# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

January 21, 2020

Sylvia Szarejko, Supervisor of Assisted Living Services Agency
BAL Avon
101 Bickford Extension
Avon, CT 06001

Dear Ms. Szarejko:

Unannounced visits were made to BAL Avon on November 27, 2018 and December 27, 2019 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 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.

An office conference has been scheduled for February 10, 2020 at 12:00 P.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut to discuss those violations. Should you wish to have legal representation, you may have an attorney accompany you to this meeting.

In accordance with Connecticut General Statutes, section 19a-496, Upon a finding of non-compliance 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 non-compliance identified in such notice. 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

DATE(S) OF VISIT: November 27, 2018 and December 27, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction to Loan.Nguyen@ct.gov may be subject to disciplinary action.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

If there are any questions, please do not hesitate to contact this office at (860) 509-8059.

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CT # 26341

DATE(S) OF VISIT: November 27, 2018 and December 27, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (i) Assisted living aide services provided by an assisted living services agency (5) (B) and/or (j) Assisted living services agency staffing requirements (10) and/or (k) Client service record (H) and/or (m) Client's bill of rights and responsibilities (5)

1. Based on surveyor observation, clinical record review, agency documentation and interviews with agency personnel, for two of three clients (Clients #1 and 2) who required assistance from the ALSA staff, the ALSA failed to ensure the assistance was provided in accordance with the agency policies, the client service plan, and failed to ensure consideration of the person's dignity during delivery of care. The findings include:

A. Client #1 was admitted to the ALSA program on 7/11/2019 with diagnoses that included hypothyroidism, hypertension, chronic pain syndrome, dementia, depression and osteoporosis.

Review of the Client Service Plan dated 12/9/19 identified the need for assistance from two persons with mechanical lift transfers, total assistance for showers on Tuesday and Friday, and the need for physical assistance to and from the bathroom.

The Continence Management documentation dated 12/9/19 identified incontinence of bladder and bowel, with the use of disposable briefs twenty-four hours a day.

The Resident Assessment and Re-Assessment form dated 12/9/19 identified occasional incontinence of urine.

i. On 12/27/19 at 11:45 AM the surveyor observed Client # 1 in bed, telling the ALSA Aide (Aide # 1) that the client had to urinate. Aide # 1 replied that Client # 1 should just urinate in the disposable brief. Client # 1 insisted to go to the bathroom, and did not want to urinate in the disposable brief.

Aide #1 continued to argue with the client that the client could not walk, could not stand for a transfer, therefore the client had to urinate in the disposable brief.

During a subsequent interview on 12/27/19, Aide # 1 explained that Client was non-ambulatory, had no weight bearing, required a mechanical lift for transfers, and the lift was not equipped with the appropriate pad for a transfer to the bathroom. Aide # 1 also was not sure that the mechanical lift would fit in the bathroom, and the facility had no bed pan available for the client's use.

Aide # 1 told Client # 1 that Aide # 1 would return in twenty minutes to see if the client voided in the disposable brief.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview with the Supervisor of Assisted Living Services Agency (SALSA) and Registered Nurse (RN) # 1 on 12/27/19 failed to identify the proper response to the Client # 1's needs for elimination in consideration of the client's dignity and self-esteem;

ii. Surveyor observation on 12/27/19 at 12:45PM identified an attempt at transferring the client in accordance with the plan of care, using a mechanical lift and the assistance of two staff members. The mechanical lift fit in the bathroom without a problem, the client tolerated the transfer but once on the toilet, the client was not able to use the toilet because the lift pad had no opening in the back.

At that point Client # 1 verbalized that in the previous facility where the client came from, the staff offered a bed pan each time the client called, and the client was fine with using the bedpan for elimination needs.

Interview with the Supervisor of Assisted Living Services Agency (SALSA) and Registered Nurse (RN) # 1 on 12/27/19 failed to identify accuracy of the Client Service Plan which described incontinence of bladder and bowels, and failed to acknowledge Client # 1's ability to verbalize the need for elimination, with a preference for the bedpan;

iii. Client # 1 was subsequently transferred into the wheelchair via mechanical lift, and the assistance of Aides # 1 and 2.

According to Aide # 2 in an interview on 12/27/19, Client # 1 received bed baths instead of showers.

