STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

April 23, 2019

Ms. Krista Wagner, Administrator
Springs At Watermark East Hill, The
611 East Hill Road
Southbury, CT 06488

Dear Ms. Wagner:

Unannounced visits were made to Springs At Watermark East Hill, The which concluded on April 11, 2019 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, a licensure inspection and a certification survey with additional information received through April 12, 2019.

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

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

The plan of correction is to be submitted to the Department by May 3, 2019.

The plan of correction shall include:

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

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

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

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

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

You may wish to dispute the violation(s) and you may be provided with the opportunity to be heard. If the violation(s) is/are

not responded to by May 3, 2019 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

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

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

Respectfully,

Norma Schuberth/CEM

Norma Schuberth, R.N., B.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

NS/LC:jf

Complaint #25244

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

1. Based on observation of the medical supply storage room, review of the clinical record, review of facility documentation, review of facility policy, and interviews, for one resident (Resident #3) reviewed for urinary catheters/appliances, the facility failed to follow physician's orders and/or follow facility policy and/or follow professional standards of care. The findings include:
    a. Resident #3 was admitted to the facility on 9/18/18 with diagnoses that included insomnia, neuromuscular bladder dysfunction, benign prostatic hyperplasia (BPH) without lower tract symptoms, Parkinson's disease, and dementia with behavioral disturbance.

    The quarterly Minimum Data Set (MDS) dated 3/28/19 identified Resident #3 had moderately impaired cognition, was frequently incontinent of bowel, had usage of an indwelling foley catheter, and required extensive assistance with most activities of daily living.

    The care plan dated 12/27/18 identified Resident #3 with a foley and a diagnosis of BPH. Interventions included to change foley catheter monthly with a 16Fr/30cc catheter.

    A physician's order (original date 12/13/18) dated 3/26/19 directed to change foley catheter every four weeks with a 16Fr every month on the 16th.

    The nurse's note dated 1/18/19 at 5:52 AM identified that the (monthly) foley catheter change had been done, the procedure was tolerated well, and catheter replaced with a 14Fr and 20 cc inflated balloon.

    Review of the January 2019 treatment administration record identified (TAR) on 1/18/19 the foley catheter was changed with a 14Fr foley catheter.

    Interview and observation of the medical supply storage room on 4/11/19 9:45 AM with Licensed Practical Nurse (LPN) #1 identified the current urinary catheter sizes available included 26FR, 22FR, 20FR, and 18FR. LPN #1 indicated if he/she did not have the size needed for a foley catheter change, the physician should be notified. LPN #1 further stated Resident #3's foley catheter supplies will now be provided by hospice.

    Interview and review of the facility policy with the Director of Nurses (DNS) on 4/11/19 at 10:00 AM identified if the proper size foley catheter per physician's order was not available, the nurse should have contacted the physician, and/or notified the oncoming shift to contact the urologist.

    Interview with Physician (MD) #2 on 4/11/19 at 1:15 pm identified although Resident #3 was seen on 10/11/18 and 12/10/18, and MD #2 ordered the foley catheter size as 16 Fr, the directive for balloon size and inflation of, was not specified. MD #2 stated the

routine, "usual" balloon inflation is 10cc.

Attempted an interview with RN #4, was not obtained.

Review of the facility policy identified catheters are to be routinely changed and the physician's order is to include catheter size and frequency of changes.

The facility failed to provide a catheter according to physician's orders.

Plan of Correction to Violation #1:

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

2. Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #79) reviewed for accidents, the facility failed to provide adequate supervision and/or ensure an assistive device was in place and/or equipment was utilized to prevent an accident. The findings included:
    a. Resident #79's diagnoses included dementia with behavioral disturbance, mood affective disorder, disorder of bone density and structure, a right below the knee amputation, and morbid obesity.

    The annual MDS dated 12/17/18 identified Resident #79 had short and long term memory problems, severely impaired cognition, required extensive assistance of 2 for bed mobility, transfers, dressing, hygiene, required total assistance for toilet use and did not walk.

    The care plan dated 12/27/18 identified Resident #79 was at risk for falls and had a self-care deficit. Interventions included to utilize floor mats on both sides of the bed, ¼ side rails to bed, and ensure the over bed table is on the right side of the bed.

    A reportable event form dated 3/15/19 at 10:15 PM identified Resident #79 rolled out of bed onto the floor. The report indicated Resident #79's physical status before the fall identified the resident required a hoyer lift with the assistance of 2 staff for transfers, and

the assistance of 2 staff for bed mobility. An assessment at the time of the fall identified Resident #79 had left hip pain upon touch and movement.

A nurse's note dated 3/15/19 at 11:15 PM identified Resident #79 had a fall out of bed at 10:15 PM with NA #4 at the bedside giving bedtime care. Resident #79 rolled and the fall was broken by NA #4 who protected the residents head. Vital Signs taken and stable at the time. Resident #79 noted to have facial grimacing and tenderness to touch upon palpation to the left hip and leg. Resident #79 was not moved from the floor, EMS was called and the resident was transferred to the hospital.

The hospital discharge summary dated 3/19/19 identified Resident #79 was admitted for a traumatic closed displaced intertrochanteric fracture of the left femur.

Interview with NA #4 on 4/11/19 at 8:56 AM identified he was alone providing incontinent care to Resident #79 and had removed the floor mats and raised the bed to the highest level so he didn't have to bend over. After providing care, NA #4 indicated he had turned away from Resident #79 to obtain an incontinent pad from a cabinet in the resident's room, when Resident #79 began to cascade off the bed and although he wasn't able to prevent the resident from falling, NA #4 was able to protect the resident's head during the fall out of bed.

Interview and review of the clinical record with the DNS on 4/11/19 at 10:41 AM identified prior to care, NA #4 should have obtained all needed supplies. Additionally, the DNS indicated NA #4 should have put Resident #79's bed in the lowest position, and restored the floor mats to the side of the bed before he went to the cabinet to get incontinent supplies.

Although facility documentation identified Resident #79 required the assistance of 2 staff for bed mobility, the facility failed to protect Resident #79 from injury when NA #4 performed incontinent care alone, with the bed in the highest position, without the benefit of floor mats, and stepped away from the resident to go to a cabinet to get supplies. Subsequently, Resident #79, rolled off the bed onto the floor and sustained a traumatic closed displaced intertrochanteric fracture of the left femur.

Plan of Correction to Violation #2:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(J).

3. Based on review of facility documentation and interviews for 1 of 3 nurse aides, (NA #1), the facility failed to ensure required dementia training was provided. The finding include:
   a. Review of staff education for 2018 or 2019 failed to reflect that NA #1 had received dementia training.

      Interview and review of facility documentation with the Administrator on 4/11/19 at 8:29 AM identified that NA #1 did not have dementia training for 2018 or 2019. Additionally, the Administrator indicated the supervisor is responsible to ensure mandatory training is complete. The Administrator identified that the electronic training calendar had not been identifying dementia training as overdue, and this was now being addressed.

      Interview with the DNS on 4/11/19 at 9:07 AM identified that she knew that she was responsible for nursing staff training, had a binder of 2018 mandatory training, and had planned to start working on 2019 training, but was busy with the changeover to electronic documentation and had not started. The DNS was not aware that any training was overdue.

      The facility policy identified that supervisors are responsible for ensuring that training is complete for associates in their direct line of supervision.

Plan of Correction to Violation #3:

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

4. Based on review of facility documentation and staff interview the facility failed to ensure a comprehensive water management plan as required. The findings include:

a. On 04/09/18 at 11:00 AM, the surveyor was not provided with documentation by the Administrator to indicate that the facility had developed and implemented a comprehensive water management plan as required. The facility was in the process of securing contractors to survey the facility and develop their water management plan, however this has not been completed to date. The plan should include but not be limited to the following: identifying dead ends in the water system, control measures such as physical controls, temperature management, disinfection level control, visual inspections and environmental testing for Legionella and other opportunistic waterborne pathogens; e.g., Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria and fungi that could grow and spread in the facility's water system.

Plan of Correction to Violation #4:

P.O.C approved DAS 5/20/19

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

1. Based on observation of the medical supply storage room, review of the clinical record, review of facility documentation, review of facility policy, and interviews, for one resident (Resident #3) reviewed for urinary catheters/appliances, the facility failed to follow physician's orders and/or follow facility policy and/or follow professional standards of care. The findings include:
    a. Resident #3 was admitted to the facility on 9/18/18 with diagnoses that included insomnia, neuromuscular bladder dysfunction, benign prostatic hyperplasia (BPH) without lower tract symptoms, Parkinson's disease, and dementia with behavioral disturbance.

    The quarterly Minimum Data Set (MDS) dated 3/28/19 identified Resident #3 had moderately impaired cognition, was frequently incontinent of bowel, had usage of an indwelling foley catheter, and required extensive assistance with most activities of daily living.

