STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

November 21, 2023

Nikki Anson, Interim Executive Director
Harborchase Of Madison
100 Bradley Road
Madison, CT 06443
Via e-mail: NAnson@hraonline.net

Dear Ms. Anson:

An unannounced visit was made to Harborchase Of Madison on October 31, 2023 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 November 6, 2023.

Attached is a violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was 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 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 December 1, 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 violation and you may be provided with the opportunity to be heard. If the violation is not responded to by December 1, 2023 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 Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail.

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

Respectfully,

Elizabeth T. Heiney BSN RN BC

Elizabeth T. Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ETH:lst

c. VL
Complaint CT #36417

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living services agency (4)(A) and (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing Services provided by an assisted living service agency (1)(4)(A) and (j) Assisted living services agency staffing requirements (5)(8).

1. Based on review of agency documentation, staff interviews and agency policy, for three of three clients (Client's #1, 2, & 4) reviewed for medication administration, the Assisted Living Service Agency (ALSA) nurses failed to follow policies for the administration of medications and the RN Designee failed to ensure nursing services were adequate to meet the needs of the clients and failed to follow on-call policies. The findings include:

    a. Client #1 was admitted to the memory care assisted living services agency (ALSA) program on 9/12/22. The admitting diagnoses included Lewey Body dementia and hearing loss. The client service plan dated 7/24/23 identified the need for assistance of one caregiver for dressing, bathing, incontinent care, transfer assistance of 2 persons with a mechanical lift and medication management.

    Review of the medication pass report for 10/29/23 identified the late administration of Extra Strength Tylenol 500 mg (milligrams), three times daily, due at 9 AM, administered at 11 AM; Metoprolol Tartrate 50 mg twice daily due at 9 AM, administered at 11 AM; Naproxen Sodium 220 mg daily due at 9 AM, administered at 11 AM and Senna S 8.6-50 mg twice daily due at 9 AM, administered at 11 AM.

    Review of the medication pass report with the National Director of Wellness on 10/31/23 at 11:10 AM identified that the expectation for medication administration is administration one hour before or after the medication is due and failed to ensure adequate staffing to meet the client's needs.

    b. Client #2 was admitted to the assisted living services agency (ALSA) program on 11/10/18. The admitting diagnoses included cerebrovascular accident with dysphagia and aphasia, coronary artery disease, hypertension and chronic kidney disease. The client service plan dated 6/15/23 identified the need for the nurse to administer medications twice daily at 5:30 AM and 8 PM.

    Review of the medication pass report for 10/29/23 identified the late administration of the following medications, due at 5:30 AM, administered at 11:13 AM: Carvedilol 6.25 mg twice daily; Amlodipine Besylate 5 mg daily; Atorvastatin 40 mg daily; Dorzoloamide/Timolol one drop into both eyes twice daily; Eliquis 2.5 mg twice daily; Famotidine 20 mg daily; Finasteride 5 mg daily; Furosemide 20 mg daily; Hydrochlorothiazide 25 mg daily; Keppra 500 mg twice daily; Lisinopril 20 mg daily; Multivitamin one tablet daily; Rhopressa Ophthalmic Solution 0.02 % one drop daily into left eye and Sertraline Hydrochloride 50 mg daily.

Interview and review of the medication pass report with the National Director of Wellness on 10/31/23 at 11:20 AM identified that the expectation for medication administration is administration one hour before or after the medication is due and failed to ensure adequate staffing to meet the client's needs.

c. Client #4 was admitted to the assisted living services agency (ALSA) program on 9/21/19. The admitting diagnoses included metabolic encephalopathy, acute respiratory failure with hypoxia and type II diabetes mellitus. The client services plan dated 7/26/23 identified the need for the nurse to administer medication daily including obtaining blood sugars daily at 6:30am, 11:30am, and 4:30 pm and administer Humalog/Novolog insulin per sliding scale for blood sugars >300 (Sliding scale is as follows: BG 300- 349= 2 units BG 350-399= 4 units BG 400-449= 6 units BG >450= 13 units and call MD).

Interview and review of the medication pass report with the National Director of Wellness on 10/31/23 at 1:20 PM failed to identify that the 10/29/23 6:30 AM blood sugar was completed to identify the need for the Humalog insulin coverage and failed to ensure adequate staffing to meet the client's needs.

On 10/29/23 at 11 AM, LPN #3 from ALSA #2 (a sister facility) arrived in the facility and administered medications to the client's needing medication administration.

Review of staffing for the weekend of Friday 10/27/23 through Sunday 10/30/23 with the National Director of Wellness on 10/31/23 at 10 AM identified that an Agency staff LPN was scheduled for Saturday, 10/28/23 for the 3-11 shift but never showed up, therefore LPN #1 stayed to cover the shift. An Agency LPN was also scheduled for 10/28/23, 11 PM-7 AM shift but called the facility and indicated that s/he wouldn't be there until 2 AM. At 2 AM, ALSA aide #2 called ALSA aide #1 (lead aide) and indicated that the nurse did not show up, ALSA Aide #1 then called the RN Designee, who was on-call for the weekend, but was unable to reach him/her by phone after several calls.

Interview with ALSA aide #1 on 10/31/23 at 11:10 AM indicated that the RN Designee did not answer the phone on 10/28/23 during the overnight hours and was informed by the Executive Director to call other staffing agencies. Agency #1 identified that an LPN would be available for the 7 AM-3 PM shift on 10/29/23, but never reported for the shift. ALSA aide #1 then called the RN Designee who refused to come in and indicated that s/he wasn't trained on a medication pass.

Interview with the former RN Designee on 10/31/23 at 2 PM indicated that on 10/29/23, s/he was called to come in due to the 7-3 nurse not showing up, s/he refused and indicated that on 10/25/23, s/he informed ALSA aide #1 that due to a torn knee ligament, s/he couldn't come in for extra shifts, additionally, he/she never shadowed and was never trained on a medication pass with the clients.

Review of the weekend schedule with the National Director of Wellness on 10/31/23 at 2:15 PM failed to identify the RN Designee followed agency policies for on-call job duties and failed to ensure staffing and on-call nursing to meet the client's needs.

Review of the agency's policy and procedure for Community Staffing Requirements, identified the on-call nurse would be reachable by telephone and be available to make an onsite visit if needed, to respond to the provisions of care to Clients and Client emergencies.

Plan of Correction to Violation #1:

Plan of Correction for 10/31/23 date of inspection

The following Plan of Correction is being submitted by HarborChase of Madison, as mandated by the Department of Public Health state of Connecticut. However, this response does not constitute agreement with the findings specified in the document.

Tag/Violation:
Section 19-13-D105 (d) Governing authority of an assisted living services agency (4)(A) and (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing Services provided by an assisted living service agency (1)(4)(A) and (j) Assisted living services agency staffing requirements (5) (8).

Corrective Action:
The Salsa will be responsible in conjunction with the Executive Director to make sure plan of correction is implemented and followed.

Systemic Changes:
SALSA and RN Designee will be trained on medication pass in community. Job description and Expectations reviewed with both RN Designee and SALSA including but not limited to on call responsibilities. Medications will be administered per company policy.

Monitoring Process:
Audit completion of education on medication pass and job expectations- completed by 11/5/2023 and ongoing for any new associate holding the position of SALSA, RN Designee or LPN.
Audit 10% of medication administration records monthly for timely medication administration. Completed by 3/1/2024

placed 1/9/24 ws

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living services agency (4)(A) and (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing Services provided by an assisted living service agency (1)(4)(A) and G) Assisted living services agency staffing requirements (5)(8).

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   a. Client #1 was admitted to the memory care assisted living services agency (ALSA) program on 9/12/22. The admitting diagnoses included Lewey Body dementia and hearing loss. The client service plan dated 7/24/23 identified the need for assistance of one caregiver for dressing, bathing, incontinent care, transfer assistance of 2 persons with a mechanical lift and medication management.

   Review of the medication pass report for 10/29/23 identified the late administration of Extra Strength Tylenol500 mg (milligrams), three times daily, due at 9 AM, administered at 11 AM; Metoprolol Tartrate 50 mg twice daily due at 9 AM, administered at 11 AM; Naproxen Sodium 220 mg daily due at 9 AM, administered at 11 AM and Senna S 8.6-50 mg twice daily due at 9 AM, administered at 11 AM.

   Review of the medication pass report with the National Director of Wellness on 10/31/23 at 11:10 AM identified that the expectation for medication administration is administration one hour before or after the medication is due and failed to ensure adequate staffing to meet the client's needs.

   The expectation for all medication administration as follows, Harbor Chase of Madison will be following medication administration policy. Our policy times of one hour before or one hour after time frame. All nurses will be educated on the proper procedure to follow in the event a nurse does not show up for work. All nurses have been in-service to ensure compliance on 11/5/2023 and 11/27/2023.

   As of 11/27/2023, we have contracted with a committed director of resident care and RN designee, that are fully trained to fill-in if needed to administer medication. His includes but not limited to on call responsibilities. There is also designated cell phone provide for the Resident Care Director as well as the RN designee.

   Daily audit will be completed for medication administration timeliness by the director of resident care to ensure compliance with medication time management observance.

   The Executive Director will ensure compliance to the plan of correction weekly.
   Completion date 3/1/2024

POC accepted 1/9/24 LDS

b. Client #2 was admitted to the assisted living services agency (ALSA) program on 11/10/18. The admitting diagnoses included cerebrovascular accident with dysphagia and aphasia, coronary artery disease, hypertension and chronic kidney disease. The client service plan dated 6/15/23 identified the need for the nurse to administer medications twice daily at 5:30 AM and 8PM.

