STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

February 13, 2019

Diane Carigliano, Supervisor of Assisted Living Services Agency
Saybrook At Haddam
1556 Saybrook Road, Route 154
Haddam, CT 06438

Dear Ms. Carigliano:

This letter is an amended version of the violation letter dated February 6, 2019

Unannounced visits were made to Saybrook At Haddam on October 24 and November 30, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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.

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 February 5, 2019.

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 to Loan.Nguyen@ct.gov 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 February 5, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

DATES OF VISIT: October 24 and November 30, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

An office conference has been scheduled for **February 7, 2019 at 1:00 PM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Complaints #24309, #24466

DATES OF VISIT: October 24 and November 30, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (a) Definitions (16) and/or (g) Supervisor of assisted living services (2) (A) and/or (B) and /or (h) Nursing services provided by an assisted living services agency and/or (k) Client service record (2) (H).

1. Based on clinical record review and staff interview, for one of six clients (Client #11) in the survey sample, the Supervisor of Assisted Living (SALSA) / registered nurse failed to provide the necessary assessments of the client's ability to self-administer medications, and failed to assign the medication administration task to the appropriate level of staff. The findings include:

Client #11 was admitted to the Memory Care Unit at the assisted living facility on 6/30/16 with diagnoses that included Alzheimer ' s dementia with behavioral disturbance, expressive aphasia, anxiety disorder, unsteady gait and wedge compression fracture of the third lumbar vertebra.

i. The client service plan dated 11/5/18 identified the need for total assistance with bathing and toileting, standby assistance with grooming and dressing, and the need for "medication reminders."

The Connecticut regulations for assisted living services agencies at 19-13-D105 (a) Definitions (16) and (h) Nursing services provided by an assisted living services agency/ALSA defined the self-administration of medications as the client taking their own medications, and indicated that an ALSA aide would only provide physical assistance (which the ALSA called "medication reminders") during the process of medication self-administration by the client.

Interview and review of the client service plan dated 11/5/18 with the SALSA on 11/30/18 failed to identify accuracy of the determination in the Client Service Plan that Client #11 required "medication reminders," which implied that a client with Alzheimer's dementia and associated behavioral disturbance was capable of medication self-administration;

ii. Interview and review of the client service plan dated 11/5/18 with the SALSA on 11/30/18 indicated that Client #11 required "medication reminders," which implied that Client #11 was capable of medication self-administration, but failed to identify a direct nursing assessment and/or visualization of the client's cognitive ability to manage own medications before assigning an ALSA aide to "remind" Client #11 of medication self-administration times;

iii. Interview and review of the agency documentation with the SALSA on 11/30/18 indicated that following the incident, ALSA Aide #11 was disciplined and the ALSA staff received in-service on medication reminders by the aide, medication administration by the nurse, scope of practice regarding pill crushing and appropriateness of crushing certain pills, but failed to identify the compiling of an

incident report, with interviews, statements and root cause analysis to prevent recurrences;

iv. Interview and review of the agency documentation with the SALSA on 11/30/18 indicated that following the incident, ALSA Aide #11 was disciplined and the ALSA staff received in-service on medication reminders by the aide, medication administration by the nurse, scope of practice regarding pill crushing and appropriateness of crushing certain pills, but failed to identify education provided to the ALSA nurses on the need to assess each client for their ability to self-administer medications prior to assigning an ALSA aide to "remind" the client of the times for medication self-administration;

vi. Interview and review of the agency documentation with the SALSA on 11/30/18 indicated that following the incident, ALSA Aide #11 was disciplined and the ALSA staff received in-service on medication reminders by the aide, medication administration by the nurse, scope of practice regarding pill crushing and appropriateness of crushing certain pills, but failed to identify a full re-assessment of all the affected clients in the facility for their ability to self-administer medications prior to assigning an ALSA aide to "remind" the client of the times for medication self-administration;

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of an assisted living services agency (4)(A) and/or (B) and/or (F) and/or (g) Supervisor of assisted living services (2)(A) and/or (B) and /or (i) Assisted living aide services provided by an assisted living services agency (1) and/or (3) and/or (5) and/or (k) Client service record (2)(L).

2. Based on review of the clinical record, agency documentation and interview with agency personnel, for one of six clients (Client #1) in the survey sample, the ALSA staff failed to complete safety checks as ordered, failed to document accurate and/ or authentic tasks, failed to supervise the performance of ALSA aides, and failed to communicate accurate and authentic facts during the transition of care. The findings include:

    a. Client #1 was admitted to the ALSA memory care unit on 4/5/17 with diagnoses that included hypertension, diabetes mellitus type II, chronic kidney disease, depression, cognitive impairment and dysphagia. Review of the client service program dated 7/25/18 identified the need for stand by assistance with bathing, minimal assistance with dressing, stand by assistance with grooming, medication management, total assistance with incontinence care, and the need for safety checks every hour, 24 hours a day 7 days a week, and indicated that Client # 1 was at risk for falls.

        i. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM indicated that ALSA Aide #2 worked the 11 PM to 7 AM shift (from 10/11/18 to 10/12/18) and did not complete the hourly

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

checks on Client #1 at 5 AM, 6 AM and 7 AM, failed to identify conformance with the plan of care, and failed to identify nursing oversight of the ALSA aide performance;

ii. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM indicated that ALSA Aide #1 worked the day shift (7 AM to 3 PM) on 10/12/18 and did not complete the hourly safety checks on Client #1 at 7 AM and 8 AM, failed to identify conformance with the plan of care, and failed to identify nursing oversight of the ALSA aide performance;

iii. The agency documentation indicated that ALSA Aide #1 checked on Client #1 at approximately 9 AM on 10/12/18, found Client #1 in the bathroom, on the shower seat, slumped over to the right, with the head resting on the shower seat. The water from the shower was still running onto Client #1's left leg. Client #1 was non-verbal, with eyes open, tracking movements. The client's left thigh was reddened with a fluid filled soft blister and skin wrinkling below that area. The ALSA registered nurse/RN documented that Client #1's pulse was 117 to 128, blood sugar was 177 and oxygen saturation was 83% to 88%. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM failed to identify communication and arrangements with the clients to ensure stand by assistance prior to the client's shower time, in accordance with the plan of care;

iv. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM indicated that ALSA Aide #2 worked the 11 PM to 7 AM shift (from 10/11/18 to 10/12/18) and provided a statement during the ALSA internal investigation, that ALSA Aide #2 checked on Client #1 at approximately 5 AM or 5:15 AM, that Client #1 was in the shower, Aide #1 spoke with the client who responded with a muffled "hi," that Aide #2 continued checking other clients, that Aide #2 also went to the kitchen for "coffee and snack," but Aide #2 failed to establish how long the Memory Care Unit client with cognitive impairment has been in the shower at 5 AM, failed to identify stand by assistance provided during the shower in accordance with the plan of care, and failed to identify safety and supervision of the aide services in the ALSA;

v. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM indicated that ALSA Aide #2 worked the 11 PM to 7 AM shift (from 10/11/18 to 10/12/18) and provided a statement during the ALSA internal investigation, that ALSA Aide #2 checked on Client #1 at

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

approximately 5 AM or 5:15 AM, did not check on Client #1 again at 6 AM or 7 AM, however ALSA Aide #2 documented for having completed the checks on Client #1 at 6am and 7am, failed to identify accurate and/or authentic documentation of a safety check on a Memory Care Unit client with cognitive impairment, and failed to identify safety and supervision of the aide services in the ALSA;

vi. Interview and review of the agency documentation with the Executive Director, the Supervisor of Assisted Living Services Agency (SALSA) and the Memory Care Unit Director on 10/24/18 at 10:15 AM indicated that ALSA Aide #1 worked the 7am to 3 PM shift on 10/12/18, that ALSA Aide #1 stopped by Client #1's apartment around 8:40 AM, heard the shower water, went to care for another client then came back to Client #1's bathroom to find Client #1 slumped over the shower bench, instead of staying with Client #1 upon finding that the client was in the shower at 8:40 AM, failed to identify stand by assistance provider during the shower in accordance with the plan of care, and failed to identify safety and supervision of the aide services in the ALSA;

vii. Review of the ambulance run sheet dated 10/12/18 indicated that the paramedics (first responders) arrived to the ALSA at 9:17 AM to find Client #1 unresponsive with distressed breathing, received report from the ALSA staff that Client #1 "was last seen at 7 AM at baseline state talking and walking without issue," and failed to identify communication by ALSA staff of accurate and/or authentic clinical information to the first responders;

i. The hospital documentation indicated that the paramedics found Client #1 unresponsive and gasping in the shower, gave 1 mg of intravenous Narcan with no effect, and intubated Client #1 with Lidocaine, Fentanyl, Etomidate and Succinylcholine. Review of the permanent legal hospital documentation identified the erroneous information provided to the paramedics by the ALSA staff that Client #1 was last seen "well" at 7 AM, and failed to identify a credible source of information from the ALSA staff.

The hospital documentation identified first and second degree burn to 10% of Client #1's body surface area, requiring plastic surgery for skin graft, and dependent atelectasis to bilateral lungs, no improvement in functional status, with plans for inpatient hospice care should the client decline.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 9d) Governing Authority of an assisted living services agency (4) (A) and/or (B) and/or (F)

3. Based review of the ALSA documentation and interview with agency staff, the ALSA failed to ensure the development of policies and procedures that affected the safety and well-being of the

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

ALSA clients. The findings include:

a. Interview and review of the ALSA policies and procedures with the Building Service Manager and the Executive Director on 10/24/18 at 1pm failed to identify policies and/or guidelines on the daily checking of water temperature in the client's apartment, with parameters, logs and assigned staff with calibrated thermometers. On 10/24/18 the hot water mixing valve in the basement was at 120 degrees Farenheit/F, in Client #1's former apartment the shower water was at 111 F, and the shower water in another apartment was 119F.

