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

July 9, 2020

Derrick Gibbs, Person-in-Charge
Change Maple Leaf Manor, Inc.
614 New Britain Avenue
Hartford, CT 06106

Dear Mr Gibbs:

Unannounced visits were made to Change Maple Leaf Manor Inc on March 15, 2019 and January 28 and 30, 2020 and March 4, 2020 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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 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 July 23, 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.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

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 may be subject to disciplinary action.

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 23, 2020 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant via email at dph.flisadmin@ct.gov or right fax number 860-622-2655. Please direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

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

Respectfully,

Karen Gworek, RN

Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:lst

c. Mairead Painter, LTC Ombudsman Program
Complaint CT #25096

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (5).

1. Based on record review, facility documentation review, facility policy review, and interviews for one of six sampled residents (Residents #1 and #5) who were reviewed for behavioral symptoms, the facility failed to ensure the hospital documented the residents were safe to return to the facility after the residents had exhibited a threatening behavior toward other residents The findings include:
   a. Resident #1's diagnoses included paranoid schizophrenia. The hospital record dated 7/2/18 identified Resident #1 had been admitted for worsening schizophrenia and post-traumatic stress disorder and had suicidal and homicidal ideations toward another group home member. The hospital record identified Resident #1 was discharged on 7/2/18 and was not a danger to self or others. The hospital record dated 9/7/18 identified Resident #1 had been admitted on 8/24/18 after an altercation with a roommate, hearing voices telling him/her to hurt people including the roommate, and Resident #1 was discharged on 9/7/18 deemed not to present an imminent risk of harm to self or others. The hospital emergency department (ED) record dated 3/12/19 identified Resident #1 was admitted on 3/12/19 at 1:49 PM with a diagnosis of agitation. The hospital record identified Resident #1 presented for medication non-compliance and was irritable and agitated enroute to the hospital. The record indicated while on continuous observations Resident #1 was calm and cooperative, and a violence checklist identified Resident #1 had an irritable behavior. The report identified a suicide risk for self-harm was unable to be confirm secondary to the resident's mentation. Resident #1 was discharged from the hospital on 3/12/19 at 3:34 PM after spending approximately one and a half hours in the Emergency Department. The hospital discharge summary failed to reflect documentation that Resident #1 was deemed not to be a danger to self and/or others. The Reportable Event Form dated 3/14/19 at 4:00 PM identified Resident #1 assaulted another resident, Resident #2, striking Resident #2 repeatedly in the face and head causing Resident #2 to become non-responsive, 911 was called, Cardio Pulmonary Resuscitation was initiated and Resident #2 was transferred to the hospital, and Resident #1 was arrested. Review of Resident #2's hospital record dated 3/14/19 identified Resident #2 arrived in the ED at 4:48 PM after he/she was involved in an altercation in a group home and was found lying on the ground face down when Emergency Medical Services (EMS) arrived. Resident #2 was admitted to the Intensive Care Unit with diagnoses of cardiac arrest, closed head injury, subdural hemorrhage and acute hypoxemic respiratory failure, and intubated. The record indicated Resident #2 was unresponsive, had no reaction to painful stimuli, a large hematoma with ecchymosis to the middle of the forehead and Resident#2's mental status was poor and neurology indicated a guarded prognosis with unlikely return to previous level of functioning. After consult with family, Resident #2's code status was changed to Do Not Resuscitate with comfort goals, Resident #2 was extubated and expired at 5:04 PM. Interview with Resident #3 on 1/28/20 at 11:29 AM identified he/she witnessed Resident #1 assault Resident #2 while they all were on the front porch. Resident #3 stated that Resident #1 was mouthing off and Resident #2 felt Resident #1 was "picking on him/her". Resident #3 stated Resident #1 then said he/she did not like black people, called Resident #2 a bad name, and started punching Resident #2 on the top of the head. Interview with Resident #4

on 1/28/20 at 11:45 AM identified he/she witnessed Resident #1 assault Resident #2. Resident #4 stated that Resident #1 accused Resident #2 of stealing an item, and Resident #1 started punching Resident #2 on the head and knocked Resident #2 off the chair. Interview with the Housekeeper on 1/28/20 at 11:59 AM identified that on 3/12/19 Resident #1 was upset because Resident #1 wanted to use the phone and another resident was using the phone. The Housekeeper stated that Resident #1 went into the dining room, picked up the chairs, threw them all on the ground, and poured water on the floor. The Housekeeper indicated Resident #1 then went up to his/her own room and started throwing items around in the room. The Housekeeper stated she called 911 and Resident #1 was taken to the hospital. Interview with the Facility Manager on 1/30/20 at 8:15 AM identified when a resident returns from the hospital after a hospital transfer due to behaviors, the facility does not receive documentation that the resident was safe to return and not a threat of injury to self or others. The Facility Manager stated that the facility expects the hospital to not discharge a resident unless the resident was safe, but she does not receive any documentation from the hospital to support the resident was safe to return to the facility. The Facility Manager stated that to keep other residents safe, staff are informed to monitor residents for any behaviors, and if any are observed to call the Mobile Crisis and/or 911. Interview with the Licensee on 1/30/20 at 9:22 AM identified after a resident was sent to the hospital for behaviors, when they return to the facility the facility does not get documentation from the hospital that the resident is not a risk of injury to themselves or others. The Licensee stated that Resident #1's behaviors prior to 3/14/19 were not good, Resident #1 did not follow the facility's smoking rules, and a meeting with Central Region, Resident #1, and Resident #1's Conservator was held on 3/8/219. The Licensee stated that at the meeting Resident #1 requested to be discharged from the facility because Resident #1 felt that he/she might hurt someone, however after Capitol Region discussed an emergency respite placement Resident #1 decided against it because Resident #1 stated he/she knew his/her coping strategies and would not harm him/herself or anyone else. The Licensee stated that Capitol Region told Resident #1 if he/she felt like he/she might harm someone to call for help and on 3/10/19 Resident #1 told him that he/she needed emergency respite placement. The Licensee identified he called Capitol Region and they said they could not find placement; the facility needed time to find placement. The facility did not seek definite information upon Resident #1's return from the hospital on 3/12/19 to indicate that Resident #1 was safe to return and was not a risk of injury to him/herself and/or others. Subsequent to Resident #1's readmission on 3/12/19, another incident occurred on 3/14/19 in which Resident 31 assaulted Resident #2. During an interview with the Licensee on 2/4/20 at 11:42 AM, he was unable to verbalize how the facility could meet the needs of Resident #1 after the resident was sent to the hospital for behaviors and ensure that other residents were safe when Resident #1 was readmitted.

