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 20, 2020

Rachael Torres, Supervisor of Assisted Living Services Agency
Spring Meadows Trumbull
6949 Main Street
Trumbull, CT 06611
rtorres@capitalseniorliving.net

Dear Ms. Torres:

This letter is an amended version of the violation letter dated August 19, 2020

An unannounced visit was made to Spring Meadows Trumbull on July 15, 2020 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 August 18, 2020.

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. The state violation 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 August 29, 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.

DATE(S) OF VISIT: July 15, 2020

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

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.

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 August 29, 2020 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 Loan.Nguyen@ct.gov.

Respectfully,

Loan D Nguyen

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

CT # 27954

THE FOLLOWING VIOLATION(S) 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 (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (h) Nursing services provided by an assisted living services agency (3) (C) and/or (k) Client service record (I).

1. Based on clinical record review and staff interview, for one of one client (Client # 1) who sustained multiple falls, the Supervisor of Assisted Living Services Agency (SALSA) failed to ensure a registered nurse (RN) completed an assessment of the client's physical and mental condition following each fall, and documented such assessment in the client's clinical record. The findings include:

   a. Client #1 was admitted to the assisted living services agency (ALSA) program on 12/1/17 with diagnoses that included diabetes mellitus, dementia and hypertension. The client service program dated 2/10/20 identified the presence of altered gait, a risk for falls, the use of a walker, the need for assistance with medication management, standby assistance with showers, verbal reminders for grooming and dressing.

   Review of the ALSA nurse documentation with the SALSA on 7/15/2020 indicated that Client # 1 sustained falls on 5/29/2020, 6/13/20, 6/15/20 and 6/27/2020.

   On 5/29/2020 at 3:15 pm Licensed Practical Nurse (LPN) #1 documented that LPN # 1 found Client #1 on the floor by the side of the bed, with blood on the nose bridge and a bruise on the forehead.

   Client # 1 verbalized to the LPN that the client was napping and fell out of bed, hitting head on the floor.

   The client complained of pain to forehead, was transferred to the Emergency department via ambulance, and discharged back to the MRC the same day. The SALSA was notified, along with the family and the client's physician.

   On 6/2/2020, the client's physician saw the client via telehealth, with no new orders or recommendations as a result.

   i. On 6/13/2020 at 1pm, LPN #2 documented that LPN # 2 found Client #1 lying calmly on the floor of the apartment. The client denied having fallen, and was able to get up independently without assistance.

   LPN # 2 documented the presence of a minor skin tear to the elbow and small abrasions on the client's back.

   The client denied hitting head and denied pain. Vital signs were stable and neurological

checks were within normal limits.

Interview and review of the nursing documentation with the SALSA on 7/15/2020 failed to identify assessment by the ALSA RN following the fall incident of 6/13/2020 with the appropriate documentation of the changes in the client's mental and/or physical condition;

ii. On 6/15/20 at 4:30PM, LPN #3 documented that LPN # 2 found Client #1 on the knees by the bedside during a safety check.

The client verbalized having slid off the bed onto the floor. The client was able to get up independently without assistance, exhibited no injury, denied pain or discomfort. The physician, the family and the SALSA were notified.

Interview and review of the nursing documentation with the SALSA on 7/15/2020 failed to identify assessment by the ALSA RN following the incident of 6/15/2020 in the setting of repeated instances of being found on the floor.

On 6/29/2020 LPN # 1 documented that the housekeeper called LPN #1 to Client #1 ' s apartment, where LPN #1 found Client #1 in bed, not breathing and pulseless. Client # 1 was lowered to the floor, RN # 1 was called to assist with compressions, which continued until the ambulance arrived.

The run form obtained from the independent ambulance company indicated that the emergency responders arrived to the facility on 6/29/2020 at 1:21 PM and found the facility staff administering cardio-pulmonary resuscitation (CPR) to Client # 1 while the client was on the floor.

The emergency responders ordered the facility staff to stop CPR for a few seconds while the emergency responders applied the mechanical resuscitation device to the client, and CPR was resumed along with the initiation of intravenous emergency treatment measures.

The client was subsequently transferred to the hospital.

August, 29, 2020

POC Accpt M. Smith

Loan Nguyen, Supervising Nurse Consultant
CT Department of Public Health
410 Capitol Ave, P.O. Box 340308
Hartford, CT 06134

Dear Ms. Nguyen

This letter is in response to the findings of noncompliance with the Regulations of the Connecticut State Agencies. The measures that the institution, Spring Meadows Trumbull intends to implement to prevent reoccurrence of each identified issue of noncompliance include:

1. The LPN will be responsible to report each fall to the RN Designee as well as the SALSA.
2. The LPN will continue to monitor a resident's condition for 72 hours after each fall, and/or for 72 hours after the return from the hospital. In this time period the LPN is responsible to communicate any changes in the resident's condition to the on-call RN for instruction as needed.
3. The RN Designee will be responsible to assess residents' condition within 24-48 hours after each fall, and no later than 72 hours after the fall (or return from the hospital).
4. If no RN Designee is scheduled to work within 24-48 hours of a fall, it is the SALSA's responsibility to complete the post-fall follow-up assessment.
5. The RN is to utilize and complete the form, "Post Fall Assessment by RN" following each fall. This form acts as a complete nursing note and is signed by the RN completing the assessment (see attachment). This shall ensure that the resident Service Plan remains appropriate and that follow-up actions are documented fully after each fall.
6. The RN completing the assessment must make a copy of the completed form and provide it to the SALSA.
7. The original form must be placed in the Nurse Assessment Tab of the resident chart to ensure that there is documentation in the client service record that the assessment took place.
8. Rachael Torres, RN, SALSA will be responsible to ensure that Post-Fall Assessments by an RN are completed timely and that documentation of such assessment is located in the client service record. The RN Supervisor will use the amended Resident Fall Log (see attachment) as an audit tool to document compliance with RN assessments as well.
9. In the absence of the SALSA, the SALSA is responsible to ensure that the Executive Director receives copies of the Post Fall Assessment Forms to compare to the Resident Fall Log to ensure compliance with this plan.
10. This plan of correction will be in effect as of September 1, 2020.

Please let me know if you have further suggestions to improve this plan of correction.

Thank you,

Rachael Torres, RN, BSN
Wellness Director/ SALSA