STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

September 26, 2022

Kelly Bieber, VP of Nursing
Via Email: kbieber@brandycare.com
Brandywine Living At Litchfield
19 Constitution Way
Litchfield, CT 06759

Dear Ms. Vaughn,

Unannounced visit was made to Brandywine Living At Litchfield on July 8, 2022 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Complaint Investigation to determine Verification of Alzheimer's special care units or programs.

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 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 October 6, 2022.

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.

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 **October 6, 2022** or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

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

Please return your response to Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail.

Respectfully,

/s/

Elizabeth Heiney, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

EH:csf

c. VL
Complaint #32457

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirements for an assisted living services agency (1) and (g) Supervisor of assisted living services (2)(A) and/or (h) Nursing Services provided by an assisted living services agency (3)(B)(C)(D)(G) and (k) Client service record (H)(i)(ii)(I) and (m) Client's bill of rights and responsibilities (5).

1. Based on clinical record reviews, agency policies and interviews with staff for five of five Clients (Client #1, #2, #3, #4, and #5) in the survey sample who resided in the Assisted Living Services Agency (ALSA) memory care unit and depended on the ALSA for assistance with activities of daily living, medication management and nursing assessments. The agency failed to ensure Clients' safety, failed care coordination with a Client's family, failed to report an allegation of abuse to a Client's family or responsible party, failed to update a Client service plan with interventions to minimize the potential for harm to self and others, failed to document a Registered Nurse (RN) assessment was completed following a change in condition and an allegation of abuse, failed to notify a law enforcement and regulatory agency of an allegation of abuse. The finding includes:

    a. Client #1 was admitted to the ALSA program on 04/22/2022 and resided on the memory care unit with diagnosis of Alzheimer's disease, depression, anxiety, and dementia with behavioral disturbances. The Client's admission elopement assessment dated 04/22/2022, identified the Client was not at risk for elopement. The Client's service plan dated 04/22/2022, identified the Client required assistance of an ALSA aide with dressing, toileting, incontinence care, grooming, showering, and nursing services for assessments and medication administration.
    b. Client #2 was admitted to the ALSA program on 11/29/2021 and resided on the memory care unit with diagnosis of Alzheimer's disease, anxiety, and chronic kidney disease. The Client's service plan dated 03/28/2022, identified the Client required assistance of an ALSA aide with

dressing, toileting, incontinence care, grooming, showering, and nursing services for assessments and medication administration.

c. Client #3 was admitted to the ALSA program on 11/01/2021 and resided on the memory care unit with diagnosis of cardiac disease, stroke, and high blood pressure. The Client's service plan identified the Client required assistance of an ALSA aide with dressing, toileting, grooming, showering, and nursing services for assessments and medication administration.

d. Client #4 was admitted to the ALSA program on 07/30/2021 and resided on the memory care unit with diagnosis of dementia, depression, and high blood pressure. The Client's service plan identified the Client required assistance of an ALSA aide with dressing, toileting, grooming, showering, and nursing services for assessments and medication administration.

e. Client #5 was admitted to the ALSA program on 08/09/2020 and resided on the memory care unit with diagnosis of dementia, and high cholesterol. The Client's service identified the Client required assistance of an ALSA aide with dressing, toileting, grooming, showering, and nursing services for assessments and medication administration.

f. Interview and review of Client #1 clinical record with the SALSA on 07/08/2022 at 10:00 AM, identified on 04/25/2022, 04/26/2022 and 04/27/2022 Client #1 paced the memory care unit, attempted to push open the exit door three times, wandered into Clients' rooms, took Clients' personal belongings and kissed Client #3. On 04/27/2022, Client #1's family requested a psychiatric evaluation consent form from the ALSA due to the Client's behaviors. The SALSA failed to identify a signed psychiatric consent form and psychiatric services were obtained for Client #1, failed to update Client #1's service plan with interventions to minimize the Client's potential for self-harm or harm to others, failed to complete a new elopement assessment to identify Client #1 as an elopement risk and failed to identify Client #3's representative or family were notified of the incident on 04/27/2022.

Review of the ALSA's policy for Coordination of Services, identified the agency would coordinate services between the ALSA and the Client, family member or responsible party. Furthermore, when a change occurred (a change in the Client's services, medical, functional, or physical needs) the agency would immediately notify and update the Client or family member.

