STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

Rec'd 4/8/24
Reviewed
+ Accepted
4/10/24
EJ Staff, SNC

March 28, 2024

Diana Lopes, Executive Director
Maplewood At Danbury Alsa, Llc
22 Hospital Avenue
Danbury, CT 06810
Via E-mail: Danburyed@maplewoodsl.com

Dear Ms. Lopes:

An unannounced visit was made to Maplewood At Danbury Alsa, Llc on February 6, 2024 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted, along with your original state violation letter, to the Department by April 7, 2024.

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 April 7, 2024 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 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.

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

Respectfully,

Elizabeth T. Heiney BSN RN BC

Elizabeth T. Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ETH:lst

c. VL
Complaint CT #37496

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living service agency (4)(A) and/or (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (1)(E)(3) and/or (j) Assisted Living Service agency staffing requirements (1)(10).

1. Based on clinical record review, personnel interviews, and review of agency policies for one of five clients (Client #5) who received assisted living services, the agency failed to ensure care and services were provided per the service plan, to a client that was left in a recliner for greater than 18 hours. The findings include.

    a. Client # 5 had a move in date to the Assisted Living Service Agency (ALSA) on 12-15-23, with diagnoses that included malnutrition, hypertensive kidney disease, cerebral infarction due to thrombosis, venous insufficiency, kidney failure, dysphagia, osteoarthritis, and lower extremity weakness.

    Review of Client #5's service plan dated 12/14/23, identified the client required assistance of 1 staff person for; bathing, hygiene, grooming, toileting at 6:00am and 3 times per day, or as needed, for ambulation to the bathroom, for transfers assist from bed to recliner and/or wheelchair, staff delivery of fluids for hydration, (to include at least 8 glasses per day), daily meal ordering/delivery to the client's apartment, and client safety checks every shift, (staff to view resident physically to confirm location, ensure safety, and evaluate their immediate surrounding). The client was reported to be continent of bowel and bladder, was a self-administer with medication administration, and clients' medications were managed by family member.

    Review of the agency aide staff schedule for the date 1/8/24 7:00am to 3:00pm shift identified, the schedule required six (6) aide assignments, and one (1) float aide assignment for the 6:00am to 11:00am float shift.

    Review of the aide staff assignments for 1/8/24 7:00am-3:00pm shift identified, two (2) aide staff were assigned on the Vista/Tides 1st and 3rd floor units, and three (3) aide staff were assigned to the Currents (Memory Care) 2nd floor unit, and one (1) float aide staff, was assigned 9:00am to 2:00pm float assignment in the facility. The agency failed to identify any float aide staff assignment for the 6:00am to 11:00am shift per the aide assignment schedule.

    Review of the agency aide staff schedule for the date 1/8/24 3:00pm to 11:00pm shift identified, the schedule required four (4) aide assignments and one (1) float aide assignment for the 4:00pm to 9:00pm in the Vistas/Tides units, and one (1) float assignment for 3:00pm to 8:00pm in the Currents unit.

    Review of the aide staff assignments for 1/8/24 for 3:00pm to 11:00pm identified, two (2) aide staff were assigned on the Vista/Tides 1st and 3rd floor units, and one (1) float aide staff was assigned to the Vitas/Tides units as a float staff 4:00pm to 9:00pm, and

two (2) aide staff were assigned to the Currents (Memory Care) 2nd floor unit, and one (1) aide float staff, was assigned to the Currents unit as a float staff 3:00pm to 8:00pm.

Review of the agency aide schedule for the date 1/9/24 11:00pm to 7:00am shift identified the schedule required four (4) aide assignments.

Review of the agency aide assignments for 1/9/24 11:00pm to 7:00am shift identified, two (2) aide staff were assigned to the Currents (memory Care) 2nd floor unit, and one (1) staff member was assigned a partial shift, 11:00pm to 4:00am to the Vitas 1st and 3rd floor units. The agency failed to identify adequate staffing was scheduled to meet the needs of the clients for the remainder of the aide assignment from 4:00am to 7:00am on 1/9/24, and for the open aide staff assignment on 1/9/24 11:00pm to 7:00am shift.

Review of the nursing schedule for the 7:00am to 3:00pm, and the 3:00pm to 11:00pm on 1/8/24 and the 11:00pm to 7:00am shifts on 1/9/24 identified one (1) nurse was assigned to the agency community.

