

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

IN RE: Hickory Hill Rest Home, Inc. of Woodbury, CT  
d/b/a Hickory Hill Rest Home  
280 Middle Road Turnpike  
Woodbury, CT 06798

**CONSENT ORDER**

**WHEREAS**, Hickory Hill Rest Home, Inc. of Woodbury, Connecticut (hereinafter the "Licensee"), has been issued License No.1834-RCH to operate a residential care home known as Hickory Hill Rest Home at 280 Middle Road Turnpike in Woodbury, Connecticut (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and,

**WHEREAS**, Wladimir Ursini is the President of Hickory Hill Rest Home, Inc. and the designated person in charge of the facility; and,

**WHEREAS**, Facility Licensing and Investigations Section of the Department (hereinafter "FLIS") conducted unannounced inspections of the Licensee's facility on various dates commencing on or about November 2, 2005 and concluding on June 16, 2006; and,

**WHEREAS**, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated November 16, 2005; April 28, 2006 and June 29, 2006. (Exhibits A, B and C attached hereto); and,

**WHEREAS**, the Department has issued a proposed statement of charges, attached hereto as Exhibits D.

**WHEREAS**, the License and Wladimir Ursini agree that the Department has sufficient evidence on which to issue a Statement of Charges against said Licensee for violations of the Connecticut

General Statutes and Regulations of Connecticut State Agencies as identified in the proposed statement of charges, attached hereto as Exhibit D.

**WHEREAS**, the Licensee and Wladimir Ursini are willing to enter into this Consent Order and agree to the conditions set forth herein.

**NOW THEREFORE**, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, the Licensee, acting herein and through Wladimir Ursini, its President, and Wladimir Ursini, individually, hereby stipulate and agree as follows:

1. The Licensee must submit a completed request for a Change of Ownership Inspection, accompanied by the applicable fee to the Department within ten (10) days of the execution of this document.
2. The Licensee and Wladimir Ursini understand and agree not to establish, conduct, operate or maintain an institution, as such term is defined in Conn. Gen. Stat. § 19-490(a), in the State of Connecticut, including but not limited to a residential care home as such term is defined in Conn. Gen. Stat. § 19a-490(c).
3. Wladimir Ursini understands and agrees not to be employed at or affiliated with any institution, as such term is defined in Conn. Gen. Stat. § 19a-490(a), in the State of Connecticut, including but not limited to any residential care home as such term is defined in Conn. Gen. Stat. § 19a-490(c).
4. The Licensee agrees that residential care home license number 1834RCH is terminated with prejudice, effective on the close of business on November 21, 2006, or immediately upon the Department's issuance of a license to the new owner(s) of the facility, whichever occurs first. Within three days of the effective date of termination, the Licensee shall deliver to the Department its residential care home license.

5. The Licensee shall pay a monetary penalty to the Department in the amount of twelve thousand dollars (\$12,000.00), by money order or certified bank check payable to the "Treasurer, State of Connecticut." Said payment shall be due on or before October 9, 2006 and shall be submitted to:

Cher Michaud, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section  
Department of Public Health  
410 Capitol Avenue, P.O. Box 340308 MS #12FLIS  
Hartford, CT 06134-0308

6. No person or resident shall be admitted, accepted or provided services by the Licensee or Wladimir Ursini at the facility unless and until such time as the Department approves and grants, in its sole discretion, a license to the new owner(s) of the facility.
7. The Licensee and Wladimir Ursini agree that a violation of this Consent Order constitutes sufficient grounds for the Department to seek a summary suspension of its license without further proof that the public health, safety or welfare imperatively requires emergency action. Should the Department seek to summarily suspended the Licensee's residential care home license number 1834-RCH for violation(s) and/or breach of this Consent Order, the Licensee and Wladimir Ursini hereby waive any and all challenges to such summary suspension.
8. This consent order is reportable and is matter of public record.
9. This Consent Order shall become effective on the day it is approved and entered by the Commissioner of Public Health or his designee.
10. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the

Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

11. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
12. The Licensee and Wladimir Ursini understand that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
13. The Licensee and Wladimir Ursini had the opportunity to consult with an attorney prior to the execution of this Consent Order.
14. The Licensee and Wladimir Ursini understand this Consent Order is a revocable offer of settlement that may be modified by mutual agreement or withdrawn at any time prior to its being signed by the Commissioner of Public Health's designee.
15. The Licensee and Wladimir Ursini agree not to sell the business operations or the real property of the Licensee to a related party if the related party intends to operate the facility as an institution as defined in Conn. Gen. Stat. § 19a-490. For the purposes of this Consent Order, "related party" shall have the same meaning as provided in § 17-311-12(h) of the Regulations of Connecticut State Agencies and shall also include any person related through civil union or cohabitation. Notwithstanding any provisions of this Consent Order, the Department retains in its sole discretion the right to determine whether to grant any type or form of license, certificate or permit to any prospective purchaser or operator of the facility at 280 Middle Turnpike Road, Woodbury, Connecticut.
16. Nothing in this Consent Order exempts or waives any obligation of the Licensee and Wladimir Ursini imposed by law regarding the termination of services and/or bed capacity at the facility in the event a change of ownership does not take place including but not limited to the requirements of the Department of Social Services.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials. The undersigned representative of the Licensee hereby certifies that he/she is fully authorized to enter into this Consent Order and to legally bind the Licensee to the terms and conditions of the Consent Order.

HICKORY HILL REST HOMES, INC OF  
WOODBURY, CT - LICENSEE

10-6-2006  
Date

By: Wladimir Ursini  
Wladimir Ursini, President

STATE OF CT

County of LITCHFIELD ) ss WOODBURY 2006

Personally appeared the above named WLADIMIR URSINI and made oath to the truth of the statements contained herein.

My Commission Expires: 1/31/11  
(If Notary Public)

Nanette Rinaldi  
Notary Public   
Justice of the Peace [ ]  
Town Clerk [ ]  
Commissioner of the Superior Court [ ]

**NANETTE RINALDI**  
**NOTARY PUBLIC**  
MY COMMISSION EXPIRES JAN. 31, 2011

**WLADIMIR URSINI, INDIVIDUALLY**

10-6-2006  
Date

By: Wladimir Ursini  
Wladimir Ursini,

STATE OF CT

County of LITCHFIELD ) ss WOODBURY 2006

Personally appeared the above named WLADIMIR URSINI and made oath to the truth of the statements contained herein.

My Commission Expires: 1/31/11  
(If Notary Public)

Nanette Rinaldi  
Notary Public   
Justice of the Peace [ ]  
Town Clerk [ ]  
Commissioner of the Superior Court [ ]

**NANETTE RINALDI**  
**NOTARY PUBLIC**  
MY COMMISSION EXPIRES JAN. 31, 2011

**STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH**

10/13/06  
Date

By: Joan D. Leavitt  
Joan D. Leavitt, R.N., M.S., Section Chief  
Facility Licensing and Investigations Section



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT <sup>A</sup>  
PAGE \_\_\_ OF \_\_\_

November 22, 2005

Walter Ursini  
Hickory Hill Rest Home  
280 Middle Road Turnpike  
Woodbury, CT 06798

Dear Mr. Ursini:

This is an ammended version of the violation letter originally dated November 16, 2005.

Unannounced visits were made to Hickory Hill Rest Home on May 12 and 19, June 23, October 27, and November 2, 5, 9, 10, 11, 12, 13, 14, 15 and 16, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for November 29, 2005 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

No referrals of health care professionals were initiated as a result of this inspection.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

*Cher Michaud, RN*

Cher Michaud, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

CM

c: licensure file



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DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,11,12,13,14,15 and 16, 2005

EXHIBIT A

PAGE OF

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (b) Physical Plant (M)(4)(b)(7).

- 1. On October 27, 2005 hot water at plumbing fixtures intended for resident use failed to register a minimum of 110 degrees Farhenheit as follows:
  - a. Recorded at 106.7 degrees in the Men's Bathroom.
  - b. Recorded at 108.5 degrees in the Community Bathroom near room 13.

Plan of Correction

Completion Date

The following is a violation of the Connecticut Public Health Code Section 19-13-D6(c) Administration (4).