Review of the ALSA's policy for Client Service Record, identified a Client's service program completed by a RN with the Client, family and others involved in the care of the Client would be reviewed and updated as often as the Client's condition required, but no less than once every one hundred and twenty days. The Client's service program would identify the Client's problems, needs, goals of management, plans for interventions and implementation of the interventions.

Interview and review of Client #1's clinical record with the SALSA on 07/08/2022 at 10:20 AM, identified on 05/08/2022 Client #1 struck an ALSA aide in the abdomen, on 05/12/2022 the Client was exit seeking throughout the memory care unit, on 05/13/2022 Client #1 was found in bed with another Client, on 05/16/2022 the Client touched an ALSA aide's buttocks, on 05/26/2022 the Client grabbed the back of an ALSA aide's neck and patted her buttocks, on 05/29/2022 Client #1 was found in another Client's bed without pants on and patted an ALSA aide's buttocks, on 06/07/2022 Client #1 kissed Client #5, on 06/08/2022 Client #1 was found in another Client's bed, on 06/13/2022 the Client slapped an ALSA aide's buttocks and on 06/14/2022 the Client was found urinating in a closet.

Interview and review of Licensed Practical Nurse (LPN) #1's note dated 06/16/2022 on 07/08/2022 at 12:35 PM, identified Client #1 grabbed LPN #1's buttocks, grabbed ALSA aide #1 breast and Person #1 observed Client #1 with his/her hands in Client #2's underwear. Additionally, ALSA aide #1 observed Client #1 aggressively touched Client #4's breast. LPN #1 notified the SALSA and the Clients' family members of the incidents.

Interview and review of Client #1's 06/16/2022 incident report with the SALSA on 07/08/2022 at 1:15 PM identified on 06/16/2022 at 8:30 PM, Person #1 visited the agency, walked past Client #2's room, heard the Client yell "stop that, that hurts" and observed a shirtless Client #1 standing at Client #2's bed possibly grabbing his/her feet. Person #1 notified an ALSA aide, Client #1 was removed from Client #2's room, brought to bed and monitored by LPN #1. The SALSA failed to identify Client #1 was monitored with one-to-one care to ensure Clients' safety, failed to identify an RN assessment was completed for Client #1 and #2 after a change in condition, failed to notify a law enforcement and regulatory agency of suspected or actual sexual abuse.

Review of the ALSA's policy for Abuse Prohibition, identified any incident of suspected or actual Client abuse or neglect would be immediately reported to the on-site supervisors. The Executive Director would immediately make an oral report to the Ombudsman, and law enforcement for suspected abuse involving sexual abuse, serious physical injury, or suspicious death. If a Client-to-Client abuse allegation was made, the accused Client would be monitored with one-on-one care until results of the investigation were determined. The main agency concern would be to protect the Client who was potentially abused, which may result in actions such as the accused Client being discharged, additional medical or psychiatric management, or other interventions as determined from the investigation.
Review of the ALSA's policy for Client Safety/ Incidents, identified when an incident occurs the agency would provide safety and immediate care of the involved clients, conduct physical assessments, document the incident, assessments, actions, and notifications in the nurse's notes.
Review of the ALSA's policy for Behaviors, identified the agency would provide a safe, therapeutic environment for Clients and staff and would facilitate treatment for Clients who required emergency care for behaviors. Clients whose behaviors were considered to present a danger to self or others would be assessed, documented upon, and referred to appropriate agencies or services. The agency would provide an immediate nursing assessment of any Client that had been judged to have actual or potential harm to self or others and the assessment would be documented in the Client's record. Additionally, staff would initiate interventions for the Client involving minimizing the potential for harm to the Client and others. In consultation with the Client's physician, the psychiatrist or the crisis center staff, the agency would determine whether the Client could be safely maintained in the community. In the event of Client-to-Client abuse, the police and regulatory agency would be notified.

