# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
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Lt. Governor

P.O. Approved DE 5/9/20

Healthcare Quality And Safety Branch

***IMPORTANT NOTICE - PLEASE READ CAREFULLY***

April 28, 2020

Andrew Wildman, Administrator
Golden Hill Rehab Pavilion
2028 Bridgeport Ave
Milford, CT 06460

Dear Mr. Wildman:

Unannounced visits were made to Golden Hill Rehab Pavilion which concluded on April 14, 2020 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and a COVID-19 Focused Survey.

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. The state violations cannot be edited by the provider in any way.

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

**The plan of correction is to be submitted to the Department by May 7, 2020.**

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

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

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 7, 2020 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

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

Respectfully,

Norma Schuberth, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

NES:mb

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

1. Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #2) reviewed for notification of change in condition, the facility failed to ensure that the resident's Conservator of Person (COP) was notified when the resident's condition changed, including orders for diagnostic testing, out of facility transfers, and changes in medications. The findings include:
   a. Resident #2 was admitted to the facility on 3/5/20 with diagnoses that included hypertension, cough, fever, and iron deficiency anemia.
   The nurse's note dated 3/6/20 at 9:29 PM identified Resident #2 was seen by the physician and new orders were obtained for a chest x-ray, EKG, and blood work to be drawn on Monday. The nurse's note failed to reflect that the resident's COP was notified of the new orders.
   The nurse's note dated 3/7/20 at 1:46 PM identified the chest x-ray result was abnormal and the APRN was notified. The APRN gave new order to send Resident #2 to the emergency room for a CT Scan of the chest. The nurse's note failed to reflect that the COP was notified of the chest x-ray result or the new order to transfer the resident to the hospital. The nurses note indicated a message was left for the Conservator of Estate to return call to the facility.
   The nurse's note dated 3/7/20 at 2:17 PM identified Resident #2 was transferred to the hospital at 1:10 PM.
   The nurse's note dated 3/7/20 at 8:30 PM identified Resident #2 returned to the facility from the hospital after being evaluated for a positive PPD (a skin test to check for tuberculosis). The initial chest x-ray prior to transfer to the hospital identified a right lower lung effusion. The chest x-ray performed at the hospital indicated a negative result, no consolidation/infiltrates noted. The APRN and DNS were made aware of Resident #2's returned to the facility. The nurse's note failed to reflect that the COP was notified of Resident #2's returned to the facility.
   The nurse's note dated 3/9/20 at 2:48 AM identified LPN #7 explained to Resident #2 that a urinalysis was needed and Resident #2 refused. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of the urinalysis or the order for the urinalysis.
   The nurse's note dated 3/9/20 at 12:53 PM identified Resident #2 refused the ordered blood work. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of blood work.
   The MDS dated 3/10/20 identified Resident #2 had mildly impaired cognition and required extensive assistance with personal hygiene.
   A physician's order dated 3/28/20 directed Resident #2 is on skilled care for observation related to presumptive Coronavirus, pulmonary monitoring, and droplet precautions.
   The nurse's note dated 3/28/20 at 3:16 PM identified Resident #2 was found on the floor at approximately 2:00 PM. The nurse's note identified a message was left for the Conservator of Estate to call the facility. The nurse's note failed to reflect that the Conservator of Estate was notified or updated regarding the fall. The nurse's note failed to reflect that the COP was notified of the fall.
   The nurse's note dated 3/31/20 at 4:00 PM identified RN #2 was called to the resident's room regarding Resident #2 temperature of 101.4 F and observed with shallow breathing. Lungs were clear to auscultation. The APRN was notified with new orders to administer oxygen as needed when oxygen saturation is < 92%, obtain a chest x-ray, swab for influenza and obtain blood work. The nurse's note identified a message was

left for the COP to call the facility. The nurse's note failed to reflect that the COP was notified or updated regarding the resident's fever, shallow breathing, and new orders.
A physician's order dated 3/31/20 directed to administer oxygen at 2 Liters per minute via nasal cannula as needed if oxygen saturated is < 92% on room air.
The nurse's note dated 3/31/20 at 10:00 PM identified new orders for Avelox (medication used to treat infection) 400 mg by mouth every day for 10 days. The nurse's note identified a message was left for the Conservator to call for update. The nurse's note failed to reflect that the COP was notified or updated regarding the chest x-ray result and new order.
A physician's order dated 3/31/20 directed to administer Moxifloxacin (Avelox) 400 mg tablets by mouth daily times 10 days.
The nurse's note dated 4/1/20 at 9:02 AM identified Resident #2 is on antibiotic for pneumonia, is on droplet precautions, influenza swab was done, and Resident #2 refused blood work. Oxygen is in place. The nurse's note failed to reflect that the COP was notified of the antibiotic order, droplet precautions, influenza swab being obtained, and Resident #2's refusal of blood work.
The nurse's note dated 4/1/20 at 6:32 PM identified Resident #2 was alert, had a dry cough noted, no labored breathing, oxygen saturation 94% with oxygen via nasal cannula, lung sounds diminished in all fields, and temperature 100.2 F. Resident #2 denied body aches, headache, gastro-intestinal upset, droplet precautions maintained, and COVID-19 test pending. The nurse's note failed to reflect that the COP was notified of the new order for COVID-19 test, or that the test was pending.
The care plan, updated on 4/2/20, identified Resident #2 is at risk for respiratory complications related to a possible exposure to COVID -19 and related to increase risk factors and advanced age. On 4/2/20 Resident #2 tested positive for COVID-19. Interventions included to complete respiratory risk assessments and monitor respiratory status for at least 14 days or as ordered. Isolate in room, medications as ordered. Notify the physician for transfer to hospital as with any acute respiratory illness. Use principles of infection control and universal/standard precautions.
The nurse's note recorded as a late entry on 4/3/20 at 12:41 PM identified a note dated 4/2/20 at 12:25 PM identified RN #1 was called to unit at 9:25 AM and identified Resident #2 was lying in bed without respiration, and staff are unable to obtain apical pulse. Resident #2 is a full code, 911 was initiated, chest compression/air high flow started. At 9:40 AM, 911 in the building, chest leads placed by 911 personnel and indicated asystole. EMS call to Medical Director at approximately 9:45 AM, 911 personnel pronounced Resident #2 expired. The APRN was notified, call placed to conservator and message left with request for call back. Call placed again to Conservator of Estate and Conservator of Person and updated on Resident #2 status.
An interview and clinical record review with RN #1 on 4/9/20 at 3:35 PM indicated he/she notified both Conservator of Estate and Conservator of Person when Resident #2 expired. RN #1 indicated he/she notified both conservators because the names in the chart listed both parties as the conservators. RN #1 indicated when there is a change in resident condition the nurses should notify the responsible party/families. RN #1indicated the nurses are responsible to follow up with making sure the responsible party/families are updated.
An interview with LPN #1 on 4/15/20 at 9:32 AM identified it is his/her usual practice to notify the family when there is a change in resident condition. LPN #1 indicated