Review of the agency incident report and documentation with the agency Supervisor of Assisted Living Service Agency (SALSA) on 2/9/24 at 12:00pm, identified that on 1/9/24 at approximately 9:20am she received a call from the ALSA agency on-duty LPN (LPN #1) identifying that Client #5 was found sitting in his/her recliner, unresponsive. SALSA identified she responded to the ALSA community for assistance, and to determine circumstance of Client #5 being found unresponsive in his/her recliner. The SALSA identified that the last staff to entered Client #5's room, and observe Client #5, was the dietary server, who delivered the clients dinner order at approximately 6pm on 1/8/24. SALSA further identified that during the remainder of the 3:00pm to 11:00pm shift on 1/8/24, and the 11:00pm to 7:00am shift on 1/9/24, no agency staff member provided any care, services or safety checks to Client #5.

Review of the agency incident documentation identified at approximately 6:00pm on 1/8/24, Dietary Server #1 (DS #1) brought Client #5's meal into his/her room and observed client sleeping in his/her recliner. Food was left on the bedside tray, next to client's recliner. The agency statement further noted as DS #1 was exiting the room, it appeared to her that Client # 5 was starting to wake up.

Interview with LPN # 1 on 2/9/24 at 2:30pm, identified she was the on-duty nurse for the agency for the 7:00am to 3:00pm shift on 1/8/24, and at no time did she assist with care, services, or safety checks for Client #5.

Interview with Aide #1 on 2/6/24 at 1:20 pm identified she worked the 7:00am-3:00pm shift on 1/8/24, and Client #5 was on his/her assignment. At the completion of her shift, at approximately 3:00pm on 1/8/24, Aide #1 performed a last safety check on Client #5, who requested to remain in his/her recliner.

Interview with LPN #2 on 2/7/24 at 2:45pm, identified she was the on-duty LPN for the 3:00pm to 11:00pm shift on 1/8/24, and at no time did she perform any care, services, or

safety checks on Client #5.

Interview with Aide # 3 on 2/7/24 at 2:37pm, identified she worked the 3:00pm-11:00pm shift on 1/8/24, and only saw and spoke to Client #5 when she took the clients dinner order. Aide # 3 indicated that Client # 5 was not on her assignment that shift for care, services, or safety checks.

Interview with LPN # 3 on 2/7/24 at 2:45pm, identified she was the on-duty LPN for the 11:00pm to 7:00am shift on 1/9/24, and at no time did she perform any care, services, or safety checks on Client #5. LPN #3 further identified, when the staff member/covering aide staff left at the end of her shift at 4:00am, she was the only nursing staff in the facility from 4:00am to 7:00am on 1/9/24.

Interview with LPN # 4 on 2/7/24 at 11:20 am, identified she worked in the role of an agency aide staff on 1/9/24 from 11:00pm to 4:00am. LPN # 4 identified Client #5 was not on his/her assignment, and no safety checks or care were performed for the client.

Interview with Aide # 1 on 2/6/24 at 1:20pm identified she cared for Client #5 on 1/9/23 for the 7:00am-3:00pm shift. At approximately 9:00am, Aide # 1 went into complete morning care on Client #1, and found client in his/her recliner, leaning to the right, and not responding to her voice. Client was found to be incontinent of bladder and had drool on the front of his/her clothing. Aide #1 called for assistance and Aide #2 responded to Client #5's room, along with the on-duty nurse. At the arrival of LPN # 1, the client was lifted from the recliner and placed on his/her bed by the 3 staff members for incontinent care. Client was bathed, changed by the aide staff, and made comfortable.

Interview with Aide #2 on 2/6/24 at12:55pm identified on 1/9/24 7a-3p shift, a call for aide assistance in Client #5's room was made over the walkie talkie radio system, around 9:10am on 1/9/24. Aides #2 responded and at his/her arrival, Client #5 was observed sitting in his/her recliner, leaning over the side. At the nurse's arrival, all 3 staff members picked the client up from the recliner and carried him/her to the bed, where they changed him/her and made them comfortable until family and the Hospice nurse arrived.

Interview with LPN #1 on 2/9/24 at 2:31pm, identified he/she was called to Client # 5 room at approximately 9:00am on 1/9/24 by agency aides. At her arrival, LPN # 1 found client sitting in the recliner, leaning to the right, and not responding to staff voices. LPN #1 and aide staff lifted the client and placed him/her on the bed, where client was changed and washed and placed into a clean gown. LPN #1 then called the SALSA, family member, and the Hospice agency, requesting a Hospice nurse to respond to the facility. At the arrival of the family members, and the hospice nurse, it was determined that Client # 1 was transitioning (a stage in the dying process when a person enters the active dying phase), and then client was prepared for transfer by ambulance to an Inpatient Hospice Unit.

