STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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Commissioner

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Healthcare Quality and Safety Branch

January 26, 2023

Lucille Bowen, SALSA
Saybrook At Haddam
1556 Saybrook Road, Route 154
Haddam, CT 06438
Via E-mail: LBowen@thesaybrookathaddam.com

Dear Ms. Bowen:

An unannounced visit was made to Saybrook At Haddam on January 9, 2023 by a representative 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 January 10, 2023.

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 to the Department by February 5, 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.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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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 February 5, 2023 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# 33558

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirements for an assisted living services agency (1) and/or (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living service agency (3)(C)(D)(G) and/or (m) Client's bill of rights and responsibilities (3) and/or Sensate Bill No.1030 Public Act No 21-185 Sec. 8 (1) (2).

1. Based on review of clinical records, agency documentation, staff interviews and agency policies for one of three Clients (Client #1) in the survey sample with a change in condition, the Assisted Living Service Agency (ALSA) failed to ensure Client safety, failed to identify a change in condition timely, failed to update the Client's assessment and service plan to reflect a change in condition and failed to maintain the Client's bill of rights. The finding includes:

    a. Client #1 was admitted to the ASLA on 09/26/2022 and resided on the memory care unit with diagnosis of dementia with behavioral disturbances, seizure disorder, high blood pressure and asthma. The Client received nursing services for assessments, medication management and ALSA aide assistance with dressing, grooming, and bathing.

    Interview and review of Client #1's clinical record with the Memory Care Director on 01/09/2023 at 11:40 AM, identified the agency would recommend delaying visitations for several days or a week to provide an adjustment period to Clients new to the memory care unit. The Memory Care Director indicated prior to Client #1's admission to the agency on 09/26/2022, Person #1 agreed to delay visitations as visits could cause behaviors in Client #1. Person #1 visited the Client on 09/30/2022 and 10/02/2022. The Memory Care Director and Supervisor of Assisted Living Services Agency (SALSA) identified after Person #1's visits on 09/30/2022 and 10/02/2022, the Client would require a longer adjustment period of an estimated two weeks without visitations. On 09/30/2022 the Client had behaviors overnight which included pounding on windows, throwing dining room chairs and shouting profanities in the hallway. On 10/03/2022 during the 7:00 AM to 3:00 PM shift, the Client was shouting profanities, threatened physical harm toward staff and threw a chair. During the duration of the episode on 10/03/2022, the visiting Registered Nurse (RN) attempted to admit the Client for nursing services but recommended sending Client #1 to the hospital for an evaluation due to behavioral disturbances and safety. The Client was identified by the Memory Care Director as not chronic and stable, therefore, was sent to the hospital at 4:15 PM on 10/03/2022 and returned to the memory care unit on 10/04/2022. On 10/05/2022, the Client became restless, shouted profanities, had suicidal ideations, exit seeking and threatened physical harm toward staff. On 10/12/2022 at 7:30 PM, the Client proceeded to knock over five chairs in the dining room breaking two of the chairs, the SALSA, identified that the Client was at risk for harm to self and other clients residing on the unit. The Memory Care Director indicated the Client would request visits from Person #1, but staff would redirect him/her. During the time of 10/03/2022 to 10/17/2022 without visitations, the Client continued to have behaviors. On 10/20/2022, the Client was observed yelling at other Clients and threatened physical harm toward staff. The Client was sent to the hospital for an evaluation and did not return to the ALSA.

Interview and review of Client #1's assessment and service plan dated 09/26/2022 with the SALSA on 01/09/2023 at 12:40 PM, failed to identify the assessment and service plan were updated to reflect the Client's change in condition on 10/03/2022 in accordance with the ALSA's policy for client assessment and service plan.

Review of the ALSA's Clients' Bill of Rights and Disclosure Statement, identified a client in the community had the right to a safe environment, the right to have no fewer rights than any other client of the state and the agency would form a partnership in care with the client's family or personal representative to enhance the time shared with family.

