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

January 7, 2020

Lavern Edwards, Administrator
Scofield Manor
614 Schofieldtown Road
Stamford, CT 06903

Dear Ms Edwards:

An unannounced visit was made to Scofield Manor on September 12, 2019 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 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 January 20, 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 may be subject to disciplinary action.

Lavern Edwards, Administrator
Schofield Manor

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 January 20, 2020 or if a request for a meeting is not made by the stipulated date, the violations 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, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG

c. Mairead Painter, LTC Ombudsman Program

Complaint #26077

Lavern Edwards, Administrator
Schofield Manor

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (h) General Conditions (3).

1. Based on clinical record review, review of facility documentation and interviews for one sampled resident (Resident #1) who had a Conservator of Person, the facility failed to report the State Agency that the resident had wandered away from the facility. The findings include:
   a. Resident #6's diagnoses included Alzheimer's disease. The record indicated Resident #6 had a Conservator of Person and was being followed by a consulting psychiatry service with an Advanced Practice Registered Nurse (APRN) on a monthly basis. Review of the shift to shift communication documentation from March 1, 2019 to June 21, 2019 did not indicate that Resident #6 had attempted to wander from the facility. On the evening of 6/21/19 Resident #6 was noted to be missing from the facility. Interview with Attendant #3 identified on 6/21/19 Resident #6 was at dinner that evening and was last seen after dinner going to his/her room. Attendant #3 stated at 8:30 PM she realized that Resident #6 was missing when passing out 8:00 PM medications and after ten(10) to fifteen (15) minutes of searching for the resident, it was determined that the police should be notified. Attendant #3 identified as per the facility protocol, 911 was called and then she called the Administrator to report the missing resident. Attendant #3 indicated that the police came and initially could not find the resident after searching the perimeter of the facility, therefore the police returned and requested the facility camera footage. Attendant #3 stated the video identified Resident #6 left the facility out the front door and down the ramp, police ended up finding the resident later in the night. Attendant #3 indicated that this was the first time the resident ever did this. Review of Resident #6's clinical record identified the consultant psych APRN progress note dated 6/27/19 identified Resident #6 had an increase in trying to leave the facility in the evening and indicted a safety plan was initiated at the facility that day to supervise the resident in the evenings until the resident was placed into a higher level of care. Interview with the Administrator on 9/13/19 identified the facility had never encountered an issue previously with Resident #6 being a flight risk, this behavior was first demonstrated on 6/21/19. Upon being aware that the resident was indeed a flight risk, they immediately reached out to inform the Conservator and initiated a plan of care to supervise Resident #6. The facility failed to ensure that the 6/21/19 incident was reported to the state agency.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or the Connecticut General Statutes 19a-550.

2. Based on review of facility documentation and interviews, the facility failed to ensure the residents are treated with respect and dignity. The findings include
   a. Interview with Resident #4 on 9/12/19 at 1:30 PM identified that the facility imposes a fine on residents who are caught smoking in any area that was not a designated area. Interview with the Administrator's Assistant on 9/12/19 at 3:00 PM she indicated that there was a $25.00 fine for any resident who was caught smoking in a non-designated smoking area and all of the residents were made aware of this practice.

SCOFIELD MANOR 614 Scofieldtown Rd, Stamford CT 06903 203.329.2388 Fax:203.329.2609

Approved
2/5/20
KEG

January 28, 2020

[redacted]
Supervising Nurse Consultant
Facility Licensing & Investigation Section
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Karen,

Below please find responses the violations dated September 12, 2019

Based on clinical record review, review of facility documentation and interviews for one sampled resident (Resident #1) who had a Conservator of Person, the facility failed to report the State Agency that the resident had wandered away from the facility. The findings include:

a. Resident #6's diagnoses included Alzheimer's disease. The record indicated she had a Conservator of Person and was being followed by a consulting psychiatry service with an Advanced Practice Registered Nurse (APRN) on a monthly basis. Review of the shift to shift communication documentation from March 1, 2019 to June 21, 2019 did not indicate that Resident #6 had attempted to wander from the facility. On the evening of 6/21/19 Resident #6 was noted to be missing from the facility. Interview with Attendant #3 identified on 6/21/19 Resident #6 was at dinner that evening and was last seen after dinner going to his/her room. Attendant #3 stated at 8:30PM she realized that Resident #6 was missing when passing out 8:00PM medications and after ten(lO) to fifteen (15) minutes of searching for the resident, it was determined that the police should be notified. Attendant #3 identified as per the facility protocol, 911 was called and then she called the Administrator to report the missing resident. Attendant #3 indicated that the police came and initially could not find the resident after searching the perimeter of the facility, therefore the police returned and requested the facility camera footage. Attendant #3 stated the video identified Resident #6 left the facility out the front door and down the ramp, police ended up finding the resident later in the night. Attendant #3 indicated that this was the first time the resident ever did this.

Review of Resident #6's clinical record identified the consultant psych APRN progress note dated 6/27/19 identified Resident #6 had an increase in trying to leave the facility in the evening and indicted a safety plan was initiated at the facility that day to supervise the resident in the evenings until the resident was placed into a higher level of care.
Interview with the Administrator on 9/13/19 identified the facility had never encountered an issue previously with Resident #6 being a flight risk, this behavior was first demonstrated on 6/21/19. Upon being aware the resident was a flight risk, they immediately reached out to inform the Conservator and initiated a plan of care to supervise Resident #6. The facility failed to ensure that the incident was reported to the state agency.

Response 1A

- Date of Correction: June 21, 2019
- Corrective Action: Effective June 21, 2019 Administrator will immediately notify DPH of all incidences that occur in the facility to insure the facility remain fully compliant with all reportable incidences. As a result of Resident #6 being the first "Wandering" occurrence, Administrator failed to report to DPH Resident #6 wandering as an unusual occurrence that had taken place in the facility.

Below were the action steps that were taken immediately after the Wandering Incident:

- Local Police, residents' family and Conservator were notified of the incident. We immediately wanted to discharge resident to a more secure facility, however, the Conservator informed the facility court approval would be required prior to moving Resident #6 to another facility.
  Upon Nurse Manager knowledge of the incident, Ascend was notified to place Resident #6 in a higher level of care facility; medical and psychiatric appointments were also made on behalf of resident.
- Administrator met with Resident #6 to find out if there were contributing factors to Resident #6 wandering. When Administrator probed further, Resident #6 indicated she was going to visit her siblings, who use to frequently visit her, however, as a result of their illnesses they no longer came for visits.

A Care Plan was put in place for Resident #6 for the duration of her stay at the facility:

- Continuous monitoring of Resident #6 whereabouts at all times
- Resident #6 will carry picture identification along with Administrator's business card & cellular number with a note in her purse stating, Administrator should be contacted in an emergency.
- Staff was requested to take resident for evening walks after dinner; other residents were also requested to inform staff member(s) if they noticed Resident #6 leaving the building.

- During evening medications, Attendants were requested to have Resident #6 sit in the dining room with the other residents who were waiting to receive their medication. (Note: the dining room is adjacent to the medication room, resulting in Resident #6 being visible).
- Upon completion of medication administration, Attendants would have Resident #6 sit in their office while they complete their paperwork. Resident #6 was also allowed to watch television in her friend's room, where still remain visible.
- Every two hours, Attendants were required to perform signed nightly room check, until Resident #6 discharge.

On January 23, 2020, Administrator documented "Missing Resident Protocol" became effective.

In the event you are aware of a Missing Resident:

(a) Perform a thorough search of the entire property, if unsuccessful, immediately contact the local police department, then the Administrator, if Administrator unavailable, contact Nurse Manager.
(b) Administrator will notify residents' family, physicians, and conservator of Missing Resident. Attendant performing the Missing Search will document the time and actions via an Incident Report to be signed by Administrator/Nurse the next business day, if incident is after hours.
(c) Upon the safe return of the resident, resident's family and conservator, next of kin will be provided with resident's status.
(d) Nurse will schedule appointments with residents' medical and psychiatric physicians to for treatment.
(e) Administrator will meet with the resident to determine if there were aware of what occurred and find out if there were any contributing factors that led to the wandering. Residents' feedback might assist in correcting or avoid reoccurrence. Camera will be reviewed to assist in the search.

Based on review of facility documentation and interviews, the facility failed to ensure the residents are treated with respect and dignity. The findings include

a. Interview with Resident #4 on 9/12/19 at 1:30 PM identified that the facility imposes a fine on residents who are caught smoking in any area that was not a designated area. Interview with the Administrator's Assistant on 9/12/19 at 3:00 PM she indicated that there was a $25.00 fine for any resident who was caught smoking in a non-designated smoking area and all the residents were made aware of this practice.

Response 2

Date of Correction – Over the past five years the Administrator and all team members at the facility are committed to the residents and provide a safe resident centered approach to all our residents. We strive to maintain and preserve the dignity, respect and safety of all residents, as well as the facility. The Administrator and her team are mindful of the venerable population we serve and go the extra mile to make their home their place of comfort and care. With one third of our smoker having mobility issues, existing and future residents were informed on December 2014, two months prior to the implementation of the Designated Smoking Area that there will be a change in the smoking policy. Residents were informed a $25.00 fine would be imposed if they were caught in a non designated area. Information and handouts were provided to residents on the harmful effects of smoking, especially smoking indoor. They were reminded that cigarettes could potentially cause fires, leading to homeless. . Residents were informed if they wish to quit smoking, I would assist with providing referrals and resources. Signage was also posted on the Activity Board as a reminder. On February 15, 2015 the "designated Smoking area" policy became effective.

Corrective Action: Continue to provide profession development training, invite speakers as well as videos to all staff a reminder of the importance of maintaining sensitivity and optimum care to all residents.

Thank you.

Lavern Edwards
Administrator
Scofield Manor
203-329-2388 ext. 3804
ledwards@charteroakcommunities.org