# STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

August 24, 2022

Lucille Bowen, SALSA
Saybrook At Haddam
1556 Saybrook Road, Route 154
Haddam, CT 06438
Via e:mail:LBowen@thesaybrookathaddam.com

Dear Ms. Bowen:

An unannounced visit was made to Saybrook At Haddam on August 3, 2022 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 was 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 September 3, 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.

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 violation and you may be provided with the opportunity to be heard. If the violation is not responded to by September 3, 2022 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail.

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

Respectfully,

Elizabeth T. Heiney BS RN BC

Elizabeth Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

EH:lst

CT #32617

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of an assisted living services agency (4) (A) and/or (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living services agency (4)(A) and/or (i) Assisted living aide services provided by an assisted living services agency (5)(B) and/or (j) Assisted living services agency staffing requirements (5).

1. Based on a review of clinical records, agency documentation, staff interviews and policy reviews, for five of five Clients (Client #1 and #2) in the survey sample, the agency failed to administer medications in a manner to prevent medication errors, failed to document Clients' statuses subsequent to medication errors, failed to conduct a complete investigation subsequent to a medication error and failed to ensure adequate staffing to meet a Client's needs. The finding includes:

    a. Client #1 had a move in date of 03/17/2021 to a traditional assisted living floor. The Client's diagnosis included high blood pressure, heart disease, congestive heart failure and atrial fibrillation. The Client's service plan dated 03/13/2022 identified the Client required Assisted Living Service Agency (ALSA) aide assistance for showering, medication cues twice daily by the ALSA aides and housekeeping.

        i. Interview and review of Client #1's incident report with the Registered Nurse (RN) Designee on 08/02/2022 at 11:30 AM, identified that on 06/28/2022, an Advanced Practitioner Registered Nurse (APRN) evaluated the Client and made changes to the medication profile. Thereafter, the RN Designee reviewed the new order and the pre-packaged medications in Client #1's medication box. Upon review the RN Designee, identified that another Client's pre-packaged medication card containing Abilify (an antipsychotic medication) was present in Client #1's medication box and subsequently Client #1 had been given two (2) doses of Abilify by the nurse. The RN Designee failed to identify how another Client's medication card was present in Client #1's medication box and why the medication was administered to Client #1. Additionally, the agency nurses failed to document the Client's status every shift for 48 hours after the medication error occurred in accordance with the ALSA's medication error policy.

    b. Client #2 had a move in date of 05/24/2022 to the memory care unit. The Client's diagnosis included dementia, depression, high blood pressure and high cholesterol. The Client's service plan dated 05/27/2022 identified that the Client required medication administration by a nurse, had a self-care deficit requiring ALSA aide assistance for all activities of daily living and mobility including assistance with ambulation.

        ii. Interview and review of Client #2's incident report dated 07/13/2022 with the SALSA on 08/01/2022 at 10:40 AM, identified on 07/13/2022, Licensed Practical Nurse (LPN #1) called out for the 07:00 AM-3:00 PM shift and a 07:00 AM-11:00 AM LPN for the memory care unit was not

scheduled. Therefore, on 7/13/22, the SALSA was the only nurse responsible for medication administration for the ALSA Clients until the RN designee reported to work at 9:30am. On 07/14/2022, LPN #2 identified Client #2's medications for 07/13/2022 were not administered. The SALSA identified her failure to administer Client #2's medications was a result of inadequate nursing staff on 07/13/2022. The SALSA indicated that the expected staffing for the 07:00 AM-3:00 PM shift was a SALSA, RN Designee, one (1) LPN for the traditional ALSA and a half-shift LPN (07:00 AM-11:00 AM) for the memory care unit, as well as a total of five (5) to six (6) ALSA aides. Additionally, the SALSA failed to identify clinical documentation of the Client's status every shift for 48 hours after the medication error occurred in accordance with the ALSA's medication error policy.

Review of the agency's policy for Medication Errors, identified a medication error is defined as the wrong medication, wrong person, wrong dose, wrong route, wrong time, missed doses and not initiating an order. The policy further identified medications were to be handled in a manner that minimizes the risk of medication error. Should a medication error occur clinical documentation on the Client's status in the clinical record would occur during every shift for 48 hours after a medication error.

**Plan of Correction to Violation #1:**

POC accepted 9.12.22
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The ALSA acknowledges that medication errors were made to Client #1 and Client #2.