Plan of Correction for Violation #1:

POC accepted
10/3/22
mes

Brandywine Living at Litchfield
Plan of Correction for Violation of Regulations of CT State Agencies sections 19-13-D105(e)
Submitted 10/03/2022

Violation	Corrective Measure	Date of effect	Compliance Management	Responsible Team Member
Failure to ensure Clients safety	The Memory Care residents receive 2 hour safety checks. Initiated a process for improved documentation of the Q2 hour safety checks.	10.3.2022	The Q2 hour safety check documentation will be audited by nursing on the following schedule: Weekly x 6 weeks (11/14/22), then Bi-weekly X 1 month (12/12/22), then Audits will be completed every month.	Health & Wellness Director (HWD)
	Ongoing Dementia training at a minimum of 8 hours/year.	2021-2022	Provide ongoing education per state regulation and based on care staff and resident needs, as well as in the moment coaching.	Reflections Coordinator
	Dementia, Sexuality, Abuse, Resident rights and resident safety training with Neuropsychologist Kevin Manning, PHD.	Training will be completed by November 30, 2022	Post-test due after in-service. Post training feedback.	Health & Wellness Director
	Discontinued agency staffing as of 9/1/2022. Brandywine hosted our own CNA program with good success. ALSA is staffed with all Brandywine employees.	8.1.2022	Brandywine staff is all our own staff with 30 days No Agency Use. All staff has completed company orientation. Nursing team to provide ongoing education and in the moment coaching with new staff. RN performs care manager evaluations every 120 days at minimum.	Health & Wellness Director
	Review the Resident Safety policy with entire staff	11.1.2022	Post test due after in-service	Health & Wellness director, Executive Director
Failed care coordination with the Clients family	Care plan meetings are offered to each family/responsible party at time of 120 day care plan review and as needed. New Nursing Care Plan Review Letter was created and will be included with the plan of care given to the family.	10.10.2022	AHWD will track and monitor the return of signed nursing care plan meeting letters along with signed care plans. Care plans will be updated with changes in condition and at a minimum of every 120 days per protocol. Nursing offers a meeting for every updated care plan. Signed care plan meeting letter to be returned with all signed care plans.	Assistant Health & Wellness Director (AHWD) Health & Wellness Director
	Dr. Kevin Manning Neuropsychologist visits the community weekly 1-2X/week with residents in their apartments and common areas. He also provides "breath health" programing.	Ongoing	Care coordination between nursing, Dr. Manning and family. Nursing will use the white boards to update providers who need a visit. Dr. to review current case load, concerns, referrals with Health and Wellness Director. This information to be reviewed at weekly nursing meeting.	Health & Wellness Director
	Future plan for Neuropsychologist to assess all memory care residents at time of admission to get baseline status/level of function.	12/2022		
	Contract with Harvest Medical – Psychiatric APRN visits bi-weekly and PRN. Psychiatrist available for emergency situations. Care coordination between provider and nursing after every visit.	Ongoing	Psych APRN writes progress notes in resident medical record. Care coordination meeting with nursing at start and end of visit. Nurse	Health & Wellness Director

POC accepted 10/3/22 mes

			contacts the family with update. Nurse to contact primary provider for approval before order submitted. Nursing will use the white boards to update providers who need a visit.	
	White boards used for resident tracking installed in each nursing unit with appointment needs and visits, skilled services, falls, changes in condition, etc.	10.24.2022	Daily monitoring of resident changes/needs. Auditing boards for updated resident changes/needs. Nursing will use the white boards to update providers who need a visit.	Health & Wellness Director
Failed to report an allegation of abuse to a Clients family/responsible party	Review Abuse Prohibition	11.1.2022	Post test given after reviewing the policy on Reporting and Abuse. Required signature after reading.	Health and Wellness Director Executive Director
	policy with the entire staff. Review reporting requirements.			
Failed to update a Client service plan with interventions to minimize the potential for harm to self or others	New Director of Health and Wellness in place full time.	8.26.2022	Health and Wellness Director will audit the quality, the accuracy, the updating of the nursing assessment and care plans. The HWD will monitor the care plans for compliance.	Health &Wellness Director
	New Assistant Director of Health and Wellness in place full time.	9.16.2022	The ADHW primary job duty is complete, track, update the nursing assessments and resident care plan, as well as assist in managing the wellness team.	Health & Wellness Director
	Initiation of weekly resident review meeting with nursing management team and executive director.	10.10.2022	Weekly review of resident roster with any resident with changes, issues, concerns, etc discussed with the nursing management team. Department head is included 1x/month at minimum.	Health & Wellness Director Executive Director
	Weekly nursing meeting with Executive Director to discuss challenges, changes in level of service, resident/family concerns, etc .	10.10.2022	Weekly Nursing meeting to evaluate nursing services, resident feedback, current provider issues and needs,	Executive Director Health & Wellness Director
Failed to document a change in condition assessment by a Registered Nurse	New Assistant Director of Health and Wellness in place full time.	9.16.2022	The ADHW primary job duty is complete, track, update the nursing assessments and resident care plan, as well as manage the wellness team.	Health & Wellness Director
	New procedure initiated for updating essential team members of resident changes/significant events, 24/7. An email will be sent to this group with changes in condition, concerns, and significant events. An email distribution lists for significant events/ resident changes in	10.10.2022	Monthly auditing to make sure this information is being added to care plans, changes in condition evaluations are In place when appropriate, notes and assessments are completed with changes in condition or following significant events.	Health & Wellness Director

