2017

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

October 4, 2017

Natalie Cswertek, Supervisor of Assisted Living Services Agency
Masonicare Home Health And Hospice
104 South Turnpike Road
Wallingford, CT 06492

Dear Ms. Cswertek:

Unannounced visits were made to Masonicare Home Health And Hospice on November 3, 4, 7 and 8, 2016 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which wasoted during the course of the visit.

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 October 18, 2017 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

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 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.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

DATE(S) OF VISIT: November 3, 4, 7, and 8, 2016

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

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

DATES OF VISIT: November 3, 4, 7 and 8, 2016

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (4) and/or (j) Assisted living services agency staffing requirements (2)

1. Based on review of the ALSA documentation and staff interview, the ALSA failed to employ qualifying staff in the required positions. The findings include:

    a. Interview and review of the personnel file of the RN Designee with the Regional Director on 11/8/16 indicated that the RN Designee worked in the past in a staffing agency unlicensed by the Connecticut Department of Public Health, failed to identify qualifying past work experience in a home health care agency or community health program that included care of the sick at home, and failed to identify the employment of a qualifying nurse in the position of RN Designee.

POC Approved
11/20/17

Masonicare

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P.O. Box 70
Wallingford, CT 06492
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www.masonicare.org

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
410 Capitol Avenue
P O Box 340308
Hartford, CT 06134-0308

ATTN: MS. LOAN NGUYEN MSN RNC
SUPERVISING NURSE CONSULTANT

Ms. Nguyen:

In response to your letter dated October 4, 2017 pertaining to the unannounced visits to Masonicare Home Health and Hospice on November 3,4,7,8 2016 regarding the alleged violation to Public Health Code 19-13-D105, Section (g) Supervisor of assisted living services sub section 1 B, which states:

"a diploma or associate's degree in nursing and at least four (4) full time or full time equivalent clinical experience in nursing within the past ten (10)years, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home."

PLAN OF CORRECTION

1. Upon review of our process, it was determined that our HR team would expand the review of the regulatory requirements of this position. In addition, the role of Clinical Director of ALSA Partnerships was added in July 2016. The Clinical Director is well-versed in DPH ALSA regulations and now reviews all applicants to make sure they meet regulatory guidelines. The RN in question, with regard to the above-referenced health code, is now fully in compliance with the required criteria even if her out-of-state home care experience is disqualified.
2. The expanded review of regulatory requirements of the SALSA DESIGNEE was implemented with HR Recruitment Department as of December 2016. And the Clinical Director of ALSA Partnerships review began in July 2016.
3. In addition to HR Recruitment screening of all applicants, the Clinical Director of ALSA Partnerships will review all SALSA and DESIGNEE applications prior to interview process.
4. The Director of Recruitment and Clinical Director of ALSA Partnerships are responsible for compliance.

If there are any questions or concerns relative to the plan of correction of any other manner, please do not hesitate to contact me.

Sincerely,

Jason Rieger
Assisted Administrator/Assisted Living
Masonicare
(203) 679-6040
jarieger@masonicare.org

4/4/17 Approved PoC (CAH)

MASONICARE HEALTH CENTER
WALLINGFORD, CT

Plan of Correction for Visit Concluding on January 27, 2017

1. Based on review of the clinical record, review of facility documentation and staff interviews for one of three sampled residents reviewed for an injury of unknown origin (Resident #271), the facility failed to conduct a thorough investigation when the resident alleged neglect in accordance to facility practice.

   The facility does conduct a thorough investigation when a resident alleges neglect.

   Resident #271 currently resides in the facility.

   All residents who have alleged neglect have the potential to be at risk. Education to all nursing staff to ensure investigations are thorough when a resident alleges neglect were completed by March 10, 2017.

   Weekly audits on any resident(s) alleging neglect to ensure thorough investigations were completed will be performed. These audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The DON and/or designee is responsible to monitor.

2. Based on review of clinical records, facility documentation, interview, and policies, the facility failed to investigate an incident when one resident's nephrostomy tube (Resident #551), was dislodged during a transfer to ensure appropriate care was provided in accordance with facility policy.

   The facility does investigate any incident in which any drains/tube(s) are dislodged during care in accordance with facility policy.

   Resident #551 no longer resides in the facility.

   All residents with tubes/drains have the potential to be at risk. Education to all nursing staff to ensure investigations are initiated when a tube/drain is dislodged during care were completed by March 10, 2017.

   Weekly audits on any resident(s) with dislodged tubes/drains will be performed. These audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The DON and/or designee is responsible to monitor.

