STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

October 25, 2022

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

Dear Mr. Gibbs:

An unannounced visit was made to Change Maple Leaf Manor, Inc, on October 11, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

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 fourteen 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 November 8, 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 violations and you may be provided with the opportunity to be heard. If the violations are not responded to by November 8, 2022 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 and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

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

Respectfully,

Karen Gworek, RN

Karen Gworek, RN, BSN
Supervising Nurse Consultant
Facility Licensing & Investigations Section

KEG:csf

cc. Mairead Painter, LTC Ombudsman Program

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4)(A).

1. Based on facility documentation review, and interviews, the facility failed to conduct reference checks in the hiring process and provide an initial orientation program prior to working independently. The findings include:

    a. Review of the personnel files failed to provide documentation that reference checks were conducted prior to employment and an initial orientation program was completed on hire prior to working independently. Interview with the Director of Facilities on 10/11/22 at 11:25 AM identified the reference checks were not documented and the orientation upon hire included a walk through the facility, meeting of residents and review of the direct care handbook.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4)(D).

2. Based on review of personnel files, facility documentation review, and interviews, the facility failed to conduct annual continuous education. The findings include:

    a. Review of the personnel files failed to reflect documentation continuous education including safety and emergency procedures, residents' rights policies, and procedures of RCH (i.e., behavioral management), food safety was provided to employees. Interview with Director of Facilities on 10/11/22 at 11:25 AM identified there was no annual continuous education provided to the employees.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (g) Recreation.

3. Based on observations and interviews, the facility failed to post recreational activities calendar and failed to ensure recreation activities were offered. The findings include:

    a. During a tour of the facility on 10/11/22 identified although the resident lounges had televisions and a bookcase with books and games, there was no calendar posted informing the residents of the recreation activities offered in October. Interview with the Facility Manager on 10/11/22 identified she did not have a chance to post a calendar for this month and there were no recreational activities offered to residents as of October 11, 2022.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(E)(i).

4. Based on clinical record review, facility documentation, and interviews for two of fifteen sampled residents (Resident #1 and #2) who were reviewed for medication administration, the facility failed to ensure medications were documented accurately on the Medication Administration Record, and for residents who received Visiting Nurse Agency (VNA) service a copy of Medication Administration Record was available to facility staff and policy and procedure for the administration of medication was available. The findings include:

   a. Review of Resident #1 and #2's Medication Administration Record (MAR) for October 2022 and interview with the Facility Manager on 10/11/22 at 12:52 PM identified there were two (2) residents the medication certified technicians administered medications to, however, the residents did not have an October MAR. The Facility Manager indicated she received a MAR for the wrong month from the pharmacy, and although she called the pharmacy last week, she still did not receive a MAR for October. The Facility Manager identified the residents were receiving their medications, but there was no record for the staff to document the medications were administered.

   b. Interview with the Facility Manager on 10/11/22 at 12:45 PM identified the facility only had access to the Medication Administration Record (MAR) of two (2) residents, because the other thirteen (13) residents received their medications from VNA nurses. The Facility Manager indicated although the Medication Administration Records were on the facility premises in locked boxes in the cabinet located in the kitchen, and facility staff did not have access to the residents MAR because the staff did not have a key to the locked boxes. The Facility Manager identified the VNA nurse did not provide keys for the facility staff to access the residents MAR. Interview with the Director of Facilities on 10/11/22 at 12:25 PM identified there was no Medication Administration Policy available for review.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

5. Based on clinical record review, facility documentation, and interviews, the facility failed to provide documentation each resident had been provided a copy of his/her rights as a resident upon admission. The findings include:

   a. Interview with the Facility Manager on 10/11/22 identified she would not be able to provide documentation or a copy of the receipt of residents right signed by each resident upon admission.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

6. Based on interview, the facility was unable to provide a copy of the "House Rules" for review by the Department of Public Health to ensure the "House Rules" did not violate resident rights. The findings include:

   a. Interview with the Director of Facilities on 10/11/22 at 1:40 PM identified he could not provide a copy of the "House Rules" for review because he did not know where copy was located.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

