2022

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity	*Signature of FLIS Staff*	
Greystone Retirement Home	Kathleen Plaskon, RN	
44 High Street	Raymond Kasidas, BFSI	
Portland, CT 06480	Dan Tomascak, BFSI	

Licensure Category:
Residential Care Home

Licensed Bed/Bassinet Capacity:58

Census: 44

Date(s) of onsite inspection: 9/13/22

Date(s) additional information obtained: _____

Personnel contacted: Person-in-Charge- Luel Swanson

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[ ] See Complaint Investigation _____

[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 10/4/22

[ ] 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 _____

[ ] CMP fund verification
[ ] CRF grant verification
[ ] Shift Coach
[ ] Full Time Infection Prevention and Control Specialist

REPORT SUBMITTED BY: Kathleen Plaskon RN **DATE OF REPORT:** 9/29/22

[X] Approval for issuance of license granted by: Karen Gworek, RN **DATE:** 9/29/22
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

October 14, 2022

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 September 13, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

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. 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 fourteen 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 October 28, 2022.

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 violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **October 28, 2022** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

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

Respectfully,

Karen Gworek, RN
Karen Gworek, RN, BSN
Supervising Nurse Consultant
Facility Licensing & Investigations Section

KEG:csf

c. Mairead Painter, LTC Ombudsman Program

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4).

1. Based on review of personnel files and interviews, the facility failed to ensure performance evaluations were conducted annually. The findings include:

    a. Interview with the Person-in-Charge on 9/13/22 identified no annual employee performance evaluations have been completed since 2019.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f) Dietary service (2).

2. Based on observations and interviews, the facility failed to post daily and weekly menus for the residents to view. The findings include:

    a. Review of facility daily posted menus dated 8/28/22 through 8/30/22 and on 9/7/22, and 9/8/22 noted breakfast and lunch menu items were posted for the residents to review, however the dinner section was left blank on those days. Interview with the Person-in-Charge noted she was unaware the daily posted menus were not filled out completely identifying the dinner meal.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b)(N)(5) and/or (c) Administration (1).

3. Based on observations and interview, the facility failed to ensure that all residents had a functioning call bell system. The findings include:

    b. Tour of the facility and interview with the Person-in-Charge on 9/13/22 identified the resident rooms were not equipped with a call bell system. The Person-in-Charge noted the facility experienced a lightning strike two (2) weeks ago and were waiting for a contractor to repair the system.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications.

4. Based on observations and interviews, the facility failed to ensure the resident was free from a medication error. The findings include:

a. Observations of a medication administration pass with Resident Aide (RA) #1 on 9/13/22 identified she administered two (2) drops of artificial tears into Resident #1's left and right eyes and immediately after administering the artificial tears administered one (1) drop of Restasis eye drops to both eyes without the benefit of waiting fifteen (15) minutes between drops. Interview with the Person-in-Charge indicated the shift nurse usually administers medications however the nurse on duty this morning had to leave the building and must have told RA #1 to administer the eye drops. The Person-in-Charge was unaware of the recommendation to wait fifteen (15) minutes between the administration of different eye drops.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b)(N)(5) and/or (c) Administration (1).

5. Based on observations and interview, the facility failed to ensure that all residents had a functioning call bell system. The findings include:

a. Tour of the facility and interview with the Person-in-Charge on 9/13/22 identified the resident rooms were not equipped with a call bell system. The Person-in-Charge noted the facility experienced a lightning strike two (2) weeks ago and were waiting for a contractor to repair the system.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications.

4. Based on observations and interviews, the facility failed to ensure the resident was free from a medication error. The findings include:

a. Observations of a medication administration pass with Resident Aide (RA) #1 on 9/13/22 identified she administered two (2) drops of artificial tears into Resident #1's left and right eyes and immediately after administering the artificial tears administered one (1) drop of Restasis eye drops to both eyes without the benefit of waiting fifteen (15) minutes between drops. Interview with the Person-in-Charge indicated the shift nurse usually administers medications however the nurse on duty this morning had to leave the building and must have told RA #1 to administer the eye drops. The Person-in-Charge was unaware of the recommendation to wait fifteen (15) minutes between the administration of different eye drops.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medication (5).

5. Based on interviews, the facility failed to have written policies that governed the administration of medications to include the types of medication administered, resident responsibilities, staff responsibilities, storage of medications, and record keeping. The findings include:

    a. Interview and review of facility documentation with the Person-in-Charge on 9/13/22 noted the facility does not have a policy related to medication administration.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2(E).

6. Based on review of facility documentation and interviews, the facility failed to document the effectiveness after an as needed (PRN) medication was administered. The findings include:

    a. Interview with the Person-in-Charge on 9/13/22 identified that although the facility documents the use of an as needed (PRN) medication when the resident requests one (1), they do not document if the medication was effective or not.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(C) and/or Connecticut General Statutes 19a-495a (3).

7. Based on review of facility documentation and interviews, the facility failed to ensure that staff who assisted with medications had current medication administration certificates. The findings include:

    a. Observations of a medication administration pass with Resident Aide (RA) #1 on 9/13/22 noted she administered two (2) drops of artificial tears into Resident #1's left and right eyes and immediately after administering the artificial tears administered one (1) drop of Restasis eye drops to both eyes without the benefit of waiting fifteen (15) minutes between drops. Interview with Person-in-Charge on 9/13/22 noted no staff at the facility have current medication administration certificates, since the shift nurse usually administers the resident's medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration (2)(F)(ii).

8. Based on observation and interviews, the facility failed to ensure shift to shift reconciliation of controlled medications were documented as completed. The findings include:

    a. Review of facility documentation failed to reflect staff were conducting narcotic medication reconciliation every shift. Interview with the Person-in-Charge on 9/13/22 noted she was unaware staff needed to count narcotic medications shift to shift.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4).

9. Based on review of facility documentation and interviews, the facility failed to ensure the Applicant Background Check Management System (ABCMS) verification was completed prior to hire. The findings include:

    a. Review of facility documentation and interview with the Person-in-Charge on 9/13/22 identified the facility conducts a background check of the new hires with the local police department in the town of which the new hire resides. The Person-in-Charge was unaware an ABCMS verification needed to be completed since the facility conducted the checks with the local police department.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b)(Q) and/or (c) Administration (1).

10. Based on observations and interview, the facility failed to ensure the resident rooms identified the capacity of each room. The findings include:

    a. Observations and interview during tour of the facility on 9/13/22 with the Person-in-Charge identified the capacity of each resident room was not posted at the doorway. The Person-in-Charge indicated she was unaware that the capacity of the resident rooms was required to be posted.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

11. Based on review of facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include:

    a. On 9/13/22 at 09:00 A.M., during a tour of the facility and while accompanied by a facility

representative, the following observations were identified:

i. The surveyor while accompanied by a facility representative observed Personal Protective Equipment (PPE) stored on the floor in the second-floor library.
ii. The surveyor while accompanied by a facility representative observed storage of combustibles in the egress stairwell in the basement.
iii. The surveyor while accompanied by a facility representative observed the basement door being held open by a foot peg. Fire doors are required to close upon alarm activation.
iv. The surveyor while accompanied by a facility representative observed the second-floor door to the egress stairwell being held open by a wood block in the frame. Fire doors are required to close upon alarm activation.
v. The surveyor while accompanied by a facility representative observed the door from the kitchen to the dry storage room being held open by a wood block. Fire doors are required to close upon alarm activation.
vi. The surveyor while accompanied by a facility representative observed the door from the kitchen dry storage room to the egress corridor held open with a wedge. Fire doors are required to close upon alarm activation.
vii. The surveyor while accompanied by a facility representative observed the egress corridor from the resident area to the smoking area being used for combustible storage. The area was not clear and available for immediate use as required.
viii. The surveyor while accompanied by a facility representative observed fire door labels throughout the facility were painted and not legible.
ix. The surveyor while accompanied by a facility representative observed the smoke barrier door to the women's wing from the main lobby being held open with a piece of cardboard.
x. The surveyor while accompanied by a facility representative observed the gap between the doors to the Recreation Room exceeded the allowable limit.
xi. The surveyor while accompanied by a facility representative observed the laundry room door held open with a foot peg. Fire doors are required to close upon alarm activation.
xii. The surveyor while accompanied by a facility representative observed a broken GFI Outlet in the kitchen above the sink near the stove.
xiii. The surveyor while accompanied by a facility representative observed the handwashing sink in the kitchen lacked the required four (4) inch wrist blades on the faucet.
xiv. The surveyor while accompanied by a facility representative observed that during a fire drill the staff relocated residents into the lounge areas at the end of the corridors and left the doors to the lounges open. Residents are required to evacuate the building by NFPA 101 section 33.7.3.3 and by the facilities written fire plan.
xv. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a sprinkler inspection was completed in the fourth quarter of 2021.
xvi. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance

with NFPA 25; i.e., There were no records that a sprinkler inspection was completed in the first quarter of 2022.

xvii. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a sprinkler inspection was completed in the second quarter of 2022.

xviii. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a sprinkler inspection was completed in the third quarter of 2022.

xix. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year obstruction test was done on the internal piping of the sprinkler system.

xx. Documentation was not provided to the surveyor from the facility to indicate that the generator was being serviced two (2) times a year (one (1) Major and one (1) Minor service) as required by NFPA 110. i.e., No record of a Minor service being completed. Major service was completed by Cummins on 6/20/22.

xxi. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a five (5) year test of the Fire Department Connection check valve was done.

xxii. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a three (3) year air loss test was done on the sprinkler system.

Greystone Retirement Home
Plan of Correction

Approved 10/28/22 KEG

***Please Note: At Greystone, the person who made the correction is the same person who will be monitoring the correction.**

1. All employee performance evaluations will be complete by 12/15/22. Will be corrected/implemented by the Manager.

2. Corrected 9/14/22. The posted menus include the dinner meal and are completely filled out. By Head of Kitchen Department.

3. Corrected 10/27/22. Brand New Complete Building Call Bell System installed = $23,000. All Residents were supplied with a bell for safety purposes while the system was under repair. By Head of Maintenance Department and the Administrator.

4. We assist with Medications only. Our pharmacy blister packs all medications with the proper dosages and times for our Residents. If a Resident has a medication that cannot be self-administered, i.e., commonly an insulin, our Nurse on duty administers these meds. The facility intends to have a staff member on each shift be medication certified in case a resident cannot assist themselves and needs an administered medication. This staff member will either be a Nurse or an RA having gone through the State Medication Training Program. This will be an ongoing process beginning 11/15/22. By the Manager and the Administrator.

5. Corrected 10/27/22. Brand New Complete Building Call Bell System installed = $23,000. All Residents were supplied with a bell for safety purposes while the system was under repair. By Head of Maintenance Department and the Administrator.

6. Corrected 9/22/22. Documentation has been added to include if a PRN has been effective or not. All pertinent staff have been in-serviced on this change. Weekly audits and complete review of MAR's to be done by Head Nurse.

7. We assist with Medications only. Our pharmacy blister packs all medications with the proper dosages and times for our Residents. If a Resident has a medication that cannot be self-administered, i.e., commonly an insulin, our Nurse on duty administers these meds. The facility intends to have a staff member on each shift be medication certified in case a resident cannot assist themselves and needs an administered medication. This staff member will either be a Nurse or an RA having gone through the State Medication Training Program. This will be an ongoing process beginning 11/15/22. By the Manager and the Administrator.

8. Corrected 9/20/22. The Administrator retrained all pertinent employees that at every shift change we conduct and document shift reconciliation, a controlled med. count. This is one of the most important things we do, and our staff knows this strictly and directly from the Administrator. Weekly audits of the controlled med. count shift reconciliation document to be done by Head Nurse.

