Bridges by Epoch

at

Trumbull

Violation letter

Plan of correction

eid 117121

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

March 18, 2021

Trish (Keaney) McKay, Executive Director
Bridges By Epoch At Trumbull
2415 Reservoir Avenue
Trumbull, CT 06611
tkeaney@bridgesbyepoch.com

Dear Ms. Keaney:

An unannounced review was concluded at Bridges By Epoch At Trumbull on January 7, 2021 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was/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 March 28, 2021.

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 Melissa.San.Souci@ct.gov may be subject to disciplinary action.

You may wish to dispute the violation(s) and you may be provided with the opportunity to be heard. If the violation(s) is/are not responded to by April 1, 2021 or if a request for a meeting is not made by the stipulated

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

date, the violations shall be deemed admitted.

Please direct your questions concerning the instructions contained in this letter to the Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Karen Donato R.N. C

Supervising Nurse Consultant/Interim
Facility Licensing and Investigations Section

Complaint #28911

DATE(S) OF VISIT: January 7, 2021

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 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 (2) (A) and/or (h) Nursing Services provided by an assisted living services agency (3) (B) (C) (D) and/or (k) Client service record (H) (i) (ii) (iii) (I) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c).

1. Based on review of the clinical record, agency documentation and interview with agency staff for one of two clients (Client #1) who resided in the memory care unit, the ALSA Registered Nurse (RN) failed to perform reassessment and/or update the service plan with a change in the client's condition and the Licensed Practical Nurse (LPN) failed to follow agency policy after a client fall. The findings include:
   a. Client #1 had a move in date of 08/03/2020 with diagnoses that included early dementia, hypothyroidism, osteoporosis, hypertension and bilateral lower extremity edema. Client #1's service plan dated 08/05/2020 identified Client #1 required assistance and/or reminders to perform activities of daily living from the assisted living services agency (ALSA) aides, had balance problems while standing and walking requiring the assistance of one staff member, was identified to be at risk for falls, required medication administration from the ALSA nurses and did not identify any behaviors of concern.

      The client underwent a behavioral health evaluation and consultation by an Advanced Practice Registered Nurse (APRN) on 08/07/2020 for depression. The documentation identified the client was sad, did not identify any aggressive behaviors or any new medication orders with a plan for the APRN to monitor for worsening of symptoms and provide behavioral health support.

      Review of physician's orders directed to start Lexapro 10 milligrams (mg) by mouth daily for depression on 08/18/2020; Trazadone 12.5 mg by mouth every eight hours as needed dated 09/15/2020; discontinuation of the Trazadone 12.5 mg as needed dated 09/22/2020; Trazadone 25 mg by mouth every six hours as needed for anxiety/agitation dated 09/22/2020 and Trazadone 25 mg by mouth every night at bedtime dated 10/02/2020.

      Interview and review of nursing notes dated 09/04/2020 to 10/02/2020 with the Executive Director (ED) on 01/07/2021 identified that the client was agitated, refused care and was physically and verbally aggressive (change in behavior since admission) and failed to identify a comprehensive nursing assessment for the client's change in condition and/or review of the service plan dated 08/05/2020 failed to identify updates to reflect the behavioral health changes and interventions.

      The Agency's policy #401 Resident Assessment identified it is the responsibility of the Supervisor of Assisted Living Services Agency (SALSA) to perform a comprehensive assessment after a significant change in condition.

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

Interview and review of the nursing notes dated 10/04/2020 with Licensed Practical Nurse (LPN) #1 on 12/29/2020 at 1:50 pm identified LPN #1 entered Client #1's room at 2:17 am for the purpose of placing Trazodone medication into the client's locked medication box and thought the client would be sleeping. LPN #1 indicated the client was sitting in a chair and indicated that she/he explained to the client why she/he was in the client's room.

LPN #1 indicated Client #1 became aggressive, flew into a rage, shouted at LPN #1 to leave the room, walked across the room and lunged at LPN #1 and knocked the lid off the medication box LPN #1 was holding causing Client #1 to lose his/her balance and fall to the floor. LPN #1 indicated the client had a nosebleed and pressure was applied to stop it; the client was unable to get up off the floor independently and required the assistance of two nurses and two ALSA aides to get up. LPN #1 indicated that the client denied pain and was assisted into bed.