7. Based on facility documentation review and interviews, the facility failed to meet with the residents on regular basis. The findings include:

   a. Interview and review of the facility documentation with the Facility Manager on 10/11/22 at 12:05 PM identified the residents had resident council meeting once this year, however she could not provide the date of the meeting. The Facility Manager indicated the residents did not want to participate in resident meetings on a monthly basis, however she never asked how often the residents would be willing to meet.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

8. Based on facility documentation review and interviews, the facility failed to provide a proof of consent from a resident if the facility was managing the resident's funds and monies. The findings include:

   a. Interview with the Director of Facilities on 10/11/22 at 11:05 AM identified the facility was managing the residents' funds and monies, however there was no documentation of consent signed by a resident for the facility to manage their funds and monies.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (f) Dietary Services (1).

9. Based on observations and interviews, for three (3) refrigerators and two (2) freezers, the facility failed to monitor refrigerator and freezer temperatures daily. The findings include:

    a. During a tour of the facility with the Facility Manager on 10/11/22 at 9:05 AM, observations in the kitchen and basement identified the refrigerators, freezers and medication refrigerator temperatures were not being monitored. Interview with the Facility Manager at the time of observation identified temperatures were not being monitored daily.

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

10. Based on observations, facility policy and interviews, the facility failed to ensure the environment was maintained in a clean, comfortable, and homelike manner. The findings include:

    a. Observations during a tour of the facility on 10/11/22 at 9:20 AM identified although, the designated areas for smoking, the front porch and picnic tables located at the rear of the building, had cigarette receptacles to discard the cigarettes, the smoking areas had multiple cigarettes butts on the ground. Interview with the Facility Manager at the time of observation identified residents were responsible to discard the cigarettes in the receptacles, however the residents were not following the rules. The Facility Manager indicated the facility staff were responsible to clean the smoking areas and she was not sure why the area was not cleaned today. Review of the Smoking Policy directed residents were responsible for discarding cigarettes in the designated cigarettes receptacles, they cannot be thrown on the ground.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4)(C).

11. Based on facility documentation review and interviews, the facility was unable to provide a copy of the abuse, and resident rights policy and procedure for review by the Department of Public Health. The findings include:

a. Interview with the Director of Facilities on 10/11/22 at 12:25 PM identified there was no abuse policy or resident rights available for review by the surveyor, the policies it did not exist.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

12. Based on review of facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include:

    a. On 10/11/22 at 9:00 A.M., during a tour of the facility and while accompanied by the facility owner, the following observations were identified:

        i. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that a sprinkler inspection was completed in the third quarter of 2022.

        ii. During document review the surveyor observed that the facilities generator needed repairs since the last inspection by Northeast Generator on 07/12/22. Inspection identified that a high temperature switch and a coolant flush were needed for the unit to be operational, the report identified these as "critical repairs". No repairs had been completed nor were any repairs scheduled to be completed at the time of survey. Facilities are required to have a working generator by section 19-13-D6(b)(2)(O) of the CT Public Health Code.

        iii. Documentation was not provided to the surveyor from the facility to indicate that the maintenance and testing of the facilities fire extinguishers has been completed as required by NFPA 1 section 13.6.4.2.4.1.4. Records show that the required monthly inspection of the
        iv. facilities fire extinguishers was not being done.

        v. The surveyor while accompanied by a facility representative observed the door from the kitchen to the basement stairs being held open by an unapproved device. There was a piece of metal holding the door open. Doors are required to close on alarm.

        vi. The surveyor while accompanied by a facility representative observed the egress door in the basement at the bottom of the stairs was rusted and in need of replacement. When the surveyor attempted to open the door, it was observed that the hinges were not attached to the door, negating the doors' ability to operate as required.

vii. The surveyor while accompanied by a facility representative observed smoking receptacles not being used correctly for discarder smoking materials at the front entrance and rear of the building. There was an excessive amount of discarded smoking materials on the ground in both locations. Noncombustible ashtrays are required by NFPA 1 section 10.9.2.

Approved 11/8/22 KEG

Date:	11/1/2022	Facility Name:	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Reference Checks	Responsible Party:	Marcus J. Steinle

Deficiency Identified:	Based on facility documentation review, and interviews, the facility failed to conduct reference checks in the hiring process and provide an initial orientation program prior to working independently. The findings include: Review of the personnel files failed to provide documentation that reference checks were conducted prior to employment and an initial orientation program was completed on hire prior to working independently. Interview with the Director of Facilities on 10/11/22 at 11:25 AM identified the reference checks were not documented and the orientation upon hire included a walk through the facility, meeting of residents, and review of the direct care handbook.
Compliance Review Report Checklist Item Number:	**(1)**
Response to Deficiency:	The requirement to document reference checks and a tangible presentation related to orientation was a previously unknown requirement by facility management.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, all facility candidates will have reference checks documented and filed along with all other new hire paperwork. Effective 11/8/22 all facility new hires will engage a thorough New Hire Orientation that both addresses a presentation style information-session that is uniform for all staff, as well as a documented in-person walkthrough of the facility and introduction to shift duties – to be delivered and signed off by the Residential Care Facility Manager and the staff in attendance.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The above new directives will become standard operating procedures effective 11/8/22. The Director of Facilities will conduct monthly reviews of documentation and orientation delivery to ensure the practice remains sound. This will be tracked electronically.
Responsible Personnel: Marcus J. Steinle	**Signature and Date:** Marcus J. Steinle 11/8/22

Date:	11/1/2022	Facility Name:	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Continuous Education	Responsible Party:	Marcus J. Steinle

Deficiency Identified:	Based on review of personnel files, facility documentation review, and interviews, the facility failed to conduct annual continuous education. The findings include: Review of the personnel files failed to reflect documentation continuous education including safety and emergency procedures, residents' rights policies, and procedures of RCH (i.e.,

	behavioral management), food safety was provided to employees. Interview with director of Facilities on 10/11/22 at 11:25 AM identified there was no annual continuous education provided to the employees.
Compliance Review Report Checklist Item Number:	**(2)**
Response to Deficiency:	Our training practices prior to inspection were primarily OJT-based under the direct supervision of the Residential Care Facility Manager. As we now recognize the importance of uniform documentation, no training will be engaged without consistent tracking. We have adopted an electronic training platform that can be utilized for delivery of CEUs to all facility staff, annually.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, the CMLM facility will deliver annual training to all facility staff including a curriculum of 14.00 courses including: Nutrition Principles, Corporate Compliance, Understanding COVID-19, Cultural Diversity, Emergency Preparedness, Fall Management and Prevention, Reporting and Recording, Fire Prevention and Safety, Sexual Harassment Prevention, HIPPA, Infection Control, Managing Your Time, Understanding Abuse and Neglect, Bloodborne Pathogens. These courses amount to 7.00 total hours of annual training.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The above annual training courses and CEU delivery will be monitored monthly by the Director of Facilities. All staff are required to complete these CEUs prior to reaching 1.00 year of employment – and subsequently every 1.00 year thereafter. Any updates, developments, or changes to the training material will be captured and applied appropriately to the curriculum above.
Responsible Personnel:	Marcus J. Steinle **Signature and Date:** Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Recreational Activities	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on observations and interviews, the facility failed to post recreational activities calendar and failed to ensure recreation activities very offered. The findings include: During a tour of the facility on 10/11/22 identified although the resident lounges had televisions and a bookcase with books and games, there was no calendar posted informing the residents of the recreation activities offered in October. Interview with the Facility Manager on 10/11/22 identified she did not have a chance to post a calendar for this month and there were no recreational activities offered to residents as of October 11th, 2022.
Compliance Review Report Checklist Item Number:	**(3)**
Response to Deficiency:	Although the facility did previously maintain a regular recreation calendar prior to the events of the COVID-19 pandemic; this practice was not appropriately returned to function in 2022.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/1/22, the Residential Care Facility Manager of CMLM will generate, maintain, and market to the residents a monthly recreational calendar containing a diverse option of activities. These activities will be based around the current season, recreation budget, and resident

