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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Hannah Gray Home
235 Dixwell Avenue
New Haven, CT 06511

Signature of FLIS Staff

Glenna Fried, LCSW
Ray Kasidas, BFSI

Licensure Category:

Residential Care Home

Licensed Bed Capacity: 20

Census: 17

Date(s) of onsite inspection: 8/29/2024

Date(s) additional information obtained: _____

Personnel contacted: Robert Page, Person-in-Charge

Email Address: robert.page@hannahgrayhome.org

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

[ ] 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 10/31/24

[ ] 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:** 8/30/24

[X] Approval for issuance of license granted by: Karen Gworek, RN **DATE:** 8/30/24
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

October 31, 2024

Robert A. Page, Person-in-Charge
Hannah Gray
235 Dixwell Avenue
New Haven, CT 06511

Dear Mr. Page:

An unannounced visit was made to Hannah Gray on August 29, 2024 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 November 14, 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 November 14, 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:lst

cc. 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 (f) Dietary service (1).

1. Based on observations, review of facility documentation and interviews, the facility failed to ensure proper methods of food storage and proper methods of food handling. The findings include:
   a. Observations during tour of the kitchen on 8/29/24 at 9:43 AM identified an open container of fresh avocados stored on the second shelf in front of stacked cartons of raw eggs and six (6) pints of fresh blueberries in open containers stored to the left of the raw eggs in the double-door refrigerator. Interview with the Chef at time of observation indicated the fresh produce was moved around due to a delivery that morning. Subsequent to surveyor inquiry, the Chef moved the fresh avocados from the refrigerator and indicated he would move the fresh blueberries away from the raw eggs.
   b. Interview and review of facility documentation with the Chef on 8/29/24 at 9:45 AM identified although temperatures of food prepared was taken prior to being served, he was unable to find the daily food temperature logs for surveyor review.

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

2. Based on review of facility documentation and interviews, the facility failed to ensure a list of residents with special diets was readily available to the kitchen staff. The findings include:
   a. Interview and review of facility documentation with the Chef on 8/29/24 at 10:35 AM indicated although there were residents with special dietary restrictions, there was no list of the residents on special diets located in the kitchen. The Chef identified there used to be one, but he was unable to find the list. The Chef indicated resident dietary restrictions and food allergy information was stored in the resident records located in the main office and information was obtained from the office staff or directly from the residents about special dietary restrictions.

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

3. Based on facility documentation review and interviews, the facility failed to ensure the Applicant Background Check Management System (ABCMS) documentation was readily available for the surveyor to review. The findings include:
   a. Interview with the Person-in-Charge on 8/29/24 at 11:45 AM identified ABCMS background checks for two (2) of two (2) recently hired staff members were not available for the surveyor to review because they were currently in the process of being completed.

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

4. Based on observations, facility policy review, and interview, the facility failed to ensure residents were disposing smoking materials in the designated smoking receptacles. The findings include:
   a. Observations during a tour of the facility on 8/29/24 at 1:30 PM identified although the designated area for smoking had cigarette receptacles to discard the cigarettes, the smoking area had numerous cigarette butts on the ground. Interview with the Person-in-Charge on 8/29/24 at 1:30 PM identified residents were responsible for discarding the cigarettes in the provided receptacles however, the residents were not following the rules. The Person-in-Charge indicated the facility staff were responsible for cleaning the smoking area. Review of the facility Smoking policy directed smoking was prohibited throughout the facility and did not specify the procedures for smoking outside of the facility.

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 (2)(C).

5. Based on review of facility documentation, review of facility policy, and interviews for four (4) of ten (10) staff members who assisted with medication administration, the facility failed to ensure Medication Administration certificates were readily available for review by the Department. The findings include:
   a. Review of facility documentation with the Lead Aide on 8/29/24 at 10:00 AM identified although Resident Aides #2, #4, #5, and #7 assisted with medication administration at the facility, there were no current medication administration certificates for those staff members. Interview with the Person-in-Charge on 8/29/24 at 1:15 PM identified Resident Aides #2, #4, #5, and #7 were in the process of completing the medication administration certification process which is why the current medication administration certificates were not available.

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

6. Based on review of facility documentation and interviews, the facility failed provide a copy of the written facility policy and procedures on infection control upon request by the Department of Public Health. The findings include:
   a. Review of facility documentation reflected there were no written policies and procedures on infection control. Interview with the Person-in-Charge on 8/29/24 at 11:45 AM identified there was no written infection control 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 Medication.