- 2. Documentation was lacking that one new employee received orientation in the area of Resident's Rights prior to working independently.

Plan of Correction

Completion Date

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,11,12,13,14,15 and 16, 2005

EXHIBIT A  
PAGE \_\_\_ OF \_\_\_

**THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED**

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (m)  
Administration of Medications.

3. The facility lacked a written policy on the administration of PRN (e.g. as needed) medications administered by medication certified attendants.
4. On November 5, 2005 the facility identified that they administer medications to the residents that are prepared by a home health nurse. They were unable to provide a list of medications and the directions for administration for each resident. For Resident #'s 2 and 3 the facility had sent the only copy of the list to the hospital with the residents. They further identified that the home health agency keeps all the records of administration. The regulations were reviewed with the facility regarding medication administration and documentation. On November 8, 2005 the facility identified that the home health nurse was coming in to administer all of the medications. On November 11, 2005 the facility identified that 2 home health agencies come in for medications. Agency #1 administers medication to Residents # 2,4,5,7,8,9,10,11,12,13 and 14. Agency #2 comes in every 2 weeks to prepour Resident #3's medications for the staff to administer. The facility then identified that they administer resident #6's medication.
5. On November 13 and 15,2005 it was noted that the facility failed, for two of two residents whose medications are administered daily by facility staff, (Resident #10 and Resident # 11) to provide documentation of clear written order of an authorized prescriber and/or written permission of the resident (or legal guardian) to administer medications.
6. For one resident (Resident #10) the facility failed to obtain a written order by the authorized prescriber including the name of the resident, the date of the medication order was written , the medication dose, method of administration, the time, the dated the medication is to be start and/or ended, the relevant side effects, a listing of any allergies or interactions with food or drugs, specific instruction form the prescriber regarding how the medication is to be given, and the name, address and telephone number of the prescriber ordering the drug.
7. On November 11,12,13,14 and 15, 2005 for residents whose medications were administered daily by the facility staff, the failed to provide documentation of individual written medication administration record for each resident. The facility failed to provide evidence of and/or implement a documentation system. It was further identified that a system was not in place prior to these dates. At each visit the regulations were reviewed with the licensee.

Plan of Correction

Completion Date

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,11,12,13,14,15 and 16, 2005

**THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED**

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (d) Medical Supervision.

8. On May 12, 2005 the facility failed to provide psychiatric/medical physician services to Resident #1 on a timely basis. The resident did not receive a scheduled psychiatric medication which resulted in an acute psychotic episode and subsequent hospitalization.
9. During the November 5, 2005 visit the facility identified that for the past 2-3 weeks Resident #2 was noted to have a change in behavior, including hearing voices regarding fires and killing others. The facility failed to notify the physician of this change.
10. For one resident (Resident #8) who had a history of physical aggression, on November 9, 2005, the facility failed to contact the resident's physician, the local police and /or the resident's conservator when the resident had an episode of physical aggression directed towards other resident.

Plan of Correction

Completion Date

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (c) Administration (5).

11. On November 1, 2005 it was noted that there was a fire in a resident's room. It was alleged that the resident was smoking in their room and placed the lit cigarette under the bed linens which then began to smolder. A visible inspection of room 12 on November 2, 2005 identified several cigarette butts in the closet. Outside the building the mattress and bedding was noted to be charred with a burned area in the middle. The Person in Charge identified that smoking within the facility was prohibited. Residents had a smoking area outside the building on the patio. Smoking was supervised hourly and lighters and/or smoking materials were maintained by facility staff. The Person in Charge stated that due to this incident smoke detectors were to be install in resident rooms by November 5, 2005. He also identified that the outside patio (smoking area) was to be

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,11,12,13,14,15 and 16, 2005

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

enclosed with a fence as well as equipped with metal freestanding ashtrays.

