2018

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Greystone Rest Home
44 High Street
Portland, CT 06480
M:

Signature of FLIS Staff
M Hoyer R

Licensure Category:
RCH

Licensed Bed
Bassinet Capacity: 58

Census: 46

Date(s) of onsite inspection: 11/20/18

Date(s) additional information obtained: _____

Personnel contacted: Cristal Player - manager
Luel Swanson, Person-in-Charge

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 # 24400

[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 1/2/19

[ ] 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: Margaret Hoyer **DATE OF REPORT:** _____

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

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

January 2, 2019

Luel Swanson, Person-in-Charge
Greystone Rest Home Inc
44 High Street
Portland, CT 06480

Dear Ms Swanson:

An unannounced visit was made to Greystone Rest Home Inc on November 20, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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.

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 16, 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 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 January 16, 2019 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

DATE(S) OF VISIT: November 20, 2018

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

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

Respectfully,

Karen Gworek, RN

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb

c. Mairead Painter, LTC Ombudsman

DATE(S) OF VISIT: November 20, 2018

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

The following is a violation of the Connecticut General Statutes Section 19a-550 (b) (8) and/or the Regulations of Connecticut State Agencies Section 19-13- D6 (c) Administration (1) and/or (h) General Conditions (3).

1. Based on record reviews, review of facility documentation, and interviews for one of forty-six residents (Resident #2) was the victim of an inappropriate behavior, the facility failed to report an incident of resident to resident abuse. The findings include:
   a. Resident #1 was admitted to the facility on 10/9/18 with diagnoses that included chronic obstructive pulmonary disease, and schizophrenia and had a Conservator of Person. Resident #2 was admitted to the facility on 9/7/07 with diagnoses that included intellectual disabilities and had a Conservator of Person. Interview with the facility's Manager on 11/20/18 at 9:30 AM identified that on 10/31/18 at approximately 10:00 PM she was notified that Resident #1 was found in Resident #2's room lying on top of Resident #2. The Manager stated that Resident #3, who was the roommate of Resident #2 , reported that he/she heard Resident #2 yelling " stop that" and when he/she looked over Resident #3 saw Resident #1 in the bed on top of Resident #2 and Resident #1 would not get off of Resident #2 until Resident #3 intervened. The Manager identified that a staff attendant, Attendant #1, reported to her that on the evening of 10/31/18 at 10:00 PM, she heard "yelling" from Resident #2's room and when she arrived she saw Resident #1 in bed with Resident #2 and Resident #3 standing and yelling at Resident #1 to get out of the room. The Manager indicated that Resident #3 told Attendant #1 he/she saw Resident #1 on top of Resident #2 and was touching Resident #2 inappropriately and had to pull Resident #1 off the bed. The Manager stated that staff separated the residents and she directed the staff to keep Resident #1 out of Resident #2's room and keep an eye on Resident #1. Interview with Attendant #3 on 11/20/18 at 12:35 PM, identified that he was the second staff person during the period of 10/31/18 at 11:00 PM to 11/1/18 at 7:00 AM, along with Attendants #1 and #2. Attendant #3 identified that he was not aware an incident occurred between Resident #1 and Resident #2 and/or he was not directed to monitor Resident #1. Interview with Attendant #2 identified that he was aware of the incident and although he monitored the residents and did frequent room checks on Resident #1, he did not provide continuous one to one (1:1) supervision. In a second interview with the Manager on 11/20/18 at 1:00 PM identified that, although she directed the night staff to keep an eye on Resident #1, the facility was not able to provide 1:1 supervision. The Manager stated that, in hind sight, Resident #1 should have been transferred to the Emergency Department on 10/31/18 when the incident occurred. The Manager identified that when she arrived to the facility on the morning of 11/1/18 around 8:00 AM, she notified Resident #1 and Resident #2's conservators, the home care nurse and the mobile crisis.

DATE(S) OF VISIT: November 20, 2018

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

The Manager stated Resident #1 was evaluated by the crisis center at the facility and was then transferred to the Emergency Department at 12:00 PM for an evaluation and treatment and Resident #2 was evaluated for no injury and/or distress and remained at the facility.
The Manager indicated that although the home care nurse informed her that she filed a report to the Department of Public Health, the facility failed to notify the state agency of the incident.
Review of the Residents' Bill of Rights identified, in part, that residents have the right to be free from mental and physical abuse.

Greystone Retirement Home 2/2/19

Dear Cher,

Thank you for meeting with Christal and I today. We are asking to Not have this submitted as a violation against Greystone. Christal nor I called D.P.H. because we conferred with, and were standing right next to our V.N.A. Nurse, Trish Coe, Middlesex Hospital, who called on our behalf from Greystone. We thought it would be redundant. Trish Coe called and spoke with Cassandra Henderson, and also filed an on-line Report with D.P.H. the morning of the incident. Trish Coe also called D.P.H., and left a message again Reporting the incident to which she did not get a Call or response back. Peg visited Greystone after this.

Approved 2/5/19 KEG

Plan of Correction

#1.) Any reportable incident will be called or sent in by Lori Swanson, Christal Player or a Greystone Employee, only.

#2.) Jan. 1st, 2019

#3.) Monitor - Christal Player, Facility Manager. In contact with All Heads of Dept.

#4.) Christal Player, Facility Manager.