RN#1 and the SALSA at 3:15 PM indicated that when Client # 1 was first admitted to the ALSA program, the client ambulated with a walker, and received showers twice a week.

Interview and review of the Client Service Plan with RN#1 and the SALSA at 3:15 PM failed to identify accuracy of the service plan which listed the needs for showers Tuesday and Friday, and failed to identify conformance with the plan of care when the aides provided bed baths instead of showers;

iv. Interview and review of Client # 1's Call Records with RN#1 on 12/27/19 at 3:30 PM for the period of 12/1/19 through 12/27/19 identified the following delayed responses to the client's call for assistance:

DATE(S) OF VISIT: November 27, 2018 and December 27, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 12/5/19 at 4:35 PM the response time to the call bell was over 24 minutes

On 12/7/19 at 8:23 PM the response time to the call bell was over 21 minutes

On 12/8/19 at 5:26 AM the response time to the call bell was over 42 minutes

On 12/8/19 at 2:49 PM the response time to the call bell was over 44 minutes

On 12/8/19 at 5:25 PM the response time to the call bell was over 20 minutes

On 12/10/19 at 4:14 PM the response time to the call bell was over 33 minutes

On 12/12/19 at 1:09 PM the response time to the call bell was over 20 minutes

On 12/14/19 at 4:03 PM the response time to the call bell was over 27 minutes

On 12/15/19 at 4:51 PM the response time to the call bell was over 23 minutes

On 12/15/19 at 5:44 PM the response time to the call bell was over 21 minutes

On 12/15/19 at 9:10 PM the response time to the call bell was over 21 minutes

On 12/16/19 at 8:56 PM the response time to the call bell was over 36 minutes

On 12/17/19 at 7:12 PM the response time to the call bell was over 26 minutes

On 12/18/19 at 5:21 PM the response time to the call bell was over 30 minutes

On 12/19/19 at 4:49 PM the response time to the call bell was over 37 minutes

On 12/21/19 at 6:29 PM the response time to the call bell was over 37 minutes

On 12/22/19 at 11:06 AM the response time to the call bell was over 28 minutes

On 12/23/19 at 4:58 PM the response time to the call bell was over 22 minutes.

The ALSA policy on Emergency Response System directed the Executive Director to inquire about responses that took eight to twelve minutes, while "further review and vigorous follow-up" might be appropriate for responses greater than twelve minutes.

Interview and review of the ALSA documentation with the SALSA and RN # 1 on 12/27/19 at 3:15PM failed to identify adherence with the agency policies and procedures firstly when the aides provided delayed responses to the client's call bell, and secondly when the Executive Director failed to follow up on the causes of the delay, in order to develop interventions that would prevent recurrences.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

2. Client #2 was admitted to the ALSA program on 9/1/19 with diagnoses that included abnormality of the red blood cells, hypertension, Parkinson's disease and diabetes mellitus.

   The Client Service Plan dated 9/18/19 identified the need for hands-on assistance with showers every day, physical assistance to and from the bathroom and assistance for all aspects of mobility.

Interview and review of Client # 2's Call Records with RN#1 on 12/27/19 at 3:30 PM for the period of 12/1/19 through 12/27/19 identified the following delayed responses to the client's call for assistance:

On 10/17/19 at 7:35 AM the response time to the call bell was over 34 minutes

On 11/24/19 at 11:19 PM the response time to the call bell was over 42 minutes

On 12/1/19 at 8:06 PM the response time to the call bell was over 42 minutes.

The ALSA policy on Emergency Response System directed the Executive Director to inquire about responses that took eight to twelve minutes, while "further review and vigorous follow-up" might be appropriate for responses greater than twelve minutes.

Interview and review of the ALSA documentation with the SALSA and RN # 1 on 12/27/19 at 3:15PM failed to identify adherence with the agency policies and procedures firstly when the aides provided delayed responses to the client's call bell, and secondly when the Executive Director failed to follow up on the causes of the delay, in order to develop interventions that would prevent recurrences.

The following are violations of the General Statutes of Connecticut Chapter 368v Sec. 19a-562a

2. Based on review of employee files and interview with facility personnel, for two of two Assisted Living Services Agency (ALSA) aides (Aides #4 and #5) who were assigned to service the clients inside the specialized dementia unit, the ALSA failed to provide the aides with the required education on dementia and/or pain recognition. The findings include:

B. Interview with the SALSA and RN#1 on 11/27/18 at 2:00 PM and review of Aide #4's employee file identified a date of hire of 3/29/17 and a current assignment on the dementia unit, however failed to identify the completion of two hours training in pain recognition for the year of 2017.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

B. Interview with the SALSA and RN#1 on 11/27/18 at 2:00 PM and review of Aide #5's personnel file identified a date of hire of 6/4/13 and a current assignment on the dementia unit, however failed to identify the completion of eight hours in dementia- specific training for the year of 2017.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13-D105 (f) Personnel policies for an assisted living services agency (1) (C)

3. Based on review of the employee files and interview with facility personnel, for two of five Assisted Living Services Agency (ALSA) aides (Aides # 3 and #4) the facility failed to complete an annual performance evaluation. The findings include:

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A. Interview with the SALSA and RN#1 on 11/27/18 at 2:00 PM and review of Aide #3's employee file identified a date of hire of 3/17/17, however failed to identify the completion of an annual performance review from March 2017 through November 2018.

B. Interview with the SALSA and RN#1 on 11/27/18 at 2:00 PM and review of Aide #5's employee file identified a date of hire of 6/4/13, however failed to identify the completion of an annual performance review for the years 2016 and 2017.

POC accepted 2-4-2020 Nguyen

**State of Connecticut Department of Public Health Plan of Correction**
**River Ridge of Avon**

**February 3, 2020**

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| **Alleged Violation 1** | ALSA failed to ensure the assistance was provided in accordance with the agency policies, the client service plan, and failed to ensure consideration of the person's dignity during the delivery of care. |
| **Measures to Prevent the Recurrence:** | As for ensuring the assistance was provided in accordance with the agency policies, the client service plan;<br>• Licensed nurses and RCAs will be re-educated on Resident Rights with emphasis on dignity and respect<br>• Licensed nurses and RCAs will be re-educated on resident Bill of Rights.<br>• Re-education on F-100-80 Resident Assessment/Service Plans<br>• Revisit the process of tracking and stand-up meetings to improve communication across disciplines.<br>• SALSA or designated RN to make random rounds and review client service plan with associate assigned to resident(s).<br>As for ensuring consideration of the person's dignity during the delivery of care;<br>• Licensed nurses will be re-educated on Policy F-100a-03 Significant Changes in a Resident Condition<br>• Licensed nurses and RCAs will be re-educated on Resident Rights with emphasis on dignity and respect<br>• Initiated shift-to-shift huddles for improved communication |
| **Date Measures will be effective** | • February 7th, 2020 |
| **Community's plan to** | • Random observational audits will be conducted by designated nursing staff throughout the day to observe for toileting needs, |

POC accepted 2-4-2020 VNguyen

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| **monitor ites quality assessment and improvement functions to ensure the corrective measure of systemic change is sustained** | interaction by associates with residents, assistance with mechanical lifts; for all three shifts for 14 days, monthly for 3 months and quarterly for 3 quarters to assure compliance with resident rights. Immediate changes in resident condition will be reported to the ALSA RN. Random review of 10% of ALSA client service plans weekly and then 10% monthly to ensure accuracy of the resident's current needs.<br>• Audit of shift to shift huddles will be for all three shifts for 14 days, monthly for 3 months, and quarterly for 3 quarters. |
| **Person responsible for monitoring** | • SALSA and/ or Designated RN |
| **Alleged Violation 1. (i)** | Failure to identify the proper response to the client #1 needs or elimination in consideration of the client's dignity and self-esteem. |
| **Measures to Prevent the Recurrence:** | • Licensed nurses and RCAs will be re-educated on Resident Rights with emphasis on dignity and respect with respect to expressed care needs and preferences.<br>• Re-education to all RCAs to bring to the RNs attention if a resident is requesting toileting or other care that deviates from service plan or may be unsafe.<br>• The community audited service plans for those on continence management and who have mechanical lifts and provided bedpans for those who can verbalize the need and service plans were updated accordingly. |
| **Date Measures will be Effective** | • February 7th, 2020 |
| **Community's Plan to monitor its quality assessment and improvement functions to ensure the corrective measure or systemic** | • Random observational audits will be conducted by designated nursing staff throughout the day to observe for toileting needs, interaction by associates with residents, assistance with mechanicals lifts; for all three shifts for 14 days, monthly for 3 months and quarterly for 3 quarters to assure compliance with resident rights. Immediate changes in resident condition will be reported to the ALSA RN. Random review of 10% of ALSA client service plans weekly, and then 10% monthly to ensure accuracy of the resident's current needs.<br>• Audits will be conducted monthly for 3 months and quarterly for 3 quarters to assure compliance |

