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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Curtis Home for the Aged
380 Crown St.
Meriden, CT 06450

Signature of FLIS Staff
Aneta Predka, NC
Raymond Kasidas, BFSI

M:

Licensure Category:

	Licensed Bed Bassinet Capacity:	Census:
RCH	32	22

Date(s) of onsite inspection: 9/12/23 and 9/20/23

Date(s) additional information obtained: _____

Personnel contacted: Shavanda Brady, Manager

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

[x] Visit **OR** Revisit for the purpose of reviewing the Plan of Correction to the violation letter dated 6/16/23

[x] See Complaint Investigation #35196

[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 10/24/23

[ ] 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 Violation YES/NO

[ ] CRF grant verification Violation YES/NO

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

October 24, 2023

Albert Mislow, Person-in-Charge
Curtis Home for the Aged, The
380 Crown Street
Meriden, CT 06450

Dear Mr. Mislow:

Unannounced visits were made to Curtis Home for the Aged, The on September 12 and 20, 2023 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and a licensure renewal 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 visits. 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 November 7, 2023

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 November 7, 2023 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 Karen Gworek, Supervising Nurse Consultant and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7472.

Respectfully,

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

KEG:lst

cc. Mairead Painter, LTC Ombudsman Program

Complaint CT #35196

Approved 11/21/23 KEG

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 facility documentation review and interviews, the facility failed to conduct reference checks during the hiring process to ensure capable personnel of good character and suitable temperament were employed to provide satisfactory care of the residents. The findings include:
   a. Review of the personnel files failed to provide documentation reference checks were conducted prior to employment. Interview with the Manger on 9/20/23 identified the Director of Nursing (DON) did not conduct reference checks for new Residential Care Home employees because it was not in the policy and the DON went off the new employee background check. The Reference Checks policy directed all hiring supervisors, managers, and/or scheduler will contact two (2) former employers (or personal references if there were no prior employers) to verify a potential employee's job history prior to making a job offer.

1. A. The HR director and hiring managers will be in serviced on reference checks for all new hires.

   B. The corrective measure will be in effect by 11/17/23.

   C. Random weekly audits will be conducted to ensure that the facility conducted and documented 2 reference checks for all new hires. These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard

   D. The Administrator and or designee shall be responsible for the monitoring of this plan of correction.

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

2. Based on facility documentation review and interviews, the facility failed to conduct annual evaluations to ensure personnel of good character and suitable temperament were employed to provide satisfactory care of the residents. The findings include:
   a. Review of the personnel files failed to provide documentation annual evaluations were conducted. Interview with the Manger on 9/20/23 identified the Director of Nursing (DON) did not complete annual evaluations for Residential Care Home employees because it was not in the policy.

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 (B)(E)(i).

2. A. The HR director and hiring managers will be in serviced on annual evaluations for all employees at the RCH.

   B. The corrective measure will be in effect by 11/17/23.

   C. Random weekly audits will be conducted to ensure that employees at the RCH have an annual review. These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard

   D. The Administrator and or designee shall be responsible for the monitoring of this plan of correction.

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 (B)(E)(i).

3. Based on clinical record review, facility documentation, and interviews for two of twenty-two sampled residents (Residents #1 and #2) who received Visiting Nurse Agency (VNA) services, a copy of Medication Administration Record was not available to facility staff and the facility failed to ensure the same staff member who prepared the medications had administered the medications. The findings include:
   a. Interview with the Manager on 9/20/23 identified the facility staff did not have access to the Medication Administration Record (MAR) of two (2) residents, because the residents received their medications from VNA nurses. The Manager indicated although the Medication Administration Records were on the facility premises in locked boxes located in the medication room, and facility staff did not have access to the residents MAR or mediations because the staff did not have a key to the locked boxes. The Manager identified the VNA nurse did not provide the keys for the facility staff to access the residents MAR or medications.
   b. Interview with the Manager on 9/20/23 identified Resident #2 received Visiting Nurse Agency (VNA) service, the visiting nurse pre-poured Resident #2's evening medication on daily basis and placed Resident #2's medications in the medication cart for the staff to administer. The Manager indicated the VNA nurse had her own MAR and the RCH staff had their own MAR for Resident #2 and VNA nurse did not sign the facility MAR, the VNA nurse signed the MAR that was locked in the medication box in Resident #2's room. Interview with the DON on 9/20/23 identified VNA nurses cannot pre-pour mediations for the facility staff to administer.

