Approved
9/30/19
KEG

September 6, 2019

[redacted]
Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capitol Avenue, P.O. Box 340308
Hartford, CT 06134-0308

Re: Southmayd Home, Inc. Licensure Inspection Corrective Action Plan

[redacted]

Below is the corrective action plan in response to the findings as a result of the unannounced visit on July 16 and 22, 2019. The corrective action plan includes responses for the eight (8) components listed in your letter dated August 28, 2019. Southmayd Home will make every effort to ensure all violations are corrected and prevented from future occurrences.

1. *Based on observations and interviews, the facility failed to provide housekeeping and maintenance repairs to ensure the environment was clean, comfortable, and homelike. The findings include:*
    a. *During tour of the facility on 7/16/19 identified the following maintenance repairs and/or housekeeping needs: In room #13 the bulb in the wall night light fixture was burnt out; rooms #6 and #31 had a strong smell of urine throughout the rooms; in the hall pink toilet bathroom on the first floor there was no cover to ceiling light fixture therefore the exposed mercury bulb was exposed; in the bathroom/tub/shower on the second floor there was grime on the tub floor and there were stains on the white shower curtain; room #23 the carpet needed to be vacuumed; in two (2) hall bathrooms on the second floor and the pink bathroom on the first floor, there was an accumulation of dirt and dust on the ceiling vent; in the pink bathroom/shower room next to room #9 the ceiling light fixture had no cover; rooms #14 and #15 there were no covers on the night lights and rooms #15 night light was not working; in the kitchen neat the dish wash area, there was a large hole in the ceiling sheetrock located over the employee's wash sink, there was a six (6) plug power strip tied to the pipe wall outlet outside of the dishwashing machine area and neat the compartment sink and trash compose*

area. Interview with the maintenance staff identified that repairs are reported verbally and there was no repair log to view. Interview with the person-in-charge and the maintenance staff identified there was no written housekeeping and/or maintenance schedule and/or log to show when the residents rooms, bathrooms, lounges were to be cleaned and/or what needed to be repaired and/or when repairs were completed.

Plan of Correction: The night light bulb in room #13 has been replaced by the maintenance assistant on 9/6/19. The rugs in rooms #6 an #31 will be professionally cleaned by 9/15/19. A cover has been placed on the ceiling light fixture in the hall pink bathroom on the first floor by the maintenance coordinator on 9/6/19. The grime from the tub floor in all bathrooms has been cleaned by the maintenance assistant on 9/6/19, new shower curtains have been ordered to replace the stained curtains. They will be hung by 9/15/19. The carpet is vacuumed in room #23 on a weekly basis. The dirt and dust on the ceiling vent in the second floor and the pink bathroom on the first floor have been cleaned by the maintenance assistant on 9/6/19. A ceiling light fixture cover has been added to the bathroom located next to room #9 on 9/6/19 by the maintenance coordinator. New night lights have been placed in rooms #14 and #15 by the maintenance assistant on 9/6/19. The large hole in the ceiling sheetrock located over the employee's wash sink will be fixed by the maintenance coordinator by 9/15/19. The Six (6) plug power strip tied to the pipe wall outlet outside of the dishwashing machine area and near the compartment sink and trach compose area was removed by the inspector on 7/16/19. Housekeeping and maintenance have been reminded of safety standards at the 9/5/19 department meeting. These violations were also reviewed with maintenance and housekeeping staff at the 9/5/19 department meeting to prevent future similar violations. There is a repair maintenance log book staff use to report repairs needed. The maintenance coordinator checks off the repairs as they have been completed. The maintenance assistant receives his orders for work through the maintenance coordinator on a day to day basis. The maintenance assistant has been made aware of the log book for future reference. Housekeeping maintains a Spring-cleaning log of all resident rooms. Spring cleaning occurs annually. A weekly log schedule will be created to show when resident rooms, bathrooms, lounges, are to be cleaned/have been cleaned by 9/30/19 by the executive director.

2. *Based on observations and interviews, the facility failed to each room had a room number posted by each door. The findings include:*
    a. *During tour of the facility on 7/6/19 identified that there were no room numbers posted by the entrance of doors of rooms #1 and #2.*

Plan of Correction: The recreation coordinator hung room numbers for the rooms identified in this violation on 7/17/19. The room numbers are 33A and 33B for the rooms identified.

3. *Based on review of personnel files and interviews, the facility failed to conduct reference and background checks prior to hiring an individual. The findings include:*
    a. *Review of personnel files identified for staff person #2, date of hire 3/18/19, the file failed to reflect documentation a background check was conducted, staff person #4, date of hire 4/29/19, failed to reflect that an application was completed and staff persons #1, #6, and #9 failed to reflect that reference checks had been obtained during the hiring process. Interview with the assistant on 7/16/19 identified there was no documentation to verify that applications, reference checks and background checks were completed during the hiring process.*

    Plan of Correction: A background check submission was not completed for staff person #2 previously to being hired through the DPH ABCMS system. An application was started and then it was withdrawn by mistake. The employee was previously fingerprinted by a former employer and was still within the eligibility guidelines for hire through the ABCMS system at the time of hire without having to complete another background check. The employee is now outside of the timeframe and will need to go through the background process from the beginning. A new application was submitted, and fingerprints will be completed by 10/4/19. A copy of the background check will be placed in the employee's file by the executive director. Staff person #4 completed an employment application and it has been placed in the personnel file. Verbal reference checks were conducted for staff persons #1, #6, and #9 by the executive director prior to employment. All future reference checks for new hires will be documented on the reference check form and placed in the employee file by the executive director.

4. *Based on review of personnel files and interviews, the facility failed to conduct annual in-services on general safety, emergency procedures, resident rights and / or the policies and procedures. The findings include:*
    a. *Review of staff person #8's personnel file failed to reflect documentation mandator in-services on general safety, fire safety, emergency procedures and resident rights were completed in 2018. Interview with the assistant identified that there was no documentation to verify staff person #8 attended and completed mandatory in-services in 2018.*

Plan of Correction: Staff person #8 will participate in all future staff trainings including but not limited to general safety, fire safety, emergency procedures and resident rights.

5. *Based on observations, record review ad interviews, the facility failed to ensure that the fire alarm system, smoke detectors, and fire extinguishers were tested and serviced semi-annually according to the State of Connecticut Fire Safety Code requirements. The findings include:*
    a. *During tour of the facility on 7/16/19 identified on two (2) fire extinguishers on near room 12 and the other near room 14, had no service tags to reflect when the extinguishers were checked. Review of the facility records on 7/16/19 and 7/22/19 failed to reflect documentation that the fire alarm system and smoke detectors were serviced semiannually. The records indicated the dire alarm system and smoke detectors were last serviced on 10/8/18 by a contracted company. Interview with the person-in-charge identified the fire alarm system and smoke detectors were not serviced semiannually.*

    Plan of Correction: Southmayd's contracted fire vendor placed tags on the two (2) fire extinguishers near room 12 and room 14 on 9/6/19. The inspection tags reflect when the smoke detectors were serviced. The contracted company responsible for inspecting the fire alarm system and smoke detectors has been contacted by the executive director and the agreement will be revised to include semiannual inspections of the fire alarm system and the smoke detectors starting in FY 2020.

6. *Based on record review and interviews, the facility failed to ensure that the generator was tested monthly and/or serviced semi-annually and monthly according to the State of Connecticut Fire Safety Code requirements. The findings include:*
    a. *Review of the facility records on 7/16/19 and 7/22/19 failed to reflect documentation that the generator system was serviced semiannually and/or monthly full load testing was completed, the records indicated the last full load test was done in January 2019. Interview with the person-in-charge and the maintenance staff identified there were unable to provide documentation to show that the generator system was serviced semiannually, and full load testing was done monthly.*

    Plan of Correction: Full load testing will be completed monthly by the maintenance coordinator and results will be documented on a spreadsheet starting October 1, 2019. The generator will be serviced semiannually by an outside vendor and service records will be kept on file for review starting October 1, 2019.

7. *Based on observations and interview, the facility failed to ensure there was a three (3) day supply of food in the dry storage. The findings include:*
    a. *Observations of the dry food storage area failed to reflect a three (3) day supply.*

    Plan of Correction: A three (3) day supply of dry food has been implemented since 7/23/19 by the kitchen supervisor.

8. *Based on observations and interview, the facility failed to ensure thermometers were located in refrigerators. The findings include:*
    a. *Observations on 7/16/19 in the kitchen identified there were eight (8) food items that belonged to staff to be stored in the main refrigerator. In addition, there were food items that were not labeled and/or dated. Further observations, a large separate refrigerator was noted in the employee break room for staff fuse. The refrigerator with attached freezer located in the basement did not have a thermometer inside the refrigerator and/or freezer.*

    Plan of Correction: Staff food items will be kept in the staff provided refrigerator located in the staff break room effective immediately and monitored by the kitchen supervisor. The kitchen supervisor will monitor and enforce all food items labeled and dated effective immediately. Thermometers will be purchased and placed inside the refrigerator and freezer located in the basement by the kitchen supervisor by 9/15/19.

Please do not hesitate to contact me should you have any questions or concerns. Thank you.

Sincerely,

Kara Cunningham, MPH
Executive Director
(p) (203) 754-0360
(f) (203) 753-1761
kvendetti@southmayd.com

Cc: File

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

August 28, 2019

Kara Vendetti, Person-in-Charge
Southmayd Home, Inc.
250 Columbia Boulevard
Waterbury, CT 06710

Dear Ms Vendetti:

Unannounced visits were made to Southmayd Home, Inc. on July 16 and 22, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting 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 visits.

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 September 11, 2019.

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 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 September 11, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

DATES OF VISIT: July 16 and 22, 2019

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

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

Respectfully,

Karen Gworek, RN

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

SNC:NC:

c. Mairead Painter, LTC Ombudsman

DATES OF VISIT: July 16 and 22, 2019

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 (S) and/or (c) Administration (1) and/or (h) General Conditions (6).

1. Based on observations and interviews, the facility failed to provide housekeeping and maintenance repairs to ensure the environment was clean, comfortable, and homelike. The findings include:
   a. During tour of the facility on 7/16/19 identified the following maintenance repairs and/or housekeeping needs: In Room #13 the bulb in the wall night light fixture was burnt out; Rooms #6 and #31 had a strong smell of urine throughout the rooms; in the hall pink toilet bathroom on the first floor there was no cover to ceiling light fixture therefore the exposed mercury bulb was exposed; in the bathroom/tub/shower on the second floor there was grime on the tub floor and there were stains on the white shower curtain; Room #23 the carpet needed to be vacuumed; in two (2) hall bathrooms on the second floor and the pink bathroom on the first floor, there was an accumulation of dirt and dust on the ceiling vent; in the pink bathroom/shower room next to Room #9 the ceiling light fixture had no cover; Rooms #14 and #15 there were no covers on the night lights and Room #15's night light was not working; in the kitchen near the dish wash area, there was a large hole in the ceiling sheetrock located over the employee's wash sink, there was a six (6) plug power strip tied to the pipe wall outlet outside of the dishwashing machine area and near the compartment sink and trash compose area. Interview with the Maintenance Staff identified that repairs are reported verbally and there was no repair log to review. Interview with the Person-in-Charge and the Maintenance Staff identified that there was no written housekeeping and/or maintenance schedule and/or log to show when the resident rooms, bathrooms, lounges were to be cleaned and/or what needed to be repaired and/or when repairs were completed.

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

2. Based on observations and interviews, the facility failed to each room had a room number posted by each door. The findings include:
   a. During tour of the facility on 7/16/19 identified that there were no room numbers posted by the entrance doors of Rooms #1 and #2.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4).

3. Based on review of personnel files and interviews, the facility failed to conduct reference and background checks prior to hiring an individual. The findings include:
   a. Review of personnel files identified for Staff Person #2, date of hire 3/18/19, the file failed to reflect documentation a background check was conducted, Staff Person #4, date of hire 4/29/19, failed to reflect that an application was completed and Staff Persons #1, #6, and #9 failed to reflect that reference checks had been obtained during the hiring process. Interview with the

DATES OF VISIT: July 16 and 22, 2019

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

Assistant on 7/16/19 identified there was no documentation to verify that applications, reference checks and background checks were completed during the hiring process.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4)(B).

4. Based on review of personnel files and interviews, the facility failed to conduct annual in-services on general safety to include fire safety, emergency procedures, resident rights and /or the policies and procedures. The findings include:
   a. Review of Staff Person #8's personnel file failed to reflect documentation mandatory in-services on general safety, fire safety, emergency procedures and resident rights were completed in 2018. Interview with the Assistant identified that there was no documentation to verify Staff Person #8to attended and completed mandatory in-services in 2018.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical plant (S) and/or (c) Administration (1) and/or (h) General Conditions (9).

5. Based on observations, record review and interviews, the facility failed to ensure that the fire alarm system, smoke detectors, and fire extinguishers were tested and serviced on a semi-annually according to the State of Connecticut Fire Safety Code requirements. The findings include:
   a. During tour of the facility on 7/16/19 identified on two (2) fire extinguishers one near Room 12 and the other near Room 14, had no service tags to reflect when the extinguishers were checked. Review of the facility records on 7/16/19 and 7/22/19 failed to reflect documentation that the fire alarm system and smoke detectors were serviced semiannually. The records indicated the fire alarm system and smoke detectors were last serviced on 10/8/2018 by a contracted company. Interview with the Person-in-Charge identified the fire alarm system and smoke detectors were not serviced semiannually.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical plant (S) and/or (c) Administration (1) and/or (h) General Conditions (9).

6. Based on record review and interviews, the facility failed to ensure that the generator was tested monthly and/or serviced semi-annually and monthly according to the State of Connecticut Fire Safety Code requirements. The findings include:
   a. Review of the facility records on 7/16/19 and 7/22/19 failed to reflect documentation that the generator system was serviced semiannually and/or monthly full load testing was completed, the records indicated the last full load test was done in January 2019. Interview with the Person-in-Charge and the Maintenance Staff identified they were unable to provide documentation to show that the generator system was serviced semiannually and full load testing was done monthly.

DATES OF VISIT: July 16 and 22, 2019

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 (H)(10)(c) and/or (c) Administration (1).

7. Based on observations and interview, the facility failed to ensure there was a three (3) day supply of food in the dry storage. The findings include:
   a. Observations of the dry food storage area failed to reflect a three (3) day supply.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Service (1).

8. Based on observations and interview, the facility failed to ensure thermometers were located in refrigerators. The findings include:
   a. Observations on 7/16/19 in the kitchen identified there were eight (8) food items that belonged to staff to be stored in the main refrigerator. In addition there were food items that were not labeled and/or dated. Further observations, a large separate refrigerator was noted in the employee break room for staff use. The refrigerator with attached freezer located in the basement did not have a thermometer inside the refrigerator and/or freezer.