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

Issued To: Elm Hill Nursing Center, Inc.
d/b/a Apple Rehab Rocky Hill
License No. 2006C
45 Elm Street
Rocky Hill, CT 06067

Whereas, pursuant to Conn. Gen. Stat. § 19a-493, Elm Hill Nursing Center, Inc. d/b/a Apple Rehab Rocky Hill ("Licensee") has been issued license No. 2006C by the Connecticut Department of Public Health ("Department") to operate a 120 bed Chronic and Convalescent Nursing Home known as Apple Rehab Rocky Hill ("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 nursing home facility imperatively requires emergency action and incorporate findings to that effect into the order; and,

Whereas, during a recertification survey conducted by the Department, an investigation was initiated concerning infection control issues and physical plant and life safety code issues. The Department conducted visits at the Facility commencing on April 5, 2021; and,

Whereas, pursuant to Chapter 368v of the Connecticut General Statutes, nursing home facilities are required to comply with all pertinent regulations promulgated by the Department;

WHEREAS, the Licensee conducted Legionella testing of the drinking water at the Facility on October 27, 2020, December 1, 2020, January 15, 2021 and/or March 16, 2021, and on one or more of such dates, the Licensee determined that the drinking water at the Facility tested positive for Legionella; and,

Whereas, during the course of the aforementioned inspections at the Facility, violations of the Regulations of Connecticut State Agencies ("Public Health Code") occurred as follows in 2020 and 2021:

a. The Licensee failed to maintain a water management plan (“WMP”) to mitigate the risk of Legionella and other water borne pathogens;

b. The Licensee failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of waterborne pathogen diseases and infections;

c. The Licensee failed to dedicate a registered nurse to be responsible for the day to day operations of the infection control surveillance program under the direction of the infection control committee;

d. The Licensee failed to restrict water use in the Facility and use potable bottled water when there was a question of Legionella transmission from the water system;

e. The Licensee failed to install micron filters on all water sources when there was question of Legionella transmission from the water system;

f. The Licensee failed to maintain documentation when the micron filters where changed in accordance with manufacturer's recommendations;

g. The Licensee failed to incorporate the WMP into the Quality Assurance and Performance Improvement (QAPI) activities;

h. The Licensee failed to ensure the water management committee members were identified or listed on the documentation provided to the Department for the WMP;

i. The Licensee failed to adequately respond when several monthly test results identified positive results for waterborne pathogens;

j. The Licensee failed to consistently document meeting minutes regarding Legionella issues within the Facility; and/or,

k. The Licensee failed to report a case of Legionella in accordance with reporting requirements.

The Commissioner finds that violations of sections of the Regulations of Connecticut State Agencies, as listed below, have occurred and/or are occurring at the Facility:

19-13-D8t(e)(1) and/or (2);
19-13-D8t(f)(3);
19-13-D8t(g)(3);
19-13-D8t(h)(2);
19-13-D8t(j)(2);
19-13-D8t(t)(2)(A)(3); and/or,
19-13-D8t(v)(2).

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. Effective immediately, the Licensee shall not admit any new residents;
2. Effective immediately, the Licensee shall restrict the use of tap water in the Facility and use, instead, potable bottled water until the Licensee provides proof, to the satisfaction of the Department, that 0.2 micron biological point-of-use filters are installed on all showerheads, sink, tub faucets and other water sources intended for use in the Facility.
3. Within two weeks of the effective date of this Summary Order, conduct a 3-month retrospective surveillance review to identify residents with pneumonia of unknown etiology (pneumonia with onset ≥48 hours after admission). Within three weeks of the effective date of this Summary Order, report its findings to the Department.
4. No later than April 16, 2021, test all residents for Legionella who are currently residing in the Facility. The Licensee shall immediately report any positive results to the Department.
5. Effective immediately, conduct active prospective clinical surveillance. Active clinical surveillance is a period of enhanced surveillance during

which healthcare Facility staff proactively and systematically identify patients with healthcare-associated pneumonia (pneumonia with onset ≥48 hours after admission). If a suspect Legionnaires' disease case(s) (i.e. patient with pneumonia of unknown etiology) is identified, collect sputum or other lower respiratory secretions for *Legionella* culture or testing via the *Legionella* urine antigen test. Within three weeks of the effective date of this Summary Order, report its findings to the Department.

6. Within two weeks of the effective date of this Summary Order, review the existing WMP and conduct an environmental assessment (using the CDC Environmental Assessment Form) to evaluate possible environmental exposures. Environmental assessments and sampling activities undertaken during an investigation are similar, but more comprehensive and detailed than activities performed during routine surveillance. Within three weeks of the effective date of this Summary Order, report its findings to the Department.
7. Within one week of the effective date of this Summary Order, establish a water sampling plan that includes, but is not limited to testing (culturing) water samples for *Legionella*, as well as testing physical and chemical parameters (temperature, disinfection residual levels, and pH in accordance with CDC guidance for environmental sampling).
8. Effective immediately, environmental culture samples must be analyzed by a lab that participates in the CDC Elite program and has been certified by the CT DPH Environmental Laboratory Certification program.
9. Remediate/ decontaminate possible environmental source(s) when identified by the Department, Facility staff and/or environmental consultants.
10. By the end of the business day on April 15, 2021, contract with an independent contractor with expertise and training in waterborne pathogens to conduct a water management review, remediation, and to repair/replace/correct items identified in this Summary Order. The independent contractor(s) must be pre-approved in writing by the Department prior to the commencement of any work. All work must begin by the end of business on April 16, 2021, unless otherwise approved in writing by the Department.

11. By the end of the business day on April 16, 2021, provide to the Department a detailed and comprehensive Plan of Correction ("POC") with timelines to remediate all the issued identified in this Summary Order. The Licensee shall provide proof, to the Department's satisfaction, of implementation of the POC.
12. The POC and the timelines contained in it must be approved in writing by the Department, and all work must be completed in accordance with the dates of completion approved by the Department. 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 Licensee's license.
13. The Licensee shall pay for all costs incurred in order to comply with this Summary Order. Failure to do so may constitute a violation of this Summary Order and may subject the Licensee to further disciplinary action.

Dated at Hartford, Connecticut this 12th day of April 2021.

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