12. On November 5, 2005 it was noted that there was a second fire noted in a resident's room. It allegedly was caused by a candle burning in the room and the window furnishings and mattress catching fire. According to facility staff the resident had a history of burning candles in their room.
13. On November 2 and 5, 2005 the facility staff identified that there were many residents found with their own lighting materials which was in violation of the facility policy.
14. According to the fire department, the facility had yet to install the smoke detectors in the residents rooms as of November 5, 2005 and were instructed to do so by the days end. Additionally the fire alarm system was not functioning up to code. Per the Fire Marshal and the Department of Public Health a fire watch was to be implemented until the fire alarm system had been repaired.
15. On November 9, 10, 11, 12, 13, and 14, 2005 the facility was not able to provide evidence of a consistent fire watch.
16. On November 11 and 12, 2005 the licensee and person in charge was not aware of the accurate census.
17. The smoking policy identified prior to the fires identified that if a resident was in violation of the smoking policy they would be given a written warning for the first offense and would be given a 30 day involuntary discharge notice for the second offense. On November 5, 2005 that facility identified that they were revising the smoking policy. On November 13, 2005 it was identified that that facility had not implemented the policy in effect.
18. For one resident who received antipsychotic medication ( Risperdal 2 mg) four times a day and had depleted his supply of the medication. The facility failed to ensure that on November 10, 2005 at 9 a.m. the medication was available to be administered.
19. The facility failed to ensure that a sufficient amount of fuel was maintained at the facility. Interviews with the residents on November 12, 2005 identified that during the morning hours on November 12, 2005, hot water was not available within the facility. An interview with the person in charge identified that during the morning hours on November 12, 2005 the furnace had ceased to function. The repairman discovered that the facility had depleted their supply of oil. Subsequently the facility received an emergency oil delivery.
20. The facility maintained a fire watch, which included monitoring for fires/smoke every twenty minutes. On November 12, 2005 at 5 a.m., Resident #10 was in the possession of two lighters subsequent to an odor of smoke in the ladies bathroom. Resident #10 denied smoking within facility. On November 12, 2005 at 4:30 p.m., subsequent to surveyor inquiry regarding the incident, the facility's owner identified a plan to prevent further occurrences. Fire monitoring would increase to every fifteen minutes.
21. The facility lacked documentation that the fifteen-minute monitoring continued. The evening shift attendant on November 12, 2005 identified that she had forgotten to inform the oncoming shift of the increase. The night shift attendant notes of November 13, 2005 identified that she was not aware that the fire watch had increased. On November 13, 2005 during the late night/early morning hours subsequent to a complaint of a suspicious odor, Resident #10 was discovered with a cigarette butt wrapped in a paper towel tucked under her pillow. Observation of the paper towel noted burn holes and several cigarette butts. At the resident's insistence in the morning, Resident #10 was transported to the crisis unit at local hospital returned to the facility the same day.

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2, 5, 9, 10, 11, 12, 13, 14, 15 and 16, 2005

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

22. An interview with the facility's owner on November 12, 2005 identified that the facility's current smoking policy was yet to be written. He stated however that it included that smoking and or lighting materials were not allowed with the facility. He noted that when the resident was non-compliant with the smoking policy, the second occurrence would result in a thirty-day notice of eviction.
23. The facility failed to appropriately respond to an incident involving the odor of smoke from a bathroom at 4:00am on November 14, 2005. It was alleged that a resident was smoking in the bathroom.
24. Documentation was lacking that the fifteen-minute Fire Watch rounds were done consistently on November 13 and 14, 2005 including 6:00am through 9:00am.
25. As of November 15, 2005 the facility's Smoking Policy had not yet been completed and/or reviewed with the residents.
26. On November 16, 2005 staff identified that a resident was allegedly smoking in the bathroom during the night.

Plan of Correction

Completion Date

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2, 5, 9, 10, 11, 12, 13, 14, 15 and 16, 2005

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (b) Physical Plant (2)(b).

27. On November 5, 2005 the facility was unable to provide evidence of the flame retardency of the window treatment in the resident rooms. According to the Fire Marshall the facility had until November 11, 2005 to provide the information. On November 11, 2005 the facility identified that they forgot to get the information and that it was so old they might not have the information any longer.

Plan of Correction

Completion Date

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (m) Administration of medications and/or Connecticut General Statutes Section 21a-257.

28. It was identified on November 5, 2005 and on November 11, 2005 in the cases where the home health nurse had and continued to prepour the medications, that controlled substances were also preprepared and not remaining in the original labeled packaging from the pharmacy.