The agency failed to ensure the assigned aide staff had agency client's added to their

assignments for the 1/8/24 3p-11p shift, and 1/9/24 11p-7a shift, and failed to identify adequate aide staffing was scheduled on 1/8/24 3:00pm to 11:00pm, and on 1/9/24 for the 11p-7a shift, for the assurance of care, and safety checks per Client #5 service plan, and failed to ensure agency oversight and supervision of nursing and aide staff in the delivery of client care, services and safety per the client service plan, and the agency policy.

Review of the Agency policy MSL-2023CT Resident Safety Checks- to ensure the safety and wellbeing of residents. Safety checks involve viewing the resident either physically, or virtually, if applicable, to confirm location, and ensure safety, and evaluate their immediate surroundings. Safety checks are determined by the agency nurse assessment. -All safety checks should be completed within the first 60 minutes of the shift. Minimum safety checks are to be performed regularly to check the status of clients.

Plan of Correction to Violation #1:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (k) Client service record (2)(L)(5).

2. Based on clinical record review and personnel interviews, for one (1) of five (5) clients (Client # 5) who received assisted living agency services, the agency failed to identify adequate supervisory oversight in the accuracy and completion of aide staff documentation, as it relates to staff care task assignments, within the clinical record. The findings include.

    a. Client #5 had a move in date to the assisted living service agency community on 12/15/23 with diagnoses that included malnutrition, hypertensive kidney disease, cerebral infarction due to thrombosis, venous insufficiency, gout, kidney failure, dysphagia, osteoarthritis, gastroesophageal disease, hypertension.

    Review of Client #5's service plan dated 12/14/23 identified client required assistance of 1 staff for activities of Daily Living, bathing, hygiene, grooming, toileting 3 times per day, and as needed, transfers to bed, chair and wheelchair, toileting three (3) times a day, hydration at least 8 glasses per day, meal ordering and delivery, and safety check every shift with documentation on care log.

    Review of the care log documentation for Client #5, with the ED and SALSA on 2/6/24 at 12:30pm identified, at the completion of client care, and/or safety checks, agency staff are to electronically document within the clients' record care log section. If a staff member neglects to document care, a code, denoted as TNC, (task not completed), is automatically entered by the agency's computer system, into the client's clinical record. The SALSA identified monthly she reviews all client care logs, for completion, accuracy, and for the TNC code. If it is identified that a staff member neglected to sign

the care log document correctly, the SALSA speaks with the assigned staff member, confirms the task was completed, or confirms that the task was not completed, and the record is amended. The SALSA identified the process for amending the client care log is to strike out any incorrect information and have the staff member initial over the strike out.

Review of Client #5's Care Log for December 2023 identified greater than 25 notations of TNC (task not completed), with a "X" strikeout, and/or illegible handwritten information over the TNC notation, was observed on the client care log, and failed to identify a date was entered for these changes.

Review of Client #5's Care Log for January 1 through 9 2024, identified greater than 25 notations of TNC (task not completed), with a "X" strikeout, and/or illegible handwritten information over the TNC notation, was observed on the client's log sheet. The care log identified as 1/2024, further identified aide staff initials for care completion were noted greater than 40 times, although the client was no longer residing in the facility (discharged 1/9/24).

The agency SALSA failed to identify authentication and accuracy of Client #5's care log, and failed to identify the legibility of the handwriting for the identification of the agency staff member who performed the updates to the client's care log.

Plan of Correction to Violation #2:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (c) Managed Residential Communities serviced by an Assisted Living Service Agencies (1)(H) and/or (4)(B).

3. Based on a review of clinical records, and review of the agency policy, for three (3) of five (5) clients (Clients # 2,3,5) who resided in the assisted Living service agency community, the agency staff failed to respond to client emergency response system pendant activations within the agency policies prescribed time frame. The findings include.

    a. Client #2 had a move in date to the assisted living service agency community on 12/21/23 with diagnoses that included Chronic Kidney disease, Type II diabetes mellitus with nephropathy, blood loss, muscle weakness, cognitive communication deficit, reduced mobility, and history of right artificial knee joint replacement.

