STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner-Designate

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

April 8, 2019

Diane Pimentel, Supervisor of Assisted Living Services Agency
Maplewood At Danbury Alsa, LLC
22 Hospital Avenue
Danbury, CT 06810

Dear Ms. Pimentel:

An unannounced visit was made to Maplewood At Danbury Alsa, Llc on March 21, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through April 5, 2019.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

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 April 22, 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.

DATE OF VISIT: March 21, 2019

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

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 **April 22, 2019** or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

If there are 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

LDN:jf

Complaint #24636

DATE OF VISIT: March 21, 2019

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

The following is a violation of the regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living services agency (4)(F) and/or (h) Nursing Services provided by an assisted living services agency (1)(D) and/or (E)

1. Based on clinical record review and staff interview, for one of one client (Client #1) with an injury of unknown origin, the Assisted Living Services Agency/ALSA failed to conduct a timely and/or comprehensive investigation. The findings include:

   a. Client #1 was admitted to the memory care unit on 11/8/18 with diagnoses that included dementia, hypothyroidism, hyperlipidemia, macular generation and a history of skin cancer and gastro-intestinal bleeding. The client service dated 11/8/18 identified the need for total assistance with bathing, hygiene, dressing, grooming.

   The patient's medications included Aspirin 81mg by mouth each day.

   The ALSA documentation dated 11/10/18 indicated that Client #1 had a private help, and the client hit the private help in the face and on the head.

   On the same day 11/10/18 Client #1 took the walker belonging to another client. The ALSA nurse separated the clients, and redirected Client #1 to own apartment, where the nurse began administering medications to Client #1. Client #1 became agitated, grabbed the nurse's left wrist, then the nurse's right arm and attempted to bite the nurse. While the nurse attempted to break free, Client #1 punched the nurse's right arm an upper back. The nurse was finally able to leave the room to return to the hallway. Client #1 barricaded the hallway and did not allow staff and other clients access to the rest of the hallway. One client walked up to Client #1, and Client #1 began hitting that client. The staff present in the hallway separated the clients.

   In a psychiatric evaluation completed on 11/12/18 at 8:14 AM Advanced Practice Registered Nurse/APRN #1 indicated that the family informed the APRN of the client's aggression and anger that frustrated several psychiatrists who previously removed themselves. The APRN assessment identified symptoms of severe cognitive deficits chronically present during the entire day, consisting of increased intolerance to be touched or moved, not recognizing people who should be familiar, becoming agitated, kicking, hitting, biting, screaming or grabbing. The client presented as irritable, distracted, uncommunicative, anxious, with a short attention span, illogical reasoning and delusional ideas. The APRN discussed with the family the need for inpatient psychiatric evaluation.

      i. The agency documentation indicated that on the same day 11/12/18 around 11:30 AM, Client #1's private help noted that Client #1's clothes were soiled, and enrolled the assistance of ALSA Aide #1 (who was covering for ALSA Aide #2's lunch break) in providing hygiene to Client #1. Client #1 agreed to walk into the bathroom, where upon undressing the client, the staff noted dry feces on the client's skin, and proceeded to

shower Client #1 to effectively remove all dry feces. ALSA Aide #2 returned from lunch break to find Client #1 punching swatting and attempting to bite the other two staff in the shower. After Client #1 was out of the shower and fully dressed, the client calmed down.

The aides subsequently noted a skin tear on Client # 1's right wrist and called the RN designee. Interview and review of the agency documentation with the RN Designee on 3/21/19 indicated that the RN designee saw "blood dripping" from the client's right wrist, the RN Designee cleansed and bandaged the wound, but failed to identify nursing inquiry to the aides present at the scene, of the circumstances preceding the skin tear, and/or notification to the SALSA of an incidence of injury of unknown origin;

ii. Interview and review of the agency policies and procedures with the SALSA on 3/21/19 failed to identify a time frame for initiating and concluding an investigation on injuries of unknown origin;

iii. The ALSA documentation dated 11/12/18 indicated that around 2:30PM Client # 1 came up from behind another client, and Client # 1 put arm around that client's neck. The ALSA Aide and the private help rushed to pull Client # 1's arm away from the other client's throat and separate the clients.

