STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

August 31, 2020

Linnea Szantyr, Person-in-Charge
Elton Residential Care Home
30 West Main Street
Waterbury, CT 06710

Dear Ms Szantyr:

An unannounced visit was made to Elton Residential Care Home on June 18, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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 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 September 14, 2020.

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.

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Telecommunications Relay Service 7-1-1
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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

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 September 14, 2020 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. Please direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Karen Gworek RN

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c. Mairead Painter, LTC Ombudsman

Complaint #27812

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

1. Based on a review of facility documentation and interviews, the facility failed to implement the protocol for monitoring the residents. The findings include:
   a. Resident #1's diagnoses included stasis dermatitis, alcohol abuse, anemia, hypertension (HTN), cervical disc fusion, vitamin deficiency and gastric reflux disease. Physician orders identified Resident #1 received Lisinopril (HTN), Protonix (acid reflux), multivitamin and Advair (asthma). A review of a facility incident report dated 6/15/20 identified at 6:30 AM a Floor Aide #2 found Resident #1 unresponsive in his/her bedroom with a string wrapped around his/her neck. The incident report identified 911 was called and the emergency responders pronounced Resident #1 deceased at the scene. A review of facility documentation titled Floor Aide job duties for the 3:00 PM to 11:00 PM shift identified Floor Aides will check resident rooms at the beginning and at the end of their shift. The Floor Aide job duties for the 11:00 PM to 7:00 AM shift identified Floor Aides will check all resident rooms at least once per shift. An interview with the Program Manager on 6/18/20 at 10:15 AM identified the job description instructs the 11:00 PM to 7:00 AM Floor Aide to check residents at least once per shift, however the facility's practice and the expectation was to check the residents two times per shift. The Program Manger identified after reviewing the surveillance camera footage, she determined Resident #1 was last checked on 6/14/20 at 5:15 PM. An interview with Floor Aide #1 on 6/18/20 at 10:30 AM identified she was assigned to Resident #1's floor on 6/14/20 for the 3:00 PM to 11:00 PM shift. Floor Aide #1 identified she worked with Resident #1 often and described him/her as quiet, secluded and Resident #1 did not like to be bothered. Floor Aide #1 indicated Resident #1 stayed in his/her room for meals and did not socialize with other residents. Floor Aide #1 stated the last encounter she had with Resident #1 was on 6/14/20 at approximately 5:00 PM when she asked Resident #1 if he/she wanted the evening inhaler medication and Resident #1 refused the medication. An interview with Floor Aide #2 on 6/18/20 at 2:13 PM identified she worked on 6/14/20 from 11:00 PM to 7:00 AM on Resident #1's floor. Floor Aide #2 identified Resident #1 did not come to the office to receive morning medications, so at approximately 6:00 AM she went to get the resident and found Resident #1 in his/her room unresponsive with a string around his/her neck. Floor Aide #2 identified she checks residents twice per shift and when she knocked on Resident #1's door on 6/15/20 at 12:00 AM and there was no answer, so she opened Resident #1's door and asked if Resident #1 was o.k. to which Resident #1 responded "yes". A follow-up interview with the Program Manager on 6/19/20 at 12:30 PM identified she reviewed the surveillance camera footage again and confirmed no staff went near Resident #1's door between 5:00 PM on 6/14/20 to 6:00 AM on 6/15/20.

The following is a violation of the regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(E) Required records(ii)(VI).

2. Based on a review of clinical record and interview, the facility failed to document a refusal of medication on the medication administration record. The findings include:
   a. Physician's order dated 4/17/20 identified Resident #1 was prescribed inhaler the Advair (for asthma) twice daily at 6:00 AM and 6:00 PM. A review of the Medication

Administration Record dated June 2020 failed to reflect documentation of the administration or Resident #1's refusal of the Advair at 6:00 PM on 6/14/20. A review of facility documentation outlining the job duties of the facility's 3:00 PM to 11:00 PM Floor Aide included but was not limited to keeping Resident Medication Administration Record information up to date. An interview with Floor Aide #1 on 6/18/20 at 10:30 AM identified she was responsible for medication administration on 6/14/20 and when she asked Resident #1 if he/she wanted the Advair inhaler to which Resident #1 refused, she forgot to document the refusal on the Medication Administration Record.

Approved 10/20/21 KEG

Elton Residential Care Home
The Elton – An Historic Landmark
30 West Main Street
Waterbury, CT 06702
Phn. (203) 756-1229
Fax (203) 596-8222

September 9, 2020

[redacted]

RE: Complaint #27812

Resident #1 was actively being seen by a visiting nursing agency and receiving therapy from a LCSW for his physical and mental health. However, he continuously refused to seek outpatient treatment or medication for his mental health issues. This incident, while unfortunate, reflects the difficulties in pursuing help for our residents who refuse care. The Elton RCH will continue to evaluate our procedures and policies around these residents and voice our concerns regarding their welfare to all their providers. The following plans have been implemented:

1. Both Floor Aides #1 & #2 have been reprimanded with warnings for failure to follow proper procedures, as dictated by the Floor Aide job duties. Administration also revised the Floor Aide Shift Notes, the Elton's form for recording events on every shift, and submitted the revised notes to the printing company on 7/29/20. Due to COVID, there was a delay in printing & receiving the new notes, but staff implemented the new shift notes officially as of 9/1/20. The revised notes now include a section where each employee records the time the Shift Rounds are completed. Twice per shift, the Floor Aide reports when each resident is checked on. Randomized checks by Administration, specifically myself, will help to eliminate any further issues.

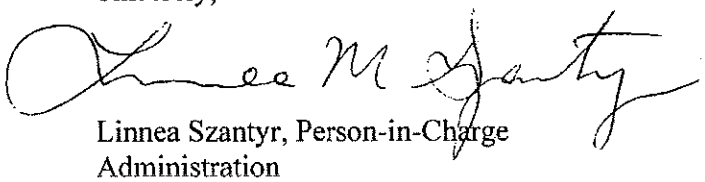
   Please see the addition our shift notes below:

*Shift Rounds:

Time Completed (within 90min of beginning of shift)	Time Completed (within 90min of end of shift)

2. Floor Aide #1 apologized while interviewed at the 6/18/20 visit and was given a verbal warning for failing to document on the M.A.R. correctly. All aides participated in a mandatory review of the Medication Administration Course and correct documentation procedures. In addition, Lead Floor Aides are to review all documents and Medication Administration Records for any errors or missing documentation. These Lead Floor Aides are to report any findings to the Administration, specifically myself, for review.

Sincerely,



Linnea Szantyr, Person-in-Charge
Administration
Elton Residential Care Home