POC accepted 3-18-19 enquyen

The Saybrook at HADDAM

An Assisted Living Retirement Community

Monitoring

Quantity: SALSA will review all Medication policy errors to ensure appropriate investigation and completion of incident report.

Frequency/Duration: All incidents will be reviewed indefinitely.

Responsible: SALSA

2. ***The following are violations of the Regulations of Connecticut State Agencies Section I9-13-D105 (d) Governing Authority of an assisted living services agency (4)(A) and/or (B) and/or (F) and/or (g) Supervisor of assisted living services (2)(A) and/or (B) and /or (i) Assisted living aide services provided by an assisted living services agency (1) and/or (3) and/or (5) and/or (k) Client service record (2)(L).***

Corrective Action

A

i, ii, iii, iv, v, vi

- Effective 10/17/18, ALSA staff received in-service training on the requirement for timely, complete and accurate execution and documentation of care provided to each resident as well as the "legal document" status of resident care records.
- Effective 10/17/18, nursing oversight of ALSA aide performance was increased to include periodic spot checking of ALSA aide shift task sheets, which reflect each resident's plan of care and hourly safety/wellness checks. Effective 2/9/19, there will be periodic observation by nursing staff of ALSA aide delivery of plan of care services as detailed below.
- By 2/14/19 or prior to the ALSA aide's next shift, ALSA aide staff will receive in-service training instructing staff to report all instances of resident non-compliance to the plan of care to the ALSA nursing staff.
- By 2/14/19 or prior to the ALSA staff's next shift, ALSA staff will be re-educated on requirements for standby assistance, when required by the plan of care, and the need to have eyes on the residents during safety checks.

POC accepted
3-18-19
cnguyen

An Assisted Living Retirement Community

Plan of Correction re: Letter Dated 1/22/19,
Findings of unannounced visits 10/24/18 & 11/30/18
ALSA License 0148

1. ***The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (a) Definitions (16) and/or (e) Supervisor of assisted living services (2) (A) and/or (B) and /or (h) Nursing services provided by an assisted living services agency and/or (k) Client service record (2) (H).***

Corrective Action

A

i, ii, iii, v, vi: Effective 2/09/2018, all RN staff performing resident assessments will be re-educated on the standards for *Self Administration of Medication* pursuant to the Public Health Code. A new assessment tool is in development and will be implemented upon completion, no later than 2/09/19, to ensure each resident is appropriately assessed for the ability to self-administer medications. All RN staff performing resident assessments will be educated on use of the new assessment tool no later than 2/13/19, or if later, then prior to the RN's next shift. No later than 2/13/19, all affected residents will be fully re-assessed by trained ALSA RN for their ability to self-administer medications.

Monitoring

Quantity:	5 client assessments will be reviewed by the SALSA
Frequency:	Monthly
Duration:	The longer period of 3 months or until 95% accuracy is achieved
Responsible:	SALSA

iv: Effective 2/6/19, all Self Administration of Medication policy and procedure errors will be addressed by an incident report (including interviews and statements) with a root cause analysis to prevent further occurrences. The ALSA nursing staff will receive in-service training, no later than 2/9/19, on implementing this process. Additionally, appropriate ALSA staff will have in-service training within 72 hours in response to any Medication policy errors.

POC accepted 3-18-19 LNguyen

The Saybrook at HADDAM

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- By 2/14/19 or prior to the ALSA staff's next shift, ALSA staff will receive in-service training on the truthful and accurate reporting of clinical information to first responders.

Monitoring

Quantity:	7 ALSA aide task sheet spot checks and 2 ALSA aide service observations will be conducted by the ALSA nursing staff for shifts covering the hours of 7 am to 11 pm; ALSA nurse will conduct 3 random checks per month for the hours 11 pm to 7 am.
Frequency:	Weekly
Duration:	The longer period of 3 months or until 95% accuracy is achieved
Responsible:	SALSA

3. ***The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 9(d) Governing Authority of an assisted living services agency (4) (A) and/or (B) and/or (F)***

Corrective Action

Per a newly developed Operational Policy (Domestic Water Temperature Recording Policy), effective 10/17/2018, daily checks of the domestic water temperature are logged. The water temperature at the facility's domestic water mixing valve is recorded daily to assure that the temperature is below 120 degrees Fahrenheit. Effective 2/1/2019, water temperature readings at locations throughout the facility are also recorded daily.

Monitoring

Quantity:	Water temperature will be logged at three locations
Frequency:	Daily (ongoing)
Goal:	Maintenance of domestic water hot water temperatures within policy standards
Responsible:	Building Service Manager