STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

July 17, 2023

Accepted
8/1/23
eTullery

Jennifer Cruz, Executive Director
Maplewood At Strawberry Hill
73 Strawberry Hill
Norwalk, CT 06855
Via e-mail: Strawberryhilled@maplewoodsl.com

Dear Ms. Cruz:

An unannounced visit was made to Maplewood At Strawberry Hill on May 24, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is a 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 July 27, 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.

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 July 27, 2023 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail. 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 #34440

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d)(4)(A) Governing Authority and/or (g)(2)(B)(D) Supervision of the Assisted Living Aides and Policies Concerning Nursing Services.

1. Based on clinical record review, interview with facility personnel, review of agency policies, and review of agency documentation, for a client that resides in a memory impaired unit, the Assisted Living Services agency (ALSA) failed to provide direct clinical supervision of a Licensed Practical nurses (LPN) in the documentation of medications administered and failed to follow the agency's medication administration policy. The findings include.
    a. Client #1 had a move in date to the memory impaired residence on 8/31/22, the admitting diagnoses included dementia, hyperlipidemia, and iron deficiency anemia. The Client Service Program identified that Client #1 received assistance with bathing, continence, hygiene, grooming, and medication administration.

       Interview and review of the agency documentation with the Supervisor of Assisted Living (SALSA) on 5/24/23 at 9:45am identified that Client #1 was admitted to a Hospice Agency #1 on 3/14/23. The Hospice plan of care indicated that Client #1 could receive 0.25ml orally every 3 hours as needed (PRN) for moderate to severe pain.

       Interview and review of agency documentation with the SALSA on 5/24/23 identified on 3/16/23, LPN #1 was the nurse on duty for the 11-7 am shift. At approximately 5:20am. LPN #1 administered Morphine Oral Solution 0.25ml as a standing order, instead of as needed every 3-hour PRN order. The ordered as needed frequency would prompt a need-based observation to evaluate pain or discomfort. LPN #1 failed to conduct a needs observation nor determination. LPN #1 falsely documented Morphine Oral Solution 0.25 ml on 3/16/23 at 12am and again at 3am. LPN #1 acknowledged signing off on the medication at 12am and 3am but reported she/he did not administer the medication at 12am nor at 3am. The LPN #1 failed to adhere to the agency medication policy regarding the documentation of medication management.

       Review of the agency-controlled substance medication policy MSL-2013ct-12AK,identified nursing staff members will follow the 7 rights for medication management per agency policy and will follow all step as outlined in the practice section, and if necessary nurses have the option of requesting assistance from a second nurse.

       Plan of Correction to Violation #1:

MAPLEWOOD
senior living

July 25, 2023

Accepted
8/17/23
CT Heiney

By Email to ElizabethHeiney @ct.gov

Elizabeth T. Heiney, BS, RN, B.C.
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 Strawberry Hill ALSA, LLC/Maplewood at Strawberry Hill, LLC

Dear Ms. Heiney:

This letter is in response to your letter dated July 17, 2023 regarding Maplewood at Strawberry Hill ALSA, LLC (the "ALSA" or the "Agency"), the licensed provider of assisted living services at Maplewood at Strawberry Hill, an assisted living community (the "Community") operated by Maplewood at Strawberry Hill, LLC (the "Operator"), located at 73 Strawberry Hill Avenue, Norwalk, Connecticut.

This letter does not constitute any admission as to any of the alleged violations set forth in your July 17, 2023 letter. It is being filed as required by applicable law and as evidence of the Community's continued commitment to quality care. Notwithstanding the foregoing, this Plan of Correction is submitted to address the following alleged violations identified during the unannounced visit to the Community by a representative of the State of Connecticut Department of Public Health Facility Licensing and Investigations Section on May 24 ,2023.

1. Violation of the Regulations of Connecticut State Agencies Section 19-13-D105(d)(4)(A) Governing Authority and/or (g)(2)(B)(D) Supervision of the Assisted Living Aides and Policies Concerning Nursing Services

   A. Measures to Prevent Re-Occurrence:

      1. The Supervisor of Assisted Living Services Agency ("SALSA") and/or the RN Designee ("RND") will re-educate (i.e. in-service) all LPNs on Maplewood Senior Living's Medication Management: Medical Administration and Medication Errors Policy, MSL-2013CT-12AL (the "Medication Administration/Errors Policy"), and will have all such nursing

personnel confirm in writing that they have reviewed, and understand, the Medication Administration/Errors Policy. Such written confirmation shall be placed in each applicable employee's file.

2. The SALSA and/or RND will re-educate (i.e. in-service) all LPNs on Maplewood Senior Living's Controlled Substances as Defined by the United State Federal Government (DEA): the Storage, Counting, Destruction and Disposal of the Controlled Substances Policy, MSL-2013CT-12J (the "Controlled Substances Policy"), and will have all such nursing personnel confirm in writing that they have reviewed, and understand, the Controlled Substance Policy. Such written confirmation shall be placed in each applicable employee's file.

3. The SALSA will conduct direct clinical supervision of Licensed Practical nurses ("LPNs") in the administration of medications and the documentation of the medications administered. The clinical supervision will be performed at least once per week for the next three (3) months. Each LPN on staff will receive direct supervision by the SALSA in the administration of medications, and the documentation of the medications administered, at least once per month for the next (3) months.

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

All corrective action as indicated above will be completed by August 15, 2023, except for on-going supervision and monitoring.

C. Plan to Monitor/Audit:

1. The Executive Director will monitor for timely completion of all in-services by no later than August 15, 2023.

2. The Regional Director of Nursing will audit the Plan of Correction binder at least once per month for the next three (3) months to confirm that the SALSA has directly supervised the administration of medications, and the documentation of the medications administered, by staff LPNs in accordance with this Plan of Correction.

3. The Regional Director of Nursing will audit no less than once per month at least ten percent (10%) of residents' charts to verify that the medication administration documentation matches medical providers' orders. The audit will continue for a period of three (3) months.

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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 Agency of the Community.

Should you have any questions, please contact me at strawberryrsd@maplewoodsl.com or (203) 429-0511.

Respectfully submitted by,

Sonja Newland, RN
Supervisor of Assisted Living Services Agency
Maplewood at Strawberry Hill ALSA, LLC

CP:an
cc: Shane Herlet (by email)
David Cahill (by email)
Arthur E. Miller (by email)
Constantin Popescu (by email)
Cristina Deguzman (by email)
Eileen Duggan (by email)
Jennifer Cruz (by email)