POC accepted 10/3/22 mes

	condition was created with IT.			
Failed to notify a law enforcement and regulatory agency of an allegation of abuse	Review policy with the entire staff. Review reporting requirements	11.1.2022	Post test given after reviewing the policy on Reporting and Abuse. Required signature after reading.	Health & Wellness Director Executive Director

BRANDYWINE
SENIOR LIVING
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Manual:	Brandywine Senior Care Living Safety Manual
Policy Title:	Resident Safety
Section:	Resident Safety: General
Effective Date:	8/02
Revision Date:	2/07

I. Purpose:

- The purpose of the Brandywine Senior Living Resident Safety Plan is to improve patient safety and reduce risk to residents through an environment that encourages:
  - Recognition and acknowledgment of risks to resident safety and medical/health care errors;
  - The initiation of actions to reduce these risks;
  - The internal reporting of what has been found and the actions taken;
  - A focus on processes and systems;
  - Minimization of individual blame or retribution for involvement in a medical/health care error;
  - Organizational learning about medical/health care errors

II. Policies and Responsibilities:

A. The Resident Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of resident safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of resident safety priorities into the new design and redesign of all relevant organization processes, functions and services.

B. As resident care, and therefore the maintenance and improvement of resident safety, is a coordinated and collaborative effort, the approach to optimal resident safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities. The Resident Safety Plan outlines the components of the organizational Resident Safety Program and is evaluated by the interdisciplinary Safety Committee and center Quality Improvement Committee.

C. An effective Resident Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of Brandywine Senior Living to adopt a non-punitive approach in its management of errors and occurrences. All personnel are ***required*** to report suspected and identified medical/health care errors. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

D. PATIENT SAFETY PROGRAM:

1. Scope of Activities

   a. The scope of the Resident Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve resident safety. Resident safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety Committee to prioritize organizational resident safety activity efforts. Types of resident safety or medical/health care errors included in data analysis are:

      - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the resident.

- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the resident.
- Any Medication Error or Adverse Drug Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the resident is being treated, which significantly increases the likelihood of a serious physical or psychological adverse resident outcome.
- Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

b. The scope of the Resident Safety Program encompasses the resident population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in resident safety issues in every department throughout the facility. There will be an emphasis on important center and resident care functions of:

- Resident Rights
- Assessment of Patients
- Care of Patients
- Resident/Family Education
- Continuum of Care
- Leadership
- Improving Organization Performance
- Management of Information
- Management of Human Resources
- Management of the Environment of Care
- Surveillance, Prevention and Control of Infection

2. Methodology:

A. The Interdisciplinary Safety Committee is responsible for the oversight of the Resident Safety Program. The Safety Committee Chairperson will have administrative responsibility for the program.

B. All departments within the center are responsible to report resident safety occurrences and potential occurrences to the ED/WD, who will aggregate occurrence information and present a report to the Safety Committee on a monthly basis. The Safety Committee will analyze the report information and determine further actions and/or follow up as indicated and report findings to the center Quality Improvement Committee.