    The care plan dated 12/27/18 identified Resident #3 with a foley and a diagnosis of BPH. Interventions included to change foley catheter monthly with a 16Fr/30cc catheter.

    A physician's order (original date 12/13/18) dated 3/26/19 directed to change foley catheter every four weeks with a 16Fr every month on the 16th.

    The nurse's note dated 1/18/19 at 5:52 AM identified that the (monthly) foley catheter change had been done, the procedure was tolerated well, and catheter replaced with a 14Fr and 20 cc inflated balloon.

    Review of the January 2019 treatment administration record identified (TAR) on 1/18/19 the foley catheter was changed with a 14Fr foley catheter.

    Interview and observation of the medical supply storage room on 4/11/19 9:45 AM with Licensed Practical Nurse (LPN) #1 identified the current urinary catheter sizes available included 26FR, 22FR, 20FR, and 18FR. LPN #1 indicated if he/she did not have the size needed for a foley catheter change, the physician should be notified. LPN #1 further stated Resident #3's foley catheter supplies will now be provided by hospice.

    Interview and review of the facility policy with the Director of Nurses (DNS) on 4/11/19 at 10:00 AM identified if the proper size foley catheter per physician's order was not available, the nurse should have contacted the physician, and/or notified the oncoming shift to contact the urologist.

    Interview with Physician (MD) #2 on 4/11/19 at 1:15 pm identified although Resident #3 was seen on 10/11/18 and 12/10/18, and MD #2 ordered the foley

catheter size as 16 Fr, the directive for balloon size and inflation of, was not specified. MD #2 stated the routine, "usual" balloon inflation is 10cc.

Attempted an interview with RN #4, was not obtained.

Review of the facility policy identified catheters are to be routinely changed and the physician's order is to include catheter size and frequency of changes.

The facility failed to provide a catheter according to physician's orders.

Plan of Correction to Violation #1:

Facility will ensure that nursing staff follow physician's orders and/or facility protocol and/or professional standards of care.

An audit was completed to identify all residents requiring Foley catheters who may be at risk for this deficient practice.

Licensed Nursing staff will be educated on proper documentation regarding Foley catheters including Foley size, balloon size and procedures to notify physician when necessary.

The nursing supervisor or designee will conduct random weekly audits 3x per week for 4 weeks for proper catheter usage and documentation and will report findings to the QAPI committee monthly.

The Director of Nursing is responsible for completion of this plan of correction and has the responsibility of ongoing monitoring of this practice and all residents requiring Foley catheters will be reviewed at weekly at risk meetings.

Date of Compliance is May 23, 2019.

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

2. Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #79) reviewed for accidents, the facility failed to provide adequate supervision and/or ensure an assistive device was in place and/or equipment was utilized to prevent an accident. The findings included:
    b. Resident #79's diagnoses included dementia with behavioral disturbance, mood affective disorder, disorder of bone density and structure, a right below the knee amputation, and morbid obesity.

    The annual MDS dated 12/17/18 identified Resident #79 had short and long term memory problems, severely impaired cognition, required extensive assistance of 2 for bed mobility, transfers, dressing, hygiene, required total assistance for toilet use and did not walk.

The care plan dated 12/27/18 identified Resident #79 was at risk for falls and had a self-care deficit. Interventions included to utilize floor mats on both sides of the bed, ¼ side rails to bed, and ensure the over bed table is on the right side of the bed.

A reportable event form dated 3/15/19 at 10:15 PM identified Resident #79 rolled out of bed onto the floor. The report indicated Resident #79's physical status before the fall identified the resident required a hoyer lift with the assistance of 2 staff for transfers, and the assistance of 2 staff for bed mobility. An assessment at the time of the fall identified Resident #79 had left hip pain upon touch and movement.

A nurse's note dated 3/15/19 at 11:15 PM identified Resident #79 had a fall out of bed at 10:15 PM with NA #4 at the bedside giving bedtime care. Resident #79 rolled and the fall was broken by NA #4 who protected the residents head. Vital Signs taken and stable at the time. Resident #79 noted to have facial grimacing and tenderness to touch upon palpation to the left hip and leg. Resident #79 was not moved from the floor, EMS was called and the resident was transferred to the hospital.

The hospital discharge summary dated 3/19/19 identified Resident #79 was admitted for a traumatic closed displaced intertrochanteric fracture of the left femur.