Review of the ALSA's policy for Psychiatric Crisis identified appropriate care would be arranged for a Client in psychiatric crisis. Caregivers would immediately report to the SALSA or nurse on duty any significant change in the Client's affect, personality or behavior. Should a Client show evidence of violence such as throwing objects, assistance would be summoned and 911 would be activated.

Review of the ALSA's policy for Assessments and Services Plans would be updated as frequently as necessary and whenever there is a significant change in the Client's status to meet the Client's current needs.

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 (h) Nursing Services provided by an assisted living service agency (4)(A).

2. Based on review of clinical records, agency documentation, agency's policy, and staff interviews for one of three Clients (Client #1) in the survey sample who received medication management, the Assisted Living Service Agency (ALSA) failed to document. The finding included:

    a. Client #1 was admitted to the ASLA on 09/26/2022 and resided on the memory care unit with diagnosis of dementia with behavioral disturbances, seizure disorder, high blood pressure and asthma. The Client received nursing services for assessments, medication management and ALSA aide assistance with dressing, grooming, and bathing.

Interview and review of Client #1's Advanced Practice Registered Nurse (APRN) order dated 10/05/2022 with the Supervisor of Assisted Living Services Agency (SALSA) on 01/09/2023 at 12:45 PM, identified Seroquel (a psychiatric medication) 25 milligrams

(mg) one tablet by mouth was to be administered every six hours as needed for agitation. Furthermore, a review of the Client's as needed medication administration log identified on three separate occasions Seroquel 25 mg was administered to the Client for agitation, but the nursing staff failed to document the date of the administration.

Plan of Correction to Violation #2:

THE SAYBROOK AT HADDAM SENIOR LIVING

POC accepted 10/30/25

This Plan of Correction is in response to the violation letter dated January 26th, 2023.
We are requesting an office conference to dispute the violations set forth in #1 of the violation letter.

Please note that the filing of this plan of correction does not constitute any admission as to any of the violations set forth in violation #1 of this letter. It is being filed as required by applicable law and as evidence of the facility's commitment to quality care.

The violations allege that the ALSA:

- "… failed to identify the assessment and service plan were updated to reflect the Client's change in condition on 10/03/22 in accordance with the ALSA's policy for client assessment and service plan."
- "Review of the ALSA's Client's Bill of Rights and Disclosure Statement …"
- "Review of the ALSA's policy for Psychiatric Crisis"
- "Review of the ALSA's policy for Assessments and Service Plans"

- Client moved into the Memory Care neighborhood on 09/26/2022. Prior to his move-in, he was formally assessed by the SALSA and Memory Care Director and was determined to be appropriate for ALSA services based on his presentation, verbal reports from the Nurse Case Manager and Social Worker of his discharging facility Middlesex Hospital, and review of written records on his medical course of treatment while hospitalized.
  On 10/03/2022, Client was visited by his Skilled Nurse, who was familiar with him while he lived in the community. Based on his presentation for this visit, the nurse recommended hospital transfer for behavioral evaluation. **The Client did not have an in-patient hospital stay. We conclude that this incident did not meet criteria for a revised assessment as there were no additional changes to his pre-exiting Service Plan which addressed Behaviors as a need. Nursing documentation in the record addressed the hospital transfer and his return.**
  The measures being taken to implement changes that the community intends to make to prevent a recurrence of this DPH determination are as follows:
  1. The RN or Designee will add to the exiting Service Plan the date/time of hospital transfer and note that the incident did/did not require a new assessment or change in the plan of care.
  2. Effective immediately and until the end of the current Quality Assurance period of April 4th, 2023 all hospital transfer records, will be audited by the RN/Designee for compliance with this measure. In event that 100% compliance is not attained, auditing will continue through the end of the next Quality Assurance period.

