

Wethersfield Health Care Center  
Certificate of Need Application  
Closure of Chronic and Convalescent  
Nursing Home Beds

November 3, 2011

Wethersfield Health Care Center  
Certificate of Need Application

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**State of Connecticut - Department of Social Services  
Office of CON & Rate Setting  
25 Sigourney Street  
Hartford, CT 06106-5033**

**APPLICATION FOR CERTIFICATE OF NEED**

**AFFIDAVIT**

**APPLICANT: 341 Jordan Lane Operating Company II, LLC d/b/a  
Wethersfield Health Care Center**

**PROJECT TITLE: Closure of Chronic and Convalescent Nursing Home Beds located at  
341 Jordan Lane in Wethersfield and Authorization for Future Bed  
Relocation Subject to State Review and Approval**

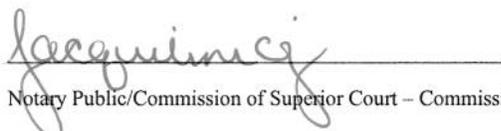
I, Kevin P. Breslin, Executive Vice President of 341 Jordan Lane Operating Company II, LLC d/b/a Wethersfield Health Care Center being duly sworn, deposes and states that the information in this Certificate of Need Application Entitled "Closure of Chronic and Convalescent Nursing Home Beds located at 341 Jordan Lane in Wethersfield and Authorization for Future Bed Relocation Subject to State Review and Approval" is accurate and correct to the best of my knowledge.

Signature: 

Title: Executive Vice President

Subscribed and sworn to before me on Nov. 2, 2011

Date



Notary Public/Commission of Superior Court – Commission expires: 2/26/2012

JACQUELINE ELISBERG  
Notary Public of New Jersey  
I.D. #2356427  
Commission Expires 2/26/2012

**1. Please complete Attachment I.**

Please see completed Attachment I for 341 Jordan Lane Operating Company II, LLC d/b/a Wethersfield Health Care Center (“Wethersfield”), located at 341 Jordan Lane, Wethersfield.

**2. Provide a narrative summary of the reasons for your request to reduce licensed beds and the termination of all nursing facility services (facility closure).**

Wethersfield made a business decision to seek closure based on the fact that excess bed capacity in the market has and will continue to limit its ability to achieve a sufficient census necessary to maintain operations. As indicated below, average census at Wethersfield has been below 88% for the past four years. Generally, facility occupancy below 90% results in inefficiencies in operations.

<u>Cost Year</u>	<u>Average Census</u>	<u>Occupancy Percentage</u>
2008	184	87.6%
2009	182	86.7%
2010	179	85.2%
2011	183	87.1%

Despite the recent closures of nursing facilities located in Rocky Hill and West Hartford, occupancy remains below 88% at Wethersfield. A nursing facility occupancy survey conducted by the Department of Social Services (“DSS”) between September 30, 2011 and October 5, 2011, identified an occupancy rate of 92.4% and 323 vacancies in the twenty-eight other facilities located within the immediate service area of Wethersfield Health Care Center comprised of Wethersfield, Hartford, Newington, Rocky Hill, Glastonbury, East Hartford, West Hartford, Farmington, New Britain and Cromwell (Attachment II). There were 738 vacancies in the sixty-three other nursing facilities located in Hartford County and the facilities had an average occupancy rate of 91.1% (Attachment III).

**DSS Occupancy Survey October 2011**

Other Facilities in Wethersfield Immediate Service Area

<u>Number of Facilities</u>	<u>Beds</u>	<u>Filled</u>	<u>Vacant</u>	<u>% Occupied</u>
28	4,256	3,933	323	92.4%

Other Facilities in Hartford County

<u>Number of Facilities</u>	<u>Beds</u>	<u>Filled</u>	<u>Vacant</u>	<u>% Occupied</u>
63	8,250	7,512	738	91.1%

Wethersfield has incurred significant financial losses over the past several years due to low census and a higher than optimal cost structure. The facility has significant unused space as it is now licensed for 210 beds but operates in a facility with a capacity of 330 beds.

Wethersfield was licensed for 330 beds prior to April 22, 2009. Costs associated with heating, lighting and property taxes associated with empty space contribute to the facility's financial losses. Wethersfield's cost per resident day for utilities and property taxes of \$11.23 in 2010 was 45% higher than the average for all nursing homes of \$7.74 per resident day.

#### Wethersfield Financial Results

<u>Cost Year</u>	<u>Profit/(Loss)</u>
2008	(\$993,234)
2009	(\$1,593,606)
2010	(\$1,553,652)
2011Estimated	(\$2,000,000)

Other factors that led to the decision to seek closure of Wethersfield were a Medicaid rate significantly below costs, reductions in Medicare payments and the new federal/state initiative to place nursing facility residents in the community.

On August 17, 2011, Wethersfield submitted a request to DSS for an interim rate of \$272.00 representing Medicaid allowable costs. The Medicaid rate for the facility of \$230.16 was not increased between July 1, 2008 and June 30, 2011. Although all Medicaid rates were increased by 3.7% effective July 1, 2011, the net increase to Wethersfield was only \$165,000 or 1.4% after accounting for additional costs associated with the state increase in the Resident Day User Fee from \$15.90 per day to \$21.02 per day. DSS has not approved an interim rate increase for Wethersfield as of this date.

A related Medicaid reimbursement factor to the decision to seek closure is the recent policy to no longer provide for annual adjustments to rates for capital improvements except for major projects authorized through a certificate of need ("CON"). Although investment in facility upgrades to Wethersfield would be beneficial to the care environment as well as enhance marketing efforts, the lack of recognition of these costs in the Medicaid rate is a disincentive to facility investment. Under Public Act 11-44, Medicaid rates are only adjusted for capital projects approved by the department through the CON process; consequently,

facility investments of less than \$2,000,000 would not be eligible for reimbursement under the Medicaid program.

Payment changes under the Medicare program are expected to reduce annual revenues nearly \$750,000.

The State of Connecticut biennial budget for fiscal years 2012 and 2013 includes funding associated with the placement of 2,251 individuals from nursing facilities to the community under the Money Follows the Person Rebalancing Demonstration Grant (“MFP”). If successful, the MFP initiative will reduce the need for nursing facility capacity throughout the state including the Wethersfield service area.

- 3. Quantify the need or lack of need for nursing facility beds in the area and explain any relationship between this need or lack of need thereof and this request. Provide information to support the addition/relocation/reduction of beds such as occupancy rates in the facility’s service area, demographics or other pertinent information to support such change in licensed beds.**

The State of Connecticut imposed a moratorium on new nursing facility beds in September 1991 and the moratorium has remained in continuous effect through several extensions adopted by the General Assembly. The latest extension to the moratorium was approved in 2007 (Public Act 07-209) revising the end date from June 30, 2007 to June 30, 2012. Based on state initiatives to offer home care alternatives and place current nursing facility residents in the community, it is likely that the moratorium on new facilities will be extended beyond June 30, 2012. The number of nursing home beds in the state has decreased from 31,545 in 2001 to 28,103 today.

When initially adopted, the moratorium included exemptions for nursing facilities restricted to use by persons with acquired immune deficiency syndrome or traumatic brain injury and beds affiliated with a continuing care facility (“CCF”). Over the years there have been other modifications to the moratorium including, subject to review and approval, the relocation of beds between facilities that meet access, cost and bed reduction criteria, and several narrow exemptions pertaining to the addition of no more than twenty beds not certified under Medicaid or Medicare, hospice service beds and beds relocated within a municipalities with a population of more than 125,000.

To the best of our knowledge, the State of Connecticut has not developed a plan for increased or decreased nursing facility capacity based on current and/or projected population trends. Section 17b-355 of the Connecticut General Statutes (“CGS”) provides that requests for the addition of nursing facility beds be assessed based on need in towns within fifteen miles of the town where beds are to be added using population projections no more than five years in the future and a 97.5% bed utilization rate. The statute specifies that DSS may also consider reductions in nursing facility need based on the increased use of, “less institutional alternatives”.

Connecticut Long-Term Care Needs Assessment, published in June 2007 by the University of Connecticut Health Center, included a comprehensive review of long-term care services but did not develop specific nursing facility bed need projections for Connecticut or a bed need methodology. There are numerous factors that influence nursing facility utilization and need including the availability of alternative services such as assisted living and home care as well as economic and social variables. The Long-Term Care Plan presented to the Connecticut General Assembly by the Connecticut Long-Term Care Planning Committee in January 2010, indicates that under an “optimal ratio of community and institutional care”, the Connecticut Medicaid program would cover approximately 8,000 fewer individuals in nursing facilities in 2025 than it does today even with a significant increase in the need for long-term care services.

A December 2010 report developed by Scripps Gerontology Center relating to the State of Ohio developed 2015 nursing facility bed need estimates based on 54.3 beds per 1,000 persons age 65 and older. A planning document prepared by the Maryland Health Care Commission that has been referenced in CON decisions issued by DSS, developed projected nursing facility bed need based on 102 nursing facility beds per 1,000 individuals age 75 and older.

In order to meet the requirements of Public Act 11-242, DSS recently engaged Mercer Government Human Services Consulting to develop a strategic plan to right-size the balance between nursing facilities and home and community-based services. The plan is expected to be finalized within the next several months.

Information available from the U.S. Census Bureau indicates that there were 130,119 individuals age 65 or older residing in municipalities within Hartford County in 2010. Of the 130,119 individuals age 65 or older, 66,366 were age 75 or older.

