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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

University Place
5 University Place
New Haven, CT 06511

Signature of FLIS Staff

Glenna Fried, LCSW
Ray Kasidas/BFSI

Licensure Category:
Residential Care Home 1877 Licensed Bed Capacity: 11 Census: 11

Date(s) of onsite inspection: 4/10/24 and 6/24/24

Date(s) additional information obtained: _____

Personnel contacted: Michele Roberts, Person-in-Charge
Email Address: _____

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

[ ] Visit **OR** Revisit for the purpose of reviewing the Plan of Correction for the violation letter dated

[X] See Complaint Investigation #30805

[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 7/10/24

[ ] 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: Glenna Fried, LCSW **DATE OF REPORT:** 6/24/24

[X] Approval for issuance of license granted by: Karen Gworek, RN **DATE:** 6/24/24
Supervisor/Title

LICENSING INSPECTION NARRATIVE REPORT:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

July 10, 2024

Michelle Roberts, Person-in-Charge
University Place
5 University Place
New Haven, CT 06511

Dear Ms. Roberts:

Unannounced visits were made to University Place on April 10, 2024, and June 24, 2024, by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a complaint investigation and 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 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 July 24, 2024.

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 July 24, 2024, 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
Healthcare Quality and Safety Branch
Facility Licensing & Investigations Section

KEG:csf

cc: Mairead Painter, LTC Ombudsman Program

Complaint #30805

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

1. Based on observations and interviews, the facility failed to ensure monthly recreational calendars were posted. The findings include:
   a. Observations during tour of the facility on 4/10/24 identified no recreational calendars were posted for the month of April 2024. Interview with the Resident Aide on 4/10/24 identified that no recreational calendar was posted, although recreational activities were offered at the facility.

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 ensure dated menus were posted and filed. The findings include:
   a. Observations during tour of the facility on 4/10/24 identified no dated menu was posted. Interview with the Resident Aide on 4/10/24 identified that there was no menu posted because the next set of menus for rotation were not yet completed and printed. The Resident Aide indicated she verbally informed residents of the daily menu at breakfast.

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)(i).

3. Based on resident record reviews, facility documentation, and interviews for eleven sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) who received Visiting Nurse Agency (VNA) services, a copy of the Medication Administration Record (MAR) or a medication list were not available to the facility staff. The findings include:
   a. Interview with the Resident Aide on 4/10/24 identified the facility staff did not have access to the MAR or a medication list for any resident because all residents in the facility received medication administration from VNA service and the facility staff did not have access to residents' medications as all medications were kept in locked boxes with access by VNA service only. The Resident Aide indicated she was unaware of the regulation to have access to the MAR for residents. Interview with the VNA nurse on 4/10/24 identified the MAR for all residents was electronic and the facility did not have access to it or access to any list of medications that residents were administered by the VNA service.

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)(F)(ii).

4. Based on observations and interviews for one of three sampled residents (Resident #1) who received medications pre-poured by the Visiting Nurse Agency (VNA) services, the facility failed to ensure the medication was kept in a secured location. The findings include:
   a. Observations during tour of the facility on 4/10/24 identified a weekly pill organizer on top of Resident #1's dresser in a room shared with Resident #2. Interview with the Resident Aide at the time of the observation indicated that Resident #1 received medication administration through the VNA service and was able to take his/her own medications. The Resident Aide was unaware of the medications that Resident #1 was prescribed and indicated that the VNA nurse was the person responsible for medication administration for Resident #1. Interview and resident record review with the VNA nurse on 4/10/24 during tour of facility identified Resident #1 had a physician's order to self-administer the pre-poured medications and indicated Resident #1 was prescribed Klonopin, which was a controlled substance.

      The VNA nurse identified the expectation was Resident #1 did not need to keep pre-poured medication in a secured location because the roommate for Resident #1 was also able to self-administer pre-poured medications and the door to the resident room was secured with a lock and key. A follow-up interview with the Resident Aide on 4/10/24 identified that although all residents have access to keys to keep resident doors locked, most residents in the facility chose not to keep their doors locked.

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

5. Based on interviews for eleven of eleven sampled residents, the facility failed to provide access to resident records. The findings include:
   a. Interview with the Resident Aide on 4/10/24 identified the facility had the records for all residents, but all facility documentation was kept in the locked office upstairs that staff did not have access to when the Person-in-Charge was not at the facility. The Resident Aide identified the Person-in-Charge was away and not able to come to the facility.

