STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

December 10, 2020

Mary Ellen Ierardi, Executive Director
Ocean Meadows
91 East Main Street
Clinton, CT 06413

mierardi@oceanmeadowsl.com

Dear Ms. Ierardi:

An unannounced visit was made to Ocean Meadows on July 21, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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 visit. The state violations cannot be edited by the provider in any way.

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

The plan of correction is to be submitted to the Department by December 20, 2020.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction to Michael.J.Smith@ct.gov may be subject to disciplinary action. Please do not send another copy via US mail.

DATE(S) OF VISIT: July 21, 2020

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 20, 2020 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

If there are any questions, please do not hesitate to contact this office at Michael.J.Smith@ct.gov.

Respectfully,

Loan D Nguyen

Loan Nguyen MSN, RN, C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CT # 28009

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

DATE(S) OF VISIT: July 21, 2020

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-D105 (h) Nursing Services provided by an assisted living services agency (1) and/or (3) (C).

1. Based on clinical record review and staff interview, the Assisted Living Services Agency (ALSA) failed to ensure assessments by a Registered Nurse (RN) prior to moving a client after a fall incident, and after subsequent changes in condition. The findings included:

   Client #2 was admitted to the memory care assisted living program on 8/1/17 with the diagnoses of dementia, coronary artery disease, normal pressure hydrocephalus, lung cancer and diabetes mellitus. The client service program dated 4/28/2020 identified the need for medication management, assistance with grooming, dressing, bathing, transfers with a mechanical lift, and the management of hand splints.

A. On 5/22/2020 Licensed Practical Nurse (LPN) # 1 documented having found Client # 2 at 2:30am on the floor lying on left side, next to the bed. Client # 2 stated the client "was going for a walk to get food for the babies because they were hungry."

   LPN # 1 checked the client's vital signs, rolled the client onto the hoyer pad and with the assistance of an aide, transferred the client back to bed using a mechanical lift. The LPN subsequently notified the Supervisor of Assisted Living Services (SALSA) and the attending physician.

   Interview and review of the ALSA documentation with the Supervisor of Assisted Living on 7/21/2020 failed to identify an onsite assessment by the ALSA Registered Nurse prior to moving a client from the floor after a fall incident.

B. Four hours later on 5/22/2020 at 6:36am LPN # 2 documented that Client #2 complained of shoulder tenderness while being assisted with dressing. LPN # 2 documented the absence of redness or swelling. Interview and review of the ALSA documentation with the Supervisor of Assisted Living on 7/21/2020 failed to identify reporting to the ALSA RN for an assessment of the client's shoulder pain;

C. On 5/22/2020 LPN #3 documented that Client #2 was grimacing and yelling out that the left hip area was hurting during incontinence care. LPN # 3 documented the absence of bruising or swelling, failed to notify the ALSA RN of the need for an assessment, amd failed to contact the attending physician. LPN # 3 administered Tylenol to Client # 2.

   On 5/23/2020, LPN # 4 documented that Client # 2 complained of pain upon movement to left hip. The LPN notified the physician, who ordered an x-ray of the hip. The x-ray identified a left femoral neck fracture, and Client #2 was transferred to the hospital.

State of Connecticut Department of Public Health

Plan Of Correction

The Shoreline of Clinton

Date Visited July 21, 2020

Unannounced visit: July 21, 2020

Alleged Violation:

Findings: Violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (h) Nursing Services provided by an assisted living services agency (1) and/or (3) (C).

The assisted living services agency failed to ensure assessments by a Registered Nurse (RN) prior to moving a client after a fall incident, and after subsequent changes in condition.

Measure to prevent recurrence:

The RN/RN Designee will either assess in person while on site or have the LPN gather the data necessary for the RN to assess and make a determination if sending the client to the hospital is needed or if they are able to assist client up from the floor. If the RN/ RN Designee deems it necessary, the LPN will call 911 and the client will be sent to the Emergency Department for evaluation.

Licensed staff to be reeducated to ensure proper reporting of a fall, pain, or change in condition to the RN/ RN designee in order for the RN to conduct an assessment. Each notification must be documented in the client's records. RN/RN designee to conduct assessment and document it in client's record.

