were drawn as requested.
Interview and review of Resident's #8 clinical record with the DON on 5/31/18 at 10:25 AM he/she indicated that pharmacy recommendations were made on 11/17/17 to obtain serum creatinine level and on 12/15/17 the physician signed the recommendation indicating labs should be obtained for serum creatinine level. DON further indicated that an order was written by him/her in Resident #8 clinical record on 12/18/17 and it was the responsibility of the charge nurse to ensure that labs were drawn the next lab day.
Further interview with DON he/she indicated that he/she was aware that pharmacy made a second recommendation for serum creatinine level on 4/27/17 and although the physician signed for labs to be drawn on 5/07/18 Resident #8 had a standing order for lab in June therefore labs would be drawn as schedule in June. The DON indicated that the lab was called on 5/31/18 but there was no documentation indicating that serum creatinine level was obtained for Resident #8 on 12/20/17.
Interview with MD #1 on 6/1/18 at 11:55AM indicated that pharmacy consult was reviewed by and he/she was in agreement for labs to be drawn as recommended on 12/15/17 and again on 5/07/18 and it was the responsibility of the facility staff to ensure labs were drawn as ordered. MD#1 further indicated that although Resident #8 had a standing order for serum creatinine level to be drawn in June the facility staff should have obtained labs when the second recommendation was signed by him/her on 5/07/18 because there were no serum creatinine level in Resident #8 clinical record within the last six months.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (r) Therapeutic Recreation (1).

4. Based on observations, clinical record review, review of facility documentation, and interviews for one of one sampled resident reviewed for activities (Resident #22) the facility failed to ensure a resident centered activity program. The findings include:
   a. Resident #22 ' s diagnoses included cerebral infarction due to embolism, vascular dementia with behavioral disturbance and osteoarthritis. The annual MDS assessment dated 1/09/18 identified Resident #22 as severely cognitively impaired and was totally dependent on staff

for transfers, eating and personal hygiene. Additionally, the staff assessment for activity preference identified that it was important for the resident to be around animals, do things with groups of people, participate in favorite activities and spend time outdoors.
A physician ' s order dated 12/13/17 directed to keep the resident NPO.
The Resident Care Plan (RCP) dated 1/18/18 identified the resident is NPO (nothing by mouth) due to dysphagia and requires a feeding via PEG tube, and would benefit from diversional activities for cognitive stimulation, social interaction due to dementia, and aphasia. Appears to enjoy watching TV, sometimes interacts in a 1:1 setting but is not consistent.
Interventions included to administer tube feeding per orders and move to a safe quiet space if over stimulated, provide 1:1 bedside visits and activities if unable to attend out of room events, and escort to activity functions.
Observation on 05/30/18 at 10:17 AM identified the resident sitting in a Broda chair in the hall in front of the nurses desk, leaning back, looking up at the ceiling.
Observation on 5/30/18 at 11:19 AM identified the resident sitting in the hall next to the fish tank, looking up at the ceiling.
Interview and review of the clinical record with the Recreational Director on 5/31/18 at 8:55 AM identified that the resident's goal was to accept two one to one visits for social/cognitive stimulation per week. The Recreation Director identified that although he/she asks everyone to attend all the activities, he/she could not identify why the resident did not attend most of the monthly group activities.
Review of Resident #22's activity logs identified in January the resident attended 7 activities, 6 of which were 1:1 and 1 in a group and did not attend 6 additional activities noted as n/a. In February the resident attended 7 activities, 6 of which were 1:1 and 1 in a group with no documented n/a. In March the resident attended 13 activities 5 were facility scheduled activities in a group and 8 were 1:1 and 1 documented n/a. In April the resident attended 11 activities 6 of which were facility scheduled activities in a group and 5 were 1:1 with 2 documented n/a.
Subsequent to surveyor inquiry the May activity log was provided, the resident attended 11 activities, 3 were facility group activities and 8 were 1:1 visits with 10 documented n/a.
A second interview and review of the clinical record with the Recreation Director on 5/31/18 at 3:15 PM identified that the resident's attendance to the glazed donut and coffee social on January 12, 2018 , the attendance to the poetry and pie activity on March 21, 2018, the attendance to the animal cracker fun (which was a discussion of animal crackers without the crackers) on April 18, 2018, and the attendance to the root beer float social on April 25, 2018 were appropriate for the resident because the resident was able to benefit from the socialization aspect, despite not being able to participate in eating due to his/her being fed via a PEG tube only and not allowed to take any food by mouth. The Recreation Director identified that the Resident observed what was happening and just that because he/she was unable to eat didn't mean he/she did not enjoy being in the setting or the environment. The Recreation Director identified that for resident's with a diminished cognitive capacity, 1:1 sensory stimulation could be hand massage, DVD's, music I pods with head sets, watching