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

6. Based on interviews and review of facility documentation, the facility failed to provide access to written facility policies and procedures on Abuse, Infection Control, and Safety and Emergency Procedures. The findings include:
   a. Interview with the Assistant Manager on 6/24/24 indicated that although the facility had policies on Abuse, Infection Control, and Safety and Emergency Procedures, she was unable to provide documentation of written facility policies and procedures.

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

7. Based on interviews and review of facility documentation, the facility failed to provide documentation that regularly scheduled meetings with residents were conducted. The findings include:
   a. Interview with the Assistant Manager on 6/24/24 identified that although the facility met twice a quarter with residents, facility staff did not document the meetings with residents.

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

8. Based on interviews and review of facility documentation, the facility failed to ensure sufficient capable personnel of good character and suitable temperament were employed to provide satisfactory care for the residents. The findings include:
   a. Interview with the Assistant Manager and review of facility documentation on 6/24/24 identified there were three (3) new staff members hired in the past year at the facility (Resident Aides #2, #3, and #4) and the Applicant Background Check Management System (ABCMS) were not completed for the new hires prior to the identified start date for Resident Aide #2 on 6/11/24, Resident Aide #3 on 6/17/24, and Resident Aide #4 on 6/20/24.

      The Assistant Manager indicated she thought there was a thirty (30) day period from after date of hire to complete the ABCMS background check on new hires.

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

9. Based on review of facility documentation and interviews for one of eleven residents, the facility failed to issue a thirty (30) day involuntary notice prior to the discharge of a resident. The findings include:
   a. Interview with the Person-in-Charge on 6/24/24 at 9:10 AM indicated that Resident #1 was discharged from the facility while Resident #1 was in the hospital for an acute medical issue.

      The Person-in-Charge indicated Resident #1's bed hold was up while Resident #1 was in the hospital, which was the reason Resident #1 was discharged from the facility. The Person-in-Charge indicated she never received a call from the hospital about Resident #1 returning to the facility and identified no thirty (30) day notice was given prior to the discharge of Resident #1 from the facility because it wasn't considered a discharge, and it was considered a transfer for a medical hospitalization. Although requested, a copy of the facility policy on facility-initiated or involuntary discharge was not provided.

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).

10. Based on review of facility documentation, observations, and interviews, the facility failed to ensure compliance with all applicable codes, standards, and regulations of the State of Connecticut Fire Safety Code and the National Fire Protection Association. The findings include:

    a. On 4/10/24 and 6/24/24 at 9:00 A.M. during a tour of the facility and while accompanied by a facility representative, the following observations were identified:
    b. Documentation was not provided to the surveyor from the Facility Representative that the facility has a written plan for protecting all persons in the event of a fire as required by Section 20.5.2.1.1 of the CSFPC.
    c. Documentation was not provided to the surveyor from the Facility Representative that staff were being trained regarding their duties and responsibilities in case of a fire as required by Section 20.5.2.1.3 of the CSFPC.
    d. Documentation was not provided to the surveyor from the Facility Representative that Emergency Egress and Relocation Drills are being conducted as required by Section 20.5.2.3.1 of the CSFPC. No drills were conducted during the night while residents were sleeping.
    e. The facility did not have noncombustible safety type ashtrays in smoking areas as required by Section 20.5.2.4.2 of the CSFPC.

f. Documentation was not provided to the surveyor from the Facility Representative to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that any sprinkler inspections were completed in the past twelve (12) months.
g. Documentation was not provided to the surveyor from the Facility Representative 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.
h. Documentation was not provided to the surveyor from the Facility Representative to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., The gauges on the sprinkler system were dated 2019 and exceed the five (5) year limit of the code.
i. Documentation was not provided to the surveyor from the Facility Representative to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., The sprinkler heads in the basement were dirty and covered in dust.
j. Documentation was not provided to the surveyor from the Facility Representative to indicate that the maintenance and testing of the facilities fire alarm system has been completed as required by Section 13.7.3.2.4.1 of the CSFPC and NFPA 72. There is no documentation that any inspections of the facilities fire alarm system and its components have been inspected or tested in the last twelve (12) months.
k. The surveyor observed the front door of the facility was locked. Unlocking and exiting required three (3) motions not meeting the requirements of Section 33.2.2.5.5 of the CSFSC.
l. The surveyor observed the patio at the rear of the building has been enclosed and is not protected by an automatic sprinkler system as required by Section 33.2.3.2.4 of the CSFSC.
m. The surveyor observed the second-floor door at the rear staircase was being held open by a wood wedge negating its ability to close as required by Section 33.3.2.2.2 of the CSFSC.
n. The surveyor observed countertops in the kitchen that were worn and delaminated, not providing a clean and sanitary surface as required.