3. A. For residents in the RCH who have homecare services manage their medications, there will be a paper stating "Medications are managed by VNA only" in the resident's medication section of their chart. The MAR will be kept in the locked box. The VNA nurse administers medications to the two clients BID. There are no pre-poured medications. There will be no shared key to the locked box. Only VNA will have access to the locked box. The resident's chart has a copy of the POS with each medication listed.

B. The corrective measure will be in effect by 11/17/23.

C. Random weekly audits will be conducted to ensure that those residents who have their medications managed by a VNS have a paper in the medication section of their chart that states " Medications are managed by VNA only" and that the POS is in the chart as well. These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard.

D. The Director of Nursing Services and / or designee shall be responsible for the monitoring of this plan of correction.

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

4. Based on facility documentation review, and interviews the facility failed to provide confidentiality to residents when withdrawing the monies from the petty cash. The findings include:
   a. Review of the petty cash receipts identified four (4) receipts per page that included the amount of monies withdrawn, the date, received by and the reason for the withdrawal of the monies. Interview and review of the petty cash receipts with the Manager on 9/20/23 identified she gave the residents the petty cash receipt book and asked the residents to fill it out. The Manager indicated the residents could see the other three (3) residents' information regarding who and how much money they withdrew. The Manager identified the residents should not see how much money the other residents withdraw.

4. A. The business office will be in serviced on maintaining confidentiality when withdrawing and distributing monies for RCH residents.

B. The corrective measure will be in effect by 11/17/23.

C. Random weekly audits will be conducted to ensure that confidentiality is maintained when monies are withdrawn and distributed to RCH residents evidenced by petty cash receipts identifying only one resident per page. These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard

D. The Administrator and or designee shall be responsible for the monitoring of this plan of correction.

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

5. Based on facility documentation review and interviews, the facility failed to report and investigate an allegation of abuse within seventy-two (72) hours to the State Agency. The findings include:
   a. Review of the undated progress note identified Resident #3 told one (1) of the aides from the kitchen he/she was constantly being abused here by the residents, this was after Resident #3 was told that none of the residents were stalking him/her. Resident #3 then responded that "the staff always sticks up for the criminals." Interview with Patient Care Aides (PCA) #1 on 6/20/23 at 1:00 PM identified Resident #3 reported to her the residents were abusing him/her, they were after Resident #3 constantly, stalking him/her. PCA #1 indicated Resident #3 told her the staff always stick out for the criminals. PCA #1 identified she reported the incident to the staff that worked with her that day. Interview and review of facility documentation with the Manager on 6/20/23 identified she was aware of the abuse allegation reported by Resident #3. The Manager indicated when Resident #3 spoke about abuse, he/she was taking about being "shocked by other residents using an elector-magnetic device." The Manager identified she was not aware the incident of abuse had to be reported to the state agency. The Abuse, Neglect, Exploitation, Mistreatment, Misappropriation of Property policy directed reports of suspected abuse, or any such signs of abuse, neglect, exploitation, mistreatment, or misappropriation of property must be reported immediately to the resident's family/representative and the DON or administrator who will promptly begin an investigation.

5. A. The RCH staff will be in serviced on the Abuse Policy.

   B. The corrective measure will be in effect by 11/17/23.

   C. Random weekly audits will be conducted to ensure that any allegation of abuse is reported within 72 hours to the state agency. These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard

   D. The Administrator and or designee shall be responsible for the monitoring of this plan of correction.

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

6. Based on observations and interviews, the facility failed to maintain a clean, comfortable, and homelike environment. The findings include:
   a. Observations on 9/12/23 during the tour of the facility the surveyor while accompanied by the House Manager and Director of Maintenance, observed worn and stained carpets, chipped, marred, and damaged wallpaper throughout the facility.

6. A. The worn and stained carpet in the front entrance, dining room, chapel and sitting room in the RCH will be replaced. The damaged wallpaper throughout the building will be repaired..

B. The corrective measure will be in effect by 01/02/24.

C. Random monthly audits will be conducted to ensure that damaged wallpaper and worn / stained carpet are being repaired / replaced . These audits will be reviewed at regular CQI meetings until the pattern of practice consistently meets the standard

D. The Administrator and or designee shall be responsible for the monitoring of this plan of correction.