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| **change is sustained** | • Audits will be reviews at Quality Assurance Meetings |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |
| **Alleged Violation 1. (ii)** | Failed to identify accuracy of client service plan which described incontinence of bladder and bowels and failed to acknowledge client #1 ability to verbalize the need for elimination with preference for the bedpan. |
| **Measures to Prevent the Recurrence:** | Failed to identify accuracy of client service plan which described incontinence of bladder and bowels.<br>• Re-education on F-100-80 Resident Assessment/Service Plans<br>• Licensed nurses will be re-educated on Policy F-100a-03 Significant Changes in a Resident Condition<br>• During assessments for resident's with mechanical lift needs, the RN will include questions as to their preference of toileting and the proper sling is available as needed.<br>• The community audited service plans for those on continence management and who have mechanical lifts and provided bedpans for those who can verbalize the need and service plans were updated accordingly.<br><br>Failed to acknowledge client #1 ability to verbalize the need for elimination with preference for the bedpan.<br>• During assessments for resident's with mechanical lift needs, the RN will include questions as to their preference of toileting and assure the proper sling is obtained and made available as needed.<br>• Client #1 Service Plan reflects to offer toileting via mechanical lift and u-shaped sling. The mechanical lift fits through the bathroom door. If the resident declines, offer a bedpan.<br><br>Re-education on Bedpans usage and sanitation. |

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| | • Re-education on Resident Rights/dignity; emphasis on right to request and use the bathroom and to have a preference |
| **Date Measures will be Effective** | • February 7th, 2020 |
| **Community's Plan to monitor its quality assessment and improvement functions to ensure the corrective measure or systemic change is sustained** | • Random review of 10% of ALSA client service plans weekly, and then 10% monthly to ensure accuracy of the resident's current needs.<br>• Audits will be conducted monthly for 3 months and quarterly for 3 quarters to assure compliance<br>• Audits will be reviews at Quality Assurance Meetings |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |
| **Alleged Violation 1. (iii)** | Failure to identify accuracy of the service plan which listed the needs for showers Tuesday and Friday and failed to identify conformance with the plan of care when the aides provided bed baths instead of showers. |
| **Measures to Prevent the Recurrence** | • An immediate audit was conducted for resident's shower and bed bath preference and schedule for accuracy with the service plan.<br>• Client #1 Service Plan updated to reflect bed baths.<br>• Re-education to RN associates on Policy F-100-80 Resident Assessment/Service Plans<br>Licensed nurses and RCAs will be re-educated on Significant Changes in a Resident Status F-100a-03 and need to update service plan accordingly.<br>Licensed Nurses and RCAs will be re-educated on Resident Service Introductory Visit F-100-25. |

POC accepted 2-4-2020 Nguyen

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| | • RCAs will be re-educated on the client service plan and care-log and to bring to the SALSA/ RNs attention for any discrepancy or need for change. |
| **Date Measures will be Effective** | • February 7th, 2020 |
| **Communities Plan to monitor its quality assessment and performance improvement to make sure measurements or systemic change is sustained** | • House audit of client service plans for the shower schedule and bath schedule will be reviewed weekly for residents. If changes are found a new service plan will be provided and an Introductory Visit form will be completed.<br>• Audits will be conducted monthly for 3 months and quarterly for 3 quarters to assure compliance<br>• Audits will be reviewed at Quality Assurance Meetings |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |
| **Alleged Violation 1 (iv)** | Failure to identify adherence with the agency policies and procedures firstly when the aides provided delayed responses to the client's call bell, and secondly when the Executive Director failed to follow up on the causes of the delay, in order to develop interventions that would prevent recurrences. |
| **Measures to Prevent the Recurrence:** | Failure to identify adherence with the agency policies and procedures firstly when the aides provided delayed responses to the client's call bell.<br>• Licensed nurses and RCAs will be re-educated on F-100-77 Emergency Response System and the safety it provides the residents.<br>• Pendent report will be brought to Stand up meeting daily and reviewed for responses greater than 7 minutes. An investigation as to the reasons for delay response will be initiated.<br>Executive Director failed to follow up on the causes of the delay, in order to develop interventions that would prevent recurrences |

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| | • The Executive Director will be re-educated on F-100-77 Emergency Response System<br>• The ED will gather findings from an investigation for pendant responses greater than 7 minutes. The investigation will include review of staff member(s) responses, resident call use frequency to ascertain additional care needs, and review of residents understanding of use of pendent, and overall review of time of day and trends.<br>• Random shift pendant testing to ensure RCA response time |
| **Date Measures will be Effective** | • February 7th, 2020 |
| **Communities Plan to monitor its quality assessment and performance improvement to make sure measurements or systemic change is sustained** | • Audits of pendant responses greater than 7 minutes will be conducted daily for 14 days, then monthly for 3 months, and quarterly for 3 quarters. The Executive Director will review responses, resident call use frequency to ascertain additional care needs, residents understanding of use of pendent, and overall review of time of day and trends to determine action.<br>• Audits will be reviewed by the Quarterly Assurance Committee |
| **Person Responsible for Monitoring** | • . SALSA and Regional Team |
| **Alleged Violation 2** | The ALSA failed to provide the Aide #4 with the required 2 hours training on pain recognition for the year of 2017. |
| **Measures to Prevent the Recurrence:** | • Aide #4 is no longer employed<br>• The SALSA will be re-educated regarding the need to ensure all aides receive 2 hours training annually on pain recognition.<br>• The community will audit all associate files to determine current compliance with pain recognition training.<br>• Associates will be provided with this training prior to assignment in the specialized dementia unit. |

POC accepted 2-4-2020 nguyen

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| **Date Measures will be Effective** | • January 27, 2020 |
| **Communities Plan to monitor its quality assessment and performance improvement to make sure measurements or systemic change is sustained** | • Audits of associate files will be conducted quarterly for 3 months to ensure compliance with dementia/pain training.<br>• Audits will be reviewed at Quality Assurance. |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |
| **Alleged Violation 2(b)** | The facility failed to identify the completion of 8 hours in dementia specific training for the year of 2017. |
| **Measures to Prevent the Recurrence:** | • Aide #5 is no longer employed<br>• The SALSA will be re-educated regarding requirement to ensure all aides have annual 8 hours of dementia specific training.<br>• The community will audit all associate files to determine current compliance for dementia training.<br>• Associates will be provided with this training prior to assignment in the specialized dementia unit. |
| **Date Measures will be Effective** | • January 27, 2020 |
| **Communities Plan to monitor its quality assessment and performance improvement to make sure** | • The community will audit all associate files for dementia training and facilitate immediate trainings as needed.<br>• Audits of associate files will be conducted quarterly for 3 months to ensure compliance with dementia/pain training.<br>• Audits will be reviewed at Quality Assurance |

POC accepted 2-4-2020 vnguyen

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| **measurements or systemic change is sustained** | |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |
| **Alleged Violation 3** | The facility failed to complete an annual performance evaluation for Aide #3 and Aide #5. |
| **Measures to Prevent the Recurrence:** | • The Salsa will be re-educated of the Talent Review Policy H-105-15<br>• Aide #3 is no longer employed<br>• Aide #5 is no longer employed<br>• A system will be developed that includes all RCAs with date the performance evaluation is completed and placed in the associate file. |
| **Date Measures will be Effective** | • February 29th, 2020 |
| **Communities Plan to monitor its quality assessment and performance improvement to make sure measurements or systemic change is sustained** | • A house audit will be conducted to ensure all performance evaluations are in place for 2019 by February 29th, 2020.<br>• An audit of 25% of associate files will be completed monthly for 4 months to assure 100 % compliance for the 2020 performance evaluations<br>• All audits will be brought to Quality Assurance for review during the 120 day QA Meeting as per regulation. |
| **Person Responsible for Monitoring** | • SALSA and/or Designated RN |

This Plan of Correction is filed as evidence of the ALSA's continuing commitment to quality care and as required by applicable law. The filing of this Plan of Correction does not constitute and may not be construed as any admission regarding the alleged violations.