Interview with LPN #1 on 12/29/2020 at 1:50 pm indicated she/he performed an assessment of Client #1 including range of motion to bilateral upper and lower extremities but failed to notify the RN on call about the client's fall and/or failed to initiate 911 for a head injury (nosebleed indicative of client hitting his/her head) and/or failed to contact the client's family member, physician, SALSA or ED and/or failed to follow the Agency's policy for Fall With Bodily Injury.

Interview with the SALSA on 12/23/2020 at 10:07 am failed to identify that LPN #1 notified the RN on call of the need to assess the client prior to making the nursing decision to move Client # 1 off the floor.

The Agency's policy #440 Fall with Bodily Injury identified if a client sustains a fall and has any suspected or obvious bodily injury, the nurse will immediately send the client to the Emergency Room via 911. Staff will not move the client but will assist the client with comfort if possible. If the injury is to the client's head the staff will not move the client's head or neck. The nurse will notify the primary care physician and the health care person/designated power of attorney, SALSA and Executive Director.

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;"

On 10/04/2020, later that morning, in an interview with LPN #1 on 12/29/2020 at 1:50 pm indicated that Client #1 was heard yelling from bed and complained of pain to his/her right leg and was unable to move it. LPN #1 indicated she/he initiated 911 and the client was transported to the hospital at 4:29 am but failed to contact the client's family member, physician, SALSA and/or Executive Director and failed to follow the Agency's policy for

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Fall with Bodily Injury.

Interview and review of documentation in Client #1's medical record with the SALSA on 12/23/2020 at 10:07 am identified the client sustained "a right orbital fracture, nasal fracture, humerus fracture and a brain hemorrhage."

Poc Accepted
04/07/21
M SanSouci RN

Bridges
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

April 2, 2021

Melissa SanSouci RN, Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Heath
Melissa.San.Souci@ct.gov

Re: Violation 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 (2) (A) and/or (h) Nursing Services provided by an assisted living services agency (3) (B) (C) (D) and/or (k) Client service record (H) (i) (ii) (iii) (I) and/or the General Statutes of Connecticut Chapter 378 Section 20-87a (a) and/or (c).

Dear Ms. SanSouci:

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 January 7,2021.

Remarkable people.
Exceptional care.

POC accepted
01/07/21
M Sandstrom RN

Bridges
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

Plan of Correction:

(1) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 410) for developing and maintaining an individualized service plan for each client. The service plan will be reviewed every 120 days and with a significant change by the SALSA (Supervisor of Assisted Living Services Agency). If the client has a significant change in status, a new service plan will be completed with associated interventions and reviewed with the SALSA, the clients Responsible party and the Assisted Living aides. A service plan can be revised at any time to reflect an episodic event. Service plan for Client #1 was not revised due to the incident that occurred on 10/4/20 where resident was sent to the hospital and did not return to the Community per family request.

(2) Effective August 3, 2020 Bridges by Epoch at Trumbull hired a new Wellness Director (SALSA). Policies and Procedures were reviewed during orientation including Policy No. 410 re: Service Plans.

(3) An audit of all service plans took place starting November 1, 2020 as a result of multiple violations related to service plans from March 2018 through March 2020. The audit was over a 30 day period with all client service plans reaching 100% compliance. In addition, service plans will be reviewed at each Quarterly review meeting moving forward to ensure 100% compliance is being upheld.

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Plan Accepted
01/07/21
Dr Sam Sinno MD

Bridges
BY EPOCH

MEMORY CARE ASSISTED LIVING
AND REMEMBRY

(4) All Licensed staff will be re-inserviced on Wellness Policy No. 440, Fall and Bodily Injury by April 9, 2021. LPN #1 was terminated after incident on 10/4/20 for failing to comply with company policies related to falls with bodily injury, failure to notify the clients family member, physician, SALSA and Executive Director.

(5) The Executive Director will ensure Community compliance by monthly tracking meetings with the SALSA and the RN Designee. Resident changes will be discussed and identified with service plans and the Assisted Living aides updated as needed.

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

Respectfully Submitted,

Patricia Keaney
Executive Director

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