3. Based on review of the clinical record, review of facility documentation, review of facility policy and/or procedures and interviews for one of three residents reviewed for allegation of mistreatment (Resident #249), the facility failed to ensure that two staff members were present during care.

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WALLINGFORD, CT

Plan of Correction for Visit Concluding on January 27, 2017

The facility does ensure that services provided or arranged by the facility as outlined by the comprehensive care plan, be provided by qualified persons in accordance with each resident's written plan of care.

Resident #249 currently resides in the facility.

All residents have the potential to be at risk. Education to all nursing staff to ensure staff are following each residents' individualized plan of care when delivering care and services was completed by March 10, 2017.

Weekly audits on five staff members to ensure they are providing care and services directed by the resident's comprehensive care plan will be performed. These audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

The DON and/or designee is responsible to monitor.

4. Based on clinical record review, observations, review of facility documentation, and interviews for one sampled resident who received specialized treatment (Resident #115), the facility failed to follow up on a recommendation in a timely manner and/or for one sampled resident with a history of PVD, the facility failed to consistently monitor the resident's skin integrity and/or implement measures to prevent further skin breakdown in a timely manner.

The facility does ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive care plan and residents' goals and preferences. The facility does ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive care plan and residents' goals and preferences.

Residents #115 and #13 currently reside in the facility.

All residents in the facility have the potential to be at risk. Education to all nursing staff to ensure residents who require pain management, have interventions in place which are consistent with professional standards, ensuring their care plan goals and preferences are met. Education to all nursing staff to ensure residents requiring dialysis have a comprehensive care plan following professional standards as well as their goals and preferences. This education was completed by March 10, 2017.

Weekly audits on five residents who require pain management services will be done to ensure a comprehensive care plan is in place. Weekly audits on residents requiring dialysis services will be done to ensure a comprehensive care plan is in place. These

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WALLINGFORD, CT

Plan of Correction for Visit Concluding on January 27, 2017

audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

The DON and/or designee is responsible to monitor.

5. Based on observations and interview, the facility failed to ensure the dietary area was maintained in a sanitary and/or safe manner.

   The Facility does ensure the dietary area is maintained in a sanitary and/or safe manner.

   All residents have the potential to be at risk.

   Mandatory in-service education shall be provided to all Dining Services staff regarding the results of the survey and expectations to assure dietary area is maintained in a safe and sanitary manner. This was completed by March 10, 2017.

   Weekly audits on sanitary and safety conditions will be performed until substantial compliance is maintained. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The Director of Dining Services and/or designee is responsible to monitor.

6. Based on observation, review of facility documentation and interview for two of four medication storage areas the facility failed to ensure the medication refrigerator and/or medication cart was clean.

   The facility does ensure medication storage areas, medication cart and refrigerator are clean.

   Education to all nursing staff to ensure medication carts and refrigerators are routinely cleaned was completed by March 10, 2017.

   Weekly audits of medication carts and refrigerators will be performed. These audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The DON and/or designee is responsible to monitor.

7. Based on observations, review of the clinical record and interviews for one of three residents reviewed for pressure ulcers (Resident #13), the facility failed to ensure infection control practices were maintained and/or maintain the oxygen Trans-fill room in a clean and sanitary manner.

   The facility does ensure infection control practices are maintained and/or maintain the Oxygen Trans-fill room in a sanitary manner.

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WALLINGFORD, CT

Plan of Correction for Visit Concluding on January 27, 2017

Resident #13 currently resides in the facility.

All residents within the facility are at risk. Education to all nursing staff to ensure infection control practices are maintained and also that the Oxygen Trans-fill room is kept in a sanitary manner was completed by March 10, 2017.

Weekly audits of five residents and the Oxygen Trans-fill room will be performed to ensure maintenance of infection control practices. These audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

The DON and/or designee is responsible to monitor.

8. Based on observation, review of facility policy and interviews the facility failed to store oxygen cylinders in a secure manner.

   The facility does ensure secure storage of oxygen cylinders.

   Education to all nursing staff on secure storage of oxygen cylinders was done by March 10, 2017.

   Weekly audits of the oxygen room will be performed until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The DON and/or designee is responsible to monitor.

9. Based on record reviews and staff interviews for two of three sampled residents reviewed for an injury (Residents #271 and 551), the facility failed to ensure the clinical records were complete.

   The facility does ensure clinical records are complete.

   Education to all nursing staff on the required completion of ADL flow sheet documentation was done by March 10, 2017.

   Weekly audits on five residents' ADL flow sheets will be performed. The audits will continue until substantial compliance is achieved. Substantial compliance was achieved on March 31, 2017. Ongoing compliance shall be monitored through MHC's Quality Improvement Program.

   The DON and/or designee is responsible to monitor.