STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

May 2, 2023

Lindsey Miller, Eecutive Director
Farmington Station A Senior Living Residence
111 Scott Swamp Rd
Farmington, CT 06032
Via Email: lmiller@farmingtonSLR.com

Dear Ms. Miller,

An unannounced visit was made to Farmington Station A Senior Living Residence on April 12, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Complaint Investigation Survey.

Attached is the 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 May 12, 2023.

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.

DATE(S) OF VISIT: April 12, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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 May 12, 2023, or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

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

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.

Respectfully,

/s/

Elizabeth Heiney, BS, RN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

EH:csf

c. VL
Complaint #34344

DATE(S) OF VISIT: April 12, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the regulations of Connecticut State Agencies Section 19-13-D105 Assisted living services agency (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 (3)(C)(D) and/or (I) Assisted living aide services (1) and/or the General Statutes of Connecticut Chapter 378 Section 20-872 (c) and/or (k) Client service record (2)(H) and/or (m) Client's Bill of Rights and Responsibilities (9).

1. Based on clinical record review, review of agency policies and staff interviews for two of two client's (Client's #1 & #2) who received assisted living services for assistance with personal care, medication management and safety monitoring, the Assisted Living Services Agency/ALSA failed to conduct an investigation after unwitnessed injuries were identified, failed to notify a Registered Nurse/RN of a change in condition, failed to revise the plan of care after multiple falls and failed to follow agency policies. The finding includes:

   a. Client #1 was admitted to the memory care assisted living services agency (ALSA) program on 3/18/22. The admitting diagnoses included dementia, legal blindness, insulin dependent diabetes mellitus and hypertension. The client service plan dated 12/13/22 identified the need for the assistance of one caregiver for dressing, bathing, transferring and medication management, was identified at risk for falls and supervision with ambulating with rolling walker and eating.

      On 1/18/23 at 7:19 PM, LPN #1 was notified by ALSA Aide #1 of significant bruising on the client's right wrist and hand, turning yellowish in color with complaints of pain upon movement side to side, along with some swelling on the outer portion of the hand. LPN #1 notified the APRN and the next of kin but failed to notify the RN on duty.

      Interview and review of LPN #1's nurses note dated 1/18/23 with the Supervisor of Assisted Living Services/SALSA on 4/12/23 at 1 PM, failed to identify an investigation was conducted after Client #1's injury was observed, failed to identify an RN was notified and/or assessed Client #1's right hand injury, and failed to follow agency policies for investigating injuries of unknown origin.

      Review of agency Incident Report policy for injuries of unknown origin directed the RN or nurse designee shall promptly undertake an investigation into the injury, which shall include an interview with the resident, interviews of any possible witnesses, caregivers, or other persons with possible information about the injury, a review of the plan of care, caregiver assignment sheets, a review of possible environmental factors and any documentation relating to the clients care and condition.

DATE(S) OF VISIT: April 12, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 2/07/23 at 7:49 PM, LPN #2 was notified by ALSA Aide #2 that the client was found sitting on the buttocks in front of a chair on the floor in the apartment. The client denied pain, had full range of motion and was able to get up off the floor with minimal assistance. LPN #2 notified the APRN and the next of kin but failed to notify the RN on duty. Interview and review of LPN #2's nurses note dated 2/07/23 with the SALSA on 4/12/23 at 1:05 PM, failed to identify an RN was notified, failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

On 2/21/23 at 10:52 PM, LPN #3 was notified by an ALSA Aide that the client was found on the floor next to the bed yelling, the client was assisted back to bed, LPN #3 notified the APRN and the next of kin but failed to notify the RN on duty.

Interview and review of LPN #3's nurses note dated 2/21/23 with the SALSA on 4/12/23 at 1:10 PM, failed to identify an RN was notified, failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

On 2/26/23 at 9:08 PM, LPN #2 was notified by an ALSA Aide that the client was found on the floor, on his/her right side next to a chair. The client was screaming to get up off the floor, denied injury or pain and was assisted up into a chair. LPN #2 notified the APRN and the next of kin but failed to notify the RN on duty.