Plan of Correction

Completion Date

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,11,12,13,14,15, and 16, 2005

PAGE \_\_\_ OF \_\_\_

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (c)  
Administration and/or Connecticut General Statutes Section 19a-550.

29. The residents meet weekly as a group and/or individually with an "psychoanalyst" from an outside agency to talk about any concerns they have. On November 11, 2005 the licensee was observed to listen in on the meeting without an invitation from the residents. The licensee identified that he often listens in to hear what they have to say.

Plan of Correction:

Completion Date:

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (c)  
Administration (5).

30. A tour of the facility on October 27, 2005 revealed the following:

- a. Two chairs in the lounge were observed with unsecured wooden arms.
- b. A dresser drawer and a closet door in room 2 were not properly in their tracks.

31. Tour of the facility on November 9, 2005 identified that three of three resident bathrooms, as well as the kitchen area, were not equipped with paper towels.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: May 12 and 19, June 23, October 27, and November 2,5,9,10,14,12,13,14,15 and 16, 2005

EXHIBIT **A**  
PAGE      OF     

**THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED**

The following is a violation of the Connecticut Public Health Code Section 19-13-D6 (f) Dietary Service (2).

- 32. On May 12 and 19 and October 27 and November 15, 2005 it was noted that a weekly menu was not posted in a conspicuous area. The regulations were reviewed at each visit with the licensee.
- 33. On May 12, 2005 it was noted that the cook did not utilize a hair restraint when preparing meals.
- 34. On November 14, 2005 iced tea was observed being served to residents in an unlabelled and undated plastic gallon milk container. An interview with the cook identified the container could not be washed in the dishwasher due to the excessive heat and consistency of the plastic. A brownish residue was noted around the top of the container.

Plan of Correction

Completion Date

\_\_\_\_\_  
Provider/Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B  
PAGE OF

April 28, 2006

Walter Ursini  
Hickory Hill Rest Home  
280 Middle Road Turnpike  
Woodbury, CT 06798

Dear Mr. Ursini:

An announced scheduled visit was made to Hickory Hill Rest Home on April 24, 2006 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a monitoring visit.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by May 13, 2006 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address the violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

No referrals of health care professionals were initiated as a result of this inspection.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cher Michaud, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

CM

c: licensure file



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DATE(S) OF VISIT: April 24, 2006

PAGE \_\_\_ OF \_\_\_

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (A)(1)(d).

- 1. Based on observation and staff interview the facility failed to submit plans and specifications for new construction and/or alterations for approval by the Department of Public Health prior to the start of construction. The findings include:
    - a. During a tour of the facility on 4/24/06, the inspectors observed the following:
      - i. Piping was noted throughout most of the facility for a new sprinkler system. The laundry area in the corridor between the kitchen and the attached apartment lacked sprinkler coverage.
      - ii. Wiring was noted throughout most of the facility for a new fire alarm system including alarm/strobe sites and smoke detector sites. The laundry area was not included.
      - iii. Aluminum studs for new walls, a new closet, and a new dresser in Room 9 were noted.
- An interview with the owner on the day of the inspection identified he did not notify the Department prior to the start of these projects.

Plan of Correction

Completion Date

\_\_\_\_\_  
Provider/Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT C  
PAGE \_\_\_ OF \_\_\_

June 29, 2006

Walter Ursini  
Hickory Hill Rest Home  
280 Middle Road Turnpike  
Woodbury, CT 06798

Dear Mr. Ursini:

On June 16, 2006 the Department concluded an investigation of Hickory Hill Rest Home.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the investigation.

An office conference has been scheduled for July 26, 2006 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

No referrals of health care professionals were initiated as a result of this inspection.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cher Michaud, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

CM

c: licensure file



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DATE(S) OF VISIT: June 15, 2006

PAGE \_\_\_ OF \_\_\_

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6(c) Administration(5).

1. Based on interview, the facility failed to provide adequate supervision of the residents. The findings include:
  - a. The licensee stated at a deposition on May 12, 2006 that the fire alarm failed to sound in the overnight attendant's sleeping quarters.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (b)Physical Plant (A)(2)(b).

