STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

January 4, 2024

Jim Tendone, Acting Executive Director
The Residence At South Windsor Farms
200 Deming Street
South Windsor, CT 06074
Via E-mail: jtendone@suffieldriver.com

Dear Mr. ~~Tendone~~ : jTedone@suffieldriver.com

An unannounced visit was made to The Residence At South Windsor Farms on October 24, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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, along with your original state violation letter, to the Department by January 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 violation and you may be provided with the opportunity to be heard. If the violation is not responded to by January 14, 2024 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 BS 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 #32679

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(B)(C) and/or (h) Nursing Services provided by an assisted living services agency (3)(E)(4)(A)(C)(i)(iii) and/or (i) Assisted living aide services provided by an assisted living services agency (5)(B) and/or Client service record (1)(2) (J).

1. Based on review of clinical records, agency documentation, interviews with staff and review of agency polices for one of three clients in the survey sample (Client #1, #2, and #3), the agency failed to provide oversite and/or supervisions of the ALSA aides, failed to follow a client's service plan, failed to follow the agency's Assisting with Routine Medications and Medication Error policies, failed to conduct a comprehensive investigation following a medication error and allegation of abuse and failed to maintain a complete client record. The findings include:
    a. Client #1 was admitted to the traditional ALSA program on 10/29/2018 with diagnosis of falls with fractures, cardiac disease, and muscle weakness. Client #1's 120-day assessment dated 08/30/2023 and service plan dated 09/06/2023, identified the Client required medication prompting at 8:00 AM and 8:00 PM by an ALSA aide and a nurse would administer the Client's eye drops. The Client required assistance from an ALSA aide with grooming and bathing.

    Review of Client #1's physician's orders dated 09/17/2023, directed to instill Timolol 0.5% (eye drops) one (1) drop into both eyes at 08:00 AM and 8:00 PM and Latanoprost 0.005% (eye drops) one (1) drop into the left eye at 8:00 PM. Additionally, the Client's medication administration record (MAR) dated 09/17/2023 to 10/14/2023 and 10/15/2023 to 11/11/2023, failed to identify Licensed Practical Nurses (LPN) consistently document a reference signature within the MAR after signing off medications.

    Interview and review of the agency's investigation dated 10/22/2023 with the Executive Director on 10/24/2023 at 10:15 AM, identified on 10/22/2023 ALSA aide #1 was performing COVID tests on assigned clients when she answered Client #1's call for service around 8:00 PM. The Client requested ALSA aide #1 administer his/her eye drops. ALSA aide #1 placed a bottle of COVID testing solution on the Client's counter, and then went to collect client's medication box. When ALSA aide #2 entered the Client's room and indicated she would administer the Client's eye drops, ALSA aide #1 left the room without the bottle of COVID testing solution. Client #1 handed the bottle of COVID testing solution to ALSA aide #2 and directed her to administer the "eye drops". ALSA aide #2 failed to read the bottle's label and proceeded to instill COVID testing solution into the Client's eyes. ALSA aide #1 returned to Client #1's room to retrieve the bottle of COVID testing solution, at the same time ALSA #2 identified instilling the COVID testing solution into the Client's eyes. Client #1 complained of a burning sensation in both eyes and alleged ALSA aide #2 pushed him/her down onto the bed to administer the eye drops. LPN #1 called the Supervisor of Assisted Living Services Agency (SALSA), the Client's physician, responsible person and 911. The Client provided the responding police officer with a statement and was transported to the emergency room. Client #1 returned to the agency the evening of 10/22/2023 and ALSA aide #2 was suspended pending the outcome of the investigation.

Interview with the Executive Director and Regional Director of Operations on 10/24/2023 at 2:30 PM, identified the agency failed to provide oversite and/or supervisions of the ALSA aides, failed to follow Client #1's service plan, failed to follow the agency's Assisting with Routine Medications and Medication Error policies, failed to conduct a comprehensive investigation following a medication error and allegation of abuse and failed to maintain a complete client record.

Review of agency's policies and procedures for Assisting with Routine Medications and Medication Errors, identified staff would assist clients with the administration of medications in a manner according to established procedures. Staff would read all information regarding the medication in a client's medication record (medication name, dosage, and time the medication would be taken). The staff must follow the six (6) R's, right client, right medication, right dose, right route, right time, and right documentation and must read the medication label to ensure the medication information and label matched exactly. Furthermore, a medication error is considered any preventable event that may cause or lead to inappropriate medication use or client harm. Following a medication error, the agency would investigate and provide education to staff and human resource intervention.

Plan of Correction to Violation #1: