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

July 30, 2019

Laverne Jarrett, Person-in-Charge
Scofield Manor
614 Schfieldtown Road
Stamford, CT 06903

Dear Ms Jarrett:

An unannounced visit was made to Scofield Manor on March 14, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a complaint 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.

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 August 13, 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.

DATE OF VISIT: March 14, 2019

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 August 13, 2019 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 (860) 509-7400.

Respectfully,

Karen Gworek, RN

Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:lst

c. Mairead Painter, LTC Ombudsman

CT #24003, #25026

DATE OF VISIT: March 14, 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 (m) Administration of Medications (D)(iv) and/or (c) Administration (1).

1. Based on clinical record reviews and interviews for two of three sampled residents (Resident #1 and Resident #4) who were reviewed for medication administration, the facility failed to administer a medication in accordance with the physician's order. The findings include:
   a. Resident #1's diagnoses included depression, bipolar disorder, anxiety, chronic pain and hyperthyroidism. A physician's order directed to administer Buprenorphine 2 milligrams (mg) sublingual give one half tablet tab (1mg) and dissolve under the tongue two (2) times per day at 10:00 AM and 6:00 PM. Review of the April 2018 Medication Administration Record identified that on 4/26/18 the 10:00 am dose was given at 8:00 AM, two hours earlier then the scheduled time, and was administered orally and not sublingual as ordered. The physician's order dated 4/26/18 directed to administer another dose of Buprenorphine sublingually now and to continue the one-half tablet sublingual twice a day. Review of the Controlled Substance Disposition Record identified on 4/27/18 Buprenorphine 3mg (1 and 1/2 tabs) was administered instead of 1mg (1/2 tab). Facility documentation identified on 4/27/18 Resident #1 had changes in mental status, slurred speech and difficulty staying awake, 911 was called and Resident #1 was transported to the hospital at 4:20 PM. The hospital discharge summary dated 5/4/18 identified that Resident #1 presented to the emergency department obtunded, hypoxic and in hyper-carbic respiratory failure due to over-medication. The summary indicated the respiratory failure was most likely secondary to new medications Buprenorphine in addition to an increased frequency of Risperidone. Interview with the Nursing Supervisor, Registered Nurse (RN) #1 on 3/14/19 at 10:00 AM identified she did became aware of the medication error when Resident #1's medications were destroyed on 8/7/18 after the resident had been discharged from the facility on 5/31/18.
   b. Resident #4's diagnoses included schizophrenia, asthma and hypertension. A physician's order dated 2/6/18 directed to administer Lorazepam 1mg tablet, take two (2) tabs (2mg) twice a day at 7:00 AM and 5:00 PM, there are two (2) tablets in each bubble of the medication package. The Reportable Event Form dated 3/1/18 at 5:00 PM identified Resident #4 had received four (4) tablets of Lorazepam 1 mg instead of two (2) tablets. Resident denied any negative effect and the doctor was notified on 3/4/18. Interview with RN #1 on 3/14/19 at 10:00 AM identified that when questioned, the staff attendant stated she was confused by the instructions. Review of facility policy failed to address staff's responsibility to obtain clarification when there was confusion with medication orders.

DATE OF VISIT: March 14, 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 (c) Administration (1).

2. Based on clinical record reviews, facility documentation and interviews for one of three sampled residents (Resident #1) reviewed for medication errors, the facility failed to notify the pharmacy to provide medication in a dosage that would be easily administered and prevent a medication error. The findings include:
   a. Resident #1's diagnoses included depression, bipolar disorder, anxiety, chronic pain and hyperthyroidism. A physician's order directed to administer Buprenorphine 2 milligrams (mg) sublingual give one half tablet tab (1mg) and dissolve under the tongue two (2) times per day at 10:00 AM and 6:00 PM. Review of facility documentation identified that on 4/25/18 and 4/26/18, the Nursing Supervisor, Registered Nurse (RN) #1 instructed staff that the Buprenorphine tablets needed to be cut in half at each medication pass and that the tabs are to be cut with a pill cutter and given under the tongue for Resident #1. Review of the medication administration policy failed to reflect documentation related to the procedure on preparing and administering medications to obtain a dose that was not commercially available. Interview with RN #1 on 3/14/19 at 10:00 AM identified she could not remember how the pills were packaged and/or if they were scored. RN #1 stated she did not think to ask the pharmacy to send half tabs and was trying to follow the physicians order.

SCOFIELD MANOR 614 Scofieldtown Rd, Stamford CT 06903 203.329.2388 Fax:203.329.2609

9/10/19 KEG

To: [redacted]

From: Lavern Edwards

Date: August 20, 2019

RE: Response to Scofield Manor March 14, 2019 Violations

1. Based on clinical record reviews and interviews for two of three sampled residents (Resident #I and Resident #4) who were reviewed for medication administration, the facility failed to administer a medication in accordance with the physician's order.

Response: 1A.

Incident #1 for Buphrenorphine –

- Date of Correction April 26, 2018.
- Corrective Action - written and verbal warming was given Medical Technician. She was also reminded to pay close attention to all changes in medication and the importance of carefully reading the MAR.

Incident # 2 for Buphrenorphine –

- Date of correction August 7, 2018
- Corrective Action include – Firm verbal warning was communicated to Medication Technician who was reminded every label must be read carefully and the serious side effect an oversight may cause.

Note: Nurse Manager was unaware the incident occurred until after the discharge of the resident while preparing to destroy the unused medicine with the off-site medical agent. We fully recognize that medication errors were made and realize it can lead to severe consequences, it is however note-worthy to explain the on-going abuse the staff endured with this particular resident. She was frequently difficult, demanding medications when desired, verbally abusive to staff and residents, threatening and frequently caused commotion in the medication room. Over time, this behavior became anxiety producing for the Medical Technician who was attempting to administer medication to the resident.

2. Based on clinical record reviews, facility documentation and interviews for one of three sampled residents (Resident #1) reviewed for medication errors, the facility failed to notify the pharmacy to provide medication in a dosage that would be easily administered and prevent a medication error.

Response: 2A.

- Date of Correction August 15, 2019
- Corrective Action – Verbal warning was given to Medical Technician who was instructed to ask questions when in doubt to Nurse Manager, LPN or Senior Medical Technician before administering medication.
- Policy was put in place stating all Medical staff in the facility must make every effort to have the pharmacy package all medicine in the correct dosage.

- Policy will become effective August 15, 2019 and will include an addendum. Staff continues to be instructed to check medication against MAR. Also, all controlled substance must be counted before and after administration. Medical Technicians are also informed to immediately notify the Nurse Manager or the LPN in the event of a medication error. In addition, residents are encouraged to use the facility pharmacy of choice to fill all medications, as they are familiar with the facility's medication policy which states "only pharmacy personnel are authorized to cut narcotics".

- As a result of the resident making an independent decision to use an outside pharmacy (Walgreens) to fill script, the dosage was packaged incorrectly. As a precautionary measure, Nurse Manger will continue to ensure all transportation forms include the pharmacy telephone/fax numbers allowing ease in locating pharmacy of choice.