Section 3

2018

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Luther Ridge
628 Congdon St West
Middletown CT 06457
M: Same
Ph 860-347-7144

Signature of FLIS Staff

Melissa J Ten Eyck RN Nurse Consultant

Licensure Category:

Assisted Living Services

Licensed Bed
Bassinet Capacity: _____

Census: 54
no memory care units

Date(s) of onsite inspection: 01/12/18, 01/16/18

Date(s) additional information obtained: 01/17/18

Personnel contacted: Nereida Lugo RN SDM, Glen Appel ED

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [✓] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[X] See Complaint Investigation # 22453

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 3/6/20

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Melissa J Ten Eyck RN **DATE OF REPORT:** 01/17/18

[✓] Approval for issuance of license granted by: Loan D Nguyen **DATE:** 1-18-18
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

March 6, 2020

Glen Appel, Executive Director
Luther Ridge
628 Congdon Street West
Middletown, CT 06457

Dear Mr. Appel:

An unannounced visit was made to Luther Ridge concluding on 1/16/18 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure renewal survey.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

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 March 16, 2020.

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 violation and you may be provided with the opportunity to be heard. If the violation is not responded to by March 16, 2020 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to Loan Nguyen, Supervising Nurse Consultant via email at Loan.Nguyen@ct.gov. Please direct your questions to the Supervising Nurse Consultant at (860) 509-8059.

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

If there are any questions, please do not hesitate to contact this office at (860) 509-8059.

Respectfully,

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

Complaint #22453

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
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) (4) (F) and/or (g) Supervisor of assisted living services (2) (A) and/or (D) and/or (h) Nursing Services provided by an assisted living services agency (1) (3) (C) and/or (D) and/or (4)(D) and/or (E) and/or (k) Client service record (1) and/or (2) (I) and/or (K).

1. Based on review of the clinical record and interview with agency personnel for one of three clients, (client #1) who required medication management, the assisted living services agency (ALSA) failed to provide the necessary services. The findings include:

   Client #1 was admitted on 09/12/16 with diagnoses that included hypertension, coronary artery disease, angina, gastroesophageal reflux disease, Horner syndrome, borderline diabetes, depression, history of cerebrovascular accident and myocardial infarction.

   The client's service plan dated 08/05/17 to 12/05/17, signed by the client, identified the client required medication assistance and received medications from the ALSA contracted pharmacy and reminders from the ALSA aides to self-administer medications.

   A physician's order dated 09/11/17 directed Montelukast sodium 10 milligrams (mg) by mouth at bedtime.

a. Interview and review of RN #1's nursing note dated 09/16/17 with the supervisor of assisted living services agency (SALSA) on 01/16/18 identified that the client complained of feeling "dizzy", thought the dizziness was a side effect of the Montekulast and the client contacted the pharmacist who directed the client to "cut it in half". The client indicated s/he "will let the doctor know on Monday and will update the nurse".

   The nursing note failed to identify that RN #1 notified the physician and/or the client's conservator of the client's dizziness and instruction by the pharmacist to cut the pill in half.

b. An office visit summary medication list dated 07/27/17 from the client's cardiologist identified Metoprolol tartrate 100 mg. by mouth twice daily.

   The service plan dated 08/05/17, signed by the primary care physician, identified Metoprolol succinate extended release (ER) 50 mg. by mouth two tablets two times a day.

   Review of the medication on time (MOT) list and the medication administration record (MAR) delivered from the pharmacy dated 07/30/17 to 08/26/17, 08/27/17 to 09/23/17, 09/24/17 to 10/21/17 and 10/22/17 to 11/18/17 and interview with the SALSA on 01/16/18 identified Metoprolol tartrate 50 mg. two tablets (100 mg.) by mouth twice a day. Metoprolol succinate ER 50 mg was not identified as administered in accordance with the physician's orders.

   Interview with the Pharmacist on 01/17/18 indicated the physician orders received by the pharmacy dated 06/27/17 directed Metoprolol tartrate 50 mg. two tablets twice a day, 120 tablets were dispensed with three refills. The Pharmacist stated an order for Metoprolol

succinate ER as identified on service plan dated 08/05/17, was not received.

Interview and review of client #1's clinical record with the SALSA on 01/17/18 stated the RN should have clarified the Metoprolol medication (tartrate vs succinate ER) order when a discrepancy was noted.

c. Review of LPN #1's nursing note dated 10/23/17 with the SALSA on 01/16/18 identified that the client "missed one 50 mg. dose of Metoprolol in the morning and one 50 mg. dose of Metoprolol in the evening. The physician was not notified of the omission until 10/25/17 (two days after the nurse was made aware of the omitted medication). Interview with the Pharmacist on 01/17/18 indicated an investigation was performed and identified the incorrect dose of Metoprolol occurred on 10/22/17 only. The medication planner (cardboard with medications sealed in blister pack) cycle started on 10/22/17 and the remainder of the planner cycle was corrected to contain the correct dosage of Metoprolol tartrate 50 mg. two tablets by mouth twice a day.

Plan of Correction for Violation #1:

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (c) Managed residential communities served by assisted living services agencies (5) (B) (i).

2. Based on review of agency documentation and interview with agency personnel the ALSA failed to ensure the quality of dining services. The finding includes:

   On 01/16/18 at 12:25 pm the surveyor observed dining service of the mid-day meal and random interviews with diners.

   a. Interview with the Food Service Director (FSD) on 01/16/18 indicated that he received a report of hair found in a meal and investigation identified that the ALSA aide assisting the client failed to wear a hairnet and indicated that he failed to document the incident and it has been resolved. The resident service coordinator failed to ensure the quality of the meal service.

Plan of Correction for Violation #2:

State of Connecticut
Department of Public Health
Facility Licensing & Investigations Section
410 Capital Avenue, MS # 12FLIS
PO Box 340308
Hartford, CT 06134-0308
Phone (860) 509-7400 Fax (860)509-7543

Fax Transmittal

DATE: March 6, 2020

TO: Amy

FROM: Cheryl Davis

COMMENT: Luther Ridge violation letter
Attached.

NUMBER OF PAGES INCLUDING THIS COVERSHEET: 5

PLEASE ADVISE IF ALL PAGES ARE NOT RECEIVED