STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

February 26, 2025

Shanique Mightly, Executive Director
BAL Rocky Hill/The Atrium at Rocky Hill
1160 Elm Street
Rocky Hill, CT 06067
Via E-mail: smightly@benchmarkquality.com

Accepted
4/7-7-25
E Tetreau

Dear Shanique Mightly:

An unannounced visit was made to Bal Rocky Hill on February 13, 2025, by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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 March 8, 2025.

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 **March 8, 2025** 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.

Respectfully,

Elizabeth T. Heiney SNC

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

ETH:ba

c. VL
Complaint # 42993

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (h) Nursing Services provided by an assisted living service agency (3) (C).

1. Based on review of clinical records, agency documentation, interviews with agency personnel and agency policies for one of three clients (Client #1) in the survey sample who received assisted living services, the agency's nursing personnel failed to identify a change in a client's condition timely. The findings include:

   a. Client #1 was admitted to the secured memory care Assisted Living Services Agency (ALSA) on 12/15/2020 with diagnoses of dementia, heart failure, pulmonary embolism and a cardiovascular accident. The Client's 120-day nursing assessment and service plan dated 11/01/2024, identified Client #1 required nursing assessments, medication administration by a nurse and assistance from ALSA aides for bathing, dressing, grooming, incontinence care, toileting, mobility, transfers and cutting up food. Additionally, the Client was admitted to hospice services for nursing assessments and symptom management.

   Review of a nursing note dated 01/31/2025 by Licensed Practical Nurse #1 (LPN), identified she was notified by ALSA aide #1 around 7:17 PM of a reddened area with two opened blisters to Client #1 right outer thigh. LPN #1 covered the area with a protective dressing and notified the Client's hospice agency.

   Review of the ALSA's incident report dated 01/31/2025, identified ALSA aide #1 and #2 were performing Client #1's personal care around 7:00 PM and observed a reddened area with blisters to the right outer thigh. LPN #1 indicated observing a long-reddened area with blisters to the Client's right outer thigh. The Client was unable to verbalize the cause of the redness and blisters. LPN #1 applied a protective dressing to the area, notified the RN Designee and the Client's hospice agency. The hospice agency scheduled a nursing visit for Client #1 on 02/01/2025.

   b. Interview with Hospice RN #1 on 02/13/2025 at 11:40 AM identified on 01/31/2025, LPN #1 notified the on-call hospice nurse that Client #1 had a reddened area with blisters to the right outer thigh. The on-call hospice nurse indicated a nurse would assess the Client on 02/01/2025. Prior to the hospice nurse's visit on 02/01/2025, the hospice's Advanced Practice Registered Nurse (APRN) was notified of the Client's reddened area with blisters. The hospice's APRN ordered Client #1 to be transferred to the hospital for an evaluation on the afternoon of 02/01/2025.

   c. Interview and review of Client #1's clinical record with the Supervisor of Assisted Living Services Agency (SALSA) on 02/13/2025 at 12:00 PM, identified the Activities Director

and staff were serving hot chocolate during a scheduled activity for clients on 01/31/2025. The Activities Director and staff directed Client #1's responsible person to hold the cup of hot chocolate for the Client to assist him/her. The Client's responsible person handed the cup of hot chocolate to the Client, resulting in the Client spilling the drink onto his/her right thigh. Additionally, the Client's reddened area was not observed until the evening of 01/31/2025. The SALSA identified the ALSA's licensed personnel failed to identify a change in Client #1's condition, following an accident with an injury within a timely manner, which resulted in a delay in treatment.

Review of the agency's Client Evaluation and Re-Evaluation Process identified a significant change in condition was an acute illness which would result in loss or deterioration in ability to perform daily living activities or a marked and sudden improvement or decline in the client's status.

Review of the agency's Reporting and Investigating Client and Visitor Incidents identified incidents that involved client injury, the client would be assessed, and interventions and appropriate referrals as needed.

Plan of correction for violation #1:

#42993

Accepted 4/2-2'25

ETHelly

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH PLAN OF CORRECTION
THE ATRIUM AT ROCKY HILL
VISIT CONCLUDED: FEBRUARY 13TH, 2025

Regulation/Finding	***Corrective Action Plan***	***Compliance Date***	***Person(s) Responsible***
Alleged violation 1: Section 19-13-D105 Assisted living services agency (ALSA) (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (h) Nursing Services provided by an assisted living service agency (3) (C). • The agency's nursing personnel failed to identify a change in a client's condition timely.	**Please note that the filing of this plan does not constitute any admission as to the alleged deficiencies set forth in the violation letter. This plan of correction is being filed as required by applicable law and as evidence of the community's commitment to quality care.** The community will take the following measures to prevent the recurrence of the alleged violation: a. Associates re-educated on policy ADM 100-03 Reporting and investigating resident and visitor incidents with emphasis on reporting change of condition in a timely manner. b. Associates re-educated on policy RES-100-31 Resident Evaluation and Re-Evaluation Process. c. Community to audit Incident Reports daily for 2 weeks to ensure compliance of Incident Report Policy Community will audit incident reports weekly for 2 weeks then weekly for 4 weeks or until compliance is reached. All findings will be brought to QA committee for the next 6 months or until deemed necessary by committee.	a. 2/3/25 b. 2/24/25 d. 3/15/25	SALSA/Designee