STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

December 6, 2022

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

Dear Ms Cuuningham:

An unannounced visit was made to Southmayd Home Inc on November 15, 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 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 December 20, 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.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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PHAB
Public Health Accreditation Board

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 December 20, 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 and Investigations Section

KEG:csf

cc. 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 interviews, for three (3) refrigerators and two (2) freezers, the facility failed to monitor refrigerator and freezer temperatures daily to ensure proper function. The findings include:

    a. During a tour of the facility with the Executive Director on 11/15/22, observations in the kitchen and basement identified the refrigerator and freezer temperatures were not being monitored daily. Further observations identified the refrigerator with an attached freezer and a refrigerator located in the basement, both appliances did not have a thermometer inside. Interview with the Kitchen Manager at the time of observation identified he was unaware temperatures were to be monitored daily and he was unaware the basement refrigerators and a freezer had no thermometer.

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

2. Based on review of resident's funds, the facility failed to ensure monthly statements and/or receipt of disbursement of funds and monies were provided to each resident. The findings include:

    a. On 11/15/22, review of the resident funds for all residents failed to reflect documentation that a monthly statement was provided to the residents and a receipt of disbursement of funds and monies to each resident were provided. Interview with the Office Manager on 11/15/22 identified she was unaware she had to provide a monthly statement or receipt of disbursement of funds/monies to the residents. The Resident Criteria Rules of Conduct and General Policies identified a detailed accounting of the found was distributed to the resident and/or responsible party each quarter.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(S) and/or (c) Administration (1) and/or (h) General conditions (6).

3. Based on observations, facility policy and interviews, the facility failed to ensure the environment was maintained in a clean, comfortable, and homelike manner. The findings include:

    a. During a tour of the facility on 11/15/22 with the Executive Director, the following were identified:

i. On the second floor, the south wing bathroom located by Room #25 was noted with no cover on the ceiling fan.
ii. On the second floor, the south wing bathroom located by Room #32 was noted with missing tiles on the wall above the bathtub.
iii. Room #29 was noted with broken drawers in the dresser.
iv. On the first floor, the south wing half bathroom had a missing toilet paper holder.

Interview with Executive Director on 11/15/22 identified there was a maintenance log for staff members or residents to report any needs of repair. The Executive Director indicated prior to the pandemic, monthly checks of rooms and common areas were conducted, however during the pandemic the efforts were put primarily into the COVID monitoring and staffing. The Executive Director identified the monthly room checks will be reinstated.

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).

4. Based on review of facility documentation, observations, and interviews, the facility failed to ensure compliance with all applicable codes, standards, and regulations of the State of Connecticut Fire Safety Code and the National Fire Protection Association. The findings include:

   a. On 11/15/22 at 9:30 A.M., during a tour of the facility and while accompanied by the Executive Director, the following observations were identified:

      i. Two extension cords were being used in the kitchen as a substitute for permanent wiring which is not in compliance with NFPA 1 section 11.1.3.2.
      ii. The egress door in the kitchen was missing the end cap on the panic bar creating a sharp surface.

Approved 12/20/22 KEG

Southmayd Home INC.

December 12, 2022

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capitol Avenue, P.O. Box 340308
Hartford, CT 06134-0308

Dear Karen Gworek,

Below is the corrective action plan in response to the findings as a result of the unannounced visit on November 15, 2022. The plan of correction includes responses for the four (4) components listed in your letter dated December 6, 2022. Southmayd Home will make every effort to ensure all violations are corrected and prevented from future occurrences.

1. *Based on observations and interviews, for three (3) refrigerators and two (2) freezers, the facility failed to monitor refrigerator temperatures daily to ensure proper function. The findings include:*
   a. *During a tour of the facility with the Executive Director on 11/15/22, observations in the kitchen and basement identified the refrigerator and freezer temperatures were not being monitored daily. Further observations identified the refrigerator with an attached freezer and a refrigerator located in the basement, both appliances did not have a thermometer inside. Interview with the Kitchen Manager at the time of observation identified he was unaware temperatures were to be monitored daily and he was unaware the basement refrigerators and a freezer had no thermometer.*

Plan of Correction: Effective November 30, 2022, thermometers have been purchased and placed in the freezer and refrigerator located in the basement. The Kitchen Manager will ensure temperatures are monitored and documented daily to ensure proper functioning of appliances. The Executive Director will monitor this plan of correction through monthly checks of rooms and common rooms to prevent reoccurrence of the identified issue.

2. *Based on review of resident's funds, the facility failed to ensure monthly statements and/or receipt of disbursement of funds and monies were provided to each resident. The findings include:*
   a. *On 11/15/22, review of the resident funds for all residents failed to reflect documentations that a monthly statement was provided to the residents and a receipt of disbursement of funds and monies to each resident were provided. Interview with the Office Manager on 11/15/22 identified she was unaware she had to provide a monthly statement or receipt of disbursement of funds/monies to the residents. The Resident Criteria Rules of Conduct and General Policies*

identified a detailed accounting of the fund was distributed to the resident and/or responsible party each quarter.

Plan of Correction: Effective December 1, 2022, the Office Manager will issue a quarterly statement to the resident or Power of Attorney (POA) of the resident's petty cash account. In addition, the Office Manager will obtain a resident signature for funds dispensed from the resident petty cash account. Resident signatures will be kept on file along with the date and the amount of funds dispensed. The Executive Director will monitor this plan of action through monthly audits of resident petty cash accounts coinciding with the monthly check of rooms and common rooms to prevent reoccurrence of the identified issue.

3. *Based on observations, facility policy and interviews, the facility failed to ensure the environment was maintained in a clean, comfortable, and homelike manner. The findings include:*
    a. *During a tour of the facility on 11/15/22 with the Executive Director, the following were identified:*
        i. *On the second floor, the south wing bathroom located by room #25 was noted with no cover on the ceiling fan.*
        ii. *On the second floor, the south wing bathroom located by room #32 was noted with missing tiles on the wall above the bathtub.*
        iii. *Room #29 was noted with broken drawers in the dresser.*
        iv. *On the first floor, the south wing half bathroom had a missing toilet paper holder.*

Interview with the Executive Director on 11/15/22 identified there was a maintenance log for staff members or residents to report any need for repair. The Executive Director indicated prior to the pandemic, monthly checks of rooms and common areas were conducted, however during the pandemic the efforts were put primarily into the COVID monitoring and staffing. The Executive Director identified the monthly room checks will be reinstated.

Plan of Correction:

- (i.) A ceiling fan cover will be installed by the maintenance coordinator in the bathroom located on the second floor, south wing near room #25 by January 1, 2023.
- (ii.) The area missing tiles in the bathroom on the second floor, south wing located by room #32 will be repaired by the maintenance coordinator by January 1, 2023.
- (iii.) The dresser with broken drawers located in room #29 was replaced on November 21, 2022 by the maintenance coordinator.
- (iv.) A toilet paper holder was installed in the first floor, south wing bathroom by the maintenance coordinator on November 21, 2022.

The Executive Director will monitor this plan of correction through the monthly checks of rooms and common rooms to prevent reoccurrence of the identified issues.

4. *Based on review of facility documentation, observations, and interviews, the facility failed to ensure compliance with all applicable codes, standards, and regulations of the State of Connecticut's Fires Safety Code and the National Fire Protection Association. The findings include:*
    a. *On 11/15/22 at 9:30A.M., during a tour of the facility and while accompanied by the Executive Director, the following observations were identified:*
        i. *Two extension cords were being used in the kitchen as a substitute for permanent wiring which is not in compliance with NFPA 1 section 11.1.3.2.*
        ii. *The egress door in the kitchen was missing the end cap on the panic bar creating a sharp surface.*

Plan of Correction:

- (i.) The two extension cords being used in the kitchen as a substitute for permanent wiring were removed by the maintenance coordinator on November 16, 2022. The maintenance coordinator will identify an electrician to provide permanent wiring for the area by March 1, 2023.
- (ii.) The emergency release push bar located in the kitchen will be replaced by the Maintenance Coordinator by January 1, 2023.

The Executive Director will monitor this plan of correction through the monthly checks of rooms and common rooms to prevent reoccurrence of the identified issues.

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