

2019

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Masonicare

January 25, 2019

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M. J. H.
2/8/19

Loan Nguyen, Supervising Nurse Consultant
Healthcare Quality and Safety Branch
State of Connecticut Department of Public Health
410 Capitol Ave. PO Box 340308
Hartford, CT. 06134

Below, please find Masonicare Home Health and Hospice Assisted Living Services Agency/ALSA's corrective action plan addressing the deficiencies cited from the investigation survey on November 28, 2018 (Complaint number 24523).

Section 19-13-D105(d) Governing authority of an Assisted living services agency (4)(A) and or (g) Supervisor of assisted living services (2) and or (k) Client service record (2) (H) (i) and/or (ii) and/or (vi):

Action Plan

- The title of the institution staff member that is responsible for ensuring the institutions compliance with its plan of correction is Supervisor of Assisted Living Services Agency (SALSA)
- In reference to Client 1, changes required were made immediately and within the week of the survey. The changes included Staff Education in relation to Medication Assistance (see below). A labeled, color coded Medication box was placed in Client 1's apartment to differentiate each spouses Medication box. Client 1 received a re-assessment upon return from the hospital on December 4, 2018. Client 1 then later received an additional assessment on January 17, 2019.
- All Masonicare ALSA Clients who score greater than 21 on the Cognitive Testing tool will have a Medication Self Administration Test completed by a Registered Nurse by February 28, 2019. The test will determine the client's ability to self-administer medications.
- Masonicare ALSA Clients who receive a score of 21 or less on the Cognitive Testing tool will not receive a Medication Self Administration Test because the results along with an assessment by a registered nurse will indicate that the Client is not capable of managing medications independently.
- The Masonicare Aide Plan of Care and Daily Aide Assignments will be updated by a Registered Nurse by February 28, 2019 for each Client to reflect the appropriate changes based on the results of the Cognitive Testing score.
- Medication Box audits will continue to be completed every two weeks a Nurse to maintain neat, organized and accurate medications.

Staff Education Plan

- In reference to Client 1, education was provided to the RN Designee and Aide involved with the incident. The in-service was performed on November 28, 2018 and included directions to provide safe medication management based on client needs.



- The SALSA will provide in-service education to the Nursing staff regarding the requirement and process of performing Cognitive testing and the indications for administering the Medication Self Administration Test by January 31, 2019.
- The SALSA will provide in-service education to all ALSA Aide and Nursing Staff referencing the policy Number NURS0065, Assisted Living Medication Administration by February 28, 2019.
- ALSA Aide Staff will attend the Medication Management Program which will review the limitations as defined by their role found in Regulation 19-13-D105 (h)(4)(C). The Program will be completed by February 28, 2019.
- The SALSA will educate all Nursing Supervisors of their responsibility to report incidents to the appropriate regulatory body in a suitable time frame. Education will be completed by February 28, 2019.
- The SALSA and the RN Designee will provide patient specific individualized orientation to the Licensed Practical Nurses and ALSA Aides regarding the updated Care Plans and ALSA Daily Aide assignment that are updated with changes based on the cognitive testing results by February 28, 2019.

Mayra Adames, RN, BSN

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ALSA

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

file

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



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

January 14, 2019

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

Dear Ms. Adams:

This is an amended edition of the violation letter originally dated January 3, 2019.

An unannounced visit was made to Masonicare Home Health And Hospice Assisted Living Services Agency/ALSA on November 29, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through December 3, 2018.

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.

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 January 28, 2019.

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 to Loan.Nguyen@ct.gov 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 January 28, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.



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Affirmative Action/Equal Opportunity Employer



DATE(S) OF VISIT: November 29, 2018

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

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

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

LN:mb

Complaint # 24523

DATE(S) OF VISIT: November 29, 2018

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(d) Governing authority of an assisted living services agency (4) (A) and/or (g) Supervisor of assisted living services (2) and/or (k) Client service record (2) (H) (i) and/or (ii) and/or (vi).

1. Based on clinical record review and staff interview, for one of one client (Client #1) who received assistance with medication self-administration, the Assisted Living Services Agency/ALSA failed to ensure proper assessment of the client's ability to self-administer medications, re-enforcement of the ALSA aide's limitations in the practice of assisting, and failed to provide safe medication services through supervision and compliance with State laws. The findings include:
 - a. Client #1 was admitted to the assisted living facility on 10/17/18 with diagnoses that included dysthymia, hypercholesterolemia, hypertension, incontinence, and transient ischemic attack. The client service program dated 10/17/18 identified the need for assistance with showers, dressing, and the need for reminders to wear hearing aides and reminders to self-administer medications three times a day.

Client # 1 shared an apartment with the client's spouse inside the assisted living facility.