We seek first to clarify findings in the written violation as related to Client #1:

The violation reads in part, "… and subsequently Client #1 was given two (2) doses of Abilify by the nurse". This is incorrect as this resident received medication cues from the RCA per her Service Plan. Upon investigation by the RN Designee, it was determined that the medication was delivered to the community in the afternoon and the Day nurse signed for its delivery. The evening nurse, per protocol, was supposed to deliver the medication to the resident's Medication Box but could not recall if she had personally done so or asked an Aide. No Aides could recall delivering the medication; hence it was unable to be determined who delivered the medication card to the wrong patient's Medication Box. The two CNAs who had cued the medication to the resident were both later identified and were given verbal counsel. We also hold the nurse responsible for this event and verbal counsel was provided to this nurse. Additionally, a written In-Service was provided to all nurses and RCAs. Copies of the Written In-service were previously provided to the DPH Representative.

Plan Of Correction to Violation #1:

Measures implemented to prevent recurrence of these errors:

1) The ALSA has initiated a new protocol that as interim medications are delivered by the pharmacy, the carbon copy with the receiving nurse's signature will be kept with the medication and then signed again by the nurse delivering the medication to the Resident's Medication box. This doubly signed carbon copy will be filed in a Folder titled "Medication Delivery Receipts" for a minimum of one (1) month. These carbon copies will be maintained in an alphabetically labeled folder located in the Wellness office
2) The ALSA has created an internal document that we have

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9.8.22
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saved under the title "Safe Harbor Medication Reference Sheet" which lists all Memory Care Residents by name, Apartment # and times that they receive medications. A copy of the document, minus the residents' full names and details is attached for your review.

3) Documentation of Medication errors will be reviewed by the SALSA/Designee each shift and a Summary RN note will be added to the record at the end of the 48-hour period.

These changes are effective September 7th, 2022.
The Quality Control Committee will be presented with these tools at our next meeting and the Minutes of the Meeting will include annotations explaining why and attaching samples of documents used to ensure better compliance.

Lucille Bowen, RN SALSA
September 7, 2022.

POC accepted 9.12.22
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# If only one nurse check Task Book for AL meds Date:9/4/22

| Evenings | | Times |
|---|---|---|
| John Z ENSURE cue by RCAs | 198 | 8am 8pm |
| Leanore Z **Ensure cue by RCAs** | 198 | 8am 8pm |
| Janice L | 199A | 8am 8pm |
| Gary L | 199-B | 8am 5pm 8pm |
| Caroline C. ncs | 1000-A | 8am 5pm |
| Virginia B. Crush/Pureed/thin liquids Ensure | 1000-B | 8am |
| Susanne B. (Continuous O2 @2L at night via concentrator) | 1001-A | 8am 8pm/ cue Flovent inhaler |
| | 1001-B | |
| Robert C. | 1003-B | 8am 8pm |
| Robert T. New Diet orders on 4/7 Soft Bite-sized High Moisture. CRUSH MEDS GIVE IN APPLESAUCE ncs LACTAID W/ EACH MEAL **MLOA** | 1004A | |
| | 1004B | |
| Theodore (Ted) K. | 1005 | 4pm tears ____ 6:30pm meds & tears |
| Page W. Nectar Thick, Pureed diet | 1006A | 6am 12N 6pm 12 MN |
| Doris W. MLOA | 1006B | |
| Jean H. | 1007 | 8am 8pm |
| Joyce D. | 1008A | 8am 4pm |
| | 1008B | |
| Harriet (Betty) Byrne (lactose free) eye gtt | 1009B | 8am 8pm |
| | 1009A | |
| Aldina (Dina) H. | 1010B | 8am 4pm 8pm |
| Maureen E. | 1010A | 8am 4pm 8pm |
| William (Bill) D. | 1010 | 8am 2pm 8pm |
| Robert (Bob) F. eye drops BID | 1011A | 8am 5pm 8pm |
| Irene O. Refuses meds unless mixed w/ ice-cream or pudding | 1012 | 8am 4pm 8pm |
| Barbara W. Lactose free | 1013 | 11am 8pm |
| Joan B. **MLOA** | 1014 | |
| Ruth A. (mechanical soft diet) MUST crush meds!. Give liquid w/ OJ. | 1015 | 8am 4pm 8pm |
| Nina C. Eye drops & wipes TID. | 1016 | 8am 2pm 8pm |
| Guy L. give Ensure, prefers Chocolate ncs | 1017 | 8am 8pm |
| | 1018A | |
| | 1019B | |
| Solomini, J | 1019A | 8am 8pm |
| Walters, C | 1019B | 8am 8pm |
| Ahern, J. Crush all meds. | Apt. 231 | 8am 7pm |