University Place (RCH)

State of Connecticut

Department of Public Health

410 Capitol Avenue, P.O. Box 340308

Hartford, Connecticut 06134-0308

RECEIVED
AUG 28 2024
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Approved
8/28/24
KEG

Attn: Karen Gworek, RN, BSN

Supervising Nurse Consultant

Healthcare Quality and Safety Branch

Facility Licensing & Investigations Section

August 16, 2024

Dear Ms. Gworek:

Preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws requires it. The plan of correction serves as the facility's allegation of compliance.

1. Based on observations and interviews, the facility failed to ensure monthly recreational calendars were posted.

(1) The activity calendar has been updated to reflect the current month
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

2. Based on observations and interviews, the facility failed to ensure dated menus were posted and filed.

(1) The menus have been updated to reflect the date
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

3. Based on resident record reviews, facility documentation, and interviews for eleven sampled residents

(1) The VNA has been notified that the MAR will be available for the facility staff as needed
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance

(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

4. Based on observations and interviews for one of three sampled residents (Resident #1) who received medications pre-poured by the Visiting Nurse Agency (VNA) services, the facility failed to ensure the medication was kept in a secured location.

(1) Resident #1 and Resident #2 over the counter medication they purchased were removed from the resident's room
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

5. Based on interviews for eleven of eleven sample residents, the facility failed to provide access to resident records.

(1) Current resident records have been stored where it is accessible to staff
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

6. Based on interviews and review of facility documentation, the facility failed to provide access to written facility policies and procedures on Abuse, Infection Control, and Safety and Emergency Procedures.

(1) Facility has written policies for abuse, infection control and safety and emergency procedures.
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

7. Based on interviews and review of facility documentation, the facility failed to provide documentation that regularly scheduled meetings with residents were conducted.

(1) Quarterly meetings will be held with the resident and documented per regulation.
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

8. Based on interviews and review of facility documentation, the facility failed to ensure sufficient capable personnel of good character and suitable temperament were employed to provide satisfactory care for the residents.

(1) Resident Aide #2, #3, and #4 background check has been submitted
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
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(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

9. Based on review of facility documentation and interviews for one of eleven residents, the facility failed to issue a thirty (30) day involuntary notice prior to the discharge of a resident.

(1) Resident# 1 was not directly discharged from the facility. Resident #1 was medically transferred and did not return to the facility.
(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

10. Based on review of facility documentation, observation, and interviews, the facility failed to ensure compliance with all applicable codes, standards, and regulations of the State of Connecticut Fire Safety Code and the National Fire Protection Association.

b. Facility has access to protecting all persons in the event of a fire per regulations;

c. Facility employees were trained on fire safety on 8/1/24;

d. Facility emergency egress and relocation drills were conducted on 8/1/24;

e. Facility has noncombustible safety type ashtrays in the smoking area per regulations;

f. Sprinkler system was scheduled;

g. A five (5) year obstruction test was scheduled;

h. Sprinkler system was inspected to comply with the (5) year regulations.

i. Sprinkler heads have been cleaned to be free of dust.

j. Facility fire alarm system has been scheduled.

K. Facility door has been changed to meet the regulations.

l. The patio at the rear of the building has been scheduled for repair or replacement.

m. The second-floor door wedge has been removed and is in compliance with the regulations.

n. The countertop in the kitchen has been replaced/repaired to meet the regulations.

(2) Facility staff will be in-serviced effective date 8/1/24
(3) A monthly audit will be conducted for 90 days to ensure compliance
(4) Facility Administrator / Designee will be responsible for ensuring institution's compliance

Respectfully submitted,

University Place Residential Care, LLC
Michelle Roberts, Administrator

RECEIVED
AUG 28 2024
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION