STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

June 16, 2022

Albert Mislow, Person-in-Charge
Curtis Home for the Aged, The
380 Crown Street
Meriden, CT 06450

Dear Mr. Mislow:

An unannounced visit was made to Curtis Home for the Aged, The on June 1, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure 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 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 fourteen 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 June 30, 2022.

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.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

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 may be subject to disciplinary action.

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 June 30, 2022 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

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

Respectfully,

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

KEG:lst

c. Mairead Painter, LTC Ombudsman Program

Approved 7/8/22 KEG

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or or (m) Administration of Medications (2)(F)(ii).

1. Based on observations and interviews, the facility failed to ensure the medication room was secured when leaving the room. The findings include:
    a. Observations of the medication room on 6/1/22 at 11:40 AM identified the 7AM-3PM Patient Care Associate (PCA) #1 left the medication room to get keys from another PCA. PCA #1 left the door open while retrieving the keys. Upon return PCA #1 and the House Manager identified that usually a staff member is in the room and if they leave the room, the bottom portion of the top and bottom split door is closed and locked. The House Manager identified the top portion does not have a lock.

POC for Violation 1

1) The Maintenance Director has installed a locking mechanism for the top door.

2) All residents in the home have the potential for the same deficient practice.

3) All staff (PCA, LPN) will be in-serviced on ensuring that a staff member is always present in the medication room or the top and bottom doors are locked.

4) Random weekly audits will be conducted to ensure that a staff member is always present in the medication room or that the door is kept locked. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/15/2022

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(E)(ii)(V).

2. Based on review of the Medication Administration Record, observations, and interviews for one sampled resident (Resident #3) who received a controlled medication, the facility failed to document on the Controlled Drug Receipt/Record/Disposition Form the medication had been administered and to ensure the count was correct. The findings include:
    a. Observations and review of the Controlled Drug Receipt/Record/Disposition Form on 6/1/22 at 11:00 AM identified Resident #3 received Clonazepam 0.5 milligrams twice a day. Upon further review, the Controlled Drug Receipt/Record/Disposition Form identified sixty (60) tablets were received on 5/17/22 and were started to be used on 5/26/22. Review of the bubble pack identified forty-seven (47) tablets and the Controlled Drug Receipt/Record/Disposition Form indicated there were 50 (50) tablets. The form failed to reflect documentation that the Clonazepam had been administered one (1) dose on 5/29/22, two (2) doses on 5/31/22 and one (1) dose on 6/1/22 at 8:00 AM. The Controlled Drug Receipt/Record/Disposition Form identified two (2) tablets had been borrowed on 5/31/22 for another resident. Interview with the House Manager identified the PCA should sign off the medication had been administered.
    Review of the Medication Orders and Administration policy directs the unlicensed personnel will document by signing with initials on the Medication Administration Record for the medications that have been administered on the appropriate date and time section. Borrowing of medications from other residents is not allowed.

POC for Violation 2

1) It was confirmed that Resident #3 did receive the medication that was not signed for.

2) All residents in the home have the potential for the same deficient practice.

3) All staff (PCA, LPN) will be in-serviced on the proper documentation on the Controlled Drug Receipt / Disposition Form to ensure medication was administered and the count is correct. Also that no borrowing of medication is permitted.

4) Random weekly audits will be conducted to ensure that a staff administering controlled medication properly signed the Controlled Receipt / Disposition Record ensuring the medication was administered and the count is correct. Also ensuring that medications are not borrowed between residents. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/16/2022

Albert Mislow, Person-in-Charge
Curtis Home For The Aged, The

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(E)(i).

3. Based on review of the Medication Administration Records, and interviews for one sampled resident (Resident #2) who had a Visiting Nurse Agency pre-pours medications for the week, the facility failed to have a list of the resident's medications and physician's orders for the medication. The findings include:
    a. Review of Resident #2's May 2022 Medication administration Record identified Resident #2 received two (2) medications Sucralfate 10 milliliter and Restasis 0.05 milligrams one (1) drop each eye two (2) times a day. Interview with the 7AM-3PM Patient Care Associate (PCA) #1 and the House Manager on 6/1/22 at 12:00 PM identified a Visiting Nurse Agency comes in once a week to pre-pour Resident #2's medications and although the facility has requested multiple times a Medication Administration Record or list of medications from the agency, the agency has not provided the facility with either one.

