STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

April 26, 2023

Peg Sullivan, Executive Director
Via Email: psullivan@allamericanatenfield.com
All American Assisted Living At Enfield
118 Hazard Ave
Enfield, CT 06082-4520

Dear Mr. Sullivan :

An unannounced visit were made to All American Assisted Living At Enfield on April 5, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Monitoring Re-Visit.

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 May 6, 2023.

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.

DATE(S) OF VISIT: April 5, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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 May 6, 2023, 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, BS, RN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

EH:csf

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DATE(S) OF VISIT: April 5, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (f) Personnel policies for an assisted living services agency (1) (A) (ii) and/or (g) Supervisor of assisted living services (A) (B) and/or (h) Nursing Services provided by an assisted living services agency (3) (C) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on a review of clinical records, review of agency documentation, interviews, and policy review for one Client (Client #1) who eloped from the secured unit, the Assisted Living Services Agency (ALSA) failed to provide a safe environment and failed to follow the agency's Elopement policy and procedure. The findings included:

   a. Client #1 was admitted to the agency on 01/21/2023 and resided on the secured unit with a diagnosis of vascular dementia. The Client's nursing assessment dated 02/27/2023, identified the Client had current and past behavioral issues of wandering outside of an immediate area, getting lost and/or becoming combative upon returning. The service plan dated 02/27/2023, identified the Client required medication administration by a nurse, assistance of one ALSA aide for bathing, grooming, dressing and personal hygiene.

   Review and interview of Client #1's clinical record and investigation for an elopement with the Executive Director on 04/05/2023 at 10:40 AM, identified on 03/10/2023 at 6:14 PM Client #1 pushed on the delayed egress door on the locked unit which released after 15 seconds, therefore, Client #1 exited the unit. The Client followed the sidewalk to the right of the building toward the maintenance entrance. ALSA aide #1 indicated being alerted twice that a door was opened on the locked unit. Licensed Practical Nurse #1 (LPN) and ALSA aide #2, identified not hearing the alarm as they were providing care for Clients. Kitchen Staff #1 opened the maintenance entrance door, observed the Client outside and let him/her into the building. At 6:15 PM, the Client entered the building, was observed at the front desk, and escorted back to the locked unit by ALSA aide #1 at 6:16 PM.

   Interview with the Executive Director on 04/05/2023 at 1:45 PM, identified Kitchen Staff #1 had not been trained on the agency's Elopement policy and procedure upon hire or after Client #1's elopement on 03/10/2023.

   The Executive Director failed to identify an updated elopement risk or nursing assessment was conducted by a Registered Nurse (RN) subsequent to the elopement, failed to identify the Client's service plan was updated, failed to identify the Client was on wellness checks for a minimum of 24 hours after the elopement, failed to ensure a staff member was trained on the elopement policy upon hire and after the occurrence.

DATE(S) OF VISIT: April 5, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

A review of the agency's Elopement policy and procedure identified Clients' safety and well-being are priorities. All employees would be trained in the elopement policy upon hire, annually and as needed. Elopement risk assessments for the Client would be completed upon admission, as required by regulations, and as needed. If a client was found to be an elopement risk, the Client would be placed on wellness checks to verify his/her location and/or a silent alarm may be placed on the Client's door to alert staff that the Client was mobile. Once a Client was located and safe, the Client would be placed on wellness checks for a minimum of 24 hours after elopement. The Client's service plan would be updated by the charge nurse/designee.

Plan of Correction for Violation #1:

5/5/23 POC accepted
-mes

All American ASSISTED LIVING

All American Assisted Living at Enfield
118 Hazard Avenue
Enfield, CT 06082
860-962-4100
allamericanatenfield.com

Elizabeth Heiney, BS, RN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capitol Avenue
PO Box 34308
Hartford, CT 06134

Dear Ms. Heiney,

I respectfully submit a Plan of Correction for the identified violation from the unannounced Monitoring Re-Visit conducted by Megan Edson-Swayer, RN, on April 5, 2023, at All American Assisted Living at Enfield.

Unannounced Visit to All American Assisted Living at Enfield on 4.5.23

Violation:

Based on a review of clinical records, review of agency documentation, interviews, and policy review for one Client (Client #1) who eloped from the secured unit, the Assisted Living Services Agency (ALSA) failed to provide a safe environment and failed to follow the agency's Elopement policy and procedure.

Plan of Correction:

(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;

POC accepted 5/5/23
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(2) the date each such corrective measure or change by the institution is effective;

a. All employees trained in the elopement policy upon hire, annually and as needed.
    i. Conduct elopement policy/procedure review in-service for all current employees – to be completed by 5.31.23
    ii. Ensure all new hires since 4.5.23 have received initial elopement policy/procedure training - to be completed by 5.31.23
    iii. Schedule annual elopement policy/procedure training - to be completed by 5.31.23

b. Elopement risk assessments for the Client would be completed upon admission, as required by regulations, and as needed.
    i. Conduct updated elopement risk assessments for all residents – to be completed by 6.15.23
    ii. Ensure all new admissions since 4.5.23 have elopement risk assessments in their clinical record – 5.31.23
    iii. In the event exit-seeking behavior is newly exhibited by a resident, conduct an elopement risk assessment immediately and update service plan to reflect strategies for redirection – Immediate and ongoing

c. *If a client was found to be an elopement risk, the Client would be placed on wellness checks to verify his/her location and/or a silent alarm may be placed on the Client's door to alert staff that the Client was mobile.*
    i. For every resident identified as an elopement risk, update service plans to reflect elopement risk assessment and schedule for wellness checks to be completed/documented– to be completed by 6.15.23

d. *Once a Client was located and safe, the Client would be placed on wellness checks for a minimum of 24 hours after elopement.*
    i. In the event of an actual elopement, update service plans to reflect requirement for hourly wellness checks to be completed/documented and schedule for wellness checks– Immediate and ongoing

e. *The Client's service plan would be updated by the charge nurse/designee.*
    i. Please refer to above corrective measures that indicate requirement to update service plans
    ii. Conduct in-service for all nursing staff to ensure understanding of the requirements for elopement documentation and service plan documentation/revision – to be completed by 5.31.23

PUC accepted 8/5/23
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(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;

i. Resident Care Director will ensure corrective measures are completed by dates established above
ii. Executive Director will conduct at least quarterly elopement drills
iii. Resident Care Director will ensure staff are aware of those residents identified as elopement risks – Ongoing
iv. Facilities Director will work with appropriate contractor to extend panic bar lock release from 15 seconds to 30 seconds (Fire Marshall ash given approval) – to be completed by 5.15.23
v. Executive Director will minimize appearance of exit doors through use of artwork – to be completed by 5.31.23

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

a. Yvette Hassett, RN,BS, Resident Care Director
Email: yhassett@allamericanatenfield.com
Phone: (860) 962-4100

Please advise if you need any further information as it relates to this Plan of Correction.

Respectfully,

Peg Sullivan

Peg Sullivan
Executive Director