he/she usually will follow through during the shift to make sure that the families are aware of what is going on with their loved ones.
An interview with LPN #2 on 4/15/20 at 10:06 AM identified he/she notified RN #1 regarding Resident #2's temperature of 100.2 F. Additionally, LPN #2 indciated RN #1 performed the Covid-19 test on the resident. LPN #2 indicated he/she did not notify the resident's family regarding the temperature of 100.2 F due to the facility protocol that read 100.4 F and above is considered a temperature. LPN #2 identified the Conservator of Estate is for finance, and Conservator of Person is responsible for medical issues. LPN #2 indicated the nurses are responsible to notify the supervisor and the responsible party with change in resident condition.
An interview with LPN #4 on 4/15/20 at 11:04 AM identified he/she left a message for the Conservator of Estate to call the facility and he/she informed the in-coming nurse to notify the conservator that Resident #2 was found on the floor. LPN #4 indicated that he/she is aware of the difference between Conservator of Estate/Person and that on 3/28/20 the COP was not listed on the face sheet, only one person was listed and that was the Conservator of Estate.
An interview with LPN #5 on 4/15/20 at 11:49 AM identified if he/she did not document that the family was notified of the refusal of blood work, that means he/she did not call or notify the family. LPN #5 indicated that the APRN was notified. LPN #5 indicated the facility protocol is to notify the family or conservator with new orders and change in resident condition.
An interview with RN #3 on 4/15/20 at 1:43 PM indicated he/she is an agency nurse. RN #3 indicated he/she spoke to the Conservator of Person when Resident #2 returned from the hospital, however, he/she does not know why the conversation was not documented.
An interview with RN #6 on 4/15/20 at 2:38 PM indicated he/she called the COP and left a message to call facility for an update regarding Resident #2's temperature of 101.4 F, new orders for a chest x-ray, flu swab, and blood work. RN #6 indicated no call was returned from the COP.
An interview with Person #7 on 4/21/20 at 3:05 PM indicated he/she is the COP for Resident #2. Person #7 indicated he/she received only 2 calls from the facility since Resident #2 was admitted. The two calls were on 3/31/20 and 4/2/20. Person #7 indicated he/she received a phone call on 3/31/20 from a Greenwich number which was unfamiliar, and he/she did not answer. Person #7 indicated on 4/2/20 around 11:25 AM he/she received a call from that same number from Greenwich that he/she had received on 3/31/20. Person #7 indicated he/she received 3 consecutive calls from the Greenwich number and answered the phone the third time. Person #7 indicated that a male nurse informed him/her that they were calling from the facility to report that Resident #2 has died. Person #7 indicated he/she asked the nurse what happened and was Resident #2 sick. The nurse indicated that when he/she went into the room Resident #2 was unresponsive and although staff attempted to resuscitate, and called 911, the resident died.
Review of the Facility Change in a Resident's Condition or Status policy identified the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative

when: The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center.
The facility failed to notify Resident #2's COP when the resident had changes in his/her medical condition, was placed on oxygen, was sent to the hospital for evaluation and returned, was tested for Covid 19, and was placed on antibiotic for infection.

**Plan of Correction to violation #1:**

The facility does not agree with the findings.

It is alleged the facility failed to notify resident representative of changes as follows:

It is stated that the facility failed to ensure that the resident #2's Conservator of Person was notified when the resident's condition changed.

Resident number 2 no longer resides at the facility.

Other residents have the potential to be affected by the same deficient practice.

**Actions taken:**

Licensed nursing staff educated by the Director of Nurses/ designee that any change of condition require MD notification, responsible party notification and documentation that MD and responsible party have been notified.

Licensed nursing staff educated by Director of Nurses/ designee on role of Conservator of Person vs Conservator of Estate.

Director of Nursing/ designee to conduct a random audit 4x weekly for 4 weeks, then 3x a week for 4 weeks, then weekly and PRN as indicated to check documentation exists to support that MD and responsible party notification occurred. Findings to be reported to QAPI committee monthly and updated as indicated.

Compliance date: 5/22/2020