STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

July 19, 2022

Neeta Dhanraj, Person-in-Charge
West Side Manor
9 West High Street
East Hampton, CT 06424

Dear Ms Dhanraj:

An unannounced visit was made to West Side Manor on June 23, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and 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 August 2, 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 violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 2, 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. Please do not send another copy via US mail.

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
Complaint #27160

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

1. Based on observations, review of facility documentation and interviews, the facility failed to ensure the serving size was noted on the posted menus. The findings include:
    a. Observations of the posted menu for the week of 6/21/22 through 6/27/22 identified the serving size for each food item was not noted on the menu. Interview with the Manager identified that the Certified Food Manager completes the menus.

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

2. Based on observations and interview, the facility failed to ensure thermometers were located in each all freezer. The findings include:
    a. Observations during a tour of the facility on 6/23/22, identified that the freezers, both chest and upright style, failed to have a thermometer. During interview on 6/23/22, the Maintenance Person stated that he did not realize the freezers must have a thermometer.

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)(VI).

3. Based on resident record reviews, review of facility policies and interviews for two of five sampled residents (Residents #2 and #3) reviewed for medication administration, the facility failed to document on the Medication Administration Record the effectiveness of an as needed medication and the results of daily blood pressures or if the resident refused. The findings include:
    a. Resident #2's diagnoses included hypertension. A physician's order directed to administer Clonidine Hydrochloride 0.1millgrams (mg) take one (1) tablet two (2) times a day if needed for blood pressure. The Medication Record indicated Resident #2's blood pressure was obtained twice a day at 7:00 AM by the Visiting Nurse and at 8:00 PM by the facility staff. Upon further review, the record failed to reflect documentation on two (2) occasions at 7:00 AM and three (3) occasions at 8:00 PM that Resident #2's blood pressure was obtained or the resident refused. Interview with Manager identified that sometimes Resident #2 refuses to have his/her blood pressure taken and that is why there is no results.
    b. Resident #3's diagnoses included insomnia, constipation, and anxiety. A physician's order directed to administer Ex-Lax 30 milliliters twice a day as needed for constipation, Miralax one (1) capful (17 grams) in a glass of water daily as needed, Hydroxyzine Hydrochloride 25 mg every four (4) hours as needed for anxiety, agitation or sleep, and Melatonin 5 mg at bedtime as needed for sleep. Review of the Medication Administration Record from 6/15/22 through 6/22/22 identified although the above

noted as needed medications had been administered and the reason denoted, the Medication Administration Record failed to reflect documentation of the results of the medication. Interview with the Person-in-Charge on 6/23/22 identified the Staff Attendants do not document the results and did not recall this part being taught in the on-line Medication Administration Training.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4)(C).

4. Based on review of personnel files and interviews, the facility failed to ensure annual continuing education was completed by the staff. The findings include:
    a. Review of the employee files identified that annual continuing education in-services had not been completed by the staff. Interview with the Person-in-Charge identified the annual continuing education in-services have not been conducted since March 2020.

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).

5. Based on observations, the facility failed to ensure the capacity of each room was posted at the doorway. The findings include:
    a. Observations during the tour with the Manager on 6/23/22 identified that although the rooms were numbered, there was no posting of the room capacity at Room #7 and #21 doorways.

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

6. Based on observations and interview for one of three sampled residents (Resident #1) who required oxygen therapy, the facility failed to ensure an oxygen in use sign was posted outside the room. The findings include:
    a. Observations with the Manager on 6/23/22 at 10:00 AM identified although an oxygen concentrator was noted in Resident #1's room, there was no sign posted on the door. Interview with the Manager identified that Resident #1 was transferred into the room and the sign was forgotten.

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 (C).

7. Based on facility documentation and interviews for three of nine Staff Attendants, the facility failed to ensure current medication administration certificates were available for review and/or the certificates were obtained through the Department of Public Health training course and not another State Agency. The findings include:
    a. Review of the Medication Administration Training Certification of Course Completion identified although one (1) Staff Attendant had completed the on-line course, the Staff Attendant was not able to retrieve the certificate to verify a passing score.
    Review of two (2) Staff Attendants identified their certificates were obtained through another State Agency and not the Department of Public Health prior to the Uniform Interagency Medication Administration Program was launched in April 2022. One (1) certificate had expired on 1/3/22 and the other Staff Attendant was hired on 4/8/22. Interview with the Person-in-Charge and the Administrative Assistant identified that neither the Staff Attendant nor the facility reached out for assistance to retrieve the certificate.

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 review of facility documentation, observations, and interviews, the facility failed to ensure a smoke detector was not rendered inoperable, fueled equipment was not stored in the basement and the sprinkler system was inspected, tested and maintained in accordance with the State of Connecticut Fire Safety Code and the National Fire Protection Association. The findings include:
    On 6/23/22 at 9:00 A.M., during a tour of the facility and while accompanied by a facility representative, the following observations were identified:
    a. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a 5-year test of the facilities Fire Department Connection was completed as required. Records show the last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
    b. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that the system gauges were replaced as required. Gauges are dated 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
    c. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a 3-year air loss test of the dry system was

completed. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.

d. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year obstruction test was done on the internal piping of the sprinkler system. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
e. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a 5 five (5) year dry pipe valve internal inspection test was done on the sprinkler system. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a three (3) year internal inspection of the facilities sprinkler water storage tank was done. Records show that last test was in 2010. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
f. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a destructive test of the facilities sprinkler heads that are 50 years old was completed. Records show that the test was due in 2010. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
g. Documentation was not provided to the surveyor from the facility owner to indicate that the generator was being serviced two times a year (1 major and 1 Minor service) as required by NFPA 110. i.e., No minor generator service was completed in the last 12 months.
h. The facility did not ensure that smoke detectors were readily available and able to be activated as required by the 2018 Connecticut State Fire Code. i.e., During inspection a detector in the basement was rendered inoperable. A rubber glove was placed over the detector.
i. The facility did not ensure that fueled equipment is stored in a room constructed for such storage as required by the 2018 Connecticut State Fire Code. i.e., gas powered snowblower, and a kerosene heater were stored in the basement of the facility.

Approved
9/19/22
KEG

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

1. ~~Based on observations, review of facility documentation and interviews, the facility failed to~~ ensure the serving size was noted on the posted menus. The findings include:
   a. Observations of the posted menu for the week of 6/21/22 through 6/27/22 identified the serving size for each food item was not noted on the menu. Interview with the Manager identified that the Certified Food Manager completes the menus.

1. A

Corrected on 6/24/22 the menus were revised to show the serving sizes. The facility assigned person is the maintenance supervisor who will check weekly

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

2. Based on observations and interview, the facility failed to ensure thermometers were located in each all freezer. The findings include:
   a. Observations during a tour of the facility on 6/23/22, identified that the freezers, both chest and upright style, failed to have a thermometer. During interview on 6/23/22, the Maintenance Person stated that he did not realize the freezers must have a thermometer.

2A

On 6/24/22 Correction was made to both the upright & chest freezer where the thermometer was placed. The facility assigned person is the Maintenance Supervisor.

3A-B

On 6/24/22 Correction was made. All staff were in-serviced regarding the follow up of documenting a "Result" after administering a PRN medication. See enclosed in-service sheet. The facility assistant Administrator will conduct weekly checks on the MAR's & report to Administrator. Administrator will conduct monthly audit on MAR's.

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)(VI).

3. Based on resident record reviews, review of facility policies and interviews for two of five sampled residents (Residents #2 and #3) reviewed for medication administration, the facility failed to document on the Medication Administration Record the effectiveness of an as needed medication and the results of daily blood pressures or if the resident refused. The findings include:
    a. Resident #2's diagnoses included hypertension. A physician's order directed to administer Clonidine Hydrochloride 0.1millgrams (mg) take one (1) tablet two (2) times a day if needed for blood pressure. The Medication Record indicated Resident #2's blood pressure was obtained twice a day at 7:00 AM by the Visiting Nurse and at 8:00 PM by the facility staff. Upon further review, the record failed to reflect documentation on two (2) occasions at 7:00 AM and three (3) occasions at 8:00 PM that Resident #2's blood pressure was obtained or the resident refused. Interview with Manager identified that sometimes Resident #2 refuses to have his/her blood pressure taken and that is why there is no results.
    b. Resident #3's diagnoses included insomnia, constipation, and anxiety. A physician's order directed to administer Ex-Lax 30 milliliters twice a day as needed for constipation, Miralax one (1) capful (17 grams) in a glass of water daily as needed, Hydroxyzine Hydrochloride 25 mg every four (4) hours as needed for anxiety, agitation or sleep, and Melatonin 5 mg at bedtime as needed for sleep. Review of the Medication Administration Record from 6/15/22 through 6/22/22 identified although

Cont of # 3.

(See Correction on Above #3)

the above noted as needed medications had been administered and the reason denoted, the Medication Administration Record failed to reflect documentation of the results of the medication. Interview with the Person-in-Charge on 6/23/22 identified the Staff Attendants do not document the results and did not recall this part being taught in the on-line Medication Administration Training.

4. Based on review of personnel files and interviews, the facility failed to ensure annual continuing education was completed by the staff. The findings include:
   a. Review of the employee files identified that annual continuing education in-services had not been completed by the staff. Interview with the Person-in-Charge identified the annual continuing education in-services have not been conducted since March 2020.

4A

Corrections were made on 6/23/22. The facility re-instated monthly staff meetings. These meetings will continue monthly. The facility appointed person is the assistant Administer. The facility Administator will Audit Quarterly.

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).

5. Based on observations, the facility failed to ensure the capacity of each room was posted at the doorway. The findings include:
   a. Observations during the tour with the Manager on 6/23/22 identified that although the rooms were numbered, there was no posting of the room capacity at Room #7 and #21 doorways.

5A

On 6/24/22 the Corrections Were made to Rm# 7 & Rm# 21
In the event of a new admission or a room change the patient Care Coordinator will make the appropriate changes.
The facility assigned person is the Assistant administrator that will do weekly Walkthrus. She will report to the Administer once a month.

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

6. Based on observations and interview for one of three sampled residents (Resident #1) who required oxygen therapy, the facility failed to ensure an oxygen in use sign was posted outside the room. The findings include:
   a. Observations with the Manager on 6/23/22 at 10:00 AM identified although an oxygen concentrator was noted in Resident #1's room, there was no sign posted on the door. Interview with the Manager identified that Resident #1 was transferred into the room and the sign was forgotten.

CoA

On 6/23/22 the correction was made with the placement of the "Oxygen in Use" Sign placed on the outside of Rm# 1
The facility assigned person is the patient Care Cordinator who will report to the administer once a week.

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 (C).

7. Based on facility documentation and interviews for three of nine Staff Attendants, the facility ~~failed to ensure current medication administration certificates were available for review and/or~~ the certificates were obtained through the Department of Public Health training course and not another State Agency. The findings include:
   a. Review of the Medication Administration Training Certification of Course Completion identified although one (1) Staff Attendant had completed the on-line course, the Staff Attendant was not able to retrieve the certificate to verify a passing score.
   Review of two (2) Staff Attendants identified their certificates were obtained through another State Agency and not the Department of Public Health prior to the Uniform Interagency Medication Administration Program was launched in April 2022. One (1) certificate had expired on 1/3/22 and the other Staff Attendant was hired on 4/8/22.
   Interview with the Person-in-Charge and the Administrative Assistant identified that neither the Staff Attendant nor the facility reached out for assistance to retrieve the certificate.

7A

Most of the Medication Certified staff have begun the current Medication Certification Course online. Regarding the Med Course Certification for the staff that wasn't able to retrive it an email was sent to the person responsible (I believe) that takes care of this. Please see attached email. The email provider to the staff that currently wasn't able to retrieve Certification Advised her that the email was shut down due to inactivity. Assigned person is Assistant Administrator who will report updates to Administrator Weekly.

8A: This will be Completed within the next 90-days per Matchless Fire Protection Company. Facility Appointed person is Maintenance Supervisor. Upon completion of Service the maintenance Supervisor will report to the administrator with report.

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 review of facility documentation, observations, and interviews, the facility failed to ensure a smoke detector was not rendered inoperable, fueled equipment was not stored in the basement and the sprinkler system was inspected, tested and maintained in accordance with the State of Connecticut Fire Safety Code and the National Fire Protection Association. The findings include:

   On 6/23/22 at 9:00 A.M., during a tour of the facility and while accompanied by a facility representative, the following observations were identified:

   a. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a 5-year test of the facilities Fire Department Connection was completed as required. Records show the last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
   b. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that the system gauges were replaced as required. Gauges are dated 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
   c. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a 3-year air loss test of the dry system was completed. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.
   d. Documentation was not provided to the surveyor from the facility owner to indicate that

the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year obstruction test was done on the internal piping of the sprinkler system. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.

e. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year dry pipe valve internal inspection test was done on the sprinkler system. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a three (3) year internal inspection of the facilities sprinkler water storage tank was done. Records show that last test was in 2010. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.

f. Documentation was not provided to the surveyor from the facility owner to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a destructive test of the facilities sprinkler heads that are 50 years old was completed. Records show that the test was due in 2010. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.

g. Documentation was not provided to the surveyor from the facility owner to indicate that the generator was being serviced two times a year (1 major and 1 Minor service) as required by NFPA 110. i.e., No minor generator service was completed in the last 12 months.

h. The facility did not ensure that smoke detectors were readily available and able to be activated as required by the 2018 Connecticut State Fire Code. i.e., During inspection a detector in the basement was rendered inoperable. A rubber glove was placed over the detector.

i. The facility did not ensure that fueled equipment is stored in a room constructed for such storage as required by the 2018 Connecticut State Fire Code. i.e., gas powered snowblower, and a kerosene heater were stored in the basement of the facility.

(8)

B. This will be completed within the next 90-day per Matchless Fire Protection Company. Facility appointed person is Maintenance Supervisor Upon completion of service he will report to Administrator.

C. Completed on 8/26/22 please see Attachmut 8C

D. Completed on 8/26/22 please see Attachmut 8D

the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year obstruction test was done on the internal piping of the sprinkler system. Records show that last test was in 2015. The deficiency was noted on reports from the sprinkler company in 2020 and in 2021.

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g. Documentation was not provided to the surveyor from the facility owner to indicate that the generator was being serviced two times a year (1 major and 1 Minor service) as required by NFPA 110. i.e., No minor generator service was completed in the last 12 months.

h. The facility did not ensure that smoke detectors were readily available and able to be activated as required by the 2018 Connecticut State Fire Code. i.e., During inspection a detector in the basement was rendered inoperable. A rubber glove was placed over the detector.

i. The facility did not ensure that fueled equipment is stored in a room constructed for such storage as required by the 2018 Connecticut State Fire Code. i.e., gas powered snowblower, and a kerosene heater were stored in the basement of the facility.

(8)

E. Per Matchless Fire this service will be Conducted in the Spring of 2023. Matchless Company is willing to speak directly in why this needs to be done only in the Spring. Facility Assigned Person is Maintenance Supervisor who will Report to the administrator upon Completion.

F. This will be completed within the next 90 days per Matchless Fire Protection. Facility assigned person is maintenance Supervisor who will report to Administrator upon Completion.

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i. The facility did not ensure that fueled equipment is stored in a room constructed for such storage as required by the 2018 Connecticut State Fire Code. i.e., gas powered snowblower, and a kerosene heater were stored in the basement of the facility.

(8)

G. Please see Attachmt 8 G - per Conversation on 6/23/22 it was noted that due to the facility running on natural gas, we are only required to have 1 major service per year. This was completed on 4/2/22

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i. The facility did not ensure that fueled equipment is stored in a room constructed for such storage as required by the 2018 Connecticut State Fire Code. i.e., gas powered snowblower, and a kerosene heater were stored in the basement of the facility.

(8)

H. Corrected on 6/23/22 Glove removed & discarded

I. Corrected on 6/23/22 moved to outdoor shed