A March 2009 AARP Public Policy Institute study using 2007 data from the fifty states, the District of Columbia, Puerto Rico and the Virgin Islands indicated that there were 45 nursing facility beds per 1,000 individuals age 65 and older. The report indicated that Connecticut had 63 nursing facility beds per 1,000 individuals age 65 and older in 2007, ranking 10<sup>th</sup> highest among the fifty states and other districts. As indicated in Attachment III, there are currently sixty-four (64) nursing facilities in Hartford County with a total of 8,460 licensed beds. Closure of Wethersfield would reduce bed capacity to 8,250 equating to 63 beds per 1,000 individuals age 65 and older. This level of nursing facility availability would continue to significantly exceed the national average of 45 beds per 1,000 individuals age 65 and older. Hartford County nursing facility bed capacity of 8,250 would provide 124 beds per 1,000 persons age 75 and older- a level 20% higher than the target bed capacity developed by the Maryland Health Care Commission.

The Connecticut Long-Term Care Needs Assessment, includes projections indicating that there will be an 11.9% increase in Connecticut's population age 65 and older between 2010 and 2015 will be 11.9%. The report indicates that the 65 and older population will increase by 11.3% between 2015 and 2020. In the event that the demand for nursing facility services increases, Section 17b-354 of the Connecticut General Statutes ("CGS") permits facilities to request addition bed capacity to meet needs. According to DSS, there are approximately 350 closed beds that are available for relocation to other nursing facilities subject to review and approval. In addition, Public Act 11-242 provides the department with broad authority to approve the addition of nursing facility beds to meet priority needs identified in the department's strategic plan.

- 4. Describe any relationship between this request and the facility's historical, current and/or future utilization statistics. Describe the current and/or projected resident payer mix percentages (Private, Medicaid, Medicare, etc.) at the facility. Identify the facility's current bed configuration by floor including the number of rooms and type of room (private, semi-private, etc.).**

As indicated in our response to Question #2, the occupancy rate at Wethersfield has been below 90% for the past several years despite a reduction in licensed capacity from 330 to 210

in April 2009. In addition, as reflected in the following chart there has been an increase in the percentage of residents paid for under the Medicaid program. Medicaid payment rates are substantially lower than Medicare and private pay per diem rates. In 2010, the average Medicare payment approximated \$498.00 per day and private pay charges were \$430.00 for private room and \$380.00 per day for a semi-private room. The Medicaid rate during the period was \$230.16.

Wethersfield Payer Mix Percentages

<u>Payer</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Medicaid	75%	76%	77%	79%
Medicare	16%	15%	13%	11%
Private	7%	6%	6%	6%
Other	2%	3%	4%	4%

Facility Bed Configuration by Floor

<u>Floor</u>	<u>Private Rooms</u>	<u>Semi-Private</u>	<u>Total Beds</u>
1 <sup>st</sup>	6	72	150
2 <sup>nd</sup>	<u>10</u>	<u>25</u>	<u>60</u>
	16	97	210

- 5. Please describe the discharge planning process that will be followed in transferring current residents. Discuss the availability of appropriate placements for the current residents and include a summary, by town, of the town of origin for current residents (do not include resident names).**

As previously stated, an October 2011 nursing facility occupancy conducted by DSS indicates that there are 323 vacant beds in the facilities within the immediate Wethersfield service area and 738 vacancies in other facilities within Hartford County. This level of bed availability suggests that there are an adequate number of vacancies to accommodate appropriate placement of current residents. In addition, it is anticipated that Wethersfield staff will work with representatives from the Money Follows the Person program and other state home care programs to make appropriate placements to community residences for those individuals seeking alternatives to nursing facility care.

Wethersfield is committed to implementing a safe and appropriate discharge plan for each resident. A representative of our interdisciplinary planning team will offer to meet with every resident and family or other responsible party to discuss the discharge process and

possibilities of alternative placements. Sessions with individuals will be available during regular business hours as well as in the evening and on weekends.

Prior to transferring any resident, Wethersfield will conduct an assessment to determine any risk of transfer and special needs and identify any preferences the resident and/or family has for transfer.

Wethersfield will comply with all applicable statutory and regulatory requirements pertaining to discharge planning and involuntary transfer. We are also fully committed to working with the Office of the Long-Term Care Ombudsman, Department of Public Health and other state agencies.

Attachment IV provides the town of origin for the residents in the facility as of October 28, 2011. The following summarizes resident town of origin information. The category labeled, "Other CT and MA Towns" includes the total of those current facility residents from a town that was listed as town of origin by three or fewer residents.

Wethersfield Health Care Center  
Residents as of October 28, 2011 by Town of Origin

<u>Town/City</u>	<u># of Residents</u>
Wethersfield	72
Hartford	55
Newington	8
Rocky Hill	8
East Hartford	5
Glastonbury	4
West Hartford	4
Other CT and MA Towns	<u>26</u>
Total	182

- 6. Please describe your efforts in finding a buyer for the nursing facility and any anticipated future use of the building and real estate should the CON be granted. If no effort has been undertaken, please explain why. If an effort has been made to sell the operation, identify the contacts made and summarize reasons why the parties contacted did not pursue purchasing the operation, if known.**

Given financial losses and a surplus of nursing facility capacity in the area, it is extremely unlikely that a sale could be completed. We recently began marketing the facility due to recent inquiries. We are not optimistic but we will continue to work with potential buyers who are evaluating purchase.

- 7. Describe the changes that would be needed to continue operations of all or a portion of the nursing facility services at its current location including any projected necessary increase to the current Medicaid rate after implementation of any cost saving measures and/or revenue increases.**

As previously indicated, on August 17, 2011, Wethersfield submitted a request to DSS for an interim rate of \$272.00 representing Medicaid allowable costs. The Medicaid rate for the facility of \$230.16 was not increased between July 1, 2008 and June 30, 2011. Although all Medicaid rates were increased by 3.7% effective July 1, 2011, the net increase to Wethersfield was only \$165,000 or 1.4% after accounting for additional costs associated with the state increase in the Resident Day User Fee from \$15.90 per day to \$21.02 per day. DSS has not approved an interim rate increase for Wethersfield as of this date.

- 8. Provide any available estimates of the cost to renovate the facility to current codes and the cost associated with new construction. Describe the changes that would be required to each department or functional area to renovate the facility to current applicable building and health codes. Please address current compliance with codes governing handicapped accessibility including ADA and improvements that would be needed to comply with ADA requirements or current Public Health Codes.**

The facility is in need of significant renovations throughout the entire facility and new construction in the closed units. In addition, many of the mechanical systems and other areas such as roof are in need of replacement. We are currently estimating that the cost to complete is approximately \$4.0 million.

- 9. Describe any changes that have or will be needed to electrical systems including changes in fire alarm systems, nurse call systems, air conditioning, lighting, furnishing and wall, floor and ceiling finishes to make the facility compliant with current Public Health and building codes.**

See above.

- 10. Provide information related to the financial feasibility of implementing necessary physical plant improvements identified in Questions #8 and #9, including prospects of securing financing at reasonable costs. Identify potential sources of funds.**

Given the previously discussed reimbursement and census factors, significant investment in the facility cannot be supported by ownership; however, the funds are either available or could be made available if circumstances changed.

**11. Explain how this closure proposal will impact the quality, cost effectiveness, and accessibility of health care delivery in the area including any projected costs or savings/cost avoidance to the publicly funded Medicaid and Medicare programs.**

The closure of Wethersfield will reduce the nursing facility service options available to individuals residing in the area. However, due to the adequate availability of nursing facility beds in the immediate and Hartford County areas, persons requiring rehabilitation or long-term care will continue to have access to necessary services. Facilities that experience improved census levels as a result of the closure of Wethersfield will benefit from increased revenues and enhanced financial stability thereby strengthening the viability of the long-term care system.

Since the current Medicaid rate for Wethersfield of \$238.68 is higher than the state-wide average Medicaid rate of approximately \$227.00, the Medicaid program may experience savings associated with the relocation of residents to other facilities. If the average Medicaid payment rate at facilities that accept transfers from Wethersfield equates to the state average of \$227.00, DSS will realize a savings of approximately \$613,000 on an annual basis.

In addition, state and federal governments may realize savings to the extent that the cost of care is lower for individuals placed in the community with support from Money Follows the Person and Medicaid home care waiver programs.

**12. Provide a synopsis, including dates, of major facility building renovations, new construction and physical plant/capital improvements including the year the facility was constructed.**

1965	\$980,682	Original Construction- 120 bed facility
1979	\$1,575,188	Expansion from 120 to 240 beds
1993	\$1,575,011	Expansion from 240 to 330 beds
1995	\$711,616	Lobby Renovation and Parking
2006	\$693,387	Misc. Renovations
2007	\$601,452	Misc. Renovations

In addition to the significant improvements to the facility identified above other fixed asset investments in the building total approximately \$2.2 million since 1980 and new and replacement moveable equipment such as beds and furnishings total \$597,501 since 2002.

**13. Please provide a copy of the most recent Department of Public Health facility inspection and compliance report.**

See Attachment V.

**14. Does the Applicant request the ability to relocate closed nursing facility beds to another Medicaid certified nursing facility as permitted by and subject to the provisions of, Sections 17b-352 through 17b-354 of the Connecticut General Statutes? Please explain.**

Yes, we are requesting that a CON decision approving closure include authorization for the option to submit applications in the future to relocate the current 210 licensed beds to other nursing facilities subject to the DSS review and approval under Section 17b-354 CGS. In addition, it is requested that an approved Wethersfield CON closure decision specify that 100 previously closed beds also be available for future relocation.