POC for Violation 3

1) The Homecare Agency was notified and a list of medications was provided. The facility pharmacy prepared an MAR and Physician's Order Sheet based on this list.

2) All residents in the home have the potential for the same deficient practice.

3) All staff (PCA, LPN) will be in-serviced on regarding ensuring that residents who have medications pre-poured or administered by a homecare agency have a medication list / MAR / Physician Orders in place.

4) Random weekly audits will be conducted to ensure that a residents who have their medications administered or pre-poured by a Homecare agency staff have a medication list / MAR / Physician's Order in place. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/15/2022

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (2)(E)(ii)(V).

4. Based on review of the Medication Administration Record, observations, and interviews for two sampled residents (Resident #1 and #2), the facility failed to document on the Medication Administration Record at the time the medications had been administered. The findings include:
   a. Interview and review of Resident #1's June 2022 Medication Administration Record with the 7AM-3PM Patient Care Associate (PCA) #1 on 6/1/22 at 11:42 AM identified the 8:00 AM medications, Lipitor, Metoprolol, Lasix, Lisinopril, Lantus Insulin and Metformin were not signed off as being administered. PCA #1 explained Resident #1 comes down to the dining room early in the morning around 6:00 AM so the 11PM-7AM Patient Care Associate administers the medication. Subsequent to the observation the House Manager contacted the 11PM-7AM Patient Care Associate and verified the medications had been administered.

   Observations of the medication administration on 6/1/22 at 11:50 AM identified Resident #2 received Sucralfate 10 milliliter and Restasis 0.05 milligrams one (1) drop each eye two (2) times a day. Review of the May 2022 Medication Administration Record identified Sucralfate 10 milliliters by mouth three times a day and there was no documentation for fifty-seven (57) out of ninety-three (93) occasions that the Sucralfate had been administered.

POC for Violation 4

1) It was confirmed that Residents # 1 and # 2 received their medication as ordered.

2) All residents in the home have the potential for the same deficient practice.

3) All staff (PCA, LPN) will be in-serviced on the proper documentation on the MAR at the time medications are administered.

4) Random weekly audits will be conducted to ensure that proper documentation on the MAR is done after medication is administered. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/15/2022

Albert Mislow, Person-in-Charge
Curtis Home For The Aged, The

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

5. Based on review of facility documentation and interviews, the facility failed to ensure monthly resident council meeting were conducted. The findings include:
   a. Review of the resident council meeting minutes provided by the House Manager identified the last meeting was held on 9/9/21. Interview with the House Manager on 6/1/22 at 11:15 AM identified although meetings were conducted monthly prior to COVID, the residents have not held a meeting for a while.

POC for Violation 5

1) A Resident Council Meeting with the RCH residents is scheduled for 6/30/2022 and then monthly.

2) All residents in the home have the potential for the same deficient practice.

3) The Social Worker will be responsible for holding the monthly meetings, documenting the minutes and the follow through of any concerns / issues.

4) Monthly audits will be conducted to ensure that a Resident Council Meeting was held, minutes documented and any concerns / issues addressed. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/15/2022

Albert Mislow, Person-in-Charge
Curtis Home For The Aged, The

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b)Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

6. Based on observations and interviews for one sampled resident (Resident #4), the facility failed to ensure the resident did not burn incense and candles in the room. The findings include:
    a. Observations during the tour of resident rooms with the Administrator on 6/1/22 identified Resident #4 had been burning incense and candles. Candle wax drippings and ashes were noted on the floor and furniture. Interview with the Administrator identified he was not aware of Resident #4's practice.

POC for Violation 6

1) The incense and candles were removed from Resident # 4 room with his permission.

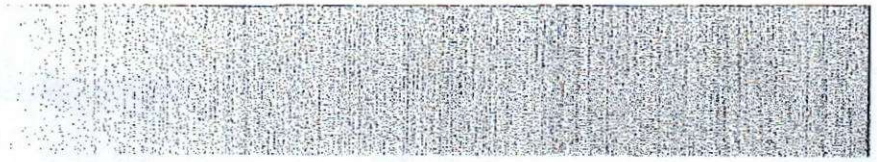
2) All residents in the home have the potential for the same deficient practice.

3) A meeting with the RCH residents and Staff will be held to educate on the dangers of burning incense and candles in one's room and possible alternatives. Staff will perform weekly inspections of resident rooms (with resident permission) to ensure residents are not burning candles, incense, etc., placing the home and other residents at the risk of a fire.

