STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

January 30, 2024

Accepted
2/7/24
ETatum SNC

Elizabeth Glennon, Administrator
Maplewood At Orange
245 Indian River Road
Orange, CT 06477
Via email: orangeed@maplewoodsl.com

Dear Elizabeth:

Unannounced visits were made to Maplewood At Orange on August 8, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through August 10, 2022.

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 visits. 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 February 9, 2024 within 10 days. Please include your agency Plan of Corrections along with the "original Violation Letter" and return within 10 days.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to

ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by **February 9, 2024** 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 via email 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.

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

Respectfully,

Elizabeth T. Heiney SNC

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

ETH:mdf

c. VL
Complaint #32647

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 Assisted living services agency (ALSA) (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing services provided by an assisted living services agency (3)(C)(D)

1. Based on client record review, interviews with the staff, and review of agency policies, for one of three clients (Client # 1), who received assisted living agency services, the Supervisor of Assisted Living Services (SALSA) failed to ensure supervisory oversight of nursing services rendered to the client by direct service staff and failed to ensure assessment and delivery of nursing services to an agency client with a wound.

    a. Client #1 moved into the assisted living facility on 3/11/22 with the diagnoses of dementia with behavior disturbance, delirium due to unknown physiological condition, alcohol abuse, non-rheumatic aortic insufficiency, non-traumatic subarachnoid hemorrhage, repeated falls, and thrombosis, unspecified of vein.

    Review of the initial client service program dated 3/21/22 indicated that Client #1 required 24-hour supervision by (2) 12-hour private duty care givers (PDA) for safety and assistance with dressing, showers transfers, meals, assistance with toileting and/or incontinence care and medication administration was provided by the assisted living agency licensed staff.

    Interview and review of the client's clinical documentation with the Supervisor of the Assisted Living Services (SALSA) on 8/8/22, identified a wound was reported to LPN #1 by one of client #1's private duty caregivers in the am of 6/30/2022. The LPN on duty attempted to observe the wound, but was not able to perform the observation, due to client's increased agitation with staff contact. On 7/7/2022 the wound was reported to the SALSA and assessed by the client's primary physician, and Home Health - Skilled nursing services were ordered for wound care. The agency staff failed to identify communication by the nursing staff and private duty caregiver for a change in condition and failed to identify the completion of a registered nurse assessment per agency policy.

    The Home Health start of care visit was conducted on 7/7/22 by a registered nurse, with the recommendation that Client #1 be transferred to the hospital for assessment and treatment by a wound center. The Home Health wound care admission was deferred, and Client #1 was transferred to Hospital # 1 on 7/7/2022 for evaluation of an infected wound.

    Interview with LPN #1 on 8/9/22 at 1:00pn identified that during shift-to-shift report with the oncoming 3p-11p LPN (LPN#2), Client # 1 's wound was discussed, and LPN #2 was to look at it after Client #1 went to bed. Review of client's clinical notes and interview with LPN #1 failed to identify any clinical documentation was completed regarding the wound, or any communication was initiated with the SALSA, or RN

designee.

Interview with LPN #2 on 8/9/22 at 1:30pm failed to identify a discussion occurred between LPN #1 an LPN #2 at shift change, regarding Client # 1 needing a skin check for a wound after he/she fell asleep, and failed to identify communication by LPN # 2 to the SALSA or RN Designee, regarding the Private Duty aide finding a wound on Client # 1, and the need for a RN assessment, as it related to a change in condition.

Review of the agency change in Condition policy identified a change in condition can occur anytime a resident demonstrates a change in his/her level of care, either an improved level of care or a decreased level of care. A nurse will make the judgement as to what is considered a change in condition, versus no change in condition. If a change in condition occurs that needs emergency medical services, then the nurse on duty enlists the services of 911 for transport to a medical facility. If the nurse determines there is a change in condition without a medical emergency, then a client assessment will be completed by a registered nurse within 24hrs., along with the completion of a service plan.