Interview and review of LPN #2's nurses note dated 2/26/23 with the SALSA on 4/12/23 at 1:15 PM, failed to identify an RN was notified, failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

On 3/18/23 at 1:53 PM, LPN #4 was notified by ALSA Aide #3 that while trying to transfer the client from the wheelchair onto the bed, the client lost his/her balance and was guided to the floor. LPN #4 documented that the client had no injuries or new bruising, was able to sit and stand with the walker onto the bed. LPN #4 notified the APRN and the next of kin but failed to notify the RN on duty.

Interview and review of LPN #2's nurses note dated 3/18/23 with the SALSA on 4/12/23 at 1:20 PM, failed to identify an RN was notified, failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

Interview and review of Client #1's clinical record with the Executive Director on 4/12/23 at 1:55 PM, failed to identify communication with the physician and family of the need to revise the plan of care to meet the safety needs of the client.

DATE(S) OF VISIT: April 12, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The Connecticut General Statutes at Chapter 378 Section 20-872 (c) defines the practice of nursing by a licensed practical nurse as, among other responsibilities, "the performing of selected tasks and sharing of responsibility under the direction of a registered nurse;"

Review of agency fall policy directed to ensure a Registered Nurse is notified in person or by phone, if an evaluation is completed by the LPN, the RN will be consulted. The RN will update the Service Plan to reflect the intervention as applicable.

Subsequently, on 3/19/23 at 2:45 PM, LPN #4 documented that the client was using the wheelchair due to increased weakness.

On 3/23/23 at 1:12 PM, LPN #4 documented swelling was noted to the client's right ankle, the skin was firm, and the client yelled out in pain when the socks and shoes were removed. The next of kin and APRN were notified, and the client was sent to the Emergency Department and diagnosed with bilateral malleolus fracture of the right ankle and osteopenia to the left hand.

Review of the agency investigation dated 3/24/23 with the Executive Director on 4/12/23 at 9:30 AM identified after staff interviews, LPN #4 and ALSA Aide #3 admitted that the client had a witnessed fall on 3/18/23. LPN #4 identified that the client was assisted off the floor along with ALSA Aide #2 and no injuries were noted at the time.

Interview with ALSA Aide #2 on 4/12/23 at 11:12 AM indicated that on 3/18/23, LPN #4 asked for assistance picking up the client off the floor and indicated that they each placed their arms under the client's arm and grabbed onto the back of the pants and lifted the client off the floor onto the bed.

Interview with ALSA Aide #3 on 4/12/23 at 11:21 AM identified that the client lost balance and was assisted to the floor. No injuries were seen at that time.

Interview with LPN #4 on 4/12/23 at 11:49 AM indicated that on 3/18/23, ALSA Aide #3, while trying to transfer the client from the wheelchair onto the bed, the client lost his/her balance and was guided to the floor. LPN #4 then instructed ALSA Aide #3 to request assistance from ALSA Aide #2 in picking up the client off the floor and indicated that they each placed their arms under the client's arm and grabbed onto the back of the pants and lifted the client off the floor onto the bed.

Interview and review of Client #1's fall on 3/18/23 with the Executive Director on 4/12/23 at 1:55 PM, indicated that LPN #4 and ALSA Aide #2 failed to follow agency policies on workplace safety including not to lift clients.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

b. Client #2 was admitted to the memory care assisted living services agency (ALSA) program on 10/19/17. The admitting diagnoses included dementia, cancer of the breast and tongue and osteoporosis. The client service plan dated 12/13/22 identified the need for the assistance of two caregivers for all activities of daily living, medication management and was at risk for falls.

On 3/02/23 at 7:19 PM, LPN #1 was notified by an ALSA Aide that the client was found on the floor, on his/her right side next to the bed. The client had range of motion to all extremities and was lifted back to bed by LPN #1 and the aide. LPN #1 notified the APRN and the next of kin but failed to notify the RN on duty.