room mates TV often sometimes his/her own. The Recreation Director was unable to identify why the resident did not attend scheduled group activities when he/she could have; and/or which 1:1 sensory activity was provided 4/6 times in January, 3/6 times in February, 8/9 times in March and 2/5 times in April.
Interview with he DNS on 5/31/18 at 3:26 PM identified that the activity calendar does not identify what the sensory stimulus activities were for the resident.
Interview with the Administrator on 5/31/18 at 3:30 PM identified that the Recreation Director should be documenting the specific recreational activity that was provided to the resident and that a food program for a tube fed resident is appropriate if it includes other consecutive activities.
Review of the Activity Program Policy identified, in part, that activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.

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 observations, clinical record review, review of facility documentation, review of facility policy and interviews for one of five sampled residents reviewed for unnecessary medication (R#8), the facility failed to ensure pharmacy recommendation were acted upon in a timely manner. The findings include:
   a. Resident #8's diagnoses included Parkinson disease, polyneuropathy and Dementia with behavioral disturbance. The annual MDS assessment dated 2/28/18 identified Resident #8 with no cognitive impairment and required extensive assistance of two persons for bed mobility and transfer.
   The Resident Care Plan (RCP) dated 12/19/17 identified history of hallucinations, delusions, dementia with behavior disturbance and intervention included administer medications as ordered.
   A physician's order dated 12/18/17 directed in-part serum creatinine level on next lab day then every six months December and June.
   The pharmacy consultant report dated 11/17/17 indicated facility should consider monitoring serum creatinine on next convenient lab day and every 6 months thereafter.
   Additional pharmacy consultant report dated 4/27/18 indicated resident has not had an assessment of renal function with the past six months, labs ordered in December and result not found.
   Review of Resident #8 progress notes dated 12/6/17 through 5/31/18 failed to indicate that labs were obtained and/or resident refused lab drawn.
   Interview and review of Resident's #8 clinical record with DON on 5/31/18 at 10:25AM identified that pharmacy recommendation were made on 11/17/17 to obtain serum creatinine level and on 12/15/17 the physician signed the recommendation indicating labs should be obtained for serum creatinine level.
   DON further indicated that an order was written by him/her in Resident #8's clinical record

on 12/18/17 and it was the responsibility of the charge nurse to ensure that labs were drawn the next lab day. DON indicated that he/she was aware that pharmacy made a second recommendation for serum creatinine level on 4/27/17 and although the physician signed for labs to be drawn on 5/07/18 the resident had a standing order for lab in June therefore labs would be drawn as schedule in June. During further interview with DON he/she indicated that the lab was called on 5/31/18 but there was no documentation indicating that serum creatinine level was obtained for Resident #8 on 12/20/17.
Interview with MD #1 on 6/1/18 at 11:55 AM identified that the pharmacy consult was reviewed and he/she was in agreement for labs to be drawn as recommended on 12/15/17 and again on 5/07/18 and it was the responsibility of the facility staff to ensure labs were drawn as ordered.
The facility did not provide a policy.

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).