7. Based on observations, resident record review, and interviews for five (5) of seventeen (17) residents (Residents #1, #2, #3, #4, and #5) reviewed for medication administration, the facility failed to ensure a physician's order directed the residents were able to self-administer medications. The findings include:
   a. A review of the resident records for Residents #1, #2, #3, #4, and #5 on 8/29/24 failed to reflect documentation Residents #1, #2, #3, #4, and #5 had a physician's order to self-administer medications and the residents were evaluated to ensure the residents were able to safely administer medications. Interview and record review with the Lead Aide on 8/29/24 identified the facility procedure was for a resident to sign a Medication Administration/Self Administration of Medication Form, if the resident was his/her responsible party and wanted to self-administer medications. The Lead Aide identified that Residents #1, #2, #3, #4, and #5 did not have a physician's order to self-administer medications.

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).

8. Based on observations, review of facility documentation, and interviews for two (2) of seventeen (17) sampled residents (Residents #1 and #2) who self-administered their own medications, the facility failed to ensure the resident's medication were secured under lock in the resident's room. The findings include:
   a. Observations during a tour of the facility on 8/29/24 at 9:08 AM with Resident Aide #2 identified a bottle of Lisinopril 40 milligram (mg) tablets, a bottle of Metoprolol ER Succinate 25 mg tablets, a bottle of Over the Counter (OTC) iron supplements, and four (4) boxes of blood glucose level strips sitting on top of a nightstand, with loose pills laying out on the nightstand in front of the medication bottles in Resident #4's room. Interview with Resident Aide #2 on 8/29/24 at the time of the observations indicated although Resident #4 shared a room with another resident, Resident #4 was able to have the medication stored in his/her room because Resident #4 was able to self-administer his/her medications. Interview with Resident Aide #2 reflected he was unaware that medications needed to be secured under lock in the resident's.
   b. Observations during a tour of the facility on 8/29/24 at 9:25 AM identified three (3) blister packs of Sevelamer Carbonate (Renvela) located on top of Resident #2's nightstand. Interview with Resident #2 at the time of observation indicated the medications belonged to him/her and he/she took his/her own medication and stored it on the nightstand in the room he/she shared with another resident. Interview with Resident Aide #2 at the time of the observations identified Resident #2 was able to have the medication stored in his/her room because Resident #2 was able to self-administer his/her medications. Resident Aide #2 indicated he was unaware that medications needed to be secured under lock.

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).

9. 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:
   On 8/29/24 at 9:00 A.M., during a tour accompanied by a representative of the facility, the following observations were identified:
   a. The surveyor while accompanied by a representative of the facility observed the doors throughout were held open by unapproved devices. Fire doors are required to close upon alarm activation.
   b. The surveyor while accompanied by a representative of the facility observed multiple oxygen tanks unsecured in the basement.
   c. The surveyor was not provided with documentation to indicate that fire drills were completed as required by NFPA 1section 20.5.2.3.1.
   d. The surveyor was not provided with documentation to indicate that generator services were completed as required by NFPA 1section 11.7.5.
   e. The surveyor was not provided with documentation 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 within the past year.
   f. The surveyor was not provided with documentation to indicate that the maintenance and testing of the facilities fire alarm system has been completed as required by NFPA 1 section 13.7.3.1.1.2, section 13.7.3.2.4.4, and section 13.7.3.2.4.1. The reports provided indicate the last fire alarm inspection was 12/7/22.
   g. The surveyor was not provided with documentation to indicate that the maintenance and testing of the facilities kitchen hood suppression system has been completed as required by NFPA 1 section 50.5.5.
   h. The surveyor was not provided with documentation to indicate that the cleaning of the facilities kitchen hood has been completed as required by NFPA 1 section 50.5.6.1.

Approved 11/25/24 KEG

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f)Dietary service (1)

No residents were affected.

The chef and dietary staff have been educated on the importance of ensuring that fresh produce and food are stored properly, following recommended safety guidelines for storage.

Temperatures of prepared food shall be recorded on a temperature log with the time, date, and temperature of recorded temperatures. The temperature log shall be secured and readily accessible for reference.

At least daily, the chef will inspect and review that the temperature is posted at its secured location, review any concerns identified, and report findings to the QA committee monthly for three months and quarterly until substantial compliance is achieved.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f)Dietary Service (1)

No residents were affected.

A list of residents with special diets has been made available to kitchen staff.

Staff have been educated on the need to ensure that any changes in residents' diets and/or residents with special diets are communicated immediately to kitchen staff. This will be followed by an updated diet slip that will be flagged to prompt kitchen staff to review the updates.

A random audit of the special diets list shall be conducted weekly x4, monthly x2, and quarterly thereafter, with new information updated immediately. The results of the audit shall be presented to the QA committee for recommendations quarterly.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or © Administration (4)

No residents were affected.