Interview and review of LPN #1's nurses note dated 3/02/23 with the SALSA on 4/12/23 at 2:15 PM, failed to identify an RN was notified, failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

On 3/30/23 at 10:58 PM, LPN #5 received a call from ALSA Aide #1 that the client was found on the floor, no injuries were noted, and the client was assisted back into bed. LPN #1 notified the APRN, the next of kin and the RN on duty.

Interview and review of LPN #4's nurses note dated 3/02/23 with the SALSA on 4/12/23 at 2:15 PM, failed to identify that the LPN completed a body audit at the time of the fall, the RN failed to assess Client #1 after the fall and failed to update the service plan to reflect interventions as applicable.

The Connecticut General Statutes at Chapter 378 Section 20-872 (c) defines the practice of nursing by a licensed practical nurse as, among other responsibilities, "the performing of selected tasks and sharing of responsibility under the direction of a registered nurse;"

Interview and review of Client #2's fall on 3/18/23 with the Executive Director on 4/12/23 at 1:55 PM, indicated that LPN's #1 and #5 and ALSA Aide #2 failed to follow agency policies on workplace safety including not to lift clients.

Review of agency policy for Workplace Safety directed to ask for assistance before lifting or moving objects that feel heavy to you and do not lift clients. Observe and adhere to all the Community policies and procedures on assisting residents with self-transfer, and on when to call outside resources if a resident needs to be lifted.

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Review of agency fall policy directed to ensure a Registered Nurse is notified in person or by phone, if an evaluation is completed by the LPN, the RN will be consulted. The RN will update the Service Plan to reflect the intervention as applicable.

Plan of Correction for Violation #1:

POC accepted 5/8/23 MD

Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

Plan of Correction for Farmington Station from state visit on April 12, 2023:

1. In accordance with SLR policy "CT Incident Report Policy and Procedure", an RN will be notified in person or by phone of any reportable incident as stated in the policy. An assessment will be made by the RN, upon return to the facility if not in the building, and documented in the record. The resident's family and physician will be notified of any covered incident.

This policy will be reviewed with all nurses by May 19, 2023.

Ongoing monitoring will include review of nurses notes and incident reports by RN on a weekly basis. Three charts will be reviewed each month for completeness to begin May 8, 2023 for a period of six months. SALSA will be responsible for monitoring compliance.

2. If the injury is of unknown origin, an investigation will ensue to include an interview of the resident/witnesses/caregivers, a review of the care plan, caregiver assignment sheets, and any environmental factors. This information shall be documented in the EHR. Updates to the POC will be made and reviewed with family as needed.

This policy will be reviewed with all nurses by May 19, 2023.

Ongoing monitoring will include review of nurses notes and incident reports by RN on a weekly basis. Three charts will be reviewed each month for completeness to begin May 8, 2023 for a period of six months. SALSA will be responsible for monitoring compliance.

ASSISTED LIVING | COMPASS MEMORY SUPPORT

111 Scott Swamp Road, Farmington, CT 06032 | p. 860.284.0505 | f. 860.470.7394 | info@farmingtonSLR.com | FarmingtonSLR.com

poc accepted 5/24/23 LA

3. In accordance with SLR policy "Response To Resident Falls", an RN will be notified in person or by phone of any fall as stated in the policy. The resident will be evaluated by the community nurse for injuries, pain or change in condition. An assessment will be made by the RN either while in the building or upon return to the building, and documented in the record. POC will be updated and reviewed with family as needed.

The policy will be reviewed with all nurses by May 19, 2023.

Ongoing monitoring will include review of nurses notes and incident reports by RN on a weekly basis. Three charts will be reviewed each month for completeness to begin May 8, 2023 for a period of six months. SALSA will be responsible for monitoring compliance.

4. Employees will follow the guidelines as outlined in their job description and associate handbook in regards to lifting restrictions. RCAs and nurses will be reeducated on the expectations and limitations of their job description.

This will be reviewed with all RCAs and nurses by May 19, 2023.

Any RCA or nurse known to lift a resident will be counseled and disciplined as deemed necessary. SALSA will be responsible for monitoring compliance.