b. Resident #5's diagnoses included schizophrenia. The hospital emergency department note dated 1/13/20 identified Resident #5 was admitted after threatening to shoot another resident, and increasingly agitated towards staff and other residents. The note identified the facility reported Resident #5 had increased agitation, paranoia and threatening behaviors, and the resident was loud and irritable upon arrival. Review of the facility record failed to reflect documentation that Resident #5 was deemed no to be a risk to self and/or others upon readmission. The hospital discharge summary dated 1/24/20 failed to reflect documentation that Resident #5 was not a risk to self or others. Interview with the Facility Manager on

1/28/20 at 9:15 AM identified Resident #5 had verbal behavior symptoms and on 1/6/20 she heard Resident #5 saying "I will kill you, I will kill you." The Facility Manager stated that on 1/13/20 Resident #5 had been aggressive and threating behaviors towards others and she observed Resident #5 standing in front of Resident #6 pointing his/her hand at Resident #6's face, saying loudly that he/she was going to kill Resident #6 by shooting Resident #6 in the head. The Facility Manager stated Resident #5 was transferred to the hospital and admitted and on 1/24/20 returned to the facility. In a follow up interview with the Facility Manager on 2/4/20 at 8:34 AM she identified that on 2/3/20 at about 4:00 AM Resident #5 was observed on the sidewalk near the street gesturing toward cars at the light in a punching motion, and then threatened to kill Residents #3, #7, and #9 Resident #5 said that he/she was going to line other residents up and kill them. The Facility Manager stated although staff called her and then the Mobile Crisis, staff did not call 911. The Facility Manager stated that when Resident #5 was readmitted to the facility on 1/24/20, the hospital did not provide, and the facility did not seek documentation that Resident #5 was not a risk of injury to self or others. Interview with the Licensee identified there was no readmission policy for surveyor review.

Review of facility Screening, Assessment and Access to Services Policy, directed in part that a requirement for admission was the client must be suitable for the level of care considered and not have a medical or psychiatric condition that would require immediate hospitalization or acute inpatient treatment.

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MAPLE LEAF MANOR
A CHANGEINC PARTNER

Approved 4/21/21 KEG

www.ChangeIncOnline.org

The following is a response to the violation of the Regulations of the Connecticut State Agencies, Section 19-13-D6 (c) Administration (1) and/or (c) Administration (5).

Resident #1 no longer resides at Maple Leaf Manor. All residents at the facility are at risk for this alleged deficient practice.

The systemic change the facility will make is: Each resident will have an assessment of harm. This assessment will be completed quarterly and with change of behavior. The facility will establish a policy and guidelines for assessment and staff will be educated. The facility manager or clinical designee will be responsible for the assessments. Date of corrective measure and education of staff shall be completed by August 30, 2020.

The facility will implement a Re-admission policy to include the need for a "No Harm" letter to accompany a resident prior to admission or re-admission, if the resident has exhibited any behaviors that may indicate they may engage in some form of self harm or expressing harm towards others. Employees shall be in-serviced to new policy. The manager or designee will immediately review admission paperwork to ensure a "No Harm" letter or document is completed and signed. A copy of the in-service and education can be provided to the department. Corrective measures and education shall be completed by August 30, 2020.

Resident #5 no longer resides at Maple Leaf manor. All residents are potentially at risk by this alleged deficiency. The systemic change the facility will make is: all residents shall have an assessment of harm. This assessment will be completed quarterly or with change of behavior. The facility will establish a policy and guidelines for assessment and staff will be educated on the completion of the assessment and when to recognize the need for an assessment. The staff will also be educated regarding emergency situations and when to call 911 and the mobile crisis unit. The facility manager or clinical designee will be responsible for the assessments and education. Date of corrective measure and education shall be completed by August 30, 2020.

The systemic change the facility will make shall be: The facility will implement a re-admission policy to include the need for a "No Harm" letter to accompany the resident prior to admission. Employees shall be in-serviced to new policy. The facility manager or designee will be responsible for monitoring these policies annually or when change is indicated to ensure compliance. A copy of this in-service can be provided to the department. Corrective measures shall be completed by August 30, 2020.