Elmbrook Village
at Bozrah
An Everbrook Senior Living Community
380 Salem Turnpike • Bozrah, CT 06334

Accepted
9/11/25
E T Heiney SNC

September 11, 2025

Elizabeth Heiney

Supervising Nurse Consultant

Facility Licensing and Investigation Section

410 Capitol Avenue

P.O. Box 340308

Hartford, Connecticut 06134-0308

Dear Ms. Heiney,

Attached is the plan of correction for the violation regarding the visit from the Facility Licensing and Investigation Section of the Department of Public Health on August 15, 2025.

Feel free to contact myself or Kristin Mangual the Executive Director if any other information is needed.

Respectfully,

Alison N. Watrous RN

Alison N. Watrous, RN, SALSA

Elmbrook Village

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Bozrah, CT 06334

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The following is the Plan of Correction for **Elmbrook Village** regarding the Statement of Deficiencies dated **September 9, 2025**. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Unannounced visit was made to **Elmbrook Village** on August 15, 2025 by a representative of the Facility Licensing and Invesitgation Section of the Department of Public Health for the purposes of conducting an investigation. The findings are as follows:
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 Assisted Living Services Agency (d) Governing Authority of an assisted living services agency (4)(A) and/or (g) Supervisor of assisted living services (2)(A) and/or (B) and/or (h) Nursing Services provided by an assisted living service agency (1) and/or (4)(A).

1. Based on clinical record review, review of agency policies, review of agency documentation and staff interviews for three of three clients (Client's #1, 2 & 3) who received assisted living services for assistance with personal care, medication management and safety monitoring, the Assisted Living Services Agency/ALSA nurses failed to administer medications in accordance with physician's orders and agency policies. The findings include:
    A. Client #1 was admitted to the memory care ALSA program on 10/08/22. The admitting diagnoses included dementia, glaucoma, hypertension and heart failure. The client service plan dated 7/10/25 identified the need for assistance with bathing, dressing, grooming, transfers, medication management, hourly safety checks and was at risk for falls. Physician's orders directed to administer Aspirin Enteric Coated 81 milligrams/mg every morning, Furosemide 20 mg every morning, Magnesium Oxide 400 mg every morning, Pantoprazole Delayed Release 40 mg every morning, Poly-Iron 150 mg and Vitamin B-12 1,000 micrograms daily. Interview with the next of kin on 8/15/25 at 11 AM identified a picture taken on 6/22/25 of a medicine cup with 6 pills in it, located on the nightstand of the client's room, containing the dosage of morning medications and on 7/27/25, a picture of Pantoprazole that s/he found on the floor left for the client to self-administer. Interview and review of the next of kin's pictures with the Registered Nurse/RN Designee on 8/15/25 at 1PM failed to identify the LPN followed physician's orders for administration and failed to follow agency policies. Review of agency policy for Medication Administration directed for persons diagnosed with dementia, the client is to be assisted with medication administration by a nurse who will encourage participation in the process, provide water and a comfortable area to take the medications and give the pill or cup to the client and provide support so they swallow the medication or crush the medication and place in applesauce.

b. Client #2 was admitted to the memory care ALSA program on 7/05/23. The admitting diagnoses included dementia, hypertension, macular degeneration and type II diabetes mellitus. The client service plan dated 5/07/25 identified the need for assistance with bathing, dressing, grooming, transfers and medication management. Physician's orders included Potassium Chloride Extended Release 20 milliequivalents twice daily at 8 AM and 7 PM, Olanzapine 10 milligrams/mg nightly at 7 PM and Melatonin 3 mg, take three tablets, 9 mg nightly at 7 PM. Elmbrook Village.

c. Client #3 was admitted to the memory care ALSA program on 6/25/25. The admitting diagnoses included atrial fibrillation, mild cognitive impairment and heart failure. The client service plan dated 6/25/25 identified the need for assistance with bathing, dressing, grooming, hourly safety checks and medication management. Physician's orders included Levothyroxine Sodium 112 micrograms daily at 8 PM. Review of the agency investigation dated 8/05/25 by the RN Designee identified receiving a call from Client #2's next of kin who was visiting the night before, on 8/04/25 at 7 PM, and believes the Agency LPN gave the wrong evening medications to the client who shares the same first name as Client #3, and was able to describe the medication in detail, Levothyroxine Sodium 112 micrograms. Additionally, the Agency LPN administered Client #2's medications to Client #3 which included Potassium Chloride Extended Release 20 milliequivalents at 7 PM, Olanzapine 10 milligrams/mg nightly at 7 PM and Melatonin 3 mg, take three tablets, 9 mg at 7 PM. The physicians and families were notified. Interview and review of the agency investigation with the RN Designee on 8/15/25 at 10 AM identified that the Staffing Agency was notified and requested that the LPN is not returned. The nursing staff failed to follow the five rights of medication administration, per the agency policies, and the agency failed to ensure the safety and rights of the clients. Review of agency policies for Medication Administration directed to inform the client that they are to take their medications and verify the 5-rights especially right dose and right time, reconcile the medication regimen with the medical order

A Corrective Action:

1. Client #1,2,3 re-education to licensed nurses on the five rights of medication distribution and medication distribution policy and procedure were completed.
2. Agency licensed nurses will be educated before starting their shift on the five rights of medication distribution and medication distribution policy and procedure.
3. SALSA/RN Designee will evaluate/monitor medication passes randomly on all shifts for compliance with medication distribution policy and procedure.
4. SALSA/RN Designee will audit medication errors.

B. Completion Date: #1 Completed 8/16/2025
#2 on going
#3 on going
#4 on going

C. Ongoing Quality Assessment and Performance Improvement Process:
1. SALSA will review medication error reports.
2. SALSA will implement review of medication error reports in QA.

D. SALSA will be responsible for the ongoing monitoring of this plan