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

December 15, 2020

Christina DeGuzman, Supervisor of Assisted Living Services Agency
Maplewood Stony Hill Bethel
46 Stony Hill Road
Bethel, CT 06801

cdeguzman@maplewoodsl.com

Dear Ms. DeGuzman:

An unannounced visit was made to Maplewood Stony Hill Bethel on December 10, 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 December 14, 2020.

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. 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 December 25, 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 Karen.Donato@ct.gov may be subject to disciplinary action. Please do not send another copy via US mail.

DATE(S) OF VISIT: December 14, 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 December 25, 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 Karen.Donato@ct.gov.

Respectfully,

Loan D Nguyen

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

CT # 29115

The following are violations of the regulations of Connecticut State Agencies Section 19-13-D105 Assisted living services agency (d) Governing authority of an assisted living services agency (4) (F) and/or (e) General requirements for an assisted living services agency (1) and/or (f) Personnel policies (1) (A) (iv) and/or (g)

DATE(S) OF VISIT: December 14, 2020

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

Supervisor of assisted living services (4) and/or (k) Client service record and/or (m) Client's Bill of Rights and Responsibilities (5) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c)

1. Based on clinical record review and staff interview, for nine of nine clients (Clients # 1 through #9) in the Memory Care unit who required hourly monitoring for safety, the Assisted Living Services Agency (ALSA) aide failed to provide the necessary monitoring, failed to ensure accurate and authentic documentation of monitoring; and for one of nine clients (Client #1) who suffered a fall episode, the ALSA failed to protect the client from neglect. The findings include:

Client #1 was admitted to the memory care unit in the assisted living services agency (ALSA) program on 8/31/2019 with diagnoses that included Alzheimer's disease, hypertension and macular degeneration. Client # 1's plan of care included the need for safety checks every hour during the night shift (11PM through 7AM).

i. The ALSA documentation indicated that on 10/18/2020, the surveillance camera placed in the hallway identified a safety check conducted by the evening (3PM to 11PM shift) aide (ALSA Aide # 3) at 10:57PM.

During the night shift (11PM to 7AM), the night shift aide (ALSA Aide # 1) was not seen on camera conducting any hourly safety checks on the clients from 12 AM to 5:33AM.

At 5:33AM, the camera showed ALSA Aide # 1 entering the room of Client # 8, then entering the room of Client # 2.

ALSA Aide # 1 was not seen on camera entering any other room on the third floor from room 316 to room 330 during the eight-hour shift. Rooms 316 to 330 were occupied by Clients # 1 through 9, who required hourly checks for safety.

Interview with the Supervisor of Assisted Living Services Agency (SALSA) on 12/10/2020 identified neglect from ALSA Aide # 1 towards Clients # 1 through 9, and failure to meet the client's needs for hygiene and safety in accordance with the clients' plan of care;

ii. Interview with the Regional Director Of Operations (DOO) on 12/10/2020 indicated that ALSA aide #1 documented the completion of hourly safety checks in the records of all the clients in rooms 316 through 330 (Clients # 1 through #9) and failed to identify accuracy and authenticity of the clinical records;

iii. The surveillance camera placed by the family inside Client # 1's room indicated that on 10/19/2020 Client #1 slid out of bed to the floor at 12:18 AM while picking up a pillow from the floor, called for help several times, and remained on the floor until Licensed Practical Nurse (LPN) #1 who worked the subsequent day shift (7AM to 3PM) found Client # 1 at 8:40 AM on 10/19/2020, after Client # 1 lay on the floor for over eight hours, incontinent, naked, calling and waiting for help.

Interview with the SALSA and the Regional Director of operations (DOO) on 12/10/2020 identified neglect

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

from ALSA Aide #1 towards the client's needs for over eight hours after a fall incident, and indicated that ALSA Aide # 1 was terminated on 10/19/2020;

iv. On 10/19/2020 at 8:40 AM, Licensed Practical Nurse (LPN) #1 documented hearing calls for help coming from Client #1's apartment. Upon arrival, LPN #1 found Client #1 lying supine and naked on the floor near the bathroom. The client was incontinent of urine.

LPN # 1 documented that the client's blood pressure and pulse were within normal limits, the client was able to move all extremities and denied pain.

Interview with LPN #1 on 12/14/2020 at 9:33 AM indicated that LPN # 1 called ALSA Aide # 2 over the walkie-talkie for assistance to lift Client # 1 to a standing position, then to place Client # 1 in a wheelchair.

LPN #1 subsequently went to the nursing office to call the next-of-kin, the physician and the Registered Nurse (RN) Supervisor of Assisted Living Services Agency (SALSA).

Interview with the ALSA RN on 12/10/2020 failed to indicate that LPN #1 notified the ALSA registered nurse of the need to assess the client prior to making the nursing decision to move Client # 1 off the floor.
The Connecticut General Statutes at Chapter 378 Section 20-87a (a) defines the practice of nursing by a registered nurse as, among other responsibilities, "the process of diagnosing human responses to actual or potential health problems."
The Connecticut General Statutes at Chapter 378 Section 20-872 (c) defines the practice of nursing by a licensed practical nurse as, among other responsibilities, "the performing of selected tasks and sharing of responsibility under the direction of a registered nurse;"

v. Interview with the SALSA on 12/10/2020 and review of the ALSA policies on Unwitnessed Falls indicated that the client should not be moved unless directed by "a nurse," that "a nurse" should perform an overall observation from the fall, but the policies failed to include the specification that in Connecticut, a Registered Nurse (RN) should assess the client after a change in condition, and a Registered Nurse should make the nursing decisions based on the outcome of the nursing assessment.

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POC accepted 1/29/2021 LS

January 29, 2021

By Email to karen.donato@ct.gov

Ms. Karen Donato
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 Stony Hill, LLC

Dear Ms. Donato:

This letter is in response to a letter from Loan Nguyen, formerly Supervising Nurse Consultant in the Facility Licensing and Investigations Section of the Connecticut Department of Public Health, dated December 15, 2020, regarding Maplewood at Stony Hill ALSA, LLC (the "ALSA"), an assisted living community (the "Community") operated by Maplewood at Stony Hill, LLC (the "Operator"), located in Bethel, Connecticut. You are identified in that letter as a contact with respect to the issues raised therein.

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 December 10, 2020, with additional information received through December 14, 2020.

1. Violations of the regulations of Connecticut State Agencies Section 19-13-D105 Assisted living services agency (d) Governing authority of an assisted living services agency (4)(F) and/or (e) General requirements for an assisted living services agency (1) and/or (f) Personnel policies (1)(A)(iv) and/or (g) Supervisor of assisted living services (4) and/or (k) Client service record and/or (m) Client's Bill of Rights and Responsibilities (5) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c)

   A. Measures to Prevent Re-Occurrence:

Maplewood Senior Living | Phone: 203.557.4777
One Gorham Island | Fax: 203.557.4783
Westport, Connecticut 06880 | www.maplewoodseniorliving.com

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POC accepted 1/21/2014 KS

1. The Maplewood Senior Living Resident Safety Checks Policy "MSL-2013CT-12BG" (the "Safety Checks Policy") has been updated to require the staff nurse working on the 11:00 p.m. – 7:00 a.m. shift (the "Overnight Shift") to perform hourly rounds throughout the Community. Under the updated Safety Checks Policy, the Overnight Shift nurse must confer with the ALSA aides working the Overnight Shift to confirm that the aides have performed all scheduled safety checks and to ascertain whether there are any concerns with any of the residents which need to be addressed.

2. The Regional Director of Resident Services will educate (i.e. in-service) the Supervisor of Assisted Living Services Agency (the "SALSA"), the RN Designee ("RND"), and the Executive Director ("ED") at the Community on the updated Safety Checks Policy and expectations.

3. The SALSA, RND and/or ED will educate all ASLA aides and nursing staff at the Community on the updated Safety Checks Policy, and will have the aides and nursing staff confirm in writing that the updated Safety Checks Policy was reviewed and understood by them. Such written confirmation shall be placed in each applicable employee's file.

4. The Maplewood Senior Living Fall Reduction Policy "MSL-2013CT-12W" was updated and re-named "Fall Reduction and Post-Fall Policy (the "Fall Reduction Policy"). Under the updated Fall Reduction Policy, a resident who has fallen and who is not able to independently, or with only minimal support, come to a standing position of their free will, should not be moved unless directed by the RN after the RN has first determined that there was no apparent injury to the resident.

5. The Regional Director of Resident Services will educate the SALSA and RND at the Community on the updated Fall Reduction Policy and expectations.

6. The SALSA, RND and/or ED will educate all nursing staff at the Community on the updated Fall Reduction Policy, and will have the nursing staff confirm in writing that the updated Fall Reduction Policy was reviewed and understood by them. Such written confirmation shall be placed in each applicable employee's file.

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

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Westport, Connecticut 06880
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All corrective action as indicated above will be completed by February 28, 2021, except for on-going monitoring.

C. Plan to Monitor/Audit:

1. The SALSA and/or RND will review daily or during next day at work residents' care logs to confirm that all scheduled safety checks are documented as having been performed in accordance with residents' service plans. The SALSA and/or RND shall review, and address in real -time with the responsible staff member, any missing or incomplete documentation in the care logs.

2. The SALSA, RND and/or ED will review the video cameras available at the Community no less that twice per week for a period of three (3) months to confirm that the overnight staff are following the updated Safety Checks Policy accordingly.

3. At least once per month for a period of three (3) months, the Regional Director of Resident Services or the Regional Director of Operations will audit 10% of resident charts to confirm that care logs are being appropriately completed, and that the SALSA, RND and/or ED have documented that they have reviewed the video in accordance with the POC.

4. The monitoring of daily care logs for safety checks will be added to the quarterly quality assurance ("QA") review, and the process and results will be audited every quarter for one (1) year following the completion of the POC.

5. RN assessments conducted after falls will be documented via progress notes to reflect proper procedure, and the process will be added and audited every quarter during the QA review for one (1) year following the completion of the POC.

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

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

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

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www.maplewoodseniorliving.com

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Respectfully submitted by,

Cristina Deguzman, RN
Supervisor of Assisted Living Services Agency
Maplewood at Stony Hill ALSA, LLC

CP:aa

cc: Amy Silva-Magalhaes (by email)
Brian Geyser (by email)
Constantin Popescu (by email)
Shane Herlet (by email)
David Cahill (by email)
Arthur E. Miller (by email)
Eileen Duggan (by email)
Denise Jones (by email)
Cristina Deguzman (by email)

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