2. Based on interview and review of facility documentation, the facility failed to conduct comprehensive fire drills. The findings include:
  - a. Staff Member #'s 1 and 2 stated during depositions on May 9, 2006 that all fire drills conducted entailed the residents exiting the building through the main lobby. No alternate exits were ever utilized as required by the Life Safety Code 1997 Section 22-7.3.

Plan of Correction

Completion Date

DATE(S) OF VISIT: June 15, 2006

PAGE OF

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5) and/or Connecticut General Statutes Section 19a-551.

- 3. Based on interview and a review of facility documentation for eleven discharged residents for whom the facility managed their funds, the facility failed to provide appropriate documentation concerning these funds. The findings include:
  - a. Review of facility documentation and interview with the facility's bookkeeper on 6/15/06, failed to provide evidence that the facility obtained written permission to handle resident finances. The facility's bookkeeper identified on 6/15/06, that the facility did not have written agreements with residents and/or their conservators concerning the handling of resident finances. Residents #2, 3, 4, 6, 9, 12, 13, and 15 received entitlements that were remitted directed to the facility. Residents #5, 10 and 11 were billed monthly. She identified that the facility made purchases (mostly smoking materials), which were tabulated and deducted from and/or charged to the resident's accounts. For Residents #2, 3, 4, 6, 12, 13, and 15, monies in excess were deposited monthly into individual resident's account at a local bank. Resident #9's money in excess was remitted toward prepaid funeral arrangements. The facility did not handle cash transactions. The owner identified on 6/15/06 that upon admission to the facility, each resident verbally committed to how their funds were to be handled and was only recent made aware that a written agreement was required.
  - b. The facility failed to provide documentation that residents and/or responsible parties were provided quarterly statements of accounting for resident funds. The facility also did not provide documentation of receipts for the purchases and/or payments made on the resident's behalf.

Plan of Correction

Completion Date

\_\_\_\_\_  
Provider/Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

October 13, 2006

EXHIBIT D  
PAGE 1 OF 5

TO: Hickory Hill Rest Home, Inc.  
d/b/a Hickory Hill Rest Home  
280 Middle Road Turnpike  
Woodbury, CT 06798  
Residential Care Home License # 1834RCH

**STATEMENT OF CHARGES**

NOW THEREFORE, the Connecticut Department of Public Health (hereinafter "the Department"), pursuant to Conn. Gen. Stat. § 19a-494, brings the following charges against Hickory Hill Rest Home, Inc.:

**COUNT ONE**

1. Hickory Hill Rest Home, Inc. d/b/a Hickory Hill Rest Home of 280 Middle Road Turnpike, Woodbury, Connecticut, (hereinafter "respondent") is, and has been at all times referenced in the Statement of Charges, the holder of Connecticut residential care home license number 1834RCH.
2. The respondent failed to adequately protect residents in violations of §§ 19-13-D6(c)(1) and/or 19-13-D6(c)(5) of the Regulations of Connecticut State Agencies (hereinafter "Regulations") when:
  - a. On or about November 1, 2005, a fire occurred in a resident's room at Hickory Hill Rest Home (hereinafter "the facility"); and/or,
  - b. On or about November 5, 2005, a fire occurred in a resident's room at the facility; and/or,
  - c. On or about November 17, 2005, a fire occurred in a resident's room at the facility rendering the building unfit for habitation; and/or,
  - d. On or about November 9, 10, 11, 12, 13 and/or 14, 2005, the respondent and/or personnel failed to maintain consistent fire watches; and/or,
  - e. From on or about November 1 to November 17, 2005, the respondent and/or personnel failed to implement the facility's smoking policies; and/or
  - f. From on or about November 1, 2005 through on or about November 17, 2005, the respondent failed to utilize window treatments in the facility that were flame retardant; and/or,

- g. The respondent failed to ensure that fire drills had been conducted on the evening and night shifts for the year 2004; and/or,
- h. The respondent failed to provide adequate supervision and interventions upon becoming aware in the Spring of 2005 that a resident had been and/or was lighting candles in the resident's private room; and/or,
- i. From on or about June 27, 1995 to on or about November 17, 2005, the respondent failed to ensure that the fire alarm system sounded in the overnight attendant's sleeping quarters; and/or,
- j. From on or about November 2004 through on or about November 17, 2005, the respondent failed to ensure that alternate evacuation routes were identified and practiced during routine fire drills.