Interview with NA #4 on 4/11/19 at 8:56 AM identified he was alone providing incontinent care to Resident #79 and had removed the floor mats and raised the bed to the highest level so he didn't have to bend over. After providing care, NA #4 indicated he had turned away from Resident #79 to obtain an incontinent pad from a cabinet in the resident's room, when Resident #79 began to cascade off the bed and although he wasn't able to prevent the resident from falling, NA #4 was able to protect the resident's head during the fall out of bed.

Interview and review of the clinical record with the DNS on 4/11/19 at 10:41 AM identified prior to care, NA #4 should have obtained all needed supplies. Additionally, the DNS indicated NA #4 should have put Resident #79's bed in the lowest position, and restored the floor mats to the side of the bed before he went to the cabinet to get incontinent supplies.

Although facility documentation identified Resident #79 required the assistance of 2 staff for bed mobility, the facility failed to protect Resident #79 from injury when NA #4 performed incontinent care alone, with the bed in the highest position, without the benefit of floor mats, and stepped away from the resident to go to a cabinet to get supplies. Subsequently, Resident #79, rolled off the bed onto the floor and sustained a traumatic closed displaced intertrochanteric fracture of the left femur.

Plan of Correction to Violation #2:

Facility will ensure that nursing staff will provide adequate supervision and/or ensure an assistive device is in place and/or equipment is utilized to prevent accident.

Nursing Staff will be educated on following the care cards regarding supervision needed and use of assistive devices and equipment to prevent accidents.

The nursing supervisor or designee will conduct random weekly audits 3x per week for 4 weeks to ensure proper supervision and assistive devices and/or equipment are in place during resident care.

The Director of Nursing is responsible for completion of this plan of correction and has the responsibility of ongoing monitoring of this practice.

Date of Compliance is May 23, 2019

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(J).

3. Based on review of facility documentation and interviews for 1 of 3 nurse aides, (NA #1), the facility failed to ensure required dementia training was provided. The finding include:
   c. Review of staff education for 2018 or 2019 failed to reflect that NA #1 had received dementia training.

      Interview and review of facility documentation with the Administrator on 4/11/19 at 8:29 AM identified that NA #1 did not have dementia training for 2018 or 2019. Additionally, the Administrator indicated the supervisor is responsible to ensure mandatory training is complete. The Administrator identified that the electronic training calendar had not been identifying dementia training as overdue, and this was now being addressed.

      Interview with the DNS on 4/11/19 at 9:07 AM identified that she knew that she was responsible for nursing staff training, had a binder of 2018 mandatory training, and had planned to start working on 2019 training, but was busy with the changeover to electronic documentation and had not started. The DNS was not aware that any training was overdue.

      The facility policy identified that supervisors are responsible for ensuring that training is complete for associates in their direct line of supervision.

Plan of Correction to Violation #3:

Nurse aides will be educated on the monthly in-service calendar posted to indicate when education will be offered. Nurse aides will be educated on the annual requirement for dementia education.

Monthly education calendars will be utilized to notify staff of dementia training sessions.

A tracking system has been developed and will be maintained by the management team to ensure all required staff members meet the annual requirements for dementia training.

The Director of Nursing or designee will audit the tracking system monthly to determine if compliance is maintained and will report findings to the QAPI committee.

The Administrator is responsible for this plan of correction.

Date of compliance is May 23, 2019.

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

4. Based on review of facility documentation and staff interview the facility failed to ensure a comprehensive water management plan as required. The findings include:
    d. On 04/09/18 at 11:00 AM, the surveyor was not provided with documentation by the Administrator to indicate that the facility had developed and implemented a comprehensive water management plan as required. The facility was in the process of securing contractors to survey the facility and develop their water management plan, however this has not been completed to date. The plan should include but not be limited to the following: identifying dead ends in the water system, control measures such as physical controls, temperature management, disinfection level control, visual inspections and environmental testing for Legionella and other opportunistic waterborne pathogens; e.g., Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria and fungi that could grow and spread in the facility's water system.

Plan of Correction to Violation #4:

The facility will develop a comprehensive water management plan as required. The facility has secured a contractor to assist in water testing and development of the water management plan.

Staff will be educated on the components of the water management plan.

The water management plan will be reviewed in safety meeting and QAPI meeting to ensure it meets the requirements of the infection control guidelines and is reviewed and updated annually.

The Administrator is responsible for this plan of correction.

Date of compliance is May 23, 2019