The ALSA documentation further identified a telephone call from the ALSA Director of the memory care unit and other staff members to the client's family on 11/12/18 around 5:30 P.M. The ALSA staff expressed to the family that based on the events of aggression from Client # 1 over the past few days, the ALSA staff was no longer able to care for Client # 1 at that time. The ALSA staff suggested a transfer to inpatient care, or a transfer to the client's home. According to the ALSA documentation, the family verbalized understanding.

The family subsequently arrived to the ALSA around 9PM on the same day 11/12/18 to take the client home.

Interview and review of the ALSA documentation with the SALSA on 3/21/19 indicated that the day following Client #1's discharge from the facility, the client's family called the facility with concerns over the bruises on Client #1's arms and forearms, and the ALSA initiated an investigation of the allegation of injuries, but failed to identify a timely investigation initiated at the time the injury was identified on 11/12/18.

The Urgent Care Clinic documentation dated 11/13/18 indicated that the family brought Client #1 to the Urgent Care Clinic with concerns that the skin tear on the client's arm might need suturing. The physician at the Urgent Care Clinic examined Client #1 and communicated to the family that the abrasion was small, superficial and did not look

infected.

The hospital record dated 11/15/18 that the family brought Client #1 to the hospital for evaluation of the bruises on both forearms. In the hospital the client was resistive to changing clothes, and the examination took place over clothing. The hospital physician documented that the client was not comfortable with touch from the family or from others. The physician further documented that the client exhibited mild bruising due to fragile skin and low dose of Aspirin use, with no evidence of abuse. The client was described as ambulating "around," hitting staff, and asking the staff to leave. The examination was witnessed by the family. The physician documented that the family agreed there was no need for labwork or radiological evaluation and the client was discharged home.

ALSA Aide #1 and ALSA Aide #2 were terminated from employment by the ALSA on 11/16/18, and were not available for interviews.

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POC accepted 4-23-19 Nguyen

April 22, 2019

By Email to Loan.Nguyen@ct.gov

Ms. Loan Nguyen, R.N., M.S.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: Maplewood at Stony Hill ALSA, LLC/Maplewood at Danbury ALSA, LLC

Dear Ms. Nguyen:

This letter is in response to your letter dated April 8, 2019, addressed to "Diane Pimentel, Supervisor of Assisted Living Services Agency, Maplewood at Danbury ALSA, LLC" ("Danbury ALSA, LLC"). At the time the events described in your letter occurred, Danbury ALSA, LLC was the licensed provider of assisted living services at Maplewood at Stony Hill, an assisted living community located in Bethel, Connecticut (the "Community"). On November 15, 2018, the Department of Public Health (the "Department" or "DPH") issued License No. 0205 to Maplewood at Stony Hill ALSA, LLC ("Stony Hill ALSA, LLC" or the "ALSA"), and since that date Maplewood at Stony Hill ALSA, LLC, not Maplewood at Danbury ALSA, LLC, has been the provider of assisted living services at the Community. Also since that date I have been the SALSA of Maplewood at Stony Hill ALSA, LLC. Since Stony Hill ALSA, LLC will be the entity responsible for implementing the Plan of Correction set forth below, I believe it is the proper entity signing this letter. If this is not correct, please let me know.

This letter does not constitute an admission that the law has been violated as alleged in the letter, that the facts as alleged in the letter are true, or of any other wrongdoing. Rather, this letter is set forth as a comprehensive Plan of Correction for the following alleged violations of the Regulations of Connecticut State Agencies and/or the General Statutes of the State of Connecticut which were noted during an unannounced visit by a representative of the State of Connecticut Department of Public Health Facility Licensing and Investigations Section on March 21, 2019.

1. **Violations of Regulations of Connecticut State Agencies Section D19-13-D105 (d) Governing authority of an assisted living services agency (4) (F) and/or (h) Nursing Services provided by an assisted living services agency (3)(D) and/or (E).**

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Alleged failures of the Community:

(i) The RN Designee failed to identify nursing inquiry to the aides present at the scene, of the circumstances preceding the skin tear and/or notification to the SALSA of an incidence of injury of unknown origin;

(ii) Interview and review of the agency policies and procedures with the SALSA on 03/21/19 failed to identify a time frame for initiating and concluding an investigation on injuries of unknown origin; and

(iii) The ASLA initiated an investigation of allegation of injuries after receiving call from the client's family post-discharge, but failed to identify a timely investigation initiated at the time the injury was identified on 11/12/18.

A. Measures to Prevent Reoccurrence:

1. The facility's Investigating and Reporting Actual or Alleged Abuse of Any Resident by an Associate or Other Person Policy (the "Policy") has been reviewed and revised to include a time frame for initiating and concluding an investigation on injuries of unknown origin i.e. to commence an investigation immediately upon an allegation, or the discovery, of such an injury and to conclude the investigation within 72 hours from the end of the shift during which the investigation commenced, barring any extraordinary circumstances.

2. The revised Policy will be in-serviced by the Regional Director of Resident Services to the SALSA, RN Designee and Service Coordinator. The in-service will include, but not limited to ensuring that all injuries of unknown origin are being investigated thoroughly; the investigation will commence immediately upon an allegation, or the discovery, of such an injury and to conclude the investigation within 72 hours from the end of the shirt during which the investigation commenced, barring any extraordinary circumstances.

3. The SALSA and/or Service Coordinator will in-service the revised Policy to all resident care staff, including ALSA nurses and aides. The in-service will include education on mandatory reporting of all injuries, including injuries of unknown origin, to the SALSA and/or Service Coordinator at the time the injury is alleged or discovered.

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4. A review of all resident care plans will be performed by the SALSA and RN Designee to ensure that each care plan includes specific instructions for ALSA aides to observe and report injuries of unknown origin, including, but not limited to, skin tears, bruises and bumps on the resident's skin.

5. All injuries, including injuries of unknown origin, will be followed by an incident report in the resident's record, opened during the same shift the injury was discovered.

B. Date of Corrective Action Plan ("CAP"):

All corrective action as indicated above will be completed by May 10, 2019 except for on-going monitoring.

C. Plan to Monitor/Audit:

1. In an effort to ensure sustained compliance, the SALSA and/or RN Designee are currently reviewing each incident report opened by a nurse. The SALSA and/or RN Designee will continue to review each incident, including incidents related to injury from unknown origin, and ensure that this type of injury was thoroughly investigated and reported in accordance with policy.

2. The Service Coordinator will have final approval of all incident reports, including incidents related to injury from unknown origin, and also ensure that this type of injury was properly investigated and reported as per policy before approving and closing the incident report.

3. In an effort to ensure sustained compliance, the SALSA and/or RN Designee will audit daily progress notes for a period of 3 months. Any progress notes entered and related to an injury of unknown origin will be cross-referenced to ensure that an incident report was issued for each such injury and each such injury was thoroughly investigated.

D. Staff Member Responsible for Monitoring the Plan of Correction:

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The staff member responsible for ensuring the Community's compliance with this Plan of Correction will be the Supervisor of Assisted Living Services Agency at the Community.

Should you have any questions, please contact me at (203) 207-4100.

Respectfully submitted by,

Diane A. Pimentel RN, RSD

Diane A. Pimentel, RN, RSD
Supervisor of Assisted Living Services Agency
Maplewood at Stony Hill

DP:aa
cc: Kim Oliver (by email)
Amy Silva-Magalhaes (by email)
Constantin Popescu (by email)
Shane Herlet (by email)
David Cahill, Esq. (by email)
Arthur E. Miller, Esq. (by email)

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