CON Docket Number 07-736 (“CON 07-736”) approved a 120 bed reduction in Wethersfield’s licensed capacity from 330 to 210. Under CON 07-736, 100 of those beds were allowed to be placed back in service subject to specified requirements. CON 07-736 allowed for the add-back of up to eighty (80) beds to Wethersfield if census increased and granted immediate authority to request the relocation of twenty (20) beds to other nursing facilities subject to parameters specified in Section 17b-354 CGS.

Authorization to seek relocation of beds is sought in the event that additional nursing facility capacity is needed in the future to serve rehabilitative and long-term care needs.

**15. Is there a clear public benefit associated with this request? Provide the following information if not previously addressed:**

**a. the area served (preferably by town) by your nursing facility services.**

Closure of any nursing facility reduces the service options available to individuals in the service area; however, information provided in this application indicates that there would continue to be a surplus of nursing facility bed availability.

**b. estimated incidence and prevalence of the medical conditions to be treated within the area served.**

Addressed in responses to Questions 2 and 3.

**c. estimated number of individuals within the service areas that need the service.**

Addressed in response to Question 3.

- d. all other providers within the service areas providing the type of services being eliminated and any available statistics on the utilization of such services compared to the capacity of such services.**

Addressed in response to Question 3.

- e. identification of any alternative less costly means of meeting the service needs of the population to be served.**

The DSS Money Follows the Person and community home care waiver programs are designed to provide lower cost alternatives to nursing facility care.

- f. estimated cost or savings/cost avoidance, if any, to the Medicaid and Medicare programs associated with facility closure.**

Addressed in response to Question 11.

**16. Identify any other factors that the DSS should consider in determining whether this request should be granted, modified or denied. Provide supporting documentation.**

There are no additional considerations that we wish to add.

**Attachment I****I. General Information****A. Identification of Applicant****1. Specify the Name and Address of the Applicant**

Applicant Name:	341 Jordan Lane Operating Company II, LLC
Address 1:	341 Jordan Lane
Address 2:	
City, State, Zip Code:	Wethersfield, CT 06109

**2. Specify the Name, Title, Address and Telephone Number of the Contact Person for this Application. The contact person shall be the person to whom all communications are directed.**

Name:	Lawrence Condon
Title:	Director of Operations
Address 1:	341 Jordan Lane
Address 2:	
City, State, Zip Code:	Wethersfield, CT 06109
Telephone Number:	(860) 563-0101
Email Address:	lcondon@healthbridgemanagement.com
Fax Number:	(860) 257-6107

**3. Specify the Name, Title, Address and Telephone Number of another person who may be contacted regarding this application, in the event that the contact person specified above is not available.**

Name:	Matthew Bavalack
Title:	Principal
Address 1:	Marcum LLP
Address 2:	555 Long Wharf Drive
City, State, Zip Code:	New Haven, CT 06511
Telephone Number:	(203) 401-2116
Email Address:	matthew.bavalack@marcumllp.com
Fax Number:	(203) 777-1065

**4. Specify existing (E) and/or proposed (P), Department of Health Services licensure categories.**

If the applicant is an existing facility, provide the following information where appropriate:

- Number of licensed beds, by licensure category:

- Primary service area (specify basis for derivation and identify geographic area encompassed, by town.

(Select all that Apply)

"X"	Facility Type/Licensing Category	(E) and/or (P)	Licensed Beds	Service Area
	Home for the Aged			
	Rest Home with Nursing Supervision (RHNS)			
	Chronic and Convalescent Nursing Home (CCNH)	E	210	Hartford County and Northern Middlesex Co.
	Other, specify:			
	Other, specify:			

**B. Type of Application**

1. Specify if a new or additional function(s) or service(s), and/or a termination of a function or service and/or a capital expenditure exceeding statutory thresholds for review, is being proposed: **CCNH Closure/Bed Relocation Authorization**

"X"	Type of Application	Filing Fee Required
	New or Additional Function(s) or Service(s) Including staff expansion proposed by coordination, assessment, and monitoring ("CAM") agencies.	No
	Termination of Service(s);	No
	Capital Expenditures: (*see definition)	
	Major Medical Equipment, exceed statutory thresholds;	Yes
	Other Capital Expenditure, exceeding statutory thresholds	Yes
	Imaging Equipment, exceeding statutory thresholds;	Yes
	Facility Licensed Bed Reduction from <u>210</u> to <u>0</u> Licensed Beds	No
	Other, specify:	No

NOTE - Conversion to different licensure categories should be reported as a termination of service and also as an introduction of an additional function or service.

2. Specify the total amount of capital expenditures proposed:

<b>Proposed Capital Expenditures:*</b>	\$ Not Applicable/Closure	**
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\* Capital Expenditures: The total of all expenditures or proposed expenditures for the acquisition, installation and initial operation of items which at the time of acquisition, have an estimated useful life of at least three years and a purchase price of at least \$500 for groups of related items, which are capitalized under

generally accepted accounting principles. Such items shall include but not be limited to the following.

\*\*Should agree with page 5, Total Proposed Capital Expenditures.

- a. Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto.
- b. The total cost of all studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquisition, improvement, expansion or replacement of physical plant or equipment or both in question, when such total costs in aggregate exceed \$50,000.
- c. Lease assets. Purchase price for leased assets, including equipment, land and/or building(s), shall be the fair market value at lease inception.
- d. Maintenance expenditures capitalized in accordance with generally accepted accounting principles.
- e. Donated assets: Donations of property and equipment which under generally accepted accounting principles, are capitalized at the fair market value at the date of contribution.

C. Proposed Capital Expenditures and Funding Sources  
**Section not applicable to a Closure CON.**

1. Itemize all anticipated capital expenditures related to the proposal, as follows:

	<b>Itemized Capital Expenditure Category</b>	<b>Amount</b>
A	Total Building Work Costs	\$
B	Total Site Work Costs	\$
C	Total Off-Site Works Costs	\$
D	Total Construction Costs	\$
E	Fixed Equipment* (use fair market value, if leased)	\$
F	Movable Equipment* (use fair market value, if leased)	\$
G	Architectural & Engineering Costs	\$
H	Land (use fair market value, if leased)	\$
I	Building(s)(use fair market value, if leased)	\$
J	Works of Art	\$
K	Consultants (specify)	\$
L	Other Costs (specify)	\$
	<b>Total Proposed Capital Expenditures:</b>	<b>\$</b>
M	Financing Fees (specify)	\$
N	Construction Period Interest	\$
O	<b>Total Capitalized Financing Costs</b>	<b>\$</b>
	<b>Total Proposed Capital Expenditures, which include Capitalized Financing Costs</b>	<b>\$</b>
	<b>Total New Construction/Renovation Square Feet</b>	/

	<b>Cost Per Square Foot Renovation/New Construction</b>	\$ /
	<b>Cost Per Bed</b>	\$ /
	<b>Year Facility was Built</b>	

\* Include an itemized listing of equipment acquisitions identifying the amount of the proposed capital expenditure for each item. Major medical equipment acquisitions exceeding statutory thresholds, as well as any capital expenditures regardless of amount which result in a new or expanded service, should be listed separately and identified with a new or expanded service, where appropriate.

2. Itemize the anticipated proposed funding sources to be used in order to finance the proposed capital expenditures: Section not applicable to a Closure CON.

<b>Anticipated Funding Source</b>	<b>Amount</b>
Equity Contribution	\$
Debt Financing	\$
Lease Financing	\$
Other (Specify):	\$
<b>Total Proposed Funding Sources</b>	<b>\$</b>

D. Ownership

For new facilities complete the following items. For existing facilities, submit the most recent copy of the Disclosure Statement of Ownership and Operation, Part I, and complete pertinent sections of 1 through 5d if required information is not included in the Disclosure Statement. All applicants must submit a Certificate of Incorporation or a Certificate of Partnership.

**See page 21 for Ownership Disclosure and page 22 for the Certificate of Formation.**

1a: Ownership

Name of Facility:	341 Jordan Lane Operating Company II, LLC
Doing Business As:	Wethersfield Health Care Center
Address 1:	173 Bridge Plaza North
Address 2:	
City, State, Zip Code:	Fort Lee, NJ 01024
Contact Person:	Kevin P. Breslin
Title:	Executive Vice President
Telephone Number:	(201) 242-4004
Fax Number:	(201) 809-1020

2a: Type of Facility/Bed Configuration/Payer Mix/Utilization Statistics

Type of Facility	Licensed Bed Capacity	Census	Date of Census
Chronic and Convalescent Nursing Home	210	182	10/28/11
Rest Home with Nursing Supervision			
Home for the Aged-Licensed Bed Capacity			
Chronic Disease Hospital-Licensed Capacity			
Bed Configuration	Private	Semi Private	3/4 bed rooms
Current Number of Rooms / Beds	16/16	97 /194	0 /0
Proposed Number of Rooms / Beds	/	/	/
Payer Mix	Medicaid %	Medicare%	Private/Other %
Current	77%	13%	10%
Anticipated			
Utilization Statistics	2010	2011	Anticipated
Occupancy Percentage as of 9/30	84%	88%	85%

2b. Form of Ownership (Choose One)

“X”	Ownership Type	“X”	Ownership Type
	Sole Proprietorship		Profit Corporation
	General Partnership		Professional Corporation
	Limited Partnership		Non-Profit Corporation
	Municipality		Joint Venture
	Other (Specify):	X	Limited Liability Corporation (LLC)

2c. Owner(s) of Facility - Please list in descending order ownership share. Also include associates, incorporators, directors and sponsors.

Name & Address	Business Phone	Ownership Phone
THCI Holding Company LLC	(201) 242-4900	(201) 242-4900
173 Bridge Plaza North		
Fort Lee, NJ 07024		

2d. If an above owner is a corporation or partnership or if the facility is operated by a corporation or partnership under a contract, identify the following related to owners or beneficial owners of ten percent (10%) or more of the stock of that corporation or for each general or limited partner of that partnership.

Name & Address	Business Phone	Ownership % *	Type **
Care Realty LLC	(201) 242-4900	100%	LLC
Daniel E. Straus, 173 Bridge Plaza North Fort Lee, NJ 07024	(201) 242-4900	Approx. 11.2%	LLC
Moshael J. Straus, 173 Bridge Plaza North Fort Lee, NJ 07024	(201) 242-4900	Approx. 11.2%	LLC

\*List in descending order by ownership share

\*\*Indicate general or limited

3a. Administrator of Facility - Individuals and/or contracted management company.

Name & Address	Title	Business Phone
Lizabeth Carmichael 341 Jordan Lane Wethersfield, CT 06109	Administrator	(860) 563-0101

3b. If a management company has been contracted to manage the day-to-day operations, identify them and specify their responsibilities in relation to those of the owner(s) and/or operators.

**Not applicable. The management company is a related entity.**

4a. Land Information

Identify who holds the record title of the land on which the facility is located

Land Title Holder Name:	The Crosstone Realty Company
Address 1:	20 Old Barn Road
Address 2:	
City, State, Zip Code:	East Windsor, CT 06088

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the landowner in the facility and the policy-making responsibilities as related to the facility's owners.

4b. Building Information

Identify who holds the record title of the building in which the facility is located.

Building Title Holder Name:	Wethersfield THCI Holding Company LLC*
Address 1:	173 Bridge Plaza North
Address 2:	
City, State, Zip Code:	Fort Lee, NJ 07024

\*Owned and controlled by Care Realty LLC

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners.

4c. Equipment Information

Note: Complete separate page for each owner of the Facility's equipment. Identify who holds title to the equipment of the facility.

Equipment Title Holder Name:	Wethersfield THCI Holding Company LLC
Address 1:	173 Bridge Plaza North
Address 2:	
City, State, Zip Code:	Fort Lee, NJ 07024

List all the equipment to which the owner holds title. If the facility or specified owner holds title to all equipment, indicate "All".

If the above-named owner is not that same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners.

5a. Submit the organization chart and a chart of legal corporate structure which identifies any relationship or affiliation with any parent or hold company, subsidiary of the facility and subsidiary of a parent or holding company.

5b. For each entity identified in 5a, above, identify:

Entity 1:

Name & Address:	Care Realty LLC
Form of Ownership:	LLC
Ownership Interest in Facility:	100% Indirect Ownership Interest
Type of Business Activity:	Real estate and health care
Ownership Type:	For Profit

Entity 2:

Name & Address:	
Form of Ownership:	
Ownership Interest in Facility:	
Type of Business Activity:	
Ownership Type:	

Also indicate profit or non-for-profit.

## II. Project Description

### A. Summary

Provide a summary or overview of the project that includes the principal reason why the application should be approved.

**Low utilization of facility, excess service supply in the area and financial losses. See responses to CON questions for detail.**

### B. Linkages

Where the proposed service is intended as a regional resource or where other providers of care are integral to ensure an effective continuum of care, provide evidence of existing or proposed agreements/understandings with these providers.

**Not applicable to a Closure CON.**

**WETHERSFIELD HEALTH CARE CENTER  
OWNERSHIP DISCLOSURE**

Attached is an organizational flow chart showing the ownership structure for Wethersfield Health Care Center. The sole member of the operating company is THCI Company, LLC. The sole member of THCI Company, LLC is Care Realty, LLC.

Oversight by ownership of the facility's finances and management rests with Care Realty, LLC, which is controlled by Daniel E. Straus, Chairman, CEO and President, Kevin P. Breslin, Executive Vice President and Treasurer, and A. Alberto Lugo, Executive Vice President, Secretary and General Counsel.

Care Realty, LLC is owned by various investment entities whose individual members, partners or shareholders are not involved in the management of the facility's operations. None of the individual members, partners or shareholders in these investment companies owns an interest in Care Realty, LLC equal to or greater than 5% with the exception of Daniel E. Straus and Moshael J. Straus who are brothers. Daniel Straus and Moshael Straus each own approximately 11.4% of Care Realty, LLC.

Day to day management of the facility's operations is contracted to HealthBridge Management, LLC.

Personal contact information for Daniel Straus and Moshael Straus is set forth below.

**Daniel E. Straus**  
**173 Bridge Plaza North**  
**Fort Lee, New Jersey 07024**  
**Phone: 201-242-4900**  
**Fax: 201-498-0590**

**Moshael J. Straus**  
**173 Bridge Plaza North**  
**Fort Lee, New Jersey 07024**  
**Phone: 201-242-4900**  
**Fax: 201-498-0590**

State of Delaware  
Secretary of State  
Division of Corporations  
Received 10:15 AM 07/28/2003  
LED 10:03 AM 07/28/2003  
SRV 030489841 - 3686136 FILE

**CERTIFICATE OF FORMATION  
OF  
341 JORDAN LANE OPERATING COMPANY II, LLC**

---

The undersigned, an authorized natural person, for the purpose of forming a limited liability company, under the provisions and subject to the requirements of the State of Delaware (particularly Chapter 18, Title 6 of the Delaware Code and the acts amendatory thereof and supplemental thereto, and known, identified, and referred to as the "Delaware Limited Liability Company Act"), hereby certifies that:

**FIRST:** The name of the limited liability company (hereinafter called the "limited liability company") is 341 Jordan Lane Operating Company II, LLC.

**SECOND:** The address of the registered office and the name and the address of the registered agent of the limited liability company required to be maintained by Section 18-104 of the Delaware Limited Liability Company Act are National Corporate Research, Ltd., 615 South Dupont Highway, Dover, Delaware 19901.

Executed on July 28, 2003.

  
James F. Segroves, Authorized Person

## Attachment II

**Wethersfield - Immediate Area Nursing Facility Utilization Review [1]**

<b>Facility</b>	<b>Town/City</b>	<b>Licensed Beds</b>	<b>Filled Beds Oct-11</b>	<b>Vacant Oct-11</b>	<b>Occupancy Percentage</b>
<b>Wethersfield and Contiguous Towns</b>					
Wethersfield HCC	Wethersfield	210	186	24	88.6%
Avery Nursing Home	Hartford	199	180	19	90.5%
Chelsea Place	Hartford	234	209	25	89.3%
Ellis Manor	Hartford	105	102	3	97.1%
Park Place	Hartford	150	135	15	90.0%
Trinity Hill	Hartford	114	104	10	91.2%
Bel-Air Manor	Newington	71	56	15	78.9%
Jefferson House	Newington	104	96	8	92.3%
Newington HCC	Newington	180	149	31	82.8%
Elm Hill	Rocky Hill	120	90	30	75.0%
Maple View	Rocky Hill	120	114	6	95.0%
Glastonbury HCC	Glastonbury	105	103	2	98.1%
Salmon Brook	Glastonbury	130	118	12	90.8%
Aurora East Hartford	East Hartford	145	141	4	97.2%
Riverside	East Hartford	345	339	6	98.3%
<b>Other Towns in Immediate Service Area</b>					
Frances Ward Towers	West Hartford	256	252	4	98.4%
Hebrew Home	West Hartford	287	268	19	93.4%
Hughes Health & Rehab	West Hartford	170	155	15	91.2%
Reservoir Rehab	West Hartford	75	70	5	93.3%
West Hartford Health	West Hartford	160	153	7	95.6%
Amber Woods	Farmington	130	115	15	88.5%
Farmington CC	Farmington	120	101	19	84.2%

<b>Facility</b>	<b>Town/City</b>	<b>Licensed Beds</b>	<b>Filled Beds Oct-11</b>	<b>Vacant Oct-11</b>	<b>Occupancy Percentage</b>
Andrew House	New Britain	90	89	1	98.9%
Brittany Farms	New Britain	282	273	9	96.8%
The Jerome Home	New Britain	94	91	3	96.8%
Monsignor Bojnowski	New Britain	60	58	2	96.7%
Walnut Hill	New Britain	150	148	2	98.7%
Apple Rehab Cromwell	Cromwell	85	65	20	76.5%
Aurora Cromwell	Cromwell	<u>175</u>	<u>159</u>	<u>16</u>	90.9%
<b>Total</b>		<b><u>4,466</u></b>	<b><u>4,119</u></b>	<b><u>347</u></b>	<b><u>92.2%</u></b>
<b>Total Excluding Wethersfield</b>		<b><u>4,256</u></b>	<b><u>3,933</u></b>	<b><u>323</u></b>	<b><u>92.4%</u></b>

[1] Information from DSS occupancy survey conducted between 9/30/11 and 10/5/11.