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POC accepted 10/31/22 ns

- Prior to Client's physical move-in, a formal meeting was held with his daughter the Complainant, the Memory Care Director, Executive Director and SALSA as was documented in his record. During this meeting, the recommendation was made to daughter that she refrain from visiting for a period of up to two weeks, subject to his presentation, to promote adjustment and minimize triggers for behaviors which was previously identified to be partly her relationship with him. Daughter was agreeable to this plan at the time. Despite verbal agreement to the plan, daughter did visit on Friday, 09/30/2022 and stayed for greater than an hour and again on 10/02/2022. Both visits were followed by increased behavioral challenges. On 10/04/2022, the team met with the Complainant as was summarized in the nursing note written on that day. During the meeting the recommendation was made again that she refrain from visiting to which she was verbally agreeable. It was at this time she informed us that she was going to Fl. and requested daily updates. These updates were provided by the SALSA, RN Designee and the Memory Care Director either by phone or emails. On the day of her return, she visited with Client. The above substantiates that at no time was the Complainant refused visitation rights to her father albeit against our recommendation. **We conclude that the client's Bill of Rights were not violated in any way as we were making every possible effort to partner with the Client's family for a successful outcome.**
  The measure to ensure that Residents Rights are maintained will be an all-staff In-Service conducted by the Executive Director no later than February 28, 2023.

- It is the standard of care, and the expectation of families that behavioral interventions are first explored for any behavioral challenges. Should behavioral interventions fail, a psychiatric crisis occurs requiring the activation of 911. As identified in the Client's Service Plan, Behaviors were identified as a need with a goal of maximizing function and an action of a cohesive team approach. Nursing documentation in the Client's record, describes noted behaviors and interventions and the instance when a Psychiatric crisis did occur. The Psychiatric Crisis protocol was followed when the Client was transferred out on his last day in the community. **The ALSA concludes that our Policy on Psychiatric Crisis was followed when warranted.**
  As a measure to refresh and familiarize all care staff with the protocol for a Psychiatric Crisis, an In-Service for Care Associates will be presented by the SALSA no later than February 28th, 2023.

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POC accepted 10/30/25 LAS

- The ALSA conducted an Initial Assessment and Service Plan for Client's move-in. The assessment and Service Plan addressed both Neurocognitive and Behavioral issues with a goal of maximizing function with care. The Client moved into the community on 09/26/2022 and was last provided service care on 10/20/2022 when 911 was activated for a Psychiatric Crisis. The Initial assessment and Service Plan remained in effect as written during this period. ALSA documentation in the resident record indicated all interventions which included, but was not limited to, the referral back to the Psychiatric APRN, PCP, and family. Changes were related to medication management only as identified in Client's MD orders and MAR and not in need of a revised assessment. **The ALSA concludes that there was no significant change in the Client's status, as his needs were being met as initially identified.**

The ALSA proports that this violation is like the one stated above whereby the DPH contends that the Policy for Assessment and Service Plans be updated when there is a significant change. The ALSA will follow steps as stated above i.e the Service Plan will be updated upon hospital transfer. Should the client require a Change in Condition assessment for return to the ALF, said assessment will be conducted for that reason. For any new assessment, a copy of the Updated Service Plan will be forwarded to the client and/or POA for review and acceptance.

Violation #2:

- The APRN had ordered Seroquel 25 milligrams PO every six hours. On three separate occasions, this medication was administered but the nurse failed to document the date of administration.

The ALSA accepts this Violation as written. It was determined after investigation, that the same nurse was the person who administered this medication on all three of these occasions.
This nurse, as of date _11/18/2022_ is no longer employed by the ALSA, based in part on multiple issues identified that required Corrective Action measures.
The measures to ensure full compliance with medication administration documentation shall include:

1. an In-Service for all nurses on correct documentation of Medication administration provided by the SALSA.
2. Effective week of 02/05/2023. weekly checks times 4 weeks of all PRN medication administration records for all Memory Care Residents for full compliance.

Respectfully submitted:

Lucille Bowen, RN SALSA.

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