Review of the medication pass report for 10/29/23 identified the late administration of the following medications, due at 5:30AM, administered at 11:13 AM: Carvedilol6.25 mg twice daily; Amlodipine Besylate 5 mg daily; Atorvastatin 40 mg daily;

Dorzoloamide/Timolol one drop into both eyes twice daily; Eliquis 2.5 mg twice daily; Famotidine 20 mg daily; Finasteride 5 mg daily; Furosemide 20 mg daily; Hydrochlorothiazide 25 mg daily; Keppra 500 mg twice daily; Lisinopril20 mg daily; Multivitamin one tablet daily; Rhopressa Ophthalmic Solution 0.02% one drop daily into left eye and Sertraline Hydrochloride 50 mg daily. HarborChase of Madison
Interview and review of the medication pass report with the National Director of Wellness on 10/31/23 at 11:20 AM identified that the expectation for medication administration is administration one hour before or after the medication is due and failed to ensure adequate staffing to meet the client's needs.

The facility has contracted with a new experienced Director of Resident care, and a RN designee, that understands duties, responsible, and expectation of their roles. The on-call rotation protocol was reviewed and is currently in compliance. All Nurses were in-service on medication time compliance on 11/5/2023 and 11/27/2023 and will be ongoing for new hires.

On 11/27/23 director of resident care and RN designee, was orientated on medication administration, and will fill-in if needed to administer medication in the facility.

Daily audit will be completed for medication administration timely manner by the director of resident care to ensure compliance with medication times.

The Executive Director will ensure compliance to the plan of correction weekly. Completed by 3/1/2024.

Client #4 was admitted to the assisted living services agency (ALSA) program on 9/21/19. The admitting diagnoses included metabolic encephalopathy, acute respiratory failure with hypoxia and type II diabetes mellitus. The client services plan dated 7/26/23 identified the need for the nurse to administer medication daily including obtaining blood sugars daily at 6:30am, 11:30am, and 4:30pm and administer Humalog/Novolog insulin per sliding scale for blood sugars >300 (Sliding scale is as follows: BG 300- 349= 2 units BG 350-399= 4 units BG 400-449= 6 units BG >450= 13 units and call MD).

Interview and review of the medication pass report with the National Director of Wellness on 10/31/23 at 1:20 PM failed to identify that the 10/29/23 6:30 AM blood sugar was completed to identify the need for the Humalog insulin coverage and failed to ensure adequate staffing to meet the client's needs.

PAccepted 1/9/24 VA

On 10/29/23 at 11 AM, LPN #3 from ALSA #2 (a sister facility) arrived in the facility and administered medications to the clients needing medication administration.
Review of staffing for the weekend of Friday 10/27/23 through Sunday 10/30/23 with the National Director of Wellness on 10/31123 at 10 AM identified that an Agency staff LPN was scheduled for Saturday, 10/28/23 for the 3-11 shift but never showed up, therefore LPN #1 stayed to cover the shift. An Agency LPN was also scheduled for 10/28/23, 11 PM-7 AM shift but called the facility and indicated that s/he wouldn't be there until 2 AM. At 2 AM, ALSA aide #2 called ALSA aide #1 (lead aide) and indicated that the nurse did not show up, ALSA Aide #1 then called the RN Designee, who was on-call for the weekend, but was unable to reach him/her by phone after several calls.

Interview with ALSA aide #1 on 10/31/23 at 11:10 AM indicated that the RN Designee did not answer the phone on 10/28/23 during the overnight hours and was informed by the Executive Director to call other staffing agencies. Agency #1 identified that an LPN would be available for the 7 AM-3 PM shift on 10/29/23, but never reported for the shift. ALSA aide #1 then called the RN Designee who refused to come in and indicated that s/he wasn't trained on a medication pass.
Interview with the former RN Designee on 10/31/23 at 2 PM indicated that on 10/29/23, s/he was called to come in due to the 7-3 nurse not showing up, s/he refused and indicated that on 10/25/23, s/he informed ALSA aide #1 that due to a tom knee ligament, s/he couldn't come in for extra shifts, additionally, he/she never shadowed and was never trained on a medication pass with the clients.

Review of the weekend schedule with the National Director of Wellness on 10/31/23 at 2:15PM failed to identify the RN Designee followed agency policies for on-call job duties and failed to ensure staffing and on-call nursing to meet the client's needs.

Resident 10/29/23 6:30 AM blood sugar was completed to identify the need for the Humalog insulin coverage, needs were not met due to staffing issues. Audits show that this was an isolated incident. Harbor Chase of Madison have since rectified the staffing problem.

As of 11/27/2023, Harbor Chase of Madison have contracted with committed director of resident care and RN designee, that are fully trained to fill-in if needed to administer medication. They also have active on-call cell phone for their weekly on call rotation.

The Executive Director will ensure compliance to the plan of correction weekly.
Completed by 3/1/2024