## Attachment III

## Hartford County- Area Nursing Facility Utilization Review [1]

Facility	Town/City	Licensed Beds	Filled Beds Oct-11	Vacant Oct-11	Occupancy Percentage
Apple Rehab Avon	Avon	60	44	16	73.3%
Avon Health Center	Avon	120	113	7	94.2%
Ledgecrest HCC	Berlin	60	51	9	85.0%
Alexandria Manor	Bloomfield	120	111	9	92.5%
Bloomfield HCC	Bloomfield	120	118	2	98.3%
Caleb Hitchcock	Bloomfield	60	47	13	78.3%
Seabury	Bloomfield	60	56	4	93.3%
Wintonbury Care Center	Bloomfield	150	143	7	95.3%
Countryside Manor	Bristol	90	87	3	96.7%
Ingraham Manor	Bristol	128	127	1	99.2%
Sheriden Wood HCC	Bristol	146	144	2	98.6%
The Pines at Bristol	Bristol	132	131	1	99.2%
Village Green of Bristol	Bristol	104	81	23	77.9%
Cherry Brook HCC	Canton	100	100	--	100.0%
Aurora East Hartford	East Hartford	145	141	4	97.2%
Riverside	East Hartford	345	339	6	98.3%
Chestnut Point	East Windsor	60	50	10	83.3%
Kettlebrook Care Center	East Windsor	166	124	42	74.7%
Blair Manor	Enfield	98	91	7	92.9%
Kindred Transitional	Enfield	130	118	12	90.8%
Saint Joseph's Residence	Enfield	25	25	--	100.0%
Amber Woods	Farmington	130	115	15	88.5%
Farmington CC	Farmington	120	101	19	84.2%
Glastonbury HCC	Glastonbury	105	103	2	98.1%
Salmon Brook	Glastonbury	130	118	12	90.8%
Meadowbrook of Granby	Granby	90	80	10	88.9%
Avery Nursing Home	Hartford	199	180	19	90.5%
Chelsea Place	Hartford	234	209	25	89.3%
Ellis Manor	Hartford	105	102	3	97.1%
Park Place	Hartford	150	135	15	90.0%
Trinity Hill	Hartford	114	104	10	91.2%
Crestfield	Manchester	155	119	36	76.8%
Manchester Manor	Manchester	126	121	5	96.0%
Touchpoints/Bidwell	Manchester	131	124	7	94.7%
Westside Care Center	Manchester	190	162	28	85.3%
Marlborough HCC	Marlborough	120	107	13	89.2%

Facility	Town/City	Licensed Beds	Filled Beds Oct-11	Vacant Oct-11	Occupancy Percentage
Andrew House	New Britain	90	89	1	98.9%
Brittany Farms	New Britain	282	273	9	96.8%
The Jerome Home	New Britain	94	91	3	96.8%
Monsignor Bojnowski	New Britain	60	58	2	96.7%
Walnut Hill	New Britain	150	148	2	98.7%
Bel-Air Manor	Newington	71	56	15	78.9%
Jefferson House	Newington	104	96	8	92.3%
Newington HCC	Newington	180	149	31	82.8%
Apple Farmington Valley	Plainville	160	118	42	73.8%
The Summit at Plantsville	Plainville	150	150	--	100.0%
Elm Hill	Rocky Hill	120	90	30	75.0%
Maple View	Rocky Hill	120	114	6	95.0%
Governor's House	Simsbury	73	62	11	84.9%
McLean Health Center	Simsbury	154	135	19	87.7%
South Windsor Rehab	South Windsor	112	93	19	83.0%
Alzheimer's Resource Ctr	Southington	120	118	2	98.3%
Southington Care Center	Southington	130	125	5	96.2%
The Suffield House	Suffield	128	127	1	99.2%
Frances Ward Towers	West Hartford	256	252	4	98.4%
Hebrew Home	West Hartford	287	268	19	93.4%
Hughes Health & Rehab	West Hartford	170	155	15	91.2%
Reservoir Rehab	West Hartford	75	70	5	93.3%
West Hartford Health	West Hartford	160	153	7	95.6%
Wethersfield HCC	Wethersfield	210	186	24	88.6%
Kimberly Hall North	Windsor	150	135	15	90.0%
Kimberly Hall South	Windsor	180	120	60	66.7%
Kindred Transitional	Windsor	108	100	8	92.6%
Bickford HCC	Windsor Locks	48	46	2	95.8%
<b>Total</b>		<b>8,460</b>	<b>7,698</b>	<b>762</b>	<b>91.0%</b>
<b>Total Excluding Wethersfield</b>		<b>8,250</b>	<b>7,512</b>	<b>738</b>	<b>91.1%</b>

[1] Information from DSS occupancy survey conducted between 9/30/11 and 10/5/11.

**Attachment IV****Wethersfield Health Care Center  
Residents as of 10/28/11 by Town of Origin**

---

Wethersfield	72
Hartford	55
Newington	8
Rocky Hill	8
East Hartford	5
Glastonbury	4
West Hartford	4
Middletown	3
New Britain	3
South Windsor	3
Berlin	2
Bloomfield	2
Plainville	2
Avon	1
Branford	1
Enfield	1
Haddam	1
Norwich	1
Old Saybrook	1
Southington	1
Waterbury	1
Windsor	1
Windsor Locks	1
Webster, MA	<u>1</u>
Total	<u><u>182</u></u>

341 Jordan Lane  
Wethersfield, CT 06109

860.563.0101  
Fax 860.257.6107

*Wethersfield Health Care Center*  
A Nursing and Rehabilitation Center

September 19, 2011

Ms. Karen Gworek, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigation Section  
State of Connecticut  
Department of Public Health  
410 Capitol Avenue-MS #12HSR  
PO Box 340308  
Hartford, CT 06134

Dear Ms. Gworek,

I am in receipt of your letter dated September 7, 2011 and the statement of violations concerning the survey and investigation recently conducted by the department. In response, please find the attached plan of correction.

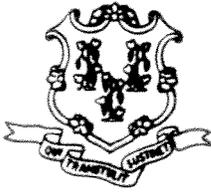
This plan of correction is Wethersfield Health Care Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

If you have any questions or concern, please do not hesitate to contact me.

Sincerely,



Stephen Roizen  
Administrator



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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

September 7, 2011

Stephen Roizen, Administrator  
 Wethersfield Health Care Center  
 341 Jordan Lane  
 Wethersfield, CT 06109

Dear Mr. Roizen:

On **August 29, 2011** a survey and investigation were concluded at your facility by the State of Connecticut, Department of Public Health, Facility Licensing & Investigations Section to determine if your facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found the most serious deficiency(ies) in your facility to be:

**Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy whereby corrections are required (D).**

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

An Enforcement Cycle has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Your Enforcement Cycle began with the *August 29, 2011* survey. All surveys conducted after *August 29, 2011* with deficiencies at a "D" level or greater become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle. Facilities are expected to achieve and maintain continuous substantial compliance.

A Plan of Correction (PoC) for the deficiencies must be submitted by the 10th day after the facility receives its Statement of Deficiencies (Form CMS-2567). Your PoC serves as your written allegation of compliance. Failure to submit a signed and dated acceptable PoC by **September 20, 2011** may result in the imposition of the remedies listed below by the 20th day after the due date for submission of a PoC.

Phone: (860) 509-7400

Telephone Device for the Deaf (860) 509-7191

410 Capitol Avenue - MS # 12HSR

P O Box 340308 Hartford, CT 06134

An Equal Opportunity Employer



Stephen Roizen  
 Wethersfield Health Care Ctr  
 Page 2

Each plan of correction must be written on the Statement of Deficiencies, with identification of the staff member by title who has been designated the responsibility for monitoring the individual plan of correction. A completion date is required for each item for each deficiency and shall be documented in the designated column.

**The plan of correction for each deficiency shall include the following components:**

- **What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice;**
- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**
- **What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,**
- **How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).**
- **Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date for each component.**

Your facility has an "opportunity to correct" the deficiencies noted. Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State of Connecticut Department of Social Services if your facility has failed to achieve substantial compliance by **October 10, 2011**. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended or revised as appropriate, on **October 10, 2011**. A change in the seriousness of the deficiencies on **October 10, 2011** may result in a change of the remedy selected. When this occurs, you will be advised of any changes in remedy.

#### Recommended Remedies

The remedies which will be recommended if substantial compliance has not been achieved by **October 10, 2011** include the following:

Civil money penalty will be recommended.

Stephen Roizen  
Wethersfield Health Care Ctr  
Page 3

If you do not achieve substantial compliance within 3 months after the last day of the survey identifying noncompliance, the CMS Regional Office and the State of Connecticut Department of Social Services must deny payments for new admissions.

We are also recommending to the CMS Regional Office and State of Connecticut Department of Social Services that your provider agreement be terminated on **February 26, 2012** if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with separate formal notification of that determination.**

#### Allegation of Compliance

The Plan of Correction serves as your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State of Connecticut Department of Social Services will impose the previously recommended remedy(ies) at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office and the State of Connecticut Department of Social Services beginning on **August 29, 2011** and to continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State of Connecticut Department of Social Services may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

#### Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of Substandard Quality of Care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy), to this office. This request must be sent during the same 10 day period you have for submitting a PoC for the cited deficiencies. Informal dispute resolution may be accomplished by telephone, review of submitted documentation or a meeting held at the Department. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Stephen Roizen  
Wethersfield Health Care Ctr  
Page 4

Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for informal dispute resolution. You will be advised in writing of the decision related to the informal dispute process.

Please return your response to the Supervising Nurse Consultant at *State of Connecticut Department of Public Health, 410 Capitol Avenue, MS #12HSR, P.O. Box 340308, Hartford, CT 06134-0308* and direct your questions regarding other deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

Sincerely,

*Karen Gworek RN SMC*

Karen Gworek, RN  
Supervising Nurse Consultant  
Facility Licensing & Investigations Section

cc: CMS Regional Office  
State of Connecticut Department of Social Services

Enclosure

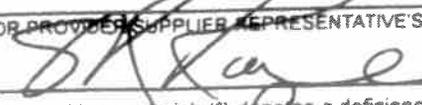
Complaint #12469, #12496

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/29/2011
NAME OF PROVIDER OR SUPPLIER  WETHERSFIELD HEALTH CARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 341 JORDAN LANE WETHERSFIELD, CT 06109	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	<p><b>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by:                      Based on observations and interviews for one of three dining rooms, the facility failed to ensure that residents were seated at dining tables that provided a comfortable and homelike environment. The findings include:</p> <p>Observations of the C/D wing dining room on 8/23/11 from 12:05 PM through 12:45 PM identified that residents were positioned at dining tables that did not accommodate their needs. Resident #22 was seated in a wheel chair with a half padded tray on the right side that was butted up to dining table and the plate of food was positioned on the table. Resident #22 was observed to make multiple attempts to manipulate the fork into his/her left hand and the plate of food was noted to be at arm's length. Resident #33 was observed eating independently and the plate of food was positioned at an arm's length from the resident. Upon surveyor inquiry, two staff boosted Resident #33 up in the chair and positioned him/her closer to the table. After being repositioned the resident thanked the staff.</p>	F 246	<p>This plan of correction is the center's credible allegation of compliance</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> <p><b>F 246</b></p> <ul style="list-style-type: none"> <li>Resident # 22, # 33 &amp; # 124 have been evaluated &amp;/or screened by therapy for proper positioning during dining &amp; for comfort. Care Plans updated. Staff in-serviced on proper positioning for each resident.</li> <li>Residents eating in the dining rooms have the potential to be affected by same practice. Residents will be monitored by licensed nurse during meals to assure proper positioning.</li> <li>Staff will be re-educated on proper positioning of residents during meals to provide a comfortable and homelike environment.</li> <li>Random audits will be performed 2 times a week x 90 days then randomly x 30 days to assure compliance. Any patterns or trends will be reviewed at the monthly Performance Improvement meeting and remedial measures initiated as deemed appropriate.</li> </ul>	

Continued  
 (X8) DATE  
 September 19, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
  
 TITLE  
 Stephen Roizen, Administrator

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WETHERSFIELD HEALTH CARE CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>341 JORDAN LANE WETHERSFIELD, CT 06109</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE

F 246 Continued From page 1  
 Resident #124 was seated in a customized wheel chair with a cloth cover across his/her chest. The wheelchair was noted to be reclined at approximately fifty degrees and the footrests were in contact with the base support of the table. The plate of food was positioned on the table at an arm's length and as Resident #124 attempted to eat independently the food dropped off the utensil onto the cloth cover.

F 311 SS=D 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  
 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:  
 Based on observations, clinical record reviews and interviews for two of three sampled residents (Resident #22 and #124) who required limited assistance with eating, the facility failed to ensure that the residents were provided the appropriate supervision and/or assistance. The findings include:

1. Resident #22's diagnoses included a history of weight loss and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated 7/13/11 identified that Resident #22 had severe cognitive impairment and required extensive assistance with eating. The Resident Care Plan (RCP) dated 8/11/11 identified a problem with splints and braces related to a left thumb fracture. Interventions directed that the resident still wanted to eat independently so to encourage and assist as needed. Observations

F 246 • The Director of Nursing or designee will be responsible for monitoring this plan of correction.  
 Completion Date: October 07, 2011.

F 311 F 311  
 • Resident's # 22 & # 124 have been evaluated &/or screened by therapy for appropriate assistive devices and needed assistance/supervision during dining and care plans up-dated. Staff re-educated on appropriate needs for each resident.  
 • Residents eating in the dining room have the potential to be affected by same practice. Residents will be monitored by licensed nurse during meals to assure appropriate supervision and/or assistance.  
 • Staff will be re-educated on policy/procedure for appropriate supervision & assistance of residents during meals.  
 • Random audits will be performed weekly x 90 days then randomly x 30 days to assure compliance. Any patterns or trends will be reviewed at the monthly Performance Improvement meeting and remedial measures initiated as deemed appropriate.

Continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/29/2011
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NAME OF PROVIDER OR SUPPLIER  WETHERSFIELD HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 341 JORDAN LANE WETHERSFIELD, CT 06109
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 311 Continued From page 2  
of the C/D wing dining room on 8/23/11 at 12:05 PM identified Resident #22 seated in a wheel chair with a half padded tray on the right side and the resident's left wrist was casted. The half tray was noted to be butted up to dining table and the plate of food was positioned on the table. Resident #22 was observed to make multiple attempts to manipulate the fork into his/her left hand and the plate of food was noted to be at arm's length. Observations from 12:15 PM through 12:45 PM identified several staff passing by Resident #22 without the benefit of providing assistance.

2. Resident #124's diagnoses included dementia with behavioral disturbances, delirium, and dysphagia. The annual MDS assessment dated 5/25/11 identified that Resident #124 had memory deficits, severe cognitive impairment and although the resident was highly involved the resident required one person guided maneuvering of a limb with eating. The RCP dated 6/3/11 identified a potential for alteration in nutrition related to dementia. Interventions directed to provide assistance with meals as needed and to utilize adaptive equipment, a nose cup and lip plate with meals. Observations of the C/D unit dining room on 8/23/11 from 12:05 PM through 12:30 PM identified Resident #124 seated in a customized wheel chair with a cloth cover across his/her chest. The wheelchair was noted to be reclined at approximately fifty degrees and the footrests were in contact with the base support of the table. The plate of food was positioned on the table at an arm's length and as Resident #124 attempted to eat independently the food dropped off the utensil onto the cloth cover. As Resident #124 ate staff were observed to be

F 311 • The Director of Nursing or designee will be responsible for monitoring this plan of correction. Completion Date: October 07, 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WETHERSFIELD HEALTH CARE CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>341 JORDAN LANE WETHERSFIELD, CT 06109</b>
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F 311 Continued From page 3  
distributing trays throughout the dining room and the resident was not provided assistance during the meal. In an interview with Licensed Practical Nurse (LPN) #1 on 8/25/11 at 10:37 AM LPN #1 was unable to explain why staff did not provide assistance to the residents as outlined in the plan of care.

F 311

F 323 483.25(h) FREE OF ACCIDENT  
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

- Resident # 41 was re-assessed on return from hospital and appropriate interventions applied and care plan revised. Alarm seat-belt is checked for proper function each time resident assisted into w/c & each shift while up in w/c to assure proper function & documented.

This REQUIREMENT is not met as evidenced by:

Based on review of the clinical record, review of facility documentation, and interviews for one of three sampled residents (Resident #41) who had a history of falls, the facility failed to check that a chair alarm was functioning properly as outlined in the plan of care. The findings include:

Resident #41's diagnoses included encephalopathy, dementia with behavioral disturbances and depression. The fall risk assessment dated 4/15/11 identified a total score of 15 which represents a high risk. The quarterly Minimum Data Set assessment dated 4/19/11 identified that Resident #41 had severe cognitive

- Residents with chair alarms have the potential to be affected by the same practice. Chair alarms will be checked for proper function each time resident in assisted into w/c and each shift.

- Staff will be educated on policy/procedure for checking of chair alarms to assure proper functioning is maintained.

- Random audits will be performed weekly for 90 days then randomly x 30 days to assure compliance. Any patterns or trends will be reviewed at the monthly Performance Improvement meeting and remedial measures initiated as deemed appropriate.

Continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WETHERSFIELD HEALTH CARE CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>341 JORDAN LANE WETHERSFIELD, CT 06109</b>	
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F 323 Continued From page 4  
 impairment, required extensive one person assistance with transfers and two person assistance with ambulating, the resident's balance during transitions and walking was not steady and the resident was only able to stabilize with human assistance, had utilized a wheel chair for mobility and a history of falls. A physician's order dated 4/23/11 directed to utilize a bed and/or chair alarm at all times and to check placement and function every shift. The Resident Care Plan dated 4/27/11 identified the resident at risk for falls related to a history of falls. Interventions directed a bed/chair alarm, a low bed with two half side rails up, and blue mat on floor next to bed. The nurse's note dated 5/18/11 identified that at 10:30 AM Resident #41 was found lying on the floor in the hall near his/her room. An assessment by the charge nurse identified a small laceration to the occipital area and numerous hematomas and the resident complained of a head ache. Upon further review of the nurse's note identified that subsequent to physician notification Resident #41 was transferred to the emergency department and admitted to the hospital. The Hospital Discharge Summary dated 5/24/11 identified the admitting diagnoses of a subarachnoid hemorrhage and a ligamentous injury of the cervical spine. Interview and review of facility documentation and the clinical record with the Director of Nurses (DON) on 8/24/11 at 12:30 PM identified that the chair alarm did not sound at the time of the fall. Interview and review of facility documentation with Nurse Aide (NA) #1 on 8/24/11, who had provided the resident with care at 8:45 AM on 5/18/11, identified that although the alarm was attached to the back of Resident #41's wheelchair the alarm failed to sound at the time of the fall.

F 323 • The Director of Nursing or designee will be responsible for monitoring this plan of correction. Completion Date: October 07, 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WETHERSFIELD HEALTH CARE CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>341 JORDAN LANE WETHERSFIELD, CT 06109</b>	
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F 323 Continued From page 5  
Interview and review of facility documentation and the clinical record on 8/24/11 at 11:15 AM and 1:00 PM with Licensed Practical Nurse (LPN) #1, who was on duty 5/18/11 identified that the placement and function of alarm checks is documented on the treatment administration record every shift. On 5/18/11 LPN #1 circled her initials for the 7-3 PM shift indicating the alarm's function was not checked prior to the fall at 10:30 AM.