4) Random weekly audits will be conducted to ensure that residents are not burning incense or candles in their rooms. Audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

5) The DNS and or designee will be responsible for the monitoring of this plan or correction.

6) Completion Date: 7/15/2022



The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b)Physical Plant (2)(S) and/or (c) Administration (1) and/or (c) Administration (5).

7. Based on observations and interviews, the facility failed to maintain a clean, comfortable, and homelike environment. The findings include:
   a. Observations on 6/1/22 upon entrance at 9:30 AM and during the tour of the facility with the Administrator and a Maintenance staff member identified worn and stained carpets, chipped, marred, and damage walls, damaged and peeling wallpaper throughout the facility, the radiators in the second and third floor bathrooms the paint was peeling off and rust was noted.
   In Room 203, there was an abundance of personal items being stored restricting the ability of the resident to exit the room in the case of an emergency as required by the 2018 "Connecticut State Fire Safety and Prevention Codes". Interview with the Maintenance staff member identified environmental rounds are conducted monthly and there is a maintenance log.

POC for Violation 7

1) Monthly rounds will be conducted to ensure that any worn or stained carpets, chipped , marred, and damaged walls, damaged and peeling wall paper, and rusted pipes and radiators are documented for repair, replacement or painting.

2) All carpets in the common areas will be cleaned by 7/30/2022 – Director of EVS and or Administrator responsible.

3) Pricing will be obtained to replace or remove existing carpeting in 6 phases if funding becomes available. Pricing will be obtained by 7/30/2022 - Administrator and or designee responsible.

4) Entry way, Phase One by 9/30/2022
   Second floor hallway, Phase Two by March 2023
   Third floor carpeting, Phase Three by August 2023

5) All areas of walls that are damaged, marred and peeling will be noted. These areas will be primed in 4 phases:
   Entry way and 2 lounges, Phase One – 7/30/2023 – Director of EVS and Administrator responsible
   Dining Room, Phase Two – 8/30/2023 – Director of EVS and Administrator responsible
   Sitting Room, Phase Three – 9/30/2023 - Director of EVS and Administrator responsible
   Chapel, Phase Four – 10/30/2023 - Director of EVS and Administrator responsible
   2nd Floor Hallway, Phase Five – 11/30/2023 - Director of EVS and Administrator responsible
   3rd Floor Hallway, Phase 6 – 1/30/2024 - Director of EVS and Administrator responsible

6) All the above areas will receive a final coat of paint when funding is available.

7) Room 203 personal items that were being stored have been removed – completion date: 6/30/2022

8) All residents have been made aware of the dangers of having large quantities being stored in their rooms.

9) Monthly rounds will be conducted and all rooms will be checked (with resident's permission) that large quantities of personal items are not being stored. Some rooms may have items that we are unaware of because permission to enter the room was not granted. Completion date: 7/14/2022 – Director of EVS and Administrator responsible.

Albert Mislow, Person-in-Charge
Curtis Home For The Aged, The

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b)Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

8. Based on observations, review of facility documentation and interviews, the facility failed to ensure the emergency lighting was tested monthly and fire drills were conducted in accordance with the State of Connecticut Fire Safety Code and the National Fire Protection Association. The findings include:
    a. Documentation was not provided to the surveyor from the facility to indicate that the emergency lighting was tested monthly for thirty (30) seconds or annually for ninety (90) minutes as required.
    Documentation was not provided to the surveyor from the facility to indicate the fire drills were being completed as required. i.e., there were no records that first shift fire drill was completed in the first quarter of 2022, a third shift fire drill was completed in the fourth quarter of 2021, a second shift fire drill was completed in the fourth quarter of 2021, and a first shift fire drill was completed in the fourth quarter of 2021.

POC for Violation 8

1) The documentation for emergency lighting and fire drills have been acquired from the vendor that provided the services. Completion Date: 6/30/2022 - Director of EVS and Administrator responsible

2) The binders that the documentation needs to be maintained in will be reviewed and approved monthly for 6 months. Completion date: 7/6/2022 - Director of EVS and Administrator responsible

3) The Director of EVS, Maintenance Staff, RCH Nurse Manager will be educated on the importance of timely inspections and proper filing of paperwork.

4) The Director of EVS and Administrator will be responsible for the monitoring of this plan or correction.

5) Completion Date: 7/15/2022