STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

May 8, 2020

Trish Keany, Executive Director
Bridges By Epoch At Trumbull
2415 Reservoir Avenue
Trumbull, CT 06611
Tkeaney@bridgesbyepoch.com

Dear Ms. Keaney:

An unannounced visits was made to Bridges By Epoch At Trumbull on May 7, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and an 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 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 May 18, 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 to Loan.nguyen@ct.gov may be subject to disciplinary action. Please do not send another copy via US mail.

DATE(S) OF VISIT: May 7, 2020

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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 May 18, 2020 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

If there are any questions, please do not hesitate to contact this office at (860) 509-8059.

Respectfully,

Loan Nguyen MSN, RN, C
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CT # 27476

DATE(S) OF VISIT: May 7, 2020

THE FOLLOWING VIOLATION(S) 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 (h) Nursing services provided by an assisted living services agency (1) and/or (3) (C) and/or (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (k) Client service record (2) (H) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c)

1. Based on clinical record review and interview with facility staff, the assisted living services agency (ALSA) staff failed to notify the Registered Nurse (RN) when a client exhibited significant changes in condition, and the RN in response to the family's concerns failed to ensure the completion of assessments, documentation and the development of interventions. The findings include:

Client #1 was admitted to the memory care unit on 1/30/2020 with diagnoses that included Alzheimer's dementia, heart disease and depression.

The nursing assessment dated 2/3/2020 indicated that Client # 1 was independent with ambulation and transfers.

On 4/4/2020 at 2:53 pm, Licensed Practical Nurse (LPN) #4 documented that Client # 1 was alert and verbal, had one episode of loose stool after lunch; the LPN encouraged fluid intake, which the client tolerated well. The LPN redirected the client to bed, and documented a temperature of 97.8 F, a pulse of 68, a respiratory rate of 20, and a blood pressure of 118/74.

i. On 4/5/2020 at 2:16 pm, LPN#3 documented that the family communicated with Client # 1 via FaceTime on an Ipad. A few moments later, LPN # 3 the ALSA Executive Director verbalized to LPN # 3 that the family called the Executive Director to share the family's feeling that Client # 1 was dying.

Interviews and review of the ALSA documentation with LPN # 3 on 5/7/2020 at 11:00 am and with the Executive Director on 5/7/2020 at 1:00 pm failed to identify the completion of an assessment by a Registered Nurse (RN) of Client #1's physical condition, functional status and any possible change in condition in response to the family's grave concerns as expressed to the Executive Director.

Instead, the Executive Director placed a telephone call to LPN # 3 and asked LPN # 3 to check on Client # 1.

LPN # 3 updated the Executive Director that Client # 1 was alert, exhibited no cardiopulmonary distress, voiced no complaint of pain or discomfort and was comfortable during LPN # 3's shift. LPN # 3 also went to the apartment to check on Client # 3 and documented that Client # 3 was eating lunch at the dining room table.

On 4/6/2020 at 2:08 pm LPN#1 documented that Client # 1 was alert, verbal and responsive, with a temperature of 98.2, pulse 74, a blood pressure of 110/60 and a pulse oximetry of 95% at room air.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Client # 1 had good appetite during breakfast, LPN # 1 encouraged fluids, and Client #1 tolerated the fluids well.

LPN # 1 further documented that Client # 1 took all medications as given, tolerated those well, had fair appetite at lunchtime, and received afternoon snack;

ii. On 4/7/2020 at 3:45 pm, LPN#1 documented that Client # 1 exhibited a decrease in mobility during a physical therapy (PT) session.

The Registered Physical Therapist (RPT) reported to the Executive Director that the client had difficulty following directions, which was a deviation from the client's baseline.

According to the RPT in an interview on 5/7/2020 at 10:30 am, the RPT had been treating Client # 1 for a few weeks, the client was usually able to follow commands, but during the last PT session, the client was lethargic and the RPT reported the change in condition to the Executive Director.

Review of the ALSA documentation failed to indicate that after gaining knowledge of Client # 1's significant change in condition from the RPT's report, the Executive Director failed to ensure the assessment of the client's change in condition by a registered nurse (RN) in order for the client to benefit from the appropriate interventions and the timely implementation of revisions to the plan of care.

While RN # 1 (the RN Designee) verbalized to the surveyor on 5/7/2020 at 1:30PM the recollection of having assessed Client # 1 on 4/7/2020 together with LPN # 1, the clinical documentation showed no evidence of an assessment by the RN, and LPN # 1 indicated in an interview on 5/7/2020 at 4:15PM that LPN # 1 was alone during the assessment of the client's change in condition, without RN # 1's presence.

The ALSA policy on Change of Status directed the Wellness Director (RN Supervisor of assisted living services agency) or the RN to complete an assessment of any change in the mental, medical or functional status of a client to document the findings in the client's clinical record;

iii. On 4/7/2020 LPN#1 documented that the client's temperature was 97.9 F, pulse was 74, blood pressure was 110/70 and pulse oximetry was 95% at room air, the LPN did not observe cardiopulmonary distress, the client's lungs were clear to auscultation, and neurological response was within normal limits.

On 4/7/2020 at 3:56 pm, LPN#1 documented that fluids were encouraged and Client # 1 tolerated fluids well.