	participation. All recreational events that occur per the calendar will also contain an attendance / participation form so the facility might better assess interest and participation for future recreational events.		
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will review the monthly recreation calendar prior to its release as well as at the conclusion of the month to assess participation and variety.		
Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Med Admin P&P	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on clinical record review, facility documentation, and interviews for two of fifteen sampled residents (Residents #1 and #2) who were reviewed for medication administration, the facility failed to ensure medications were documented accurately on the Medication Administration Record, and for residents who received Visiting Nurse Agency (VNA) service a copy of Medication Administration Record was not available to facility staff and policy and procedure for the administration of medication as not available. The findings include: Review of Resident #1 and #2's Medication Administration Record (MAR) for October 2022 and interview with the Facility Manager on 10/11/22 at 12:52 OM identified there were two (2) residents the medication certified technicians administered medications to, however, the residents did not have an October MAR. The facility Manager indicated she received a MAR for the wrong month from the pharmacy and although she called the pharmacy last week, she still did not receive a MAR for October. The facility Manager identified the residents were receiving their medications but there was no record for the staff to document the medications were administered. Interview with the Facility Manager on 10/11/22 at 12:45 PM identified the facility only had access to the Medication Administration Record (MAR) of two (2) residents, because the other thirteen (13) residents received their medications from VNA nurses. The Facility Manager indicated although the Medication Administration Records were on the facility premises in locked boxes in the cabinet located in the kitchen, and facility staff did not have access to the residents MAR because the staff did not have a key to the locked boxes. The Facility Manager identified the VNA nurse did not provide keys for the facility staff to access the residents MAR. Interview with the Director of Facilities on 10/11/22 at 12:25 identified there was no Medication Administration Policy for review.
Compliance Review Report Checklist Item Number:	**(4)**
Response to Deficiency:	It was our understanding, prior to this survey, that if MAR documentation needed to be provided on behalf of a VNA – that agency could be contacted by DPH or any inquiring authority to be produced by that VNA. As this is now known not to be the case, we are working to have access

	provided to us by each VNA staff. As far as a "MAR Policy" – other than the standards and directions included in the Connecticut Uniform Interagency Medication Administration Certification Program – Student Manual – CMLM does not have a separate MAR Policy to date.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	If a pharmacy does not or will not produce an accurate MAR for a resident in our care needing medication administration; we will continue to request this verbally (and in writing if possible) to the pharmacy in question, and we will also immediately notify Karen Gworek, RN (Supervising Nurse Consultant) – or the after hours contact line at DPH – of this incident. Effective 11/1/22, CMLM management will work with each VNA outfit and representative to have access provided to all resident MARs and medical documentation. In the event this documentation is requested by DPH or any other authority; we will be able to readily provide all records – whether we (CMLM) or a VNA are the responsible parties for the medication administration of a particular resident.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Residential Care Facility Manager will review and sign-off on all medication passes for all residents within the facility monthly – this is a secondary check and balance to ensure there are no missing, omitted, or inaccurate MARs in our possession – and furthermore to ensure no pass is missed or errored. This will be done weekly. On a monthly basis – the Director of Facilities will review the signoffs generated by the RCFM to ensure completion and uniformity. There will be two sets of management eyes on this process moving forward – weekly and monthly.
Responsible Personnel:	Marcus J. Steinle — **Signature and Date:** Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Resident Rights	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on clinical record review, facility documentation, and interviews, the facility failed to provide documentation each resident had been provided a copy of his/her rights as a resident upon admission. The findings include: Interview with the Facility Manager on 10/11/22 identified she would not be able to provide documentation or a copy of the receipt of residents right signed by each resident upon admission.
Compliance Review Report Checklist Item Number:	(5)
Response to Deficiency:	Most residents currently living at the CMLM facility were admitted in the years preceding current ownership. The documentation of resident rights was either missing or omitted (if ever completed) during the tenure of prior ownership. For those newer residents, a uniform signing of rights practice was overlooked by current management.
Corrective Action Plan:	Effective 11/8/22, all current CMLM residents will be provided with a current Resident Rights document in which they will read and sign in the presence of facility management. This document

(Action taken to correct specific deficiency identified)	will then be filed in that resident's profile. For all future admissions, this practice will be encompassed by the full admission process and required for completion before the finalization of any resident placement within the facility. The Residential Care Facility Manager will ensure all current residents have this documentation signed once prepared.		
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will ensure that all current residents have this completed within 30.00 days of submission of this Plan of Correction. In addition, all new resident placements will be confirmed (eyes on) by the Director of Facilities to have this document signed and filed prior to or upon their arrival at the facility.		
Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) House Rules	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on interview, facility was unable to provide a copy of the "House Rules" for review by the Department of Public Health to ensure the "House Rules" did not violate resident rights. The findings include: Interview with the Director of Facilities on 10/11/22 at 1:40 PM identified he could not provide a copy of the "House Rules" for review because he did not know where a copy was located.
Compliance Review Report Checklist Item Number:	**(6)**
Response to Deficiency:	We do have a "House Rules" document we utilize for residents upon arrival – it is simply not on CMLM company letterhead and was a borrowed document from a sister facility. I did not feel it appropriate to provide a non-entity related document during this DPH survey.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, all policy, procedure, and rule-based documentation ("House Rules" included); will be appropriately transcribed to Change Maple Leaf Manor, Inc letterhead and formal handbooks and policy write-ups. All current residents will receive (and sign) a copy of the House Rules for filing in their records. One these updated forms are prepared – the Residential Care Facility Manager will facilitate the singing by each current resident. Additionally, all forthcoming resident placements will have the "House Rules" document included in their admission paperwork – to be completed prior to finalization of placement.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will ensure that all current residents have this completed within 30.00 days of submission of this Plan of Correction. In addition, all new resident placements will be confirmed (eyes on) by the Director of Facilities to have this document signed and filed prior to or upon their arrival at the facility.

Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Resident Meetings	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on facility documentation review and interviews, the facility failed to meet with the residents on a regular basis. The findings include: Interview and review of the facility documentation with the Facility Manager on 10/11/22 at 12:05 PM identified that the residents had a resident council meeting once this year, however, she could not provide the date of this meeting. The Facility Manager indicated the residents did not want to participate in resident meetings monthly, however she never asked how often residents would be willing to me.
Compliance Review Report Checklist Item Number:	**(7)**
Response to Deficiency:	The occurrence of resident meetings has traditionally been left up to the desire of the residents to meet. Moving forward this will be a structured, cyclical (monthly) block of time allotted for resident council meetings – attendance will be taken and logged for record, monthly.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, a council meeting block for all residents will be allotted and attendance will be documented and filed. A meeting agenda will be maintained for each instance along with the attendance sheet. The topics, focuses, and inquiries are to be resident generated – unless facility management has any updates, concerns, or questions to present the resident body. Regardless of attendance, these will occur monthly moving forward.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will receive confirmation from management monthly that the resident meetings have occurred, and all associated documentation has been tracked.

Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Proof of Consent	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on facility documentation review and interviews, the facility failed to provide a proof of consent from a resident is the facility was managing the resident's funds and monies. The findings include: Interview with the Director of Facilities on 10/11/22 at 11:05 AM identified the facility was managing the resident's funds and monies, however, there was no documentation of consent signed by a resident for the facility to manage their funds and monies.
Compliance Review Report Checklist Item Number:	**(8)**
Response to Deficiency:	The distribution of monthly resident allowance is a requirement of the RCH program – it was previously an unknown requirement to produce a separate, singular document signed by residents that allows CMLM to distribute these monthly amounts as has been occurring since the opening of the facility.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, CMLM will produce and release to all residents a Monthly Allowance Proof of Consent Form – this will detail our ability to (with resident consent) continue to receive, store, and distribute the monthly allowances for our residents. The Residential Care Facility Manager will facilitate the signing of these forms.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will ensure that all current residents have this completed within 30.00 days of submission of this Plan of Correction. In addition, all new resident placements will be confirmed (eyes on) by the Director of Facilities to have this document signed and filed prior to or upon their arrival at the facility.
Responsible Personnel:	Marcus J. Steinle **Signature and Date:** Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Appliance Temps	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on observations and interviews for three (3) refrigerators and two (2) freezers, the facility failed to monitor refrigerator and freezer temperatures daily. The findings include: During a tour of the facility with the Facility Manager on 10/11/22 at 9:05 AM, observations in the kitchen and basement identified the refrigerators, freezers, and medication refrigerator