6. Based on observations, clinical record review, review of facility documentation, review of facility policy and interviews for one of one sampled residents reviewed for dialysis (R# 195), the facility failed to ensure medication were secure. The findings included:
   a. Resident # 195's diagnoses included end-stage renal disease.
   An admission nursing assessment dated 5/25/18 identified resident as alert, slow to respond and required extensive assistance with transfer and dressing.
   The Resident Care Plan (RCP) dated 5/25/18 identified Resident#195 with AV dialysis fistula. Interventions included to observe for fever, chills, malaise and mental status changes.
   A physician's order dated 5/25/18 directed in-part gabapentin 300 mg three times weekly to be given at dialysis.
   Nurse's note dated 5/30/18 at 13:57 identified that Resident #195 returned from dialysis at noon, AV fistula intact, positive bruit and thrill.
   During observation on 5/31/18 at 2:15 PM with the DON Resident #195 dialysis communication book/binder was noted on the residents' chart rack located at the nurses' station and upon opening the communication book a blister packet with 5 tablets was located in the binder which was identified as gabapentin 300 mg.
   During interview with the DON he/she indicated Resident #195 goes to dialysis on Monday, Wednesday and Fridays and the medication is sent with resident to be taken at dialysis and it is the responsibility of the charge nurse to secure medications when resident returns to facility. DON further indicated that Resident #195 went to dialysis on 5/30/18 and returned to facility during the day shift and medications should be place in medication cart upon resident's arrival to facility.
   Interview with LPN#1 on 6/01/18 at 11:48 AM identified that Resident #195 returned from dialysis during his/her shift on 5/30/18 and at that time he/she reviewed the resident's communication book, however did not remove medication from book. LPN#1 further

indicated that medication should be removed from dialysis communication book/binder and placed in the medication cart upon resident's return from dialysis.
Review of facility storage and expiration of medication, biological, syringes and needles policy indicated in-part that facility should ensure all medications including treatment items, are securely stored in a locked cabinet/cart or locked medication room and is inaccessible by residents and visitors.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (o) Medical Records (2)(H)(4).

7. Based on observation, review of the clinical record, facility documentation, facility policy, and interviews reviewed for Outpatient Physical Therapy (OPPT), the facility failed to verify the treatment plan with the physician according to policy. The findings include:
   a. A review of Person #1 ' s clinical record on 5/30/18 at 12:32PM.
   Identified that therapy was initiated on 5/03/18. The clinical record did not include a PT evaluation.
   Interview with the Rehabilitation Director on 5/30/18 at 12:32bPM identified that the evaluation is sent to the unit for physician evaluation and would need to follow up on why it had not yet been returned.
   Subsequent to surveyor inquiry, the evaluation dated 5/03/18 was signed by the physician on 5/30/18 and included in the clinical record.
   The facility policy directs that the referring physician will be notified by phone within 24 hours of the initial evaluation to verify the treatment plan. The original evaluation is to be sent to the MD for signature within (3) days of the evaluation

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (o) Medical Records (2)(H)(4).

8. Based on observation, review of the clinical record, facility documentation, facility policy, and interviews reviewed for Outpatient Physical Therapy (OPPT), the facility failed to secure clinical records in accordance with facility policy. The findings include:
   a. Observation on 5/30/18 at 12:32 PM identified the file cabinet holding the patient clinical records was unlocked. Interview with the Rehabilitation Director at the time identified that the cabinet should have been locked.
   The facility policy regarding confidentiality directs that therapy records shall be maintained in a confidential manner that ensures protection of patient privacy and confidentiality. Records are to be stored in a locked file drawer that is not accessible to visitors or other unauthorized individuals.

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 (k) Nurse supervisor (1) and/or (t) Infection Control (2)(A).

9. Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 sampled residents reviewed for pressure ulcers (Resident # 7) the facility failed to follow infection control standards per facility policy. The findings include:
   a. Resident # 7 was admitted on 11/17/11 with diagnoses that included type II diabetes, rheumatoid arthritis and atrial fibrillation.
   The quarterly MDS assessment dated 2/28/18 identified severe cognitive impairment and required total one person assist with personal care.
   The physicians orders dated 5/25/18 directed weekly skin checks, alternating pressure mattress, soft booties on while in bed and skill care boots on at all times.
   The care plan dated 5/28/18 identified a potential alteration in skin integrity related to mobility, diabetes and incontinence. Interventions included soft booties on while in bed, skill care heel boots at all times, bed cradle and turn and position every two hours.
   The physician ' s orders dated 5/28/18 directed triad cream to the coccyx region every shift for seven days then re-evaluate.
   Observation of wound care on 5/30/18 at 10:31 AM identified upon completion of wound care, RN #1 placed socks on Resident #7, touched Resident # 7 's blouse, put on clothing and covered the resident with a blanket without the benefit of first removing gloves and performing hand hygiene.
   Interview with RN #1 on 5/31/18 at 10:40 AM identified that while he/she was aware that hand hygiene should be performed between tasks, he/she failed to do so as stated because she became distracted.
   Interview with the ADNS on 5/31/18 at 10:44 AM identified that it was his/her expectation that hand hygiene be performed following the completion of wound care and that he/she should have intervened when it was not completed.
   The facility policy for hand hygiene identifies that hand hygiene is to be performed whenever they are soiled from any source.