Review of the agency policy on Private Duty Aides identified that in an emergency or a safety issue or change in client condition, the PDA must notify the Residence Services Director or Designee if there is a significant change in the client's condition.

Plan of Correction for Violation #1

MAPLEWOOD
AT ORANGE

February 8, 2024

By Email to Elizabeth.Heiney@ct.gov

Accepted
2/7/24
ETHeiney SNC

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 Orange ALSA, LLC/Maplewood at Orange, LLC
Connecticut Department of Public Health Complaint No. 35610 – Plan of Correction

Dear Ms. Heiney:

This letter is in response to your letter dated January 30, 2024 regarding Maplewood at Orange ALSA, LLC (the "ALSA"), the licensed provider of assisted living services at Maplewood at Orange, an assisted living community (the "Community") operated by Maplewood at Orange, LLC (the "Operator"), located in Orange, Connecticut, a copy of which letter is enclosed. This letter does not constitute an admission that the law has been violated as alleged in the letter, that the facts as alleged in the 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 Heath on August 8, 2022.

1. Violations of the Regulations of Connecticut State Agencies Section D19-13-D105 Assisted living services agency (ALSA) (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing services provided by an assisted living services agency (3)(C)(D).

A. Measures to Prevent Re-Occurrence:

1. Regional RN to provide Change of Condition Policy in-service to the SALSA and RN Designee at the community: Policy requires assessment of, and customized Service Plan for, resident with each change of condition, including skilled disciplines, as needed, and documenting such interventions on the Service Plan and Memo of Understanding.
2. By 07/14/2022, the SALSA and/or RN Designee educated/in-serviced all nursing staff employed at the Community at that time regarding identifying and reporting to the RN any changes in resident's condition,

such as physical and mental changes, changes or decline in physical function, changes in skin integrity, or complaints of pain.

3. The Community Department Heads, including the SALSA, Service Coordinator, RN Designee, Currents Program Director/LCSW, Culinary Service Director and Programming, will continue to have bi-weekly acuity/tracking meetings to determine resident appropriateness for retention, overall safety of residents, as well as facilitate the exchange of critical information needed to identify and safely manage resident's changes of condition.

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

The corrective action as described above will be completed by March 1, 2024.

C. Plan to Monitor/Audit:

1. Change of condition tracking process was implemented to identify and address efficiently and effectively all changes of condition identified by RNs in the Community with a goal of achieving compliance within a six (6) month timeframe as described below:

- A print-out of the daily progress notes will be generated by the overnight shift nurse and placed in the SALSA/RN Designee box for review and further evaluations by the RNs.
- The SALSA and/or RN Designee will review and initial the Progress Notes report daily and determine all appropriate interventions to address if and when a change of condition has occurred. The SALSA and/or RN Designee will maintain a record of the reviewed and initialed Progress Notes report for thirty (30) days after being reviewed.
- The Service Plan will be updated by an RN with appropriate interventions related to changes of condition identified by the SALSA and/or RN Designee and the changes will be communicated via task logs to the staff.

2. In an effort to ensure sustained compliance, at least once each calendar month the Regional RN will randomly audit six (6) residents' records, including, but not limited to, the Progress Notes entered in the last thirty (30) days, in order to ascertain whether any changes of condition that occurred during such time period with respect to said residents were appropriately addressed. At the time of each audit the Regional RN will ensure that the change of condition has been identified and appropriate interventions are documented on the Service Plan.

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.

Should you have any questions, please contact me at (203) 795-3117 or by email at orangersd@maplewoodsl.com.

Respectfully submitted by,

Jerrica Clements, RN
Supervisor of Assisted Living Services Agency
Maplewood at Orange ALSA, LLC

CP:aa
cc: Shane Herlet (by email)
Arthur E. Miller (by email)
James Doyle (by email)
Constantin Popescu (by email)
Cristina Deguzman (by email)
Eileen Duggan (by email)
Larry Zackery (by email)