C. Upon identification of a medical/health care error, the resident care provider will immediately:

- Perform necessary healthcare interventions to protect and support the resident's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others.
- Contact the resident's attending physician and responsible party to report the error, carrying out any physician orders as necessary.
- Preserve any information related to the error (including physical information). Preservation of information includes documenting the facts regarding the error on an incident report, and in the medical record *as appropriate* to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Complete the incident report as per center policy.

A. Any individual in any department identifying a potential resident safety issue or hazardous condition will immediately notify his or her supervisor.

B. Staff will educate residents and their families about their role in helping to facilitate the safe delivery of care.

C. Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to resident care.

D. Medical/health care errors and occurrences will be reported internally and externally, per Brandywine Senior Care policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

E. Resident safety reports from the Safety Committee will be submitted to the center Quality Improvement Committee, which exists as the oversight committee for the Safety Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Quality Improvement Committee, with all information submitted held under the auspices of the Quality Improvement Committee.

F. An annual comprehensive Quality Improvement survey will be conducted by the corporate Quality Improvement Team to assess compliance with resident safety practices, Safety and Quality Improvement Committee functions. Results of the survey and the center report cards will be communicated to the Compliance Committee for the Board of Directors.

Brandywine Living at Litchfield

Nursing Care Plan Review

Dear _____,

The Nursing care plan was updated for _____ on _____.

Brandywine offers a care plan review meeting with our nursing team following the completion of each quarterly nursing assessment and care plan update. The responsible party can choose to schedule a meeting with nursing to review the care plan in person or via phone or they can choose to decline the meeting if they understand the plan of care and have no concerns or questions,. Please complete the following form and return to Brandywine with the care plan. This care plan is also sent to the primary physician for review and signature.

Please review the included care plan and kindly sign and return to Brandywine at the earliest convenience. You can mail the signed care plan using the self-addressed, pre-stamped included envelope, you may drop it off in person to concierge desk or fax to Julie Troy RN @ 860-567-5386.

Please select one choice. Kindly return to Brandywine, with the signed, updated care plan.

☐ I would like to schedule an in person care plan review meeting. Best contact to schedule the meeting: _____.

☐ I would like to schedule a phone call to review the care plan. Best contact to schedule the meeting: _____.

☐ I will Decline the offer for a care plan meeting at this time. I am aware that I can call at any time to set up a meeting with the Brandywine team.

Please contact Julie Troy RN, Assistant Health and Wellness Director at:

(860)567-9500 ext or JTroy@brandycare.com with any questions.

Thank you. We appreciate you getting this back to us in a timely manner.

BRANDYWINE LIVING

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Manual:	Brandywine Living Manual
Policy Title:	T.R.U.S.T. Program: Abuse Prohibition
Effective Date:	June, 2006
Revision Date:	Nov, 2007, April 2015

I. Purpose:

- To provide all employees, residents, families with a full understanding of Abuse as specified in the State regulations and laws through education and commitment
- To provide specific guidelines and support materials for identification, reporting, and investigating all suspected abuse incidents including potential resident to resident abuse or visitor to resident abuse
- To protect residents from any incident of abuse.

II. Policy and Responsibilities:

All communities will participate in the Brandywine Living T.R.U.S.T. (Treating Residents with Understanding, Sincerity and Tenderness) Program. This program is a Zero Tolerance for Abuse Program and is reflective of Brandywine's commitment to provide an environment of care that protects our residents from any form of resident abuse.

A. Any incident of suspected or actual resident abuse or neglect will be immediately reported to the on-site supervisor:
   - Infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
   - Willful deprivation of goods or service which are necessary to maintain physical or mental health.
   - Sexual harassment, rape or abuse.
   - Exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident.
   - Neglect which results in physical harm, pain or mental anguish.
   - Abandonment or desertion

B. The identified staff member will immediately be suspended pending an investigation of the charges.

C. The ED will immediately make an oral report to the Ombudsman regional office, DOH as office as required and law enforcement for suspected abuse involving sexual abuse, serious physical injury, serious bodily injury or if a death is suspicious. If this involves a visitor the visitor will be identified. If this is resident to resident abuse both residents will be identified.

D. Within 48 hours of making all oral reports, the ED shall make a written report to the Ombudsman and Department of Health as required under reportable incidents. .

