STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

September 13, 2022

Cheryl Dence, Person-in-Charge
Char-Laine Manor
15 Ellington Avenue
Rockville, CT 06066

Dear Ms Dence:

An unannounced visit was made to Char-Laine Manor on September 2, 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 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 <u>September 27, 2022</u>.

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 27, 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:csf

c. Mairead Painter, LTC Ombudsman Program

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

1. Based on observations and interview, the facility failed to document the food temperatures were obtained prior to serving. The findings include:

    a. Observations and interview with the cook on 9/2/22 at 10:45 AM identified temperatures of the food items are obtained prior to serving; however, she does not document the temperatures on a log.

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 facility documentation and interview, the facility failed to document when shift to shift controlled medication count was conducted and the hand off of the keys. The findings include:

    a. Review of the lock box key records from 7/1/22 through 9/2/22 failed to reflect documentation of the specific shift, 7AM-3PM, 3-11PM and 11PM-7AM, the record stated from/to. Upon further review the record lacked consistent documentation of the staffs' initials. The Medical Assistant identified the staff are to sign off when handing off and receiving the keys after the narcotic count.

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).

3. 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 when the medication had been administered to ensure the count was correct. The findings include:

    a. Observations of the medication administration on 9/2/22 at 12:00 AM identified Resident #2 received Pregabalin 125 milligrams three (3) times a day. After administering the medication, the Medical Assistant signed the Controlled Drug Receipt and Disposition record. Upon review of the medication bubble packaging the number of tablets remaining did not match the number remaining on the controlled drug record. The Controlled Drug Receipt and Disposition record indicated fifty-five (55) tablets were remaining and fifty-four (54) were noted in the package. At that time the Medical Assistant identified the 9/1/22 bedtime dose had not been signed for.

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 (E)(ii)(V).

4. Based on resident record reviews, review of facility documentation, observations, and interview, the facility failed to document the name and initials of the staff member who administered medications. The findings include:

    a. Observations of the medication administration on 9/2/22 at 10:00 AM identified medications were administered by the Medical Assistant and signed off as given. Review of the back side of the Medication Administration Record identified the signature and initials of the Medical Assistant, however the record lacked documentation of the 3-11PM staff member who had administered medications on 9/1/22.

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 (E)(ii)(V).

5. Based on resident record review, review of facility documentation, observations, and interview, the facility failed to document the effectiveness after an as needed (PRN) medication was administered. The findings include:

    a. Observations of the medication administration on 9/2/22 at 10:00 AM identified Resident #1 was administered Tylenol 500 milligrams for a headache. Interview and review of the Medication Administration Records with the Medical Assistant on 9/2/22 at 10:00 AM identified that although the staff documents the date, time, medication, and reason for the use of an as needed (PRN) medication when the resident requests one (1), the staff do not document if the medication was effective or not.

The following are violations 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 review of facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include:

    a. On 09/02/22 at 09:000 A.M., during a tour of the facility and while accompanied by the facility representative, the following observations were identified:

        i. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., there were no records that any first shift fire drills were completed in the first quarter of 2022.
        ii. Documentation was not provided to the surveyor from the facility to indicate that the fire

drills were being completed as required by NFPA 101. i.e., there were no records that any second shift fire drills were completed in the second quarter of 2022.

iii. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., there were no records that any third shift fire drills were completed in the second quarter of 2022.

iv. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 101. i.e., There were no records that any second shift fire drills were completed in the fourth quarter of 2021.

v. Documentation was not provided to the surveyor from the facility to indicate that the Fire Extinguishers throughout the facility were inspected annually as required by NFPA 101. i.e., no inspection reports were available, and tags on extinguishers indicated that the last required annual inspection was completed in July of 2021.

Approved 11/21/22 KEG

Plan of Correction for Violation 1:

1.The systemic change that the institution intends to implement is to log the temperature of food items directly onto the daily menu and have the cook sign off on the menu they prepared.

2. The date this corrective measure by the institution will be September 2, 2022.

3. The institutions plan to ensure that the systemic change is sustained is to periodically audit the food temperature log.

4. The title of the institution staff member will be the Qualified Food Operator and the administrator to ensure the institution complies.

Plan of Correction for Violation 2:

1. The systemic change that the institution intends to implement is to create a log with dates and times for certified medication employees to initial when controlled medication count was conducted and the handing off the keys was completed.
2. The date this corrective measure by the institution will be effective is September 2, 2022.
3. The institution plan to ensure that the systemic change is sustained is to periodically audit the lock box key records to ensure certified medication employees entered their initials for the transfer of the medication lock box key.

4. The title of the institution's staff member that is responsible for the ensuring the institution's compliance will be the responsibility of the Medical Director and the Administrator.

Plan of Correction for Violation 3:

1. The systemic change that the institution intends to implement is to ensure the certified medication employees enters the proper controlled medication count and their initials.
2. The date this corrective measure will be effective September 2, 2022.
3. The institutions plan to ensure that the systemic change is sustained is to periodically audit the MAR's to determine if the certified medication employees are entering the proper controlled medication count and their initials.
4. The title of the institution's staff member that is responsible for ensuring the institutions compliance will be done by the Medical Director and Administrator.

Plan of Correction for Violation 4:

1. The systemic change that the institution intends to implement is to ensure the certified medication employees documents the medication given and enters their initials.

pg 4

2. The date this corrective measure will be effective will be September 2, 2022.
3. The institution plans to ensure that the systemic change is sustained is to periodically audit the back side of the MAR to be sure the certified medication employees' initials and signature are documented.
4. The title of the institution's staff member to be responsible will be the medical director and the administrator to ensure that the institution complies.

Plan of Correction for Violation 5:

1. The systemic change that the institution intends to implement is to ensure that the certified medication employees document the effectiveness of PRN medication.
2. The date this corrective measure will be effective is September 2, 2022.
3. The institution plan to ensure that the systemic change is sustained is to periodically audit the documentation of the effectiveness of the PRN medication given.
4. The title of the institution's staff member responsible for ensuring that the institution's compliance will be the medical director and the administrator.

Plan of Correction for Violation 6:

1. The systemic change that the institution intends to implement is to ensure each shift completes 1 fire drill every quarter.
2. The date of this corrective measure by the institution is effective will be September 2, 2022.
3. The institution plans to ensure that the systemic change is sustained is to follow the NFPA regulations to implement a plan to have each shift complete 1 fire drill every quarter.
4. The title of the institution's staff member that is responsible for the ensuring of the institution complies will be the responsibility of the administrator.
5. The systemic change that the institution intends to implement is to ensure that the annual inspection of fire extinguisher reports is completed as required by the NFPA.
6. The date such corrective measure by the institution is effective will be September 23, 2022.
7. The institution plans to ensure that the systemic change is to contact the fire department to provide the institution with the annual inspection report.
8. The systemic change that the institution intends to implement is to ensure that the fire extinguishers documentation is updated monthly on fire extinguisher tags.
9. The date such corrective measure by the institution is effective September 2, 2022.

10. The institution plans to ensure that the systemic change is sustained by periodically audit the fire extinguishers documentation.
11. The title of the institution's staff member that is responsible for ensuring that the institution complies will be the maintenance employee of the institution.