    Review of the Client #2's initial service plan dated 2/6/24 identified the client required assistance with Activities of Daily Living, Bathing, Bladder and Bowel incontinence including toileting every 4 hours and as needed, assistance from staff for heel off-loading to relieve pressure to wound on heel, dressing, hygiene, grooming, medication administration and management by nursing, and transfer assist of 1 staff

member to wheel chair and transportation within facility, and has home health services for management of ulceration to right heel, and therapy services.

Review of the pendant response logs for Client #2 for the time period 1/1/24 through 2/6/24, identified a greater than 10 minutes staff response to client's need, 158 times, with the longest staff response time of 1 hour and 23 minutes.

b. Client # 3 had a move in date to the assisted living service agency community on 10/7/21 with diagnoses that included Pre-Diabetes, atrial tachycardia, anemia, elevated white cell count-unspecified, Gastroesophageal reflux disease (GERD), hypertension (HTN), chopped diet and thin liquids.

Review of Client #3's service plan dated 12/30/23, identified client required assistance with Activities of Daily Living, total assist with 1 staff for bathing, dressing, hygiene, grooming, toileting for continence, and nursing administration of medications, and assistance of 2 staff for transfers in/out of bed and wheelchair.

Review of the pendant response logs for Client #3 for the time period 1/1/24 through 2/5/24, identified a greater than 10 minutes staff response to client's needs, 73 times with the longest staff response 1 hour and 40 minutes.

c. Client #5 had a move in date to the assisted living service agency community on 12/15/23 with diagnoses that included malnutrition, hypertensive kidney disease, cerebral infarction due to thrombosis, venous insufficiency, gout, kidney failure, dysphagia, osteoarthritis, gastroesophageal disease, hypertension.

Review of Client #5's service plan dated 12/14/23 identified client required assistance of 1 for Activities of Daily Living, bathing, hygiene, grooming, toileting 3 times per day, and as needed, transfers to bed, chair and wheelchair, toileting three (3) times a day, hydration at least 8 glasses per day, meal ordering and delivery, and safety check every shift with documentation on care log.

Review of the pendant response logs for Client #5 for the time period 1/1/24 through 1/10/24, identified greater than 10-minute staff response to client's needs, 19 times.

Interview with the ED and SALSA, on 2/6/24 at 12:30pm, identified that clients residing in the Tides and Vistas units are afforded emergency call pendants for activation for service needs, and/or emergencies. The ED identified it is the agency expectation that the emergency response system, pendant activations will have an agency staff response of around 7-10 minutes.

Review of agency policy on Emergency Response System MSL-2013MA-12N, identified each community has an internal emergency response system with an

immediate goal of optimal resident safety and access to community personnel. Response Time expectations will be determined by each community based on the resident population and average response time but should not exceed 7-10 minutes.

Plan of Correction to Violation #3:

MAPLEWOOD
AT DANBURY

Rec'd 4/8/24
Reviewed + Accepted 4/10/24 + Taskey SWC

April 8, 2024

By Email to Elizabeth.Heiney@ct.gov

Ms. Elizabeth Heiney
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: Maplewood at Danbury ALSA, LLC/Maplewood at Danbury, LLC
Connecticut Department of Public Health Complaint No. 37496
Plan of Correction

Dear Ms. Heiney:

This letter is in response to your letter dated March 28, 2024 (sometimes, the "Violation Letter") regarding Maplewood at Danbury ALSA, LLC (the "ALSA"), the licensed provider of assisted living services at Maplewood at Danbury, an assisted living community (the "Community") operated by Maplewood at Danbury, LLC (the "Operator"), located in Danbury, Connecticut, a copy of which letter is enclosed. This letter does not constitute an admission that the law has been violated as alleged in your letter, that the facts as alleged in your letter are true, or of any other wrongdoing. Rather, this letter is set forth as a comprehensive Plan of Correction for the following alleged violations of the Regulations of Connecticut State Agencies and/or the General Statutes of the State of Connecticut which were noted during an unannounced visit by a representative of the Facility Licensing and Investigations Section of the Department of Public Health on February 6, 2024.

1. Violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living service agency (4)(A) and/or (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (1)(E)(3) and/or (j) Assisted Living Service agency staffing requirements (1)(10).

A. Measures to Prevent Re-Occurrence:

1. The Regional Director of Resident Services will educate (i.e. in-service) the Supervisor of Assisted Living Services Agency (the "SALSA"), the RN Designee ("RND"), the Memory Care Director ("MCD"), the Assisted Living Director ("ALD"), and the Executive Director ("ED") at the Community on the updated Resident Service Plan, and Resident Safety Checks policies, procedures, and expectations.