RN/RN designee educated to conduct RN assessment prior to getting Client up off of the floor either onsite or via phone.

Licensed staff reeducated to ensure notification to the MD of any change in condition or new onset of pain status post fall. Each notification must be noted in the client record.

Date Measure will go into effect: January 1, 2021

The Facilities plan to monitor its quality improvement to ensure measures and systemic change is sustained includes:

- Retraining to ensure RN assessment occurs immediately after a client's fall and before they are assisted up. If RN/RN designee unavailable onsite, the LPN will gather the data needed for the RN to assess. This assessment will take place onsite or via phone. The RN/RN designee will make a determination if it is safe to get the client up from the floor or if 911 needs to be called and client sent to Emergency Department for evaluation. Document all information in the client's record including family udate.
- Retrain staff to notify RN, MD & family when a change in client's condition is noted and document it in clients record.
- RN, when notified regarding change in condition, RN will conduct assessment. The MD will be updated and the notification will be documented it in the client's record.
- Fall reviews and any client with a change of condition will be reviewed in morning report to ensure all parties have been properly updated and documented in the clients record.
- Monthly audit of at least 60% of incident reports and charts for notification of all parties and corresponding documentation. If notification and corresponding documentation found missing or omitted. Appropriate notification completed immediately and documented. The Staff member will be reeducated on the notification and documentation policy. Then notification.
- Monthly Audit of at least 60% of incident reports and charts to be conducted to ensure RN assessment completed prior to client being assisted off of floor or sent to ED for evaluation. If notes not found, reeducation of Licensed staff will occur.
- Monthly Audit of at least 60% of incident reports to ensure RN assessment complete when a client has a change of condition. If not completed, reeducation of RN needed.
- These audits will be performed until 90% or greater compliance is achieved for 3 consecutive months.

Person Responsible for Monitoring: SALSA RN/ RN Designee

Audit Tool

Incident Report Review

Month ________________ Year __________

Client Name	Date of Report	MD Notification Documented		RN Notification Documented		Family Notification Documented	

Client Name	Date of Report	New onset of Pain	Change of Condition	RN Assessment & Documentation

Month _____ Year_____

Audit Tool

RN Assessment & Change in Condition

Inservice Fall Protocol

12/17/2020

- If a resident falls, LPN to notify RN **immediately**, prior to moving resident off of the floor
- If a resident has a fall, the RN will assess the resident, (while on the floor), if available onsite, or the LPN will call RN/RN designee and provide the data needed for the RN to assess and make a determination if the client needs to be sent out to Emergency Department for evaluation. If the RN deems it necessary to go to ED, the LPN will call 911 and the client will be sent to hospital for further assessment and evaluation. The LPN will document this in the client record, notify family/emergency contact, & MD
- If a fall occurs, the LPN is responsible for notifying the RN of fall and documenting that communication.
- The LPN is responsible for informing the MD of the fall and any change of condition noted immediately after the fall or if attributed to the fall thereafter. This must be documented in the clients record. Monitor and document on the fall in the client's record for a minimum of 72 hours status post fall.
- The LPN must notify the resident's POA of the fall and document it in the client's record.
- The RN, when notified of a change in condition, will assess the resident. The RN will document the assessment in the client record and determine a plan of care. If needed the MD, POA and Client's record will be updated of the change.

Date	Name/Signature	Title
12-17-20	Janet Mroczka	RN
12/17/20	MaryEllen Terardi	ED
12/17/20	[illegible]	[illegible]
12/18/20	[illegible]	[illegible]
12/18/20	Maria Fumiano LPN	LPN
12-18-20	Jeanne Whitehead	LPN

- If a resident has a fall
  - LPN to notify RN **immediately** prior to moving resident.
  - If RN not onsite, LPN to call RN with all pertinent assessment data
  - The LPN to follow recommendations to either assist resident off the floor or call 911 and send them to the emergency department for evaluation.
  - Notify RN/MD/Family/emergency contact of fall and related change in condition
  - Document in the client's record for a minimum of 72 hours status post fall.
  - If a change in condition is noted, the RN must be notified so the RN may complete a plan of care and document it in the client's record.
  - Notify MD and family/emergency contact regarding change in condition and document it.