The assigned/designee responsible shall ensure that the facility follows the requirements for all newly hired staff by completing and maintaining information for the Applicant Background Check Management System (ABCMS).

The assigned staff/designee will be educated on the need to ensure that this information is readily available for review by appropriate authorities.

As part of the QA process, the assigned staff designee will review the ABCMS records for newly hired staff monthly. The audit results shall be presented at the quality assurance meeting for deliberation until substantial compliance is achieved.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or © Administration (4)

No resident ill-effect was noted.

The facility has updated its smoking policy to include designated areas, procedures for disposing of cigarette butts, and staff oversight to ensure that this policy is being adhered to.

Staff and residents have been educated on the updated policy.

At least daily, staff will tour designated smoking areas to ensure that the area is free of cigarette butts. In addition, staff will educate smokers who are found to violate the smoking policy. The tour will be documented on a daily tour checklist.

At least weekly, assigned staff will review the smoking tour sheet and identify any issues that need to be addressed. The findings will be presented to the quality assurance committee quarterly for review and recommendations until substantial compliance is achieved.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medication (2)(C)

No resident ill-effect was noted.

An audit of staff has been completed to identify those with active medication certificates and those without. Resident aides with no medication certification are in the process of enrolling in and/or have enrolled in a medication certification course.

Assigned staff/designee have been educated to ensure that new staff with no medication certification are not allowed to administer medications to residents.

At least quarterly, a designated staff member will review the records of newly hired staff to ensure that all requirements, including the medication certification, are readily available and active. The audit results shall be presented to the QA committed to review and recommendations.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (C) Administration (4)(B)

No residents were affected as a result of this violation.

The facility has implemented a written infection control policy. Staff have been educated on the policy and the need to ensure it is readily available for reference by staff and appropriate authorities.

The infection control policy will be reviewed by the QA committee at least annually and as needed and updated as necessary.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medication

No resident ill-effect was noted.

The facility has contacted physicians for residents #1, #2, #3, #4, and #5 to obtain orders on file for medication self-administration. Residents without an order for self-administration are not allowed to self-administer their medication.

Staff have been educated on medication administration policy and the need to administer and supervise medication only as directed by physician order.

A random audit of physician orders for medication administration will be conducted monthly to ensure that resident medications are administered as directed by the order. The audit's results will be presented to the quality assurance committee for review and recommendations until compliance is achieved.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medication

No resident ill-effect was noted.

For residents who self-administer their medications, the facility has made available a secured lock to ensure their medications are safe in their rooms.
Staff and residents have been educated to ensure that residents' medications are locked and secured after each administration.

Random rounds will be completed daily for 4 weeks, weekly for 3 weeks, monthly for 2 months, and quarterly thereafter to ensure that residents' medications are locked after each administration. The audit results will be reviewed, and the QA is committed to making recommendations until compliance is achieved.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Regulation of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5)

No resident ill-effect was noted.

All unapproved devices have been removed from the fire doors to ensure that the doors close upon alarm activation. In addition, oxygen tanks in the basement/storage have been properly secured.

The facility has implemented a system to ensure that required preventative maintenance for the generator, hood suppression system, kitchen hood cleaning, sprinklers, fire drills, and fire alarm system occurs regularly according to NFPA standards. The documentation for such maintenance is securely stored for easy reference.

A random audit shall be performed quarterly to ensure all completed preventative maintenance documentation is on file. The audit results shall be presented to the QA for review and recommendations.

The Person in Charge/designee shall be responsible for monitoring this corrective action.

Completion Date: January 31, 2025

Robert Page, LCSW, BCD
Executive Director

Hannah Gray Home, Inc.
235 Dixwell Avenue
New Haven, CT 06511
Phone: 203-907-052
Fax: 203-907-0446

November 24, 2024

Karen Gworek, RN, BSN
Supervising Nurse Consultant
Facility Licensing & Investigations Section
Department of Public Health
410 Capitol Avenue
P.O Box 340308
Hartford, CT 06134

Re: POC for Survey Visit Ending August 29, 2024.

Dear Ms. Gworek:

Attached, please find the Plan of Correction (POC) for the unannounced survey visit conducted on August 29, 2024. The submission of this POC does not constitute an admission or denial of the statements of violations set forth in the Department of Public Health (DPH) letter relating to the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut. The facility submits this plan of correction only because state law requires it.

Please do not hesitate to contact me at (203) 907-4052 with any further questions.

Sincerely,

Robert Page, LCSW, BCD
Person in Charge