39914
Accepted
8/10/24
CT Heiney

AddisonPlace
at Glastonbury
Assisted Living & Memory Care

August 13, 2004

Elizabeth Heiney, BS, RN, BC

Supervising Nurse Consultant

Facility Licensing and Investigation Section

410 Capital Avenue – MS# 12FLIS

P.O. Box 340308

Hartford, CT 06134-0308

Elizabeth.Heiney@ct.gov

Re-conducting an investigation

Dear Ms. Heiney, BS, RN, BC

Enclosed please find a Plan of Correction for Addison Place at Glastonbury related to the unannounced visit on July 15, 2024. Please note, Addison Place at Glastonbury, the Managed Residential Community, and the Assisted Living Agency submit this plan of Correction to comply with state regulatory provisions. The preparation and submission of the plan of correction does not constitute an admission of fault or liability on the part of Addison Place at Glastonbury, the Managed Residential Community and or the Assisted Living Services Agency or any agreement regarding the truth or accuracy of the facts alleged or the conclusions drawn.

If you have any questions regarding the enclosed Plan of Correction, please contact me at 860-652 3444.

Sincerely

Marty Sawyer RN, BSN

Resident Care Director

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

Accepted
8/10/24
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August 5, 2024

Sandra Carlmark, Executive Director
Addison Place At Glastonbury
1177 Hebron Avenue
Glastonbury, CT 06033
Via E-mail: scarlmark@hallkeen.com

Dear Ms. Carlmark:

An unannounced visit was made to Addison Place At Glastonbury on July 15, 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 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, along with your original state violation letter, to the Department by August 15, 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

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Public Health

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(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 August 15, 2024 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 #39914

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirement for an Assisted Living Service Agency (1) and/or (g)(2)(B)(E) Supervision of Assisted Living Aides and (i) Assisted Living Service Agency staffing requirement (5)(B) and/or (m)(5) Client Bill of Rights.

1. Based on clinical record review, interview with facility personnel, review of agency policies, review of video surveillance and review of agency documentation, for one of three clients (Client #1) in the survey sample, the Assisted Living Service Agency (ALSA) failed to ensure the quality of care delivery to a client, and failed to ensure supervisory nursing oversight of the aide staff in the delivery of services and care needs to the client, and failed to ensure that the client was treated with respect and dignity as it related to incontinent care management. The findings include.
    a. Client #1 and their spouse had a move in date to the Traditional ALSA on 8/12/21. The admitting diagnoses included dementia, hypertension, and hyperthyroidism. Client #1 moved into the memory care unit on 1/12/23, and then was admitted to hospice on 2/2/24.

       Review of the client's service plan identified staff assist with toileting, dressing and grooming, cueing for ambulation to dining room, and cueing for eating of meals, hourly staff safety checks, safety reminder for fall prevention and use of rolling walker, nursing administration of medications, requires frequent supervision for safety,

       Review of Client #1's clinical record and agency investigative documentation with the Executive Director (ED) and the Supervisor of Assisted Living (SALSA) on 7/15/24 at 10:00am identified that on July 5, 2024, Client #1 was observed by a family member in the memory care dining room, during mealtime, with what appeared to be fecal matter on his/her hands and under their fingernails. Client #1's was escorted back to his/her room by the family member, and upon arrival noted fecal matter on the floor in the bathroom, living area, and bedding, along with a very strong odor of the same.

       Interview and review of the statement given by Aide #1 on 7/7/24, identified she was assigned to Client #1 for her shift. Upon entering client's apartment, client was found unclothed with fecal matter on her lower body and hands and nails, and on the living area and bathroom floor. Client and surrounding areas were cleaned by aide, and then client was taken to breakfast in the dining room. During breakfast client was incontinent a 2nd time, was returned to his/her apartment, cleaned up and then sat down to rest. Aide #1 identified the bed was changed, and the apartment was clean prior to her leaving for her next assignment.

       Interview with ED and SALSA on 7/15/24 10:00am, identified in the interview of ALSA Aide #1, that she had been assigned to shadow another agency aide staff, but had been assigned independently to care for Client #1. Upon entering Client #1's apartment, she found client naked with stool on her body and on the surrounding floor.

ALSA Aide #1 stated that Client #1 was cleaned and brought to the memory care dining room for breakfast. Client #1 was again incontinent of stool while at breakfast, and was brought back to his/her apartment, cleaned, dressed, and returned to the community living area, where he/she met up with his/her spouse, to rest. Aide #1 stated all clothing and bedding had been changed in the apartment before moving on to her next assignment.
Aide staff #1 subsequently voluntarily terminated on 7/8/24.

Interview and review of a second agency complaint investigation with the ED and SALSA on 7/15/24 at 10:45am, identified a verbal complaint with a video surveillance recording from 7/8/24 at 10:55am, that showed Aide #2 ALSA using a technique to move client's legs off bed that caused discomfort to client. Aide #2 was observed on video camera, getting Client #1 up for the day and dragging clients' legs across the bed.

Review of Aide #2's interview regarding the complaint of 7/8/24 with the agency SALSA on 7/15/24 at 10:45am, identified ALSA Aide #2 was assigned to care for Client #1 for am care and was attempting to assist client up for the day. Client #1 was resistant to getting up, so Aide #2 used her arm in a hook motion to scoop up the clients' legs, and pivot client to the edge of the bed, to stand.

Interview with the agency SALSA on 7/15/24 at 10:45 am identified, ALSA Aide #2 was assigned to care for Client #1 for am care. Client #1 was resistant to getting up, so Aide #2 used her arm in a hook motion to scoop up the clients' legs, and pivot client to the edge of the bed, to stand. Per family member this technique of moving the client caused unnecessary pain and discomfort.
SALSA Aide #2 received in-service retraining on the proper technique to transfer Client's safely, to decrease discomfort and pain.

The agency staff failed to ensure the quality of care delivered to the agency client and failed to ensure the supervisory nursing oversight in the Aide care delivery to clients, and failed to ensure the clients were treated with dignity and respect by agency care staff.

Plan of Correction to Violation #1:

AddisonPlace
at Glastonbury
Assisted Living & Memory Care

Accepted 8/16/24 Entering

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D105 E General requirement for an Assisted Living Service Agency (1) and/or (g)(2)(B)(E) Supervision of Assisted Living Aides and (i) Assisted Living Service Agency staffing requirement (5)(B) and/or (m)(5) Client Bill of Rights.

1. Based on clinical record review, interview with facility personnel, review of agency policies, review of video surveillance and review of agency documentation, for one of three clients (Client #1) in the survey sample, the Assisted Living Service Agency (ALSA) failed to ensure the quality of care to a client, and failed to ensure supervisory nursing oversight of the aide staff in the delivery of services and care needs to the client, and failed to ensure that the client was treated with respect and dignity as it related to incontinent care management. The findings include.
    a. Client #1 and their spouse had a move in date to the Traditional ALSA on 8/12/21. The admitting diagnosis included dementia, hypertension, and hyperthyroidism. Client #1 moved into the memory care unit on 1/12/23, and was admitted to hospice on 2/2/24.

Plan of correction to violation #1

Resident Care Director/RN Designee will inservice the memory care aides on infection control, personal hygiene, resident dignity and respect and resident rights. These inservices will be completed in 60 days.

Resident Care Director will inservice the nursing team of RN and LPNs on the implementation of resident rounds for the purpose of identifying care issues early and the tool to be used to document rounds by August 15, 2024. The nursing team will make rounds no less than two times a day. These rounds will be initiated by August 16, 2024. Nursing rounds will be two times a day for 45 days. Nursing rounds will decrease to 20% for 6 months. Nursing rounds will decrease to 10% until next survey.

Effective immediately and ongoing Service Plans include specific needs of resident including incontinent care no less than every 120 days.

Resident rounds will be added to the QA/QI plan and reviewed at each QA meeting no less than three times a year.