F 371 SS=D 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  
The facility must -  
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observations, review of policy and procedures, and interviews, the facility failed to ensure that undelivered meal trays were stored under sanitary conditions. The findings included:

Observations during the noon meal on 8/23/11 staff were noted to serve and set up resident trays on the D wing. Further observations at 1:14 PM identified that staff cleared the trays after residents completed the meal and placed those trays into the food cart which still had full meal trays. The undelivered

F 323

F 371

F 371

- The Staff members on D-Wing have been re-educated on policy/procedure to ensure that undelivered meal trays are stored under sanitary conditions prior to being served.

- Residents receiving meal trays have the potential to be affected by the same practice. Resident meal service will be monitored by licensed nurse to assure undelivered meal trays are stored under sanitary conditions prior to being served.

- Staff will be re-educated on policy/procedure for sanitary storage of undelivered meal trays prior to being served.

- Random audits will be performed weekly x 90 days then randomly x 30 days to assure compliance. Any patterns or trends will be reviewed at the monthly Performance Improvement meeting and remedial measures initiated as deemed appropriate.

Continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/29/2011
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F 371 Continued From page 6  
trays were distributed to residents who had not received their noon meal. Review of the facility policy and procedure identified in part soiled trays cannot be placed in food carts with undelivered trays. Interview with the D-wing Unit Manager, Registered Nurse #2, on 8/23/11 at 1:28 PM identified that the soiled trays should not be mixed with trays waiting to be distributed.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to

F 371 • The Director of Nursing or designee will be responsible for monitoring this plan of correction.  
Completion Date: October 07, 2011.

F 431 • LPN # 2 was re-educated on standard of practice & policy for the proper securing and storage of medications. Supervisors re-educated on policy for checking of medication in emergency box for expiration dates and replacement prior to expiration.  
• Residents receiving medications have the potential to be affected by the same practice. Medication pass will be monitored by the Unit Managers for compliance with standards of practice and proper storage of medications, including checking for expiration dates.  
• Licensed nursing staff will be re-educated on standards of practice and proper securing and storage of medications, including the checking of expiration dates and replacement prior to expiration.  
• Random audits will be performed weekly x 90 days then randomly x 30 days to assure compliance. Any patterns or trends will be reviewed at the monthly Performance Improvement meeting and remedial measures initiated as deemed appropriate.

Continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/29/2011</b>
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F 431 Continued From page 7  
 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can't be readily detected.

This REQUIREMENT is not met as evidenced by:  
 Based on observations, clinical record review, review of facility policy and procedure and interviews, the facility failed to ensure that medications and/or biological supplies were stored in a secure (locked) location and/or that medications had not expired and were available for administration. The findings include:

1. Observations on 8/23/11 at 9:15 AM identified a medication cart in front of a resident room and the door to the room was shut. On top of the medication cart was a plastic container that was noted to contain eleven vials of insulin and three insulin syringes in the package. Across from the medication cart a resident (Resident #244) stood in the doorway. At 9:31 AM a Licensed Practical Nurse (LPN) came from behind the closed door and stood at the medication cart. When notice was made to the plastic container, LPN #2 identified that she meant to put the container away in the refrigerator. LPN #2 proceeded to the medication room and secured the container of insulin vials and the syringes. Interview at this time with LPN #2 identified that the last dose of insulin was administered at about 8:45 AM therefore the container sat on the medication cart for approximately forty-five minutes. Interview with the Director of Nurses on 8/25 /11 at 3:30 PM

F 431 • The Director of Nursing or designee will be responsible for monitoring this plan of correction. Completion Date: October 07, 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTER'S FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/29/2011
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NAME OF PROVIDER OR SUPPLIER  WETHERSFIELD HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 341 JORDAN LANE WETHERSFIELD, CT 06109
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F 431 Continued From page 8  
 identified that the facility follows the standards of practice and LPN #2 was inserviced regarding medications will not be left unattended and to store the medications when not being prepared.

2. Review of the facility's emergency medication box with Registered Nurse (RN) #8 on 8/29/11 at 12:30 PM identified an Epi-pen with an expiration date 1/11 and one vial of Lorazepam 2 milligrams per milliliter with an expiration date of 5/1/11. Interview with the Director of Nurses (DON) on 8/29/11 at 1:15 PM indicated that the emergency box was just checked by the night supervisor and the pharmacist approximately one week ago. Interview with RN #8 on 8/29/11 at 1:30 PM identified that he/she was not sure why the expired Lorazepam vial wasn't discovered prior to the observation.

F 431

*Wethersfield Health Care Center*  
A Nursing and Rehabilitation Center

September 19, 2011

Ms. Barbara Cass, RN  
Section Chief  
State of Connecticut  
Department of Public Health  
Facility Licensing & Investigations Section  
Building & Fire Safety Unit  
410 Capitol Avenue-MS #12HFC  
PO Box 340308  
Hartford, CT 06134

Dear Ms. Cass,

I am in receipt of your letter dated August 25, 2011 and the statement of violations concerning the survey and investigation recently conducted by the department. In response, please find the attached plan of correction. Per our conversation, this plan is being submitted timely on September 19, 2011 as adjusted based on receipt of the department's letter.

This plan of correction is Wethersfield Health Care Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

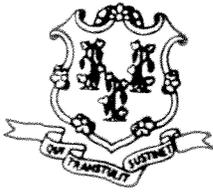
All efforts will be made to comply with the dates specified in the plan of correction. The center will stay in touch with your office should there be any delays in getting materials or commitments from contractors within these time frames.

If you have any questions or concern, please do not hesitate to contact me.

Sincerely,



Stephen Rbizen  
Administrator.



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

August 25, 2011

Stephen Roizen, Administrator  
Wethersfield Health Care Ctr  
341 Jordan Lane  
Wethersfield, CT 06109

Dear Mr. Roizen:

An unannounced survey was conducted at the above facility by the State of Connecticut Department of Public Health, Facility Licensing & Investigations Section, Building & Fire Safety Unit on *August 24, 2011* to determine if your facility was in compliance with federal requirements for safety from fire in nursing homes participating in the Medicare and/or Medicaid programs. The findings of the survey indicate that standards were out of compliance.

Based on the findings of this survey, the facility is not certifiable at this time. The attached Statement of Deficiencies (form CMS 2567) identifies the apparent deficiencies noted during the course of the visit.

An "Enforcement Cycle" has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Facilities are expected to achieve and maintain continuous substantial compliance.

Your facility has an "opportunity to correct" the deficiencies noted. Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State of Connecticut Department of Social Services, if your facility has failed to achieve substantial compliance by *November 22, 2011*.

It is advised that an acceptable plan of correction be prepared and implemented as expeditiously as possible. The consideration for continued certification will be based on the correction of deficiencies. Please respond by *September 8, 11* *3/26/11* with an acceptable plan of correction.

*Conrad & Barbara Case*  
*3/26/11*

The plan of correction must be written on the Statement of Deficiencies (form CMS 2567). Attachments may not replace the plan of correction. A completion date is required for each item of each deficiency and should be documented in the designated column (X5). A signature is required at the bottom of the first page of the Statement of Deficiencies in the designated row (X6).

Please address each deficiency with a prospective plan of correction that includes the following components:

- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change;
- Identify the staff member by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each deficiency.

The Plan of Correction serves as your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State of Connecticut will impose any recommended remedies at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the appropriate remedies be imposed by CMS and the State of Connecticut beginning on August 24, 2011 until substantial

Phone: (860) 509-7500

Telephone Device for the Deaf (860) 509-7191

410 Capitol Avenue - MS # 12HFC

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer



compliance is achieved. Additionally, the CMS Regional Office or the State of Connecticut may impose revised remedies, based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

A temporary waiver of time frames to implement denial of payment for new admissions and/or termination of the provider agreement can be requested for LSC deficiencies requiring more than ninety (90) days to correct. This waiver request must be made on the plan of correction for each individual deficiency that will require an extended completion date beyond these time frames.

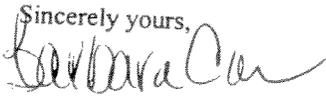
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy), to this office. This request must be sent during the same 10 day period you have for submitting a PoC for the cited deficiencies. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for informal dispute resolution. You will be advised in writing of the decision related to the informal dispute. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended or revised as appropriate.

You will note that these deficiencies pertain to Fire Safety and we request that your response to these deficiencies be returned directly to:

*State of Connecticut Department of Public Health  
Facility Licensing & Investigations Section, Building & Fire Safety Unit  
410 Capitol Avenue, MS #12 HFC  
P.O. Box 340308  
Hartford, CT 06134-0308.*

If you have any questions, please do not hesitate to contact this office at (860) 509-7500.

Sincerely yours,



Barbara Cass, RN  
Section Chief  
Facility Licensing & Investigations Section

c: certification file  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>075058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WETHERSFIELD HEALTH CARE CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>341 JORDAN LANE WETHERSFIELD, CT 06109</b>
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K 000 INITIAL COMMENTS

K 000

Wethersfield Health Care Center was surveyed pursuant to the National Fire Protection Association, "Life Safety Code" (NFPA 101, 2000 edition) as referenced in 42 CFR Part 483.70 (a).

K 020 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

K 020

Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.

This STANDARD is not met as evidenced by:  
The facility did not ensure that stairways, elevator shafts, light and ventilation shafts, chutes and other vertical openings between floors were enclosed with construction having a fire resistance rating of at least one hour as required by the referenced LSC.