Review of the documentation failed to identify notification by LPN #1 to the ALSA registered nurse of

DATE(S) OF VISIT: May 7, 2020

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Client # 1's change in condition, for the client to benefit from a nursing assessment conducted by a registered nurse, followed by appropriate interventions to address the client's change in condition in a timely manner.

Instead, LPN # 1 indicated in an interview on 5/7/2020 at 4:15 pm that LPN # 1 notified the physician who ordered a urine sample for urinalysis.

The General Statutes of Connecticut Chapter 378 Section 20-87a (a) defines the practice of a nursing by a registered nurse as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse.

The General Statutes of Connecticut Chapter 378 Section 20-87a (c) defines he practice of nursing by a licensed practical nurse as the performing of selected tasks and sharing the responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician, physician assistant, podiatrist, optometrist or dentist;

iv. On 4/9/2020 at 4:54 pm, Registered Nurse #1 (the RN Designee) documented a conversation with the physician to request an order for urine culture and sensitivity, and additional labwork. RN # 1 also documented that the resident was ambulating in the community without assistance, tolerated meals well. RN # 1 failed to conduct a thorough assessment of the client's physical condition following a reported decline in functioning;

v. Review of an electronic mail (e-mail) exchange indicated that on 4/10/2020 Client # 1's family emailed the ALSA Executive Director at 8:19AM to express concerns regarding the client's decline and/or change in condition after the family spoke with the client the previous day on 4/9/2020 in the afternoon. The Executive Director replied on 4/10/2020 at 12:32 PM via email that the ALSA would make sure the client received the needed attention.

Review of the ALSA documentation failed to identify the completion of a nursing assessment of the client by an RN on 4/10/2020 after the family voiced concerns over the

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clients' decline and/or change in condition.

On 4/10/2020 at 3:19 pm, LPN#2 documented that LPN # 2 was called to the client's apartment when the ALSA staff found the client unresponsive and lethargic.

LPN # 2 documented that Client # 1's temperature was 99.2 F, pulse was 212, respiratory rate was 28, and LPN # 2 was unable to obtain a blood pressure. LPN # 2 called the physician who directed to transfer the client to the Emergency Department. Client # 1 left the memory care unit via ambulance at 2:15 pm, the Executive Director and the family were notified.

On 4/15/2020 at 10:18 am, RN#1 documented that Client # 1 tested positive for covid 19 and passed away in the hospital on 4/15/2020.

POC accepted 5/28/2020 via email to L. Nguyen

May 29, 2020

Loan Nguyen MSN,RN,C
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134-0308
Loan.nguyen@ct.gov

Re: Violations of Public Health Code: Section 19-13-D105(h)Nursing services provided by an assisted living services agency (1) and/or (3) (C) and/or(g) Supervisor of assisted living services (2) (A) and/or(B)and/or(k) Client service record (2) (H) and/or General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or(c).

Dear Ms. Nguyen:

Please see below the Plan of Correction submitted by Bridges by Epoch at Trumbull as a result of an unannounced visit to the Community on May 7, 2020. The visit ensued a violation stating the ALSA staff failed to notify the RN when a client exhibited significant changes in condition and the RN in response to the family's concerns failed to ensure the completion of assessments, documentation and the development of interventions.

Plan of Correction:

(1) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 203) for change of status in the event there is a known significant change in the resident's condition.

(2) Effective May 21, 2020 all noticeable changes in mental, medical or functional status of a resident will be assessed and documented by the Wellness Director/ RN Designee. If the change is significant the Wellness Director/RN Designee will update the service plan, document a wellness

POC accepted 5/29/2020 Legislation for Compliance

note and include the date/time the authorized resident representative and resident physician was notified. In the absence of an RN the Executive Director will be notified of the change and notify the Wellness Director/RN on call timely. The Executive Director will dispatch the RN to assess the resident. When changes in a resident are noted by the LPN , all data collected indicating a change will be reported to the Wellness Director/RN designee to assess the client.

(3) An inservice was held on 5/19/2020 with LPN's and the RN Designee reviewing the Wellness Policy and Procedure for change of status. All licensed staff will be inserviced on the Wellness Policy and Procedure for change of status by May 29, 2020. Residents status will be discussed during weekly huddles on each household alternating between shifts. Input will be a team approach involving CNA's, LPN's, Life Enrichment and Wellness Director/Designee. If resident changes are noted, interventions will be discussed and the Wellness Policy and Procedure for Change of Status followed if the change is significant. Monthly review of resident charts to begin June 2020 for compliance with residents who have experienced significant changes. The number of charts reviewed will be based on 10% of all resident records. Once there is 100% compliance with the internal random audits for 3 consecutive months, we will return to quarterly audits.

(4) The Executive Director will ensure Community compliance by making weekly rounds with the Wellness Director/Designee. During rounds the residents with changes identified in the weekly huddle will be reviewed by the Executive Director for proper protocol by the Wellness Director/Designee.

Please do not hesitate to contact me if you have any questions at (203)-397-6800.

Respectfully Submitted,

Patricia Keaney
Executive Director
Bridges by Epoch at Trumbull

P&L accepted
5/31/2020
as Donated
for Engagement