EVERGREEN
WOODS

June 18, 2018

Maria LaRocco, RN
State of Connecticut
Department of Public Health
Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: Evergreen Woods Health Center
Survey Exit Date: June 1, 2018

Dear Ms. LaRocco:

Enclosed please find our completed plan of correction for the annual survey conducted at our facility, May 30, 31 and June 1, 2018.

Evergreen Woods submits this plan of correction to demonstrate compliance with applicable laws. The filing of this plan does not constitute any admission by the facility, its' officers, employees or agents as to any findings or violations as set forth in your survey.

If you have any questions, please contact me at (203) 483-3231.

Sincerely,

Jaclyn Martinelli
Administrator

88 Notch Hill Road, North Branford, CT 06471
Phone 203-488-8000 • www.evergreen-woods.com

EVERGREEN WOODS

88 Notch Hill Road, North Branford, CT 06471
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POC accepted mml 6/25/18

Section 19-13 D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (r) Therapeutic Recreation (1): The facility failed to ensure the resident's dignity was met during an activity.

- Resident #22's activity participation plan has been updated to reflect participation in activities that promote dignity, enhance quality of life, individuality and maintaining and enhancing her esteem and self-worth. The programming staff have been re-educated on updating resident's activity participation plan to reflect participation in activities that promote dignity, enhance quality of life, individuality, maintaining and enhancing esteem and self-worth. Random audits of resident participation logs will be conducted by the Assistant Director or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.

- June 25, 2018

- The Assistant Director of Nursing is responsible for this plan.

Section 19-13 D8t (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(1): The facility failed to review and/or revise the plan of care following a fall and/or for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #7) the facility failed to review and revise the plan of care when there was an identified change.

- Resident #2's care plan has been reviewed and revised as needed. Resident #7's physician's orders and Certified Nursing Assistant's care card and care plan have been updated to reflect current needs. Care plans will be reviewed and revised as needed by the Interdisciplinary Team following a fall or when a care plan review or revision is needed. Random audits of care plan review and revisions will be conducted by the MDS Coordinator or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.

- June 25, 2018

- The MDS Coordinator is responsible for this plan

Section 19-13 D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A): The facility failed to obtain lab work as per pharmacy recommendation and/or per physician's order.

- Resident #8 has had recommended lab work obtained per pharmacy recommendation and/or per physician's order. A tracking system has been initiated to ensure lab work is obtained per pharmacy recommendation and/or physician order. Licensed Nursing staff have been educated on the tracking system that has been developed to ensure lab work is obtained per pharmacy recommendation and/or per physician's order. Random audits of the tracking system will be conducted by the Director of Nursing or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.
- June 25, 2018
- Director of Nursing is responsible for this plan

Section 19-13 D8t (f) Administrator (3) and/or (r) Therapeutic Recreation (1): The facility failed to ensure a resident centered activity program.

- Resident #22 is participating in resident centered programming. Her program has been designed to encourage maximum individual participation and is geared to her individual needs. The programming staff have been re-educated on resident centered programming. Random audits of resident activity preference assessment and care plans will be conducted by the Assistant Director or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.
- June 25, 2018
- Assistant Director of Nursing is responsible for this plan

Section 19-13 D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1): The facility failed to ensure pharmacy recommendation was acted upon in a timely manner.

- Resident #8 has had recommended lab work obtained per pharmacy recommendation and/or per physician's order. A tracking system has been initiated to ensure lab work is obtained per pharmacy recommendation and/or physician order. Licensed Nursing staff have been educated on the tracking system that has been developed to ensure lab work is obtained per pharmacy recommendation and/or per physician's order. Random audits of the tracking system will be conducted by the Director of Nursing or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.

- June 25, 2018
- The Director of Nursing is responsible for this plan.

Section 19-13 D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1): The facility failed to ensure medication were secure.

- The Health Center has established a procedure to ensure medications that the Health Center sends with the resident to be administered while at Dialysis are secured when a resident returns to the Health Center from Dialysis. Licensed Nursing Staff have been educated on the securing of medications for Dialysis residents upon return to Health Center from Dialysis. Random audits of Dialysis residents who require medication during Dialysis will be conducted upon their return to the Health Center for the securement of medications by the Nursing Supervisor or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.
- June 25, 2018
- The Director of Nursing is responsible for this plan.

Section 19-13 D8t (f) Administrator (3) and/or (o) Medical Records (2)(H)(4): The facility failed to verify the treatment plan with the physician according to policy.

- The original evaluation has been sent to the MD for signature and is in the clinical file. A tracking system has been initiated to ensure the original evaluation has been sent to the MD for signature within 3 days of the evaluation. The Director of Rehabilitation and/or Designee has been educated on the tracking system. Random audits of the tracking system will be conducted by the Director of Nursing or Designee for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.
- June 25, 2018
- Director of Nursing is responsible for this plan.

Section 19-13 D8t (f) Administrator (3) and/or (o) Medical Records (2)(H)(4): The facility failed to secure clinical records in accordance with facility policy.

- The Director of Rehabilitation was in the office where the clinical files are stored in cabinets when the State Surveyor opened the file cabinet to review clinical files. At no time were the

files unlocked without the Director of Rehabilitation or the staff in the office allowing visitors or unauthorized individuals access to confidential clinical files.

- June 25, 2018

Section 19-13 D8t (k) Nurse Supervisor (1) and/or (t) Infection Control (2)(A): The facility failed to follow infection control standards per facility policy.

- Licensed Nursing Staff have been re-educated on hand hygiene, infection control standards. Random audits of hand hygiene for residents who receive wound care for pressure ulcers will be conducted by the Assistant Director of Nursing for 90 days or until substantial compliance has been achieved. Findings will be submitted to QA for review and recommendations.
- June 25, 2018
- The Assistant Director of Nursing is responsible for this plan.

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

June 13, 2018

Jaclyn Martinelli, Administrator
Evergreen Woods
88 Notch Hill Road
North Branford, CT 06471

Dear Ms. Martinelli:

An unannounced visit was made to the above facility on ***June 1, 2018*** by a representative of the Facility Licensing & Investigations Section, Building and Fire Safety Unit for the purpose of conducting certification and/or licensure inspection.

Attached are the violations of the regulation of Connecticut State Agencies and/or General Statutes of Connecticut, which were noted during the course of this visit.

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 ***June 27, 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:

- 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;
- the date each such corrective measure or change by the institution is effective;
- 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
- 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.

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

Sincerely yours,

Anthony M. Bruno / KMP

Anthony M. Bruno,
Building Construction & Fire Safety Unit Supervisor
Facility Licensing & Investigations Section

Enclosures
c: licensure file

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13D8t(f)(3):

1. During a tour of the facility and subsequent documentation review and staff interviews on *June 1, 2018*, the following were observed:

   a. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has contacted any, local, emergency preparedness officials and discussed the facilities emergency plan, as required by the Emergency Preparedness Codes, *§483.73 (a) (4), Requirement for States and Long Term Care (LTC) Facilities;* i.e. there is no documentation of the facilities efforts to contact such officials;

   b. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has developed, maintained and reviewed at least annually, a means of providing information about the facilities occupancy, needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center-or designee, as required by the Emergency Preparedness Codes, *§483.73 (c) (7), Requirement for States and Long Term Care (LTC) Facilities;* i.e. the facility has not yet embraced any form of an Incident Management/Command System;

   c. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has developed, delivered to staff and reviewed at least annually, policies & procedures including evacuation, as required by the Emergency Preparedness Codes, *§483.73 (b) (3), Requirement for States and Long Term Care (LTC) Facilities;* i.e. the facility has no records or reports that demonstrate all staff have received instruction on the Emergency Plan;

   d. The surveyor was not provided with documentation by the Director of Facilities to indicate that the facility fire alarm is being inspected, tested & maintained every 6 (six) months as required by NFPA 72,"*National Fire Alarm Code* "and by the facility's procedures & policies; i.e. fire alarm inspection was last conducted 05/17/17-over a year ago;

   e. The surveyor, while accompanied by the Director of Facilities observed that a remote annunciator that is storage battery powered is not provided to operate outside of the generating room in a location readily observed by operating personnel, as required by section #'s 6.4.1.1.17 & 6.4.1.1.17.5 of NFPA 99, "*Health Care Facilities Code* "; i.e. annunciator panel for generator is not provided;

   f. The surveyor was not provided with documentation from the Director of Facilities to indicate that all fire door assemblies throughout the facility were inspected and tested annually, as required by section # 5.2 of the 2010 edition of NFPA 80, "*Standard for Fire Doors and Other Opening Protectives* " , section # 's 8.3.3.1 of "*Life Safety Code*", CMS (Centers for Medicare & Medicaid Services) S&C 17-38-LSC and as part of the facility maintenance program ; i.e. Full compliance with the annual fire door assembly inspection and testing was required by January 1, 2018;

   g. The surveyor was not provided with documentation from the Director of Facilities to indicate that all non-rated doors such as corridor doors to patient care rooms and smoke barrier doors throughout the facility are routinely inspected, as required by CMS (Centers for Medicare & Medicaid Services) S&C 17-38-LSC and as part of the facility maintenance program.

State POC
App. 7-24-18 TB

EVERGREEN WOODS

July 2018

Dear Mr. Bruno,

We have received our 2018 Life Safety 2567 and wish to request a slight change to our POC for the following violation:

K916 Electrical Systems – Essential Electric System, CFR(s): NFPA101

Electrical Systems – Essential Electric System Alarm Annunciator

A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g. building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)

"On 6.1.18 at 1:45pm the surveyor, while accompanied by the Director of Facilities observed that a remote annunciator that is storage battery powered is not provided to operate outside of the generating room in a location readily observed by operating personnel."

Our initial response indicated we would seek to repair this by August 2018. However, acknowledging this piece of our operation has been absent for the 25+ years EGW has been in existence, we are pushing this to our 2019 capital improvement list. We have done our due diligence in receiving bids and we do not feel moving this project to 2019 poses any undue threat to our residents or staff – as it has not for 25+ years.

Kris Care, Maintenance Director, will continue to monitor fuel levels and other system indicators during our routine generator inspections.

I hope this can be considered in advance of our upcoming re-inspection.

Respectfully Submitted,

Blair Quasnitschka, LNHA, FACHCA

Executive Director – Evergreen Woods

88 Notch Hill Road, North Branford, CT 06471
Phone 203-488-8000 • www.evergreen-woods.com

Edgehill

A Benchmark Senior Living Community

State POC.

Appl 7-24-18 JB

July 10, 2018

Mr. Bruno, Building Construction & Fire Safety Unit Supervisor
Facility Licensing & Investigations Section
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Edgehill Health Center
Plan of Correction
Credible Allegations of Compliance

Dear Mr. Bruno,

As you are aware, the Department of Public Health ("DPH") completed a survey at our facility, Edgehill Health Center on June 11, 2018.

On June 12, 2018, we received your letter, which notified us that the DPH had determined that Edgehill Health Center did not comply with certain Regulations of Connecticut State Agencies and/or Connecticut General Statues.

Your letter stated that we must submit a signed and dated acceptable POC by June 26, 2018 and pursuant to discussion with Mr. Chris Doyle on July 10th that we would remain in compliance if submitted by today.

Enclosed is Edgehill's plan of correction (POC) which addresses each of the alleged violations, which are cited in the Violations of the Regulations of Connecticut State Agencies and/or Connecticut General Statues that accompanied you letter. This Plan of Correction constitutes the facility's allegations of compliance.

The filing of this Plan of Correction does not constitute and may not be construed as an admission to the alleged violations. This Plan of Correction is filed in accordance with applicable law and as evidence of the facility's continuing commitment to high quality care.

Please let us know if you have any questions or if you required any additional information.

Sincerely,

Greg Shahum PhD Administrator

Gregory Shahum, PhD, LNHA, MHA, OTR/L
Edgehill Healthcare Administrator
Phone: (203) 595-2407
Email: gshahum@benchmarkquality.com

Edgehill

A Benchmark Senior Living Community

FACILITY: Edgehill Health Center
DATE(S) OF VISIT: June 11, 2018

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

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13D8t(f)(3):

During a tour of the facility and subsequent documentation review and staff interviews on *June 11, 2018*, the following was observed:

a. The surveyor was not provided with documentation from the Director of Engineering that would indicate that the dry pendant fire sprinkler heads in the facility have been inspected and tested as required by the referenced LSC standard. i.e.; the fire sprinkler contractor noted on each quarterly sprinkler report over the past year that the dry pendant sprinkler heads are in need of required inspection and/or testing.

- The facility has taken the following measures to resolve the cited deficiency, implement change, and prevent recurrence by:
    - Facility sprinkler provider, Fire Protection Team (FPT), 1701 Highland Avenue, Cheshire, CT 06410, Phone:(203)-250-1115, was at the facility on June18, 2018 to begin an immediate inspection and testing process of dry pendant fire sprinkler heads.

- The date each corrective measure or change will take place by the facility include:
    - Phase 1 (June 18, 2018) FTP measures dry pendant fire sprinkler heads to be removed in order that 4 heads be fabricated (2 loading dock and 2 garage).
    - Phase 2 (early July 2018) FTP returns to Edgehill with fabricated dry pendant fire sprinkler heads and swaps them out.
    - Phase 3 (early July 2018) FTP sends original dry pendant fire sprinkler heads fora 10-year UL testing which may take between 4 - 6 weeks for results. Future action will be based on test results and advice from vendor.

- The facility's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure is sustained includes:
    - Ensure regular quarterly scheduled sprinkler inspection is timely and complete
    - Ensure Vendor scheduled 10-year inspection is timely and complete

- The title of the facility's staff member that is responsible for ensuring the institution's compliance with its plan of correction is:
    - Executive Director or designee pendant

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

June 13, 2018

Jaclyn Martinelli, Administrator
Evergreen Woods
88 Notch Hill Road
North Branford, CT 06471

Dear Ms. Martinelli:

An unannounced visit was made to the above facility on ***June 1, 2018*** by a representative of the Facility Licensing & Investigations Section, Building and Fire Safety Unit for the purpose of conducting certification and/or licensure inspection.

Attached are the violations of the regulation of Connecticut State Agencies and/or General Statutes of Connecticut, which were noted during the course of this visit.

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 ***June 27, 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:

- 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;
- the date each such corrective measure or change by the institution is effective;
- 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
- 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.

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

Sincerely yours,

Anthony M. Bruno

Anthony M. Bruno,
Building Construction & Fire Safety Unit Supervisor
Facility Licensing & Investigations Section

Enclosures
c: licensure file

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13D8t(f)(3):

1. During a tour of the facility and subsequent documentation review and staff interviews on *June 1, 2018*, the following were observed:

   a. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has contacted any, local, emergency preparedness officials and discussed the facilities emergency plan, as required by the Emergency Preparedness Codes, *§483.73 (a) (4), Requirement for States and Long Term Care (LTC) Facilities;* i.e. there is no documentation of the facilities efforts to contact such officials;

   b. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has developed, maintained and reviewed at least annually, a means of providing information about the facilities occupancy, needs and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center-or designee, as required by the Emergency Preparedness Codes, *§483.73 (c) (7), Requirement for States and Long Term Care (LTC) Facilities;* i.e. the facility has not yet embraced any form of an Incident Management/Command System;

   c. The surveyor was not provided with documentation from the Director of Facilities or the Administrator to indicate that the facility has developed, delivered to staff and reviewed at least annually, policies & procedures including evacuation, as required by the Emergency Preparedness Codes, *§483.73 (b) (3), Requirement for States and Long Term Care (LTC) Facilities;* i.e. the facility has no records or reports that demonstrate all staff have received instruction on the Emergency Plan;

   d. The surveyor was not provided with documentation by the Director of Facilities to indicate that the facility fire alarm is being inspected, tested & maintained every 6 (six) months as required by NFPA 72,"*National Fire Alarm Code* "and by the facility's procedures & policies; i.e. fire alarm inspection was last conducted 05/17/17-over a year ago;

   e. The surveyor, while accompanied by the Director of Facilities observed that a remote annunciator that is storage battery powered is not provided to operate outside of the generating room in a location readily observed by operating personnel, as required by section #'s 6.4.1.1.17 & 6.4.1.1.17.5 of NFPA 99, "*Health Care Facilities Code* "; i.e. annunciator panel for generator is not provided;

   f. The surveyor was not provided with documentation from the Director of Facilities to indicate that all fire door assemblies throughout the facility were inspected and tested annually, as required by section # 5.2 of the 2010 edition of NFPA 80, "*Standard for Fire Doors and Other Opening Protectives* " , section # 's 8.3.3.1 of "*Life Safety Code*", CMS (Centers for Medicare & Medicaid Services) S&C 17-38-LSC and as part of the facility maintenance program ; i.e. Full compliance with the annual fire door assembly inspection and testing was required by January 1, 2018;

   g. The surveyor was not provided with documentation from the Director of Facilities to indicate that all non-rated doors such as corridor doors to patient care rooms and smoke barrier doors throughout the facility are routinely inspected, as required by CMS (Centers for Medicare & Medicaid Services) S&C 17-38-LSC and as part of the facility maintenance program.

EVERGREEN WOODS

App 6-26-18 JB

June 20, 2018

Anthony Bruno
Building Construction & Fire Safety Unit Supervisor
State of Connecticut Department of Public Health
Facility Licensing & Investigations Section, Building and Fire Safety Unit
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Mr. Bruno:

Enclosed please find our completed plan of correction responding to the annual Building and Fire Safety survey conducted at our facility on June 1, 2018. If you have any questions please contact me at (203) 483-3231.

Sincerely,

Jaclyn Martinelli
Administrator

88 Notch Hill Road, North Branford, CT 06471
Phone 203-488-8000 • www.evergreen-woods.com

1.

a. The local Emergency Management Director has reviewed our facilities emergency preparedness plan. A process has been developed to ensure the local Emergency Management Director has reviewed our facilities emergency preparedness plan when changes are made. The Director of Maintenance has been in-serviced on ensuring the local Emergency Management Director has been contacted and reviewed our emergency preparedness plan when changes are made.

- Compliance Date: 07.09.18

- The Director of Maintenance is responsible for this plan.

b.

- The local Emergency Management Director has been provided information about the Health Center's occupancy, needs and ability to provide assistance to the authority having jurisdiction. A process has been developed to ensure the local Emergency Management Director has been provided information about the Health Center's occupancy, needs and ability to provide assistance to the authority having jurisdiction annually. The Director of Maintenance has been in-serviced on ensuring the local Emergency Management Director has been provided information about the Health Center's occupancy, needs and ability to provide assistance to the authority having jurisdiction annually.

- Compliance Date: 07.09.18

- The Director of Maintenance is responsible for this plan.

c.

- The Emergency Preparedness Policies and Procedures have been developed and delivered to staff as required. A process has been developed to ensure the Emergency Preparedness Policies and Procedures have been developed, delivered and reviewed at least annually. The Director of Maintenance has been in-serviced on ensuring the Emergency Preparedness Policies and Procedures have been developed, delivered and reviewed at least annually.

- Compliance Date: 07.09.18

- The Director of Maintenance is responsible for this plan.

d.

- The fire alarm system has been inspected and was tested as required on June 11, 2018. The fire alarm testing has been placed on a preventative maintenance schedule. The Director of Maintenance has been re-educated on ensuring the Health Center fire alarm is being inspected, tested and maintained

every 6 months as required. Random audits of fire alarm testing will be conducted for 90 days or until substantial compliance has occurred. Findings will be submitted to QA for review and recommendations.

- Compliance Date: 07.09.18
- The Director of Maintenance is responsible for this plan.

e.

- Bids to provide a remote annunciator that is storage battery powered for the generator have been collected. The wiring and installation of a remote annunciator that is storage battery powered will be installed outside of the generator area in a location readily observed by operating personnel by August 30, 2018.
- Compliance Date: 07.09.18
- The Director of Maintenance is responsible for this plan.

f.

- The inspection and testing of all fire door assemblies throughout the Health Center as required has begun. Fire door assembly inspection and testing throughout the Health Center has been placed to occur annually on our preventative maintenance calendar. Maintenance Director has become online certified for NFPA 80 to ensure Fire Door assemblies are inspected and tested annually in accordance with NFPA 80. Results of fire door assemblies inspections will be brought to QA for review and recommendations.
- Compliance Date: 07.09.18
- The Director of Maintenance is responsible for this plan.

g.

- The routine inspection of non-rated Health Center doors throughout the Health Center have begun. Non-rated Health Center door inspections have been placed on a preventative maintenance schedule to be conducted twice a year. Results non-rated Health Center door inspections will be brought to QA for review and recommendations.
- Compliance Date: 07.09.18
- The Director of Maintenance is responsible for this plan.