	temperatures were not being monitored. Interview with the Facility Manager at the time of observation identified temperatures were not being monitored daily.
Compliance Review Report Checklist Item Number:	**(9)**
Response to Deficiency:	Prior to this onsite inspection and per the current public health code related to RCHs; it was not made clear that temperatures of refrigerators and freezer equipment are to be recorded daily.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22, all facility refrigeration appliances including freezers will be assigned a monthly log. This log will be utilized to record the internal temperature of the appliances in question – to be completed by kitchen staff per day. These sheets will be regularly completed by facility staff and maintained for ongoing record. The Residential Care Facility Manager will ensure this practice is consistent for all appliances.
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will monitor the completion of these temperature reports monthly.
Responsible Personnel:	Marcus J. Steinle **Signature and Date:** Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Smoking Areas	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on observations, facility policy and interviews, the facility failed to ensure the environment was maintained in a clean, comfortable, and homelike manner. The findings include: Observations during a tour of the facility on 10/11/22 at 9:20 AM identified although, the designated areas for smoking, the front porch and picnic tables located at the rear of the building, had cigarette receptables to discard the cigarettes, the smoking areas had multiple cigarette butts on the ground. Interview with the Facility Manager at the time of observation identified residents were responsible to discard the cigarettes in the receptables, however, the residents were not following the rules. The Facility Manager indicated the facility staff were responsible to clean the smoking areas and she was not sure why the area was not cleaned today. Review of the Smoking Policy directed residents were responsible for discarding cigarettes in the designated receptables, they cannot be thrown on the ground.
Compliance Review Report Checklist Item Number:	**(10)**
Response to Deficiency:	This has been an ongoing issue since we purchased the facility in 2018. Maintaining rules and regulations throughout the facility for residents, while not violating resident's rights.

Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22 the facility staff will engage daily inspections of the exterior smoking areas. A summary of findings and corrective actions (cleanup) will be completed. I will also instruct the Residential Care Facility Manager to include the smoking residents themselves in the cleanup of these spaces as they are utilized by them.		
Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Residential Care Facility Manager will ensure this additional inspection is permanently included in the shift duties for each shift. The Director of Facilities will inspect these spaces at random.		
Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Administration (1) Abuse & Resident Rights	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on facility documentation review and interviews, the facility was unable to provide a copy of the abuse, and resident rights policy and procedure for review by the Department of Public Health. The findings include: Interview with the Director of Facilities on 10/11/22 at 12:25 PM identified there was no abuse policy or resident rights available for review by the surveyor, the policies it did not exist.
Compliance Review Report Checklist Item Number:	**(11)**
Response to Deficiency:	Outside of the Resident Toolkit documentation provided to us via email on 9/13/21 by: **Mairead Painter** State Long Term Care Ombudsman Department of Aging and Disability Services 55 Farmington Avenue, Hartford CT 06105 Tel: (860) 424-5238 Fax: (860) 772-1704 Mairead.painter@ct.gov We did not have any additional policies, procedures, or documentation to encompass abuse or residents' rights. This Toolkit is made available to all staff and was reviewed during the in-person, OJT orientations previously occurring at the facility.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Effective 11/8/22 CMLM will generate separate policies in its administrative / staff handbook(s) which encompass and include all related abuse and resident rights-based material provided to us by the Department of Public Health. The Residential Care Facility Manager will ensure, once provider, that all staff and residents have reviewed the information, acknowledged that review, and always have access to this material.

Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will include this review with all aforementioned (monthly) staff and resident documentation reviews.		
Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22

Date:	11/1/2022	**Facility Name:**	Change Maple Leaf Manor, Inc
Protocol Title:	Physical Plant (2) Fire Safety Needs	**Responsible Party:**	Marcus J. Steinle

Deficiency Identified:	Based on review of the facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include: A. On 10/11/22 at 9:00 AM, during a tour of the facility and while accompanied by the facility owner, the following observations were identified: i. Documentation was not provided to the surveyor from the facility to indicate that the sprinkler system was being tested, inspected, and maintained in accordance with NFPA 25; i.e., There were no records that sprinkler inspection was completed in the third quarter of 2022 ii. During document review the surveyor observed that the facilities generator needed repairs since the last inspection by Northeast Generator on 7/12/22. Inspection identified that a high temperature witch and a coolant flush were needed for the unit to be operational, the report identified these as "critical repairs". No repairs had been completed nor were any repairs scheduled to be completed at the time of survey. Facilities are required to have a working generation by section 19-13-D6(b)(2)(O) of the CT Public Health Code. iii. Documentation was not provided to the surveyor from the facility to indicate that the maintenance and testing of the facilities fire extinguishers has been completed as required by NFPA 1 section 13.6.4.2.4.1.4. Records show that the required monthly inspection of the facilities fire extinguishers was not being done. iv. The surveyor while accompanied by a facility representative observed the door from the kitchen to the basement stairs being held open by an unapproved device. There was a piece of metal holding the door open. Doors are required to close on alarm.

	v. The surveyor while accompanied by a facility representative observed the egress door in the basement at the bottom of the stairs was rusted and in need of replacement. When the surveyor attempted to open the door, it was observed that the hinges were not attached to the door, negating the door's ability to operate as required. vi. The surveyor while accompanied by a facility representative observed smoking receptables not being used correctly for discarder smoking materials at the front entrance and rear of building. There was an excessive amount of discarded smoking materials on the ground in both locations. Noncombustible ashtrays are required by NFPA 1 section 10.9.2.
Compliance Review Report Checklist Item Number:	**(12)**
Response to Deficiency:	Unfortunately, this year our scheduling of the sprinkler inspections occurred on 6/30/22 – the last day of the second quarter. Essentially, our third quarter inspection was conducted a day too early. This has been since corrected with the vendor. We did receive the quotation for the generator repair on same date as our DPH inspection, 10/11/22. This has been approved and will be completed. Our fire extinguishers are on automatic inspection (annually) by Encore Fire Protection – we will increase the frequency of these checks to now monthly per the feedback provided after this inspection. The item lodged into the kitchen door to prevent its closing has been prohibited – any staff found to violate this requirement will be disciplined accordingly. The basement egress door will be replaced entirely – Accurate Door is our fire safety door vendor. The issue of the smoking areas and receptacles continues to be a problem as residents will often dismiss the smoking rules and/or utilize the smoking receptacles inappropriately or not at all.
Corrective Action Plan: (Action taken to correct specific deficiency identified)	Within 60.00 days of the submission of the Plan of Correction – all physical plant related repairs (noted above) and inspections (noted above) will be completed. The 60.00-day timeframe represents time for scheduling and vendor availability to complete the associated work. We will conduct a 2nd fourth quarter sprinkler inspection as an offset to the accidental early scheduling of the 3rd quarter inspection – 6/30/22, instead of 7/1/22. We have addressed our plans for the issue of smoking receptacle usages and the discarding of smoking materials around the grounds of the facility in earlier violation corrective action steps.

Preventative Action Plan: (Action taken to prevent the reoccurrence of this problem in the future)	The Director of Facilities will ensure that by 1/8/22 all the above repairs and omitted inspections are complete.		
Responsible Personnel:	Marcus J. Steinle	**Signature and Date:**	Marcus J. Steinle 11/8/22