STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

March 4, 2024

Nathalie Murray, SALSA
Whitney Center
200 Leeder Hill Drive
Hamden, CT 06517

Dear Ms. Murray:

An unannounced visit was made to Whitney Center on January 22, 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 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 March 14, 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.

Connecticut Department of Public Health

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Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

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 March 14, 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 BS 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 #37209

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (h) Nursing Services provided by an assisted living service agency (3)(D) and/or (k) Client service record (H)(K).

1. Based on clinical record reviews, interviews with agency personnel and agency policies for one of three clients in the survey sample (Client #1) who depended on the Assisted Living Services Agency (ALSA) for assistance with activities of daily living, medication management and nursing assessments. The Assisted Living Services Agency (ALSA) failed to ensure coordination of services with a client's responsible person involved in the service program, and failed to ensure a client's service program was explained to, reviewed with, and agreed upon by the client's responsible person. The findings included:

    a. Client #1 was admitted to the Assisted Living Services Agency (ALSA) on 06/19/2023 with diagnosis of dementia, high blood pressure and cardiac disease. The Client initial nursing assessment and service plan were dated 06/19/2023. The service plan identified the Client required nursing assessments and medication administration by a nurse and assistance from ALSA aides for grooming, bathing, dressing, and ambulation with a walker. Client #1 was at risk for falls and required hourly safety checks by the ALSA aides.

        i. Interview and review of Client #1's clinical record with the Supervisor of Assisted Living Services Agency (SALSA) on 1/22/2024 at 10:00 AM, identified on 01/04/2024 the Client's responsible person requested a copy of Client #1's service plan. The SALSA failed to identify the service plan was sent to Client #1's responsible person in June of 2023 for review and a signature but identified the subsequent service plan dated 06/19/2023 was sent to the responsible person in January 2024 for review and a signature.

        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 (i) Assisted living aide services provided by an assisted living services agency (5)(B) and/or (k) Client service record (L) and/or Client's bill of rights and responsibilities (m)(5).

2. Based on clinical record reviews, interviews with agency personnel and agency policies for one of three clients in the survey sample (Client #1, #2 and #3) who depended on the Assisted Living Services Agency (ALSA) for assistance with activities of daily living, medication management and nursing assessments. The Assisted Living Services Agency (ALSA) failed to maintain complete client records to reflect the care provided, failed to ensure clients' safety, and failed to ensure a client's (Client) rights were maintained. The findings included:

    a. Client #1 was admitted to the Assisted Living Services Agency (ALSA) on 06/19/2023 with diagnosis of dementia, high blood pressure and cardiac disease. The Client initial nursing assessment and service plan were dated 06/19/2023. The service plan identified the Client

required nursing assessments and medication administration by a nurse and assistance from ALSA aides for grooming, bathing, dressing, and ambulation with a walker. Client #1 was at risk for falls and required hourly safety checks by the ALSA aides.

b. Client #2 was admitted to the ALSA on 10/31/2022 with diagnosis of vascular dementia, pain, weakness, and a history of falls. The Client's 120-day nursing assessment and service plan dated 10/27/2023, identified the Client required nursing assessments and medication administration by a nurse and assistance from ALSA aides for grooming, bathing, dressing, and ambulation with a walker for short distances and wheelchair mobility for long distances. Client #1 was at risk for falls and required hourly safety checks by the ALSA aides.

c. Client #3 was admitted to the ALSA on 10/31/2022 with diagnosis of type II diabetes, dementia, anxiety, and a history of falls. The Client's 120-day nursing assessment and service plan dated 09/11/2023, identified the Client required nursing assessments and medication administration by a nurse and assistance from ALSA aides for grooming, bathing, dressing, transfers, and wheelchair mobility. Client #1 was at risk for falls and required hourly safety checks by the ALSA aides.

Review of Client #1's clinical record and an ALSA investigation dated 01/05/2024, identified on 01/04/2024 Client #1's responsible person reported an allegation of verbal abuse toward the Client which occurred on 01/02/2024 to the Supervisor of Assisted Living Services Agency (SALSA). The Client's responsible person identified observing ALSA aide #1 via an in-room camera monitor verbally abuse Client #1. Based on the agency's investigation, ALSA aide #1 was terminated on 01/05/2024.

i. Interview with Person #1 on 01/22/2024 at 08:45 AM, identified Client #1 had an in-room camera monitor. Person #1 identified on 01/02/2024, observing ALSA aide #1 verbally abuse the Client will providing personal care. Person #1 identified through intermittent observations of the monitor during the 3:00 PM to 11:00 PM shift on 01/05/2024 and 01/06/2024, Client #1 failed to receive personal care. Additionally, Person #1 indicated through intermittent observations of Patient #1's in-room camera monitor during the 11:00 PM to 07:00 AM shift, identify hourly safety checks were not consistently performed by the ALSA aides.

ii. Interview and review of Client #1, #2 and #3's hourly safety check logs from October, November, December of 2023, and January of 2024 with the SALSA on 01/22/2024 at 11:00 AM, identified the agency failed to ensure the ALSA aides consistently performed hourly safety checks on each shift for Client #1, #2 and #3 and failed to ensure the Client's rights were maintained by remaining free from verbal abuse and care needs were meet.

Plan of Correction to Violation #2: