

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner



Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

HEALTH CARE QUALITY AND SAFETY BRANCH

EMERGENCY ORDER PURSUANT TO CONN. GEN. STAT. § 19a-534a

Issued To: JACC Healthcare Center of Norwich, LLC
d/b/a Three Rivers
License No. 2398
60 Crouch Avenue
Norwich, CT 06360-7329

Whereas, pursuant to Conn. Gen. Stat. § 19a-493, JACC Healthcare Center of Norwich, LLC ("Licensee") has been issued license No. 2398 by the Connecticut Department of Public Health ("Department") to operate a 102 bed Chronic and Convalescent Nursing Home known as Three Rivers ("Facility"); and,

Whereas, Conn. Gen. Stat. § 19a-534a authorizes the Commissioner of Public Health ("Commissioner") to issue a Summary Order if the Commissioner finds that the health, safety, or welfare of any patient or patients in any chronic and convalescent nursing home imperatively requires emergency action and incorporate findings to that effect into her order; and,

Whereas, on August 17, 2020, the Department commenced a Focused Infection Control Survey ("Survey") at the Facility to determine whether the Facility was in compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs; and,

Whereas, the results of the Survey performed by the Department indicated a pattern of deficiencies with respect to infection control and prevention that constitute immediate jeopardy to the health and safety of its residents; and,



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Affirmative Action/Equal Opportunity Employer



Whereas, the Department has determined that Respondent failed to ensure appropriate cohorting of residents to prevent the transmission of COVID-19.

Whereas, on August 24, 2020, the Department issued a Directed Plan of Correction (“DPOC”) which, among other things, ordered the Facility to cease all admissions and hire an Independent Nurse Consultant; and,

Whereas, after an extended survey conducted on September 9, 2020, the Department issued an Amended Directed Plan of Correction (“Amended DPOC”) on September 10, 2020, which, among other things, increased the hours of the Independent Nurse Consultant, and in which the Facility was required to contract with a Temporary Manager who possessed broad duties to oversee and control all operations of the Facility; and,

Whereas, on September 13, 2020, the Independent Nurse Consultant reported serious continued failures in infection control and prevention practices by the Facility and its staff; and,

Whereas, as of the date of this Order, the Temporary Manager has reported that there have been five Covid-19 related deaths in the Facility, and there are 17 residents who remain in isolation for Covid-19 infections, and there are seven residents quarantined for observation for the development of Covid-19; and,

Whereas, on September 15, 2020, the Temporary Manager filed a report which identified widespread facility problems in its performance of basic care delivery obligations; and,

Whereas, the Temporary Manager concluded that the Facility’s inability to comply with the Amended DPOC and other state and federal requirements presented a meaningful risk of harm to the Facility’s residents.

Whereas, the Temporary Manager’s report demonstrated serious deficiencies at the Facility including deterioration of systems of accountability, staff education, the absence of controls and the absence of necessary staff which may result in serious harm to the residents and concludes that the Facility cannot be brought into compliance with regulatory requirements by the time permitted under federal law and the Department’s Order; and,

Whereas, the Department makes the allegations contained in the Statement of Charges dated September 15, 2020 attached as Exhibit A to this Order:

Whereas, the Commissioner finds that violations of the Regulations of Connecticut State Agencies have occurred and are occurring at the Facility:


Whereas, based on the foregoing, the Commissioner finds that the health, safety, and welfare of patients in the Facility imperatively requires emergency action.

Therefore, pursuant to the authority provided by the Connecticut General Statutes § 19a-534a, the Commissioner ORDERS that the Licensee take the following actions:

1. As soon as possible considering all relevant circumstances, and in consultation with the Department and under the direction and authority of the Temporary Manager, discharge all patients to appropriate licensed facilities or other appropriate locations.

Failure to comply with this Order will be cause for additional actions pursuant to Connecticut General Statutes § 19a-534a which actions could include summary revocation or suspension of the Facility's license and/or all other available legal remedies.

Dated at Hartford, Connecticut this 16th day of September 2020.



Deidre S. Gifford, MD, MPH
Acting Commissioner
Connecticut Department of Public Health



HEALTH CARE QUALITY AND SAFETY BRANCH
EMERGENCY ORDER PURSUANT TO CONN. GEN. STAT. § 19a-534a

Issued To: JACC Healthcare Center of Norwich, LLC
d/b/a Three Rivers
License No. 2398
60 Crouch Avenue
Norwich, CT 06360-7329

Received

Thomas Doyle, Director of Nurses
JACC Healthcare Center of Norwich, LLC
d/b/a Three Rivers

9/16/2020

Signature



September *16th*, 2020

Received

Katharine B. Sacks, Esq.
Temporary Manager
JACC Healthcare Center of Norwich, LLC
d/b/a Three Rivers

Katharine B Sacks

September *16*, 2020

Exhibit A

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

TO: JACC Healthcare Center of Norwich, LLC
d/b/a Three Rivers
License No. 2398
60 Crouch Avenue
Norwich, CT 06360-7329

STATEMENT OF CHARGES

Pursuant to the provisions of Connecticut General Statutes § 19a-494 the Connecticut Department of Public Health, Facility Licensing and Investigations Section ("Department") brings the following charges against JACC Healthcare Center of Norwich, LLC d/b/a Three Rivers ("Respondent" or "Facility").

COUNT ONE

1. Respondent is and has been at all times referenced in this Statement of Charges the holder of Chronic and Convalescent Nursing Home License No. 2398.
2. In August and/or September of 2020, Respondent failed to ensure appropriate cohorting of residents to prevent the transmission of COVID-19.
3. The above referenced conduct violates section 19-13-D8t (f)(3); (k)(1); and (t)(2)(A) of the Regulations of Connecticut State Agencies.

COUNT TWO

4. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
5. In August and/or September of 2020, Respondent failed to ensure staff utilized Personal Protective Equipment ("PPE") in accordance with Centers for Disease Prevention and Control (CDC) standards by the following:
 - a. Failed to ensure masks without valves were used by staff; and/or,

- b. Failed to ensure that face masks and/or covering were worn by visitors when visiting with residents outdoors at the Facility;
6. The above referenced conduct violates section 19-13-D8t (f)(3); (j)(2); (m)(2)(A); (t)(2)(A) of the Regulations of Connecticut State Agencies.

COUNT THREE

7. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
8. In August and/or September of 2020, Respondent failed to ensure it had adequate staffing at the Facility to meet the needs of the residents.
9. The above referenced conduct violates section 19-13-D8t (f)(3)(F); (j)(2); (k)(1); (m)(2)(C) of the Regulations of Connecticut State Agencies.

COUNT FOUR

10. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
11. In August and/or September 2020, Respondent failed to ensure a fourteen-day (14) quarantine was maintained for the implementation of the Facility's COVID-19 protocols for residents with possible exposure or whose COVID-19 status was under investigation.
12. The above referenced conduct violates section 19-13-D8t (f)(3); (j)(2); (m)(2)(A); (t)(2)(A) of the Regulations of Connecticut State Agencies.

COUNT FIVE

13. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
14. On and prior to August 17, 2020, Respondent failed to ensure that an aerosolized medication was administered to a resident in a manner consistent with current infection control standards.
15. The above referenced conduct violates section 19-13-D8t(j)(2); (m)(2)(A); (t)(2)(A) of the Regulations of Connecticut State Agencies.

COUNT SIX

16. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
17. On and prior to August 17, 2020, with respect to COVID-19, Respondent failed to ensure comprehensive visitor screening which included a person's recent travel history.
18. The above referenced conduct violates the standard of care and/or section 19-13-D&t(j)(2) of the Regulations of Connecticut State Agencies.

COUNT SEVEN

19. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
20. In September 2020, Respondent failed to:
 - a. Implement measures to protect a resident from dehydration resulting in the hospitalization of such resident; and/or,
 - b. Implement the bowel regime protocol to prevent constipation and a hospital evaluation.
21. The above referenced conduct violates section 19-13-D&t (j)(2); (k)(1); (m)(2)(A); and (m)(2)(C) of the Regulations of Connecticut State Agencies.

COUNT EIGHT

22. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
23. In August and/or September 2020, Respondent failed to:
 - a. Properly use personal protective equipment;
 - b. Ensure appropriate storage of reusable isolation gowns to maintain infection control standards;
 - c. Appropriately perform hand hygiene after glove use;
 - d. Store soiled linen according to infection control standards of practice;
 - e. Conduct a risk assessment for the use of face masks;
 - f. Reapply a face mask or implement alternative measures to promote infection control for the residents who resided on a specialty dementia unit;
 - g. Ensure the drinking water containers were cleaned under sanitary conditions prior to reuse; and/or,
 - h. Use an environmental cleaner in accordance with manufacturer's directions.

24. The above referenced conduct violates section 19-13-D8t (f)(3); (j)(2); (k)(1); (m)(2)(A); (t)(2)(A) of the Regulations of Connecticut State Agencies.

COUNT NINE

25. Paragraph 1 of Count One is hereby incorporated by reference as it set forth fully herein.
26. In August and/or September 2020, Respondent failed to:
- a. Ensure documentation of assessments were conducted after a change in residents' condition;
 - b. Ensure current progress note documentation;
 - c. Ensure documentation of COVID-19 assessments;
 - d. Ensure accurate documentation when there were two versions of vital signs and COVID-19 flowsheets for a resident;
 - e. Ensure that vital signs and nursing assessments were not documented in advance;
 - f. Conduct and document fifteen (15) minute checks;
 - g. Consistently document daily weights; and/or,
 - h. Document COVID-19 status on transfer documents to the hospital.
27. The above referenced conduct violates Section 19-13-D8t (j)(2) (k)(1); (m)(2)(A) and (o)(2) of the Regulations of Connecticut State Agencies.

COUNT TEN

28. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
29. On and prior to August 17, 2020, Respondent failed to ensure staff testing for COVID-19 was conducted for approximately twenty-nine percent (29%) of the employees;
30. The above referenced conduct violates The Governor's Executive Order No. 7AAA and/or violates section 19-13-D8t (f)(3) and/or (j)(2) of the Regulations of Connecticut State Agencies.

COUNT ELEVEN

31. Paragraph 1 of Count One is hereby incorporated by reference as if set forth fully herein.
32. Prior to and in September 2020, Respondent failed to:
 - a. Provide the services of a dietician to meet the needs of the residents;
 - b. Conduct resident dietary assessments.
33. The above referenced conduct violates section 19-13-D&t (f)(3)(A); (q)(1) of the Regulations of Connecticut State Agencies.

Therefore, the Department of Public Health prays that: the Commissioner of the Department, as authorized in 19a-494 of the Connecticut General Statutes revoke or take any other actions as authorized in said section against the Chronic and Convalescent Nursing Home license of JACC Healthcare Center of Norwich, LLC as she deems appropriate and consistent with law.

Dated at Hartford, Connecticut this 16th day of September 2020.

By: Donna Ortelle, R.N., M.S.N.
Donna Ortelle, R.N., M.S.N.
Section Chief
Department of Public Health
Facility Licensing and Investigations Section