9. The facility intends to register all new hires in the ABCMS system beginning 12/22. All current employee jackets and police reports have been reviewed. By the Manager.

10. Every resident room will have a permanent placard installed indicating room capacity number by 12/31/22. By Head of Maintenance Department.

11.a.

i. Corrected September 14, 2022. All PPE was lifted off the floor and put on palettes permanently. Head of Maintenance Department.

ii. Corrected September 14, 2022. All combustibles in the egress stairwell of the basement have been removed permanently. Head of Maintenance Department.

iii. Corrected September 14, 2022. All foot pegs have been removed from Fire Doors permanently. Daily rounds by Head of Maintenance Department will be conducted to ensure all Fire Doors remain closed.

iv. Corrected September 14, 2022. Wood Block removed permanently. Daily rounds by Head of Maintenance Department will be conducted to ensure all Fire Doors remain closed.

v. Corrected September 14, 2022. Wood Block removed permanently. Daily rounds by Head of Maintenance Department will be conducted to ensure all Fire Doors remain closed.

vi. Corrected September 14, 2022. Wedge removed permanently. Daily rounds by Head of Maintenance Department will be conducted to ensure all Fire Doors remain closed.

vii. Corrected September 15, 2022. All metal folding chairs in their chassis have been removed from the maintenance hallway permanently. Head of Maintenance Department.

viii. Corrected September 15, 2022. All paint has been carefully removed from the labels on the Fire Doors. Head of Maintenance Department.

ix. Corrected September 13, 2022. The cardboard was removed and the magnet that holds the door open that broke in the lightning strike has been fixed. Head of Maintenance Department.

x. Corrected September 14, 2022. The hinges on the door were adjusted and the gap is much smaller. Head of Maintenance Department.

xi. Corrected September 14, 2022. All foot pegs have been removed from Fire Doors permanently. Daily rounds by Head of Maintenance Department will be conducted to ensure all Fire Doors remain closed.

xii. Corrected September 15, 2022. GFI outlet in the kitchen fixed. Head of Maintenance Department.

xiii. The facility intends to install four-inch wrist blades on the faucet in the hand washing sink in the kitchen by November 30, 2022. Head of Maintenance Department.

xiv. Corrected September 14, 2022. The staff has been notified to take the Residents outside during a fire drill. A log has been implemented to document date, time, shift and if everyone exited the building. This

commences on our next fire drill scheduled for December 2022. Head of Maintenance Department.

xv. Corrected September 13, 2022. On this day we had a complete sprinkler inspection by our vendor Hartford Sprinkler. We passed our inspection and have quarterly sprinkler inspections scheduled. These inspection records are kept in our Maintenance Documentation File. Head of Maintenance Department.

xvi. Corrected September 13, 2022. On this day we had a complete sprinkler inspection by our vendor Hartford Sprinkler. We passed our inspection and have quarterly sprinkler inspections scheduled. These inspection records are kept in our Maintenance Documentation File. Head of Maintenance Department.

xvii. Corrected September 13, 2022. On this day we had a complete sprinkler inspection by our vendor Hartford Sprinkler. We passed our inspection and have quarterly sprinkler inspections scheduled. These inspection records are kept in our Maintenance Documentation File. Head of Maintenance Department.

xviii. Corrected September 13, 2022. On this day we had a complete sprinkler inspection by our vendor Hartford Sprinkler. We passed our inspection and have quarterly sprinkler inspections scheduled. These inspection records are kept in our Maintenance Documentation File. Head of Maintenance Department.

xix. November 2022. The facilities five (5) year obstruction test is signed and contracted for and is in the process of being scheduled. Head of Maintenance Department.

xx. Corrected September 13, 2022. Documentation emailed to Inspector Ray Kasidas. Administrator.

xxi. Corrected September 13, 2022. Documentation emailed to Inspector Ray Kasidas. Administrator.

xxii. November 2022. The facilities three (3) year air loss test is signed and contracted for and is in the process of being scheduled. Head of Maintenance Department.