2. The SALSA, RND, MCD, ALD, and/or ED will educate all ASLA aides and nursing staff at the Community on the policies and procedures, and will have the aides and nursing staff confirm in writing that the updated policies and procedures were reviewed and understood by them. Such written confirmation shall be placed in each applicable employee's file.

3. The SALSA, RND, MCD, ALD, and/or ED will educate all ASLA aides and nursing staff at the Community to ensure that any handwritten documentation, including staff initials, is legible, and the person documenting can be easily identified on the care log.

B. Date of Corrective Action Plan ("CAP"):

All corrective action as indicated above will be completed by April 19, 2024, except for on-going monitoring.

C. Plan to Monitor/Audit:

1. The SALSA, RND, MCD and ALD, will review daily or during next day at work residents' care logs to confirm that all scheduled safety checks, and all other care services are documented as having been performed in accordance with residents' service plans. The SALSA, RND, MCD and ALD shall review, and address in real -time with the responsible staff member, any missing or incomplete documentation in the care logs, therefore ensuring all services are provided according to the service plan.

2. At least once per month for a period of three (3) months, the Regional Director of Resident Services or the Regional Director of Operations will audit 10% of resident charts to confirm that care logs are being appropriately completed.

3. The monitoring of care logs will be added to the quarterly quality assurance ("QA") review, and the process and results will be audited every quarter for one (1) year following the completion of the POC.

Section 19-13-D105(j)(10) states that:

> The supervisor of assisted living services shall be responsible for ensuring that sufficient numbers of assisted living aides are available to meet the needs of clients at all times based on the clients' service programs.

The paragraph beginning at the bottom of page 5, and continuing onto the top of page 6, of the Violation Letter, states that:

The agency failed to ensure the assigned aide staff had agency client's added to their assignments for the 1/8/24 3p-11p shift, and 1/9/24 11p-7a shirt, and filed to identify adequate aide staffing was scheduled on 1/8/24 3:00pm to 11:00pm, and on 1/9/24 for the 11p-7a shift, for the assurance of care, and safety checks per Client #5 service plan, and failed to ensure agency oversight and supervision of nursing and aide staff in the delivery of client care, services and safety per the client service plan, and the agency policy.

According to the aide's schedules, Carestream and the aides' task logs, Client #5 was designated by the RN as Assignment 4, which was assigned to (a) Tahmia E on 01/08/2024 for the 3:00 p.m. to 11:00 p.m. shift; in fact, Tahmia E punched-in at 2:56 p.m. and punched-out at 11:06 p.m.; and (b) Jossilyn (Josselin) M on 01/08/2024 -01/09/2024 for the 11:00 p.m. to 4:00 a.m. shift (i.e. the overnight shift); in fact, Josselin punched-in at 11:00 p.m. and punched-out at 4:01 a.m.

The second full paragraph on page 5 of the Violation Letter states that:

> Interview with LPN # 3 on 2/7/24 at 2:45pm, identified she was the on-duty LPN for the 11:00pm to 7:00am shift on 1/9/24, and at no time did she perform any care, services, or safety checks on Client #5. LPN #3 further identified, when the staff member/covering aide staff left at the end of her shift at 4:00am, she was the only nursing staff in the facility from 4:00am to 7:00am on 1/9/24.

However, there were two (2) aides in the Currents neighborhood on 01/08/2024 – 01/09/2024 for the 11:00 p.m. to 7:00 a.m. overnight shift who would float to the third (3rd) floor when needed: (a) Clara S, who punched-in on 01/08/2024 at 11:09 p.m., and punched-out on 01/09/2024 at 7:24 a.m., and (b) Jodie C, who punched-in on 01/08/2024 at 11:07 p.m., and punched-out on 01/09/2024 at 7:24 a.m. In addition, another aide, Nelsi U, was assigned to work in the Vistas and Tides neighborhoods on 01/09/2024 from 6:00 a.m. to 11:00 a.m.; in fact, Nelsi punched-in at 6:02 a.m. and punched-out at 11:00 a.m.

In short, at no time during the 11:00 p.m. – 7:00 a.m. overnight shift on 01/08/2024 – 01/09/2024 was LPN #3 the only nursing staff in the facility.