The client's spouse self-administered medications without the assistance from ALSA staff.

- i. Interview and review of the clinical record with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. identified an undated assessment of Client # 1 using a form developed by a Veteran Administration Medical Center, with scores assigned to each answer by Client # 1, based on questions testing the client's ability to recall information, but failed to identify the total score for Client # 1's assessment at the end of the test;
- ii. Interview and review of the clinical record with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. concluded that the assessment score for Client # 1 would be 18, with the legend at the bottom of the form specifying that any score between 1 and 20 was indicative of dementia, and failed to identify the appropriateness of qualifying Client # 1 as able to "self-administer" medications, for the purpose of assigning an ALSA aide to "remind" the client to "self-administer" medications;
- iii. Interview and review of the clinical record with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. failed to identify the documentation of an assessment by the ALSA nurse of Client # 1's ability to verbalize the need for taking certain medications to treat certain diagnoses, and/or Client # 1's ability to direct the operations of medication self-administration, and the clients' ability to initiate the request for physical assistance from the aide for medication removal, for the purpose of self-administering medications with assistance.
- iv. Interview and review of ALSA Aide # 1's personnel files with the Registered Nurse Designee (RN

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Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. identified a medication "quiz" form with the logo of a pharmacy dated 8/23/18, with ten questions for Aide # 1 to answer, including the full identification of the medication Coumadin in the "red medication cards," the "administration" of medications by opening a bubble pack, the "administration" of both yellow cards, "giving" white or orange medication cards, etc. and failed to identify the limitation of the aide performance to the time reminders and the physical assistance as directed by the client during the medication self-administration process, without knowledge of the medication name and without initiating the process of medication administration;

v. The agency documentation indicated that on 11/19/2018, ALSA Aide #1 was assigned to "remind" Client # 1 to self-administer medications at 5 p.m., walked into Client # 1's apartment, and without any directions from Client # 1, proceeded to "pop" the medications out of the package to give to Client # 1, and failed to identify an acceptable process of medication self-administration directed by the client, with only the physical assistance from the ALSA aide upon request from the client;

vi. Interview and review of the agency documentation with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. indicated that instead of reading Client # 1's first name and last name on the medication package, ALSA Aide # 1 only read the last name and handed the client's spouse medications to Client # 1 (Warfarin, Vitamin D3, Carvedilol, Magnesium, Gabapentin, and a probiotic capsule) instead of Client # 1's own medications, and failed to identify a safe system for medication management;

vii. Interview and review of the agency documentation with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. indicated that Client # 1 was supposed to self-administer only 2 medications at 5 p.m., but did not recognize the medication error and swallowed the 6 tablets handed by the ALSA aide on 11/19/18, and failed to identify Client # 1's ability to recognize, count or name the client's own medications, in order to "self-administer" daily medications with only the physical assistance from the ALSA aide;

viii. Interview and review of the agency documentation with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. indicated that the ALSA staff did not identify the medication error, instead Client # 1's spouse identified the medication error and notified the ALSA staff, and failed to identify proper supervision of the medication management process by the Supervisor of Assisted Living services Agency/SALSA to ensure safety and quality of the services;

ix. Interview and review of the agency documentation with the Registered Nurse Designee (RN

Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. indicated that following the incident, the ALSA re-educated the

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ALSA aides, but failed to identify an agency-wide re-assessment of each client for the cognitive ability to direct the process of self-administering medications, prior to assigning an ALSA aide to assist the clients with the medication self-administration;

x. Interview and review of the agency documentation with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. indicated that following the incident, the ALSA re-educated the ALSA aides, but continued to teach the aides to "give medications to" the clients, instead of just reminding the clients of the medication time and assisting the clients with unpackaging if requested by the clients;

xi. Interview and review of the agency documentation with the Registered Nurse Designee (RN Designee), the Operation Director of Assisted Living Partnerships and the Corporate Lead Clinical Director on 11/29/18 at 10:06 a.m. identified a Current Summary of Medication Event dated 11/27/18 for the medication error involved Client # 1 on 11/19/18, with blank spaces under the header of "Follow-up actions" and "Resolution and Outcomes," and failed to identify a comprehensive investigation of the incident with an accurate root cause analysis and timely interventions to prevent recurrences.

Following the medication errors on 11/19/18, Client # 1's physician ordered to transfer the client to the Emergency department (ED) for evaluation.

The ED record indicated that Client # 1 had a new onset of shortness of breath, fatigue and headache. Examination revealed expiratory wheezes and a few rhonchi. The client verbalized "feeling lousy," and exhibited mild cognitive impairment. The client received oxygen therapy for hypoxia, Solumedrol intravenous administration, and Duoneb inhalation treatments. The client was discharged back to the assisted living facility four days later on 11/23/18.