On 08/24/11 at 1:30 PM and times throughout the day, the surveyor and maintenance supervisor observed that the door to the stairwell from the basement to the first floor business office had been modified to make repairs utilizing a non-approved means of repair negating the rating of the door i.e. adding a 1" inch strip to the top of a door to make it large enough to fit in the door frame, and the door also failed to self-close and positively latch.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

K 025

Smoke barriers are constructed to provide at

**K 020**

Obtaining quotes to replace doors with one hour fire rated doors is in process. One quote has been received and others anticipated by the end of September 2011. Doors will then be purchased and installed as soon as received.

After installation, doors will be checked each month to assure self-closing and positive latching is functioning as required.

Director of Maintenance or designee will monitor quote process to assure installation of doors by end of December 2011.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE \_\_\_\_\_

*[Handwritten Signature]*

*Administrator*

*9/19/11*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/24/2011
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NAME OF PROVIDER OR SUPPLIER  WETHERSFIELD HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 341 JORDAN LANE WETHERSFIELD, CT 06109
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K 025 Continued From page 1  
least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:  
The facility did not ensure that smoke barriers were constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.

On 08/24/11 at 11:00 AM and times throughout the day, the surveyors, Director of Maintenance, and Maintenance Tech observed that the smoke barriers throughout the facility had voids and penetrations used for the passage of sprinkler pipes and wires that were not sealed using a UL approved system for fire stopping through a smoke barrier and the smoke door by C-07 failed to close and latch as designed.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from

K 025

**K 025**  
Fire rated caulk has been applied to all passages of pipes and wires to provide proper fire stoppage. The smoke door by C-07 was re-adjusted by maintenance to assure proper closure and latching.

All completed by September 12, 2011.

Director of Maintenance or designee will monitor monthly to assure door self-closes and positive latching is functioning as required.

K 029

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K 029 Continued From page 2  
other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:  
The facility did not ensure that hazardous areas were either separated by construction providing at least a one hour fire resistance rating or protected by an automatic extinguishing system, where the sprinkler option is used the areas shall be separated by smoke resisting partitions and self closing doors as required by 19.3.2.1

On 08/24/11 at 2:30 PM, the surveyor along with the Director of Maintenance observed the following in the D-Wing basement:  
a. The patient belongings storage area lacked a door and the adjacent storage room had large holes in the wall communicating not maintaining the required resistance to the passage of smoke.  
b. Storage room # 4 door had been kicked in and was not able to self-close and positively latch as required to maintain resistance to the passage of smoke.  
c. The basement adjacent to the kitchen had an electrical room door that would not self-close and positively latch as required to maintain resistance to the passage of smoke.

K 050 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E  
Fire drills are held at unexpected times under

K 029  
K 029  
Areas in D-Wing basement:  
a. Hole in wall between storage areas is being closed with fire resistant sheet rock.  
b. Obtaining quotes to replace door on storage room # 4 with one hour fire rated doors is in process. One quote has been received and others anticipated by the end of September. Door will then be purchased and installed as soon as received.  
c. Obtaining quotes to replace door on electrical room in basement adjacent to the kitchen with one hour fire rated doors is in process. One quote has been received and others anticipated by the end of September. Door will then be purchased and installed as soon as received.

After installation, doors will be checked each month to assure self-close and positive latching is functioning as required.

Director of Maintenance or designee will monitor quote process to assure installation of doors by end of December 2011.

K 050

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K 050 : Continued From page 3  
varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:  
The facility did not ensure that fire drills were held at unexpected times under varying conditions at least quarterly on each shift as required by the referenced LSC.

On 08/24/11 at 9:30 AM, the surveyor was not provided with documentation by the Director of Maintenance that fire drills were conducted for the 1st and 3rd shifts in the 1st and 2nd quarter of 2011 and the 2nd shift for the 3rd quarter of 2010.

K 067  
SS=E  
NFPA 101 LIFE SAFETY CODE STANDARD  
Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:  
The facility did not ensure that the facilities air conditioning and ventilation equipment was in

K 050

**K 050**  
Fire Drills will be scheduled beginning September 2011 to meet and comply with the standard. Drill times will be varied and compliant to the 8 hour shift period for each shift for each quarter.

The Director of Maintenance will ensure the schedule is adhered to and all documentation for each drill is in compliance for all shifts.

K 067

**K 067**  
Obtaining quotes to correct deficiencies identified 7-18-11 with smoke dampers and mechanical fire damper inspection is in process. All quotes anticipated by the end of September 2011. All work will then be scheduled as soon as possible to meet standard.

After repairs, bi-annual inspections by FPT will be done to assure compliance. Documentation will be kept for records.

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**K 067** Continued From page 4  
accordance with NFPA 90A: Standard for the Installation of Air Conditioning and Ventilation Systems as required by the referenced LSC.  
  
On 08/24/11 at 10:00 AM, The surveyor was not provided with documentation by the Director of Maintenance that the deficiencies identified on the 07/18/11 smoke dampers and mechanical fire damper inspection were quoted and or were scheduled to be repaired as required in NFPA 90A and the LSC.

**K 067**  
Director of Maintenance or designee will monitor quote process to assure complete by end October 2011 with work complete by end of December 2011. Director of Maintenance will monitor bi-annual inspection to assure compliant.

**K 071** NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E  
Rubbish Chutes, Incinerators and Laundry Chutes:  
  
(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.  
  
(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.  
  
(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.  
  
(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82

**K 071**  
The latch to the 2<sup>nd</sup> floor linen chute has been repaired so as to latch. A new door was ordered September 5, 2011 to be installed as soon as arrives to ensure the required fire and smoke protection between floors.  
  
All linen chute doors were checked to ensure compliance with fire and smoke protection and will be checked monthly for proper function.  
  
The Director of Maintenance or designee will monitor monthly as part of the preventive maintenance program.

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K 071 Continued From page 5

K 071

This STANDARD is not met as evidenced by:  
The facility did not ensure that linen and trash chutes, incinerators and trash collection rooms were protected as required by the referenced LSC.

On 08/24/11 at 9:45 AM, the surveyor along with the Maintenance Tech observed that the latch to the 2nd floor linen chute was damaged and failed to latch in order to provide the required fire and smoke protection between floors.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

K 072

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.  
7.1.10

**K 072**

The company (Dubaldo Security) was notified & date of September 27, 2011 as the earliest date available to service doors.

This STANDARD is not met as evidenced by:  
The facility did not ensure that means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

The Director of Maintenance or designee will check weekly the delayed-egress of the magnetic locked doors to assure release when pressure applied to doors as part of preventive maintenance program

On 8/24/11 at 10:35AM, the surveyor along with the Maintenance Tech that the E-Wing exit door to the exterior delayed egress door failed to release as designed; i.e. magnetic lock on delayed-egress locking arrangements did not release when pressure applied to door;

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**K 130** NFPA 101 MISCELLANEOUS  
SS=E  
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:  
1. The facility did not ensure that electrical receptacle outlets were being inspected at least annually as required in NFPA 99 " Health Care Facilities " .

08/24/11 at 10:00 AM, the surveyor was not provided with documentation by the Director of Maintenance that electrical receptacle outlets are inspected annually as required in NFPA 99, Section 3-3.3.3 and 3-3.4.2.3 and as part of the facilities preventive maintenance program.

2. The facility did not ensure that patient care electrical devices in-patient areas were being inspected as required in NFPA 99 " Health Care Facilities " .

On 08/24/11 at 11:00 AM and times throughout the day, the surveyor, Director of Maintenance, and Maintenance tech observed the following:  
a. Rooms F-16 & F 15 had air mattresses that lacked preventive maintenance inspection stickers  
b. Room C 11 had a bipap that lacked preventive maintenance inspection stickers  
c. That the facility was storing approximately 12 oxygen concentrators in the basement porter area that lacked that lacked current preventive maintenance inspection stickers

**K 147** NFPA 101 LIFE SAFETY CODE STANDARD

**K 130**

**K 130**

1. Electrical receptacle outlets are being inspected starting immediately. C & D Wings will be completed by September 30, 2011 and E & F Wing will be completed by October 31, 2011. A Tension Tester has been purchased and is being used for testing as recommended by the State Inspector. Annual inspections will be conducted and documented.

2. Preventive Maintenance checks were done on air mattresses and Bi-pap unit and stickers applied on September 12, 2011. Annual inspections will be conducted and documented for all electrical devices in patient areas and stickers applied. All oxygen concentrators stored in basement porter areas have been discarded and removed from facility.

Re-education of staff to report prior to use any electrical device brought into patient areas. Maintenances will do safety checks and apply sticker.

The Maintenance Director will do random audits to assure all devices have been inspected and stickers applied.

**K 147**

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K 147 Continued From page 7  
SS=E

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:  
The facility did not ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

On 08/24/11 at 11:00 AM and times throughout the day, the surveyor along with the Administrator and/or Director of Maintenance observed the following:

1. The facility had loose electrical receptacles within their mounting boxes in multiple locations.
2. Extension cords and multi plug adapters powering televisions and equipment in resident rooms not identified in facility audits.
3. Electrical cords that had been repaired utilizing a non UL approved means of repair.
4. The E-Wing exit stair contained a window air conditioner powered by an extension cord run through the ceiling of the enclosure.

K 147

**K 147**

1. Electrical receptacles with loose mounting boxes are being repaired with an anticipated completion date of October 31, 2011
2. Extension cords and multi plug adaptors are being removed as additional outlets are installed by contracted Electrician with anticipated completion date of December 31, 2011.
3. Repaired electrical cords have been removed and/or replaced with proper plugs.
4. The air conditioner has been removed from the E-Wing exit stairs.

The Director of Maintenance or designee will do random audits of rooms for electrical safety issues as part of monthly preventative maintenance program.