E. The resident's designated person shall be notified of the abuse/neglect allegation by the ED.

F. The ED is responsible for conducting a comprehensive investigation to substantiate or unsubstantiated the allegations utilizing the Incident Reporting guidelines and procedures. Investigations will be handled in a confidential and discrete manner.

G. If a visitor is the potential abuse allegation the police will be notified and the visitor will be escorted from the building and will not be allowed on premises until investigation is completed and results of investigation determined.

H. If a resident to resident abuse allegation is made the resident accused will be monitored with one on one care until results of investigation determined, The main issue will be to protect the resident who was potentially abused. This may result in actions such as resident accused being discharged, additional medical or psychiatric management, or other interventions as determined from the resullts of the investigation.

I. Every staff person will participate in the General Orientation Program immediately upon hire that will include a detailed explanation of the TRUST Program and a commitment that begins with a signed pledge that they understand abuse and neglect will not be tolerated.

J. Pre-employment screening will be the responsibility of Human Resources may include

a. Conducting background checks and drug screening; reference checks; 1-9 reports; current licenses and certifications; and other appropriate personnel checks as required by current State Regulations/Laws
b. Training during Orientation and at least annually on all aspects of Abuse laws and regulations and corporate policies.

J. Failure to report abuse/neglect will be considered as abuse and subject to disciplinary actions and failure to report laws in the current state.

K. Centers will ensure the protection of residents by:

- Providing a safe and secure environment
- Hiring qualified staff
- Educating residents on Abuse Recognition and Prevention
- Providing locked drawers for valuables/money
- Providing safe for resident funds
- Educating staff on Abuse Recognition and Prevention
- Maintaining a restraint free environment.

III. Documents:

- TRUST Pledge
- TRUST Card
- TRUST Pamphlet
- TRUST Policy Signature Page

Reflection Serenade Safety Checks

STAFF TO DO CHECKS ON IDENTIFIED RESIDENT'S AS REQUESTED BY *Licensed Nurse, Document location using legend and initial after each log*

DATE: _____

Resident Name	APT #	7 AM	9 AM	11 AM	1 PM	3 PM	5 PM	7 PM	9 PM	11 PM	1 AM	3 AM	5 AM
	120												
	121												
	122												
	123												
Vetere, Barry	124												
Kentana, V	125												
	126												
Coard, Jane	127												
Dwight, E	128												
Waldo, Joan	129												
Whalen, B	130												
Gildersleeve, J	131												
Gyolai, Doris	132												
Turcik, M	133												
	134												
Bosco, F	135												
Pavone, J	136												
Carnicke, K	137L												
	137R												
Rogers, Sheila	138R												
Burns, R	139												
Rees, H	140L												

Resident Name	APT #	7 AM	9 AM	11 AM	1 PM	3 PM	5 PM	7 PM	9 PM	11 PM	1 AM	3 AM	5 AM
Avampato, I	140R												
	141												
	142												
Zunino, N	143												
Partridge, B	144												
Bondeson, D	145												
Birkett, M	146												
Therrien, Joe	147												
Bartosiewicz	148												
Tucker, F	149												
Sturm, Irmgard	150												
Beauregard, T	151L												
Warren, S	152												
Romano, C	153L												
Goody, Hazel	153R												

LEGEND			
BD	*Bedroom*	**CT**	*Courtyard*
LR	*Living Room*	**DR**	*Dining Room*
H	*Hallway*	**RO**	*Reflections Office*
S	*Spa*	**P**	*Patio*
OOA	*Out on Appointment*	**A**	*Activity*
OWF	*Out with family*		

All staff assigned to complete checks are to complete the following:

AM Shift Staff Signature: _____ Initial: _____
AM Shift Staff Signature: _____ Initial: _____
AM Shift Staff Signature: _____ Initial: _____
AM Shift Staff Signature: _____ Initial: _____

PM Shift Staff Signature: _____ Initial: _____
PM Shift Staff Signature: _____ Initial: _____
PM Shift Staff Signature: _____ Initial: _____
PM Shift Staff Signature: _____ Initial: _____

Overnight Staff Signature: _____ Initial: _____
Overnight Staff Signature: _____ Initial: _____
Overnight Staff Signature: _____ Initial: _____