STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

November 29, 2022

Rose Thomason, Executive Director
Patrice Heuschkel, SALSA
The Residence At Brookside
117 Simsbury Road
Avon, CT 06001

Dear Ms. Thomason and Ms. Heuschkel,

An unannounced visit was made to The Residence At Brookside on October 20, 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 Survey.

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 December 9, 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.

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
www.ct.gov/dph
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 December 9, 2022 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 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/

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The Residence At Brookside

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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.

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Respectfully,

/s/

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

EH:csf

c. VL
Complaint #33177

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (3)(C)(D)(4)(A).

The Residence At Brookside

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1. Based on review of clinical records, agency documentation, staff interviews and agency policies for one of three clients (Client #1) in the survey sample, with a change in condition, the Assisted Living Service Agency (ALSA) failed to ensure oversight of care rendered to a client, failed to ensure a Registered Nurse (RN) assessment was completed based on a client's change

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (3)(C)(D)(4)(A).

1. Based on review of clinical records, agency documentation, staff interviews and agency policies for one of three clients (Client #1) in the survey sample, with a change in condition, the Assisted Living Service Agency (ALSA) failed to ensure oversight of care rendered to a client, failed to ensure a Registered Nurse (RN) assessment was completed based on a client's change in condition and failed to communicate a change in condition to the client's responsible party/family. The finding includes:

   a. Client #1 was admitted to the ALSA on 08/29/2019 and resided on the memory care unit with diagnosis of type II diabetes, high blood pressure, cardiac murmur. Client#1 received nursing services for assessments, medication management and ALSA aide assistance with dressing, grooming, bathing, incontinence care and mobility. Additionally, Client #1 had a Do Not Resuscitate order dated 10/19/2021.
   Interview and review of Client #1's clinical record with the Supervisor of Assisted Living Services Agency (SALSA) on 10/19/2022 at 10:25 AM, identified on 09/24/2022 the client presented with increased confusion and wheezing with breathing. Advance Practice Registered Nurse #1 (APRN) assessed Client #1 on 09/26/2022, ordered Lasix (medication to treat fluid retention) 20 milligrams (mg) daily for four days from 09/27/2022 to 09/30/2022, along with monitoring of the client for increased wheezing, shortness of breath, swelling, with a re-evaluation of Client #1 after completion of the Lasix. The SALSA failed to identify documentation that the Client was monitored from 09/27/2022 to 09/30/2022 and failed to identify an RN assessment occurred on 10/01/2022 to determine the effectiveness of the Lasix.
   Interview and review of Client #1's clinical record and investigation with the SALSA on 10/19/2022 at 12:10 PM, identified on 10/02/2022 at 11:30 AM, Licensed Practical Nurse (LPN) #1 was called to the memory care activities room by ALSA aide #1. ALSA aide #1 indicated she was unable to wake Client #1 for an estimated time of six minutes. LPN #1 identified the client was breathing, awoke while vital signs and a blood glucose were obtained. LPN #1 notified the SALSA of the Client's episode of unresponsiveness. Client #1 remained at the facility, went to the noon and dinner time meals, participated in activities, and slept through the night. On 10/03/2022 at 06:45 AM, ALSA aide #2 called the SALSA to indicate the client was in respiratory distress and became unresponsive. The SALSA instructed ALSA aide #2 to call 911, the client was transported to the hospital and pronounced deceased in the emergency room. The SALSA failed to identify the client's family/responsible party and physician were notified of the client's change in condition on 10/02/2022.
   Review of the agency policy for Change of Client Status, identified in the event of a significant change in the Client's mental, medical, or functional status the SALSA would be notified, as well as the Client's family/responsible party and the physician of record.

Plan of Correction for Violation #1:

POC accepted
1/31/23
MS

THE RESIDENCE at Brookside

117 Simsbury Road
Avon, CT 06001
T 860-284-5000
F 860-284-5002

December 8, 2022

Elizabeth Heiney, R.N.
Supervising Nurse Consultant
Department of Public Health
Facility Licensing and Investigations Section

Dear Ms. Heiney,

In response to the unannounced visit to The Residence at Brookside on October 20,2022, you will find our Plan of Correction below.

Please do not hesitate to reach out to me if you have any additional questions or requests.

Thank you,
Rose Thomason
Senior Executive Director/Service Coordinator
The Residence at Brookside
203-560-3115 (cell)
860-284-5000 (main)

Plan of Correction for Violation #1:
The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (3)(C)(D)(4)(A).

(1): Prevention of Recurrence:
- Re-training of LPNs to report and observe potential change of condition to the RN nurses. The RN nurses will determine if there is a change of condition has occurred and will commence an assessment.
- Re-training of LPNs and RNs on the LCB Change of Condition policy.
- Re-training of RNs on the CT Regulation 19-13-D105(g) (2)(A)(B) and or (h) Nursing Services Agency (3)(C)(D)(4)(A).
- Re-training LPNs and RNs about utilizing community resources for change of condition such as hospital, urgent care, skilled nursing services, physician.

(2). Date of Completion:
- December 28, 2022

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(3). Quality Assessment/ Quality Improvement:
- Monthly reviews of 10% of resident census for the next 90 days for resident change of condition.
- Service Coordinator/Executive Director and RNs monitoring weekly communication logs, incident reports, progress notes for the next 90 days for change of condition.

(4). Responsible Staff Members:
- Executive Director
- Resident Care Director (SALSA)
- RN Designee