### **COUNT TWO**

3. Paragraph 1 of Count One is incorporated herein by reference as if set forth in full.
4. The respondent failed to adequately supervise residents in violation of § 19-13-D6(c)(1) and/or 19a-13-D6(h)(13) of the Regulations when:
  - a. From on or about November 1 to November 17, 2005, residents at the facility were found to have cigarettes on their person in violation of the facility's smoking policy; and/or,
  - b. On or about November 1, 2005, "cigarette butts" were found in at least one resident's closet in violation of the facility's smoking policy; and/or,
  - c. From on or about November 1 to November 17, 2005, residents were found smoking cigarettes inside the facility in violation of the facility's smoking policy; and/or
  - d. Prior to November 17, 2005, residents were not given warnings for first time violations of the smoking policy and/or residents were not issued a thirty (30) day notice of discharge for subsequent violations of the smoking policy.

### **COUNT THREE**

5. Paragraph 1 of Count One is incorporated herein by reference as if set forth in full.
6. The respondent failed to comply with §§ 19-13-D6(c)(1) and/or 19-13-D6(d) of the Regulations when:

- a. On or about November 5, 2005, the respondent failed to obtain the services of a physician when a resident was noted to have a change in behavior, including hearing voices about starting fires and killing other persons.

**COUNT FOUR**

7. Paragraph 1 of Count One is incorporated herein by reference as if set forth in full.
8. The respondent failed to comply with § 19-13-D6(A)(2)(b) of the Regulations in that:
  - a. On or about November 9, 10, 11, 12, 13 and/or 14, 2005, the respondent failed to maintain a consistent fire watch as required by §§ 7-6, 7-6.1.8, 23-2.3.4, 23-2.3.4.1 of the National Fire Protection Association – 101 Life Safety Code, 1997 Edition; and/or,
  - b. The respondent failed to utilize flame resistant window treatments as required by §§ 6-6.1, 23-7.5 of the National Fire Protection Association – 101 Life Safety Code, 1997 Edition; and/or,
  - c. On or about February 2, 2005, the respondent failed to ensure that fire drill had been conducted for the evening and night shifts for the previous year as required by Life Safety Code 1997 Section 23-7.3.

**COUNT FIVE**

9. Paragraph 1 of Count One is incorporated herein by reference as if set forth in full.
10. The respondent failed to comply with General Statutes § 19a-551 in that:
  - a. From on or about June 2004 through on or about March of 2005, the respondent failed to obtain written permission from the residents or the conservators to manage resident funds; and/or,
  - b. From on or about November 17, 2003 through on or about November 17, 2005, the respondent failed to maintain individualized itemized records of quarterly accountings of resident funds managed by the facility; and/or,
  - c. From on or about November 17, 2003 through on or about November 17, 2005, the respondent failed to maintain individualized itemized records of purchases and/or expenditures made on the resident's or residents' behalf.

**COUNT SIX**

11. Paragraph 1 of Count One is incorporated herein by reference as if set forth in full.

12. The respondent failed to comply with § 19-13-D6(b)(A)(1)(d) of the Regulations in that:

- a. In approximately 2006, the respondent failed to submit plans and/or specifications for new construction and/or alterations for approval by the Department of Public Health prior to the start of construction.

**NOW WHEREFORE**, the Facility Licensing and Investigations Section, Department of Public Health prays that:

The Commissioner of Public Health as authorized in Conn. Gen. Stat. § 19a-494 revoke or take such other action as authorized in said section against the Residential Care Home license of Hickory Hill Rest Home, Inc., as he deems appropriate and consistent with the law.

Dated at Hartford, Connecticut this \_\_\_\_\_ of \_\_\_\_\_, 2006.

\_\_\_\_\_  
Joan Leavitt, Section Chief  
Facility Licensing and Investigation Section  
Department of Public Health