2. **Violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (k) Client service record (2)(L)(5).**

A. Measures to Prevent Re-Occurrence:

1. The Regional Director of Resident Services will educate (i.e. in-service) the Supervisor of Assisted Living Services Agency (the "SALSA"), the RN Designee ("RND"), the Memory Care Director ("MCD"), the Assisted Living Director ("ALD"), and the Executive Director ("ED") at the Community on the updated Resident Care Logs policy, and expectations.

2. The SALSA, RND, MCD, ALD, and/or ED will educate all ASLA aides and nursing staff at the Community on the policy and procedure, and will have the aides and nursing staff confirm in writing that the updated policies and procedures were reviewed and understood by them. Such written confirmation shall be placed in each applicable employee's file.

B. Date of Corrective Action Plan ("CAP"):

All corrective action as indicated above will be completed by April 19, 2024, except for on-going monitoring.

C. Plan to Monitor/Audit:

1. The SALSA, RND, MCD and ALD, will review daily or during next day at work residents' care logs to confirm that all scheduled safety checks, and all other care services are documented as having been performed in accordance with residents' service plans. The SALSA, RND, MCD and ALD shall review, and address in real -time with the responsible staff member, any missing or incomplete documentation in the care logs, therefore ensuring all services are provided according to the service plan.

2. At least once per month for a period of three (3) months, the Regional Director of Resident Services or the Regional Director of Operations will audit 10% of resident charts to confirm that care logs are being appropriately completed.

3. The monitoring of care logs will be added to the quarterly quality assurance ("QA") review, and the process and results will be audited every quarter for one (1) year following the completion of the POC.

3. Violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (c) Managed Residential Communities serviced by an Assisted Living Service Agencies (1)(H) and/or (4)(B).

A. Measures to Prevent Re-Occurrence:

1. The Regional Resident Services Director will in-service (i.e. educate) the ED, SALSA, RND, MCD, and ALD at the Community regarding Maplewood Senior Living's updated Emergency Response System Policy (the "ERS Policy"), which requires staff at the Community to respond to pendant calls within twelve (12) minutes.

2. The Service Coordinator, SALSA, and RN Designee at the Community will in-service the RSAs/CNAs, LPNs, Currents Program Director, and Assisted

Living Director regarding the Emergency Response System Policy. The in-service will set forth the twelve (12) or fewer minutes response expectation, as well as the order of response. The order of response designates the CNA assigned to the resident who pressed the pendant as first response. If the assigned CNA is not able to respond to the pendant call, the assigned CNA will use the walkie talkie system to request immediate support from another CNA. If no other CNA can respond, the LPNs, or any available Department Head listed above, will respond to the pendant call.

B. Date of Corrective Action Plan ("CAP"):

The corrective action as described above will be completed by April 19, 2024, except for on-going monitoring described in paragraph C below.

C. Plan to Monitor/Audit:

1. Each day while at work, the ED and/or SALSA will print and review the Daily Pendant Alert Report ("Daily Report") from the previous day(s). Any responses to pendant calls greater than twelve (12) minutes will be reviewed with the Department Heads set forth above, who will follow up with the staff assigned to the resident and investigate why there was a delay in responding to that resident's pendant call.

2. The ED and/or SALSA shall promptly coach and, where appropriate, discipline staff who failed to respond to a pendant call within twelve (12) minutes for which the staff failed to provide a satisfactory explanation.

3. The result of the investigation and follow up with staff for responses greater than twelve (12) minutes will be documented and kept for sixty (60) days for review by the Regional Director of Operations ("RDO") or the Regional Resident Service Director ("RRSD").

4. In an effort to ensure sustained compliance, at least once each month for the following four (4) months, the RDO or RRSD will randomly audit six (6) Daily Reports in order to evaluate improvement of pendant call responses at the Community, including investigations/follow ups for responses greater than twelve (12) minutes.

D. Staff Member Responsible for Monitoring the Plan of Correction:

The staff member responsible for ensuring the Community's compliance with this Plan of Correction will be the Supervisor of Assisted Living Services.

Please note that we are hereby requesting an office conference to dispute the violations set forth in #2 (relating to staffing) above.

Should you have any questions, please contact me by email at southportrsd.com or by phone at (203) 919-8799.

Respectfully submitted by,

Elizabeth Masi, RN
Supervisor of Assisted Living Services Agency
Maplewood at Danbury ALSA, LLC

CP:an
cc: Shane Herlet (by email)
Arthur E. Miller (by email)
James Doyle (by email)
Constantin Popescu (by email)
Jerrica Clements (by email)
Liz Castiline-Gannon
Eileen Duggan (by email)
Diana Lopes (by email)