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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

March 30, 2021

Jessica Ferreira, Executive Director
Farmington Station A Senior Living Residence
111 Scott Swamp Road
Farmington, CT 06032
jferreira@farmingtonSLR.com

Dear Ms. Ferreira:

An unannounced visit was made to Farmington Station A Senior Living Residence on March 10, 2021 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is a violation 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 April 9, 2021.

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 Megan.Edson-Sawyer@ct.gov may be subject to disciplinary action.

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 April 9, 2021 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

DATE(S) OF VISIT: March 10, 2021

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

Please direct your questions concerning the instructions contained in this letter to the Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Karen Donato RN, C

Karen Donato, RN, C
Supervising Nurse Consultant/Interim
Facility Licensing and Investigations Section

KD:lst

Complaint CT #29631

The following are violations of the regulations of Connecticut State Agencies Section 19-13-D105 Assisted living services agency (d) Governing authority of an assisted living services agency (4) (A) (F) and/or (e) General requirements for an assisted living services agency (1) and/or (f) Personnel

DATE(S) OF VISIT: March 10, 2021

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

policies (1) (A) (iv) and/or (g) Supervisor of assisted living services (2) (A) (B) and/or (h) Nursing Services provided by an assisted living services agency (3) (C) (D) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c)and/or (k) Client service record.

1. Based on clinical record review and staff interviews for one of one client (Client #1) who received assisted living services for assistance with personal care, medication management and safety monitoring, the Assisted Living Services Agency (ALSA) failed to conduct an investigation after unwitnessed injuries were identified, failed to notify a Registered Nurse (RN) of a change in condition, failed to revise the plan of care to address behaviors and governing authority failed to develop policies to conform to state regulations. The findings include:

   a. Client #1 was admitted to the memory care assisted living services agency (ALSA) program on 12/10/2019. The admitting diagnoses included dementia, anxiety disorder and hyperlipidemia. The client service plan dated 11/07/2020 identified the need for the assistance of one caregiver for dressing, bathing, and incontinence care and medication management. The Client was independent with eating, ambulation and transfers.

   On 2/08/2021 at 8:30 AM, LPN #1 was notified by ALSA Aide #1 that Client #1 had a
   LPN #1 on 3/10/2021 at 9:45 AM indicated he/she assessed the Client's
   injuries, notified the spouse and physician but failed to notify the RN on
   duty.

   Review of LPN #1's nurses notes dated 2/08/2021 failed to indicate an RN was notified

   Interview and review of LPN #1's nurses note dated 2/08/2021 with the Supervisor of
   failed to identify an RN was notified and/or assessed Client #1's right forehead
   and shoulder injuries on 2/08/2021, and failed to indicate a policy and/or guideline
   for investigating injuries of unknown origin had been developed.

   The Connecticut General Statutes at Chapter 378 Section 20-87a (a) defines the practice of nursing by a registered nurse as, among other responsibilities, "the process of

   The Connecticut General Statutes at Chapter 378 Section 20-872 (c) defines the practice of nursing by a licensed practical nurse as, among other responsibilities, "the
   performing of selected tasks and sharing of responsibility under the direction of a registered
   nurse;"

   Interview and review of the clinical documentation with Licensed Practical Nurse #1
   his/her incontinence briefs several times throughout the day/night urinating in his/her
   indicated the client would not allow ALSA staff to move piles of
   clothes off the bed, would throw food, cups and napkins on the floor. The

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

housekeeping staff and ALSA Aides would attempt to clean the client's room which would cause Client #1 to become agitated. LPN #1 indicated that the ALSA staff would redirect the client, provide him/her with a quiet environment and slowly re-approach for personal care after time had lapsed.

Interview with ALSA Aide #2 on 3/10/2021 at 12:20 PM, identified the client would personal care to the client the morning of 2/03/2021 when Client #1 allegedly hit ALSA Aide #2.

Interview and review of Client #1's clinical record with the Executive Director on care needs of the client.

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Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

April 8, 2021

410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Attention: Karen Donato, RN, C
Supervising Nurse Consultant/Interim
Facility Licensing and Investigations Section
CT# 29631

To Whom It May Concern,

This letter is in response to the communication received from you on March 30, 2021 by Farmington Station Assisted Living. Below please find the plan of correction based on the visit made to the community.

Description of Findings:
The following is a violation of the Regulations ofConnecticut State Agencies Section 19-13-D105 Assisted living services agency (d) Governing authority of an assistedliving services agency (4) (A) (F) and/or (e) General requirements for an assisted living services agency (1) and/or (f) Personnel policies (1) (A) (iv) and/or (g) Supervisor of assisted living services (2) (A) (B) and/or (h)Nursing Services provided by an assisted living services agency (3) (C) (D) and/or the General Statutes of ConnecticutChapter 378 Section 20-87a (a) and/or (c)and/or (k) Client service record.

1. Based on clinical record review and staff interviewsfor one of one client (Client #1) who received assistedliving services for assistance with personal care, medication management and safety monitoring, the Assisted Living Services Agency (ALSA) failed to conduct an investigation after unwitnessed injuries were identified, failed to notify a Registered Nurse (RN) of a change in condition, failedto revise the plan of care to address behaviors andgoverning authority failed to develop policies to conform to state regulations.

The findings include: a. Client #1 was admitted to the memory care assisted living services agency (ALSA) program on 12/10/2019. The admitting diagnoses included dementia, anxiety disorder and hyperlipidemia. The client service plan dated 11/07/2020 identified the need for the assistance of one caregiver for dressing, bathing,and incontinence care and medication management. The Client was independent with eating, ambulation and transfers.

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Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

On 2/08/2021 at 8:30 AM, LPN #1 was notified by ALSA Aide #1 that Client #1 had a bruise and skin shearing to the right side of the forehead as wellas bruising to the right shoulder. Client #1 was unable to verbalize the cause of the injuries. Interview with LPN #1 on3/10/2021 at 9:45 AM indicated he/she assessed the Client's injuries, notified the spouse and physician but failed to notify the RN on duty. Review of LPN #1's nursesnotes dated 2/08/2021 failed to indicate an RN was notified of the Client's injuries. Client #1's spouse declinedsending the client to the hospital for an evaluation. Interview and review of LPN #1's nurses note dated 2/08/2021with the Supervisor of Assisted Living Services (SALSA) on3/10/2021 at 10:00 AM, failed to identify an investigation was conducted after Client #1 injuries of unknownorigin were observed, failed to identify an RN was notified and/or assessed Client #1's right forehead and shoulder injuries on 2/08/2021, and failed to indicate a policy and/or guideline for investigating injuries of unknown originhad been developed. The Connecticut General Statutes at Chapter 378 Section 20-87a (a) defines the practice of nursing by a registered nurse as, among otherresponsibilities, "the process of diagnosing human responses to actualor potential health problems." The Connecticut General Statutes at Chapter 378 Section 20-872 (c) defines the practice of nursing by a licensed practical nurse as, amongother responsibilities, "the performing of selected tasksand sharing of responsibility under the directionof a registered nurse;

Interview and review of the clinical documentationwith Licensed Practical Nurse #1(LPN) on 3/10/2021 at 11:45 AM, identified the client had a history of decliningpersonal care such as showers, nail care and incontinence care. The client would remove his/her incontinence briefs several times throughout the day/night urinating in his/her closet, on the carpet and mattress. LPN # 1 identified Client #1 would become combative with staff whenproviding personal care. LPN #1 further indicated the client would not allow ALSA staff to move piles of clotheoff the bed, would throw food, cups and napkins on the floor. The housekeeping staff and ALSA Aides would attempt toclean the client's room which would cause Client #1 to become agitated. LPN #1 indicated that the ALSA staff would redirect the client, provide him/her with a quiet environment and slowly re-approach for personal care after time had lapsed. Interview with ALSA Aide #2 on 3/10/2021 at 12:20 PM, identified the client would become agitated when ALSA staff would attempt to provide personalcare and/or cleaning his/her room. ALSA Aide #2 further indicated he/she had attempted to provide personal care to the client the morning of 2/03/2021 whenClient #1 allegedly hit ALSA Aide #2. Interview and review of Client #1's clinical record with the Executive Director on 3/10/2021 at 12:55 PM, failed to identify communication with the physician and family of the need to revisethe plan of care to address behaviors in order to meetthe personal care needs of the client.

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Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

Farmington Station's Plan of Correction for the above outlined findings 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;

- The Community's Incident Report Policy is being revised to include the following:
  - Any staff member who becomes aware of any injury toa resident shall promptly report such injury to the Registered Nurse (RN) on duty, in addition to providing appropriate notification to the resident's family and/or physician;
  - The nurse shall complete an Incident Report (IR) on the injury within twenty-four (24) hours of learning of the injury, and shall providea copy of the IR to the Supervisor of Assisted Living Services (SALSA) upon its completion. Such IR shall include all relevant information about the resident and the injury, including any witnesses to the injury, the resident's accounting of the origin and cause(s) of the injury, and any other known information bearing on the origin and cause(s) of the injury. The RN shall document that they have reviewed the incident report.
  - The IR process shall include the following policy and guidelines for investigating resident injuries of unknown origin: If the injuryis of unknown origin, then the RN or their nurse designee shall promptly undertake an investigation into the injury, which investigation shall include an interview of the resident, interviews of any possible witnesses, caregivers or other persons with possible information about the injury, a review of the resident's plan of care, caregiverassignment sheets, a review of possible environmental factors such as furniture, lighting, etc., and any documents relating to the resident's care and condition. The IR shall conclude with a recitation of the investigatory process, the information discovered, and a conclusion as to the probable cause of the injury or a statement that the cause and origin of the injury remains unknown;
  - If the RN determines that the resident has developed or demonstrated behaviors that are not already known to the resident's physician and family, and are not addressed in the resident's plan of care, then the RN shall notify the physician and family of such behaviors and shall undertake to revise the resident's plan of care accordingly in order to meet the personal care needs of the resident..

(2) the date each such corrective measure or change by the institution is effective;

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Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

- Review the revised Incident Report Policy with the SALSA, all staff RNS, LPNs and other nursing department caregiving staff no later than April 30th, 2021

(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;

- Resident injury Incident Report policy and application of investigation policy and guidelines to be reviewed monthly as part of the community's Quality Improvement Risk Management Program ("QIRM") Committee

(4) the title of the institution's staff member thatis responsible for ensuring the institution's compliance with its plan of correction.

- Compliance with the revised IR policy to be overseen directly by the SALSA, with additional oversight by the Executive Director.

If additional information is needed please do not hesitate to contact me.

Sincerely,

Jessica Ferreira

Jessica Ferreira, RN
Executive Director

Farmington Station
111 Scott Swamp Road
Farmington, CT 06032