STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

December 30, 2024

Allied
11513B
CTHebronSNF

Scot Kauffman, Executive Director
Colebrook Village At Hebron
55 John E. Horton Boulevard
Hebron, CT 06248
Via E-mail: skauffman@colebrookvillage.com

Dear Mr. Kauffman:

An unannounced visit was made to Colebrook Village At Hebron on December 11, 2024 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and a licensure renewal inspection.

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 January 9, 2025.

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 January 9, 2025 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, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ETH:lst

c. VL
Complaint CT #38390

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) and/or (m) Client's bill of rights and responsibilities (5) and/or (9).

1. Based on clinical record reviews, interviews with agency personnel and an agency policy for two of six clients in the survey sample (Client #5 and #6) who depended on the Assisted Living Services Agency (ALSA) for assistance with activities of daily living, medication management and nursing assessments. The agency failed to follow the agency's Resident Maltreatment, Abuse, Neglect and Exploitation policy and failed to ensure clients' safety. The findings include:
    a. Client #5 was admitted to the agency on 04/30/2022 with diagnoses of Parkinson's disease, weakness, and anxiety. The Client's 120-day nursing assessment and service plan dated 02/20/2024, identified the Client required nursing assessments and medication management. Additionally, the Client required ALSA aide assistance for bathing, dressing, grooming, toileting and transfers from the wheelchair.

    b. Client #6 was admitted to the agency on 05/16/2022 with diagnoses of dementia, hypertension and high blood pressure. The Client's 120-day nursing assessment and service plan dated 07/10/2023 identified the Client required nursing assessments and medication management. Additionally, the Client required ALSA aide assistance for bathing, dressing, grooming, toileting and with ambulation.

    Interview and review of the agency's investigation with the Executive Director on 12/11/2024 at 1:30 PM, identified on 03/02/2024 at 7:35 PM the agency received a report from Client #5's responsible person that Client #5 was inappropriately touched by Client #6. Client #5 identified on 03/02/2024, Client #6 had entered his/her apartment and asked to borrow sugar. Client #6 proceeded to sit down next to Client #5, placed his/her hands between Client #6's legs and touched his/her genital area over clothing. Client #5 pushed Client #6's hands away and Client #6 left the apartment. Client #6 remained in his/her apartment until 03/04/2024 and was removed from the agency related violating the lease agreement which identified clients were prohibited from engaging in actions which pose a risk of harm to themselves, to other clients or staff members. The Executive Director identified the investigation started on 03/02/2024 but failed to identify the agency immediately reported the allegation of sexual assault to law enforcement (the allegation was reported to law enforcement on 03/03/2024) and failed to document interventions in place to ensure clients' safety as Client #6 remained at the agency until 03/04/2024.

    Review of the agency's Resident Maltreatment, Abuse, Neglect and Exploitation policy, staff who suspect maltreatment of a client (abuse, financial exploitation or neglect) or

who have knowledge that a client had sustained a physical injury would take immediate action to protect, or keep safe the client affected, call 911 if emergency assistance was needed. All staff have the right to report suspected abuse directly to law enforcement.

Plan of Correction to Violation #11

Colebrook Village
at HEBRON
A SENIOR LIVING COMMUNITY

Jan 15, 2025

Elizabeth Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
FLIS Elizabeth.Heiney@ct.gov

"Plan of Correction associated with violation noted during a FLIS investigation December 11th, 2024."

Colebrook Village has received a written notice of noncompliance from FLIS dated December 30, 2024.
It is indicated that, "The agency failed to follow the agency's Resident Maltreatment, Abuse, Neglect and Exploitation Policy and failed to ensure clients' safety." The letter of violation further states: "The Executive Director identified the investigation started on 03/02/2024 but failed to identify the agency immediately reported the allegation of sexual assault to law enforcement (the allegation was reported to law enforcement on 03/03/2024) and failed to document interventions in place to ensure clients' safety …. "

While the call to the police was indeed made the morning of 03/03/2024, and not the evening of 03/02/2024, there was no continued threat the night of March 2nd. Interventions were in place. Doors were locked, safety checks were performed. Colebrook Village nursing department documented the interventions. Interventions that ensured client #5's safety were in-place and documented.
211 - Elderly protective services was called on Sunday morning 03/03/2024 at approximately 9:45AM ---- within 24 hours of the alleged incident. RN Designee Michelle Erba.

Of note, the statement was elicited by the nursing department pursuant to a call to Colebrook Village from the alleged victim's daughter, who was insistent that her mother, the alleged victim, submit a statement. The allegation came about after 'client #5' had spoken with her daughter by phone in the evening of 03/02/2024. The daughter called the

concierge/front desk at Colebrook to relay her conversation with her mother (Client#5.) At this time, the concierge notified both the Executive Director and the shift nurse. The shift nurse proceeded to take a statement directly from 'client #5,' while on the phone with the on-call RN.
Every effort was taken to ensure the safety of the alleged victim in this case. Intent of policy was followed vis a vis ensuring safety of the alleged victim, taking action to prevent a reoccurrence, notifying the appropriate authorities, and escalating the investigation to CT State Police & Elderly Protective Services.

The letter further states, "Review of the agency's Resident Maltreatment, Abuse, Neglect and Exploitation policy staff who suspect maltreatment of a client (abuse, financial exploitation or neglect) or who have knowledge that a client sustained a physical injury would take immediate action to protect, or keep safe the client affected, call 911 if emergency assistance was needed."

There was no physical injury reported. No physical injury occurred. There were no witnesses beyond the alleged victim and alleged perpetrator. Emergency assistance was not needed therefore no 911 call was made at this time.

Interventions:

Colebrook Village nursing department locked client#5's door, implemented hourly safety checks, and asked if she wished to pursue the allegation. Actions documented in nursing notes.
Resident (client#5) concerns were "What will happen to his wife and what will happen to him, if/when law enforcement gets involved."
Resident expressed remorse for having said anything to her daughter. "Wished she had never said anything."
SALSA Maryla called family of the alleged groper and informed the daughter that police are being informed of the alleged incident and that Client #6 would need to be removed from the property pending investigation OR place a 24-hour private duty aide/sitter with client #6 to prevent any contact with client #5. Son came in to be with client #6.
Approximately 9:45AM, Elderly protective services was informed via phone and voicemail.

Approximately 10AM 03/03/2024 Executive Director called CT State Police and they sent someone out to interview the residents.
CSP asked if dementia was involved with either resident. Executive Director confirmed the diagnoses in both client #5 and #6.
CSP interviewed Residents and SALSA and spoke with Executive Director.
Client #6 was advised by his attorney not to say anything to the police.
Client #6 son, Charlie (also client#6's attorney) indicated that his father "vehemently denies it" and "shouldn't have to leave."
Exec. Director implored the son to take #6 off-property while an investigation is underway.

Executive Director, Scot Kauffman, asked Trooper Croteau what can be done at this point – how can I ensure R#5's safety?
Response from CSP Trooper Croteau: "This is (client#6's) home. Eviction is a housing issue – he cannot simply be removed. Evidence will be presented to the court to decide whether an arrest warrant would be issued or not. You cannot evict someone based on an allegation."
Colebrook Village nursing department had called 211 & left message on Sunday 03/03/2024 at approximately 9:45AM. Emailed and Faxed W675 to Elderly Protective Services.
Client #6 was removed from property by family Monday 03/04/2024. He did not come back home and passed away (off-property) on 03/16/2024.
At no time after the evening of 03/02/2024 did client #5 see client #6.
Appropriate actions were taken, and interventions were documented.
Elderly Protective services, CT State Police, CT Mental Health Services, and other entities were involved. No arrest warrant was issued. Trooper Croteau was advised by his supervisor to stop pursuing the investigation, as both parties involved had dementia diagnoses, and no further police action would be taken.

Colebrook Village policy titled Resident Maltreatment, Abuse, Neglect and/or Exploitation will be amended to indicate a timeframe for reporting of any reportable incidents of maltreatment, abuse, neglect, and/or exploitation to Elderly Protective Services. The existing policy will show that all reportable incidents are reported to Elderly Protective Services within 24 hours of any such report/incident/abuse.

The date of the policy revision shall be 01/15/2025.
Provisionally effective 01/15/2025, the policy will show that there is a 24-hour window in which to inform elderly protective services of any reported

maltreatment, abuse, neglect, and/or exploitation. Policy amendment will be officially adopted at the next QA meeting.

Future Quality Assessment meeting minutes will reflect the above policy amendment, adoption, and sustained compliance with said amendment.

The Executive Director and/or Resident Care Director (SALSA) will be responsible for overseeing the policy amendment and maintaining continued compliance with policy.

Kind regards,

Scot Kauffman
Executive Director,
Colebrook Village at Hebron
skauffman@colebrookvillage.com

Maryla Underwood, RN
Resident Care Director/SALSA
Colebrook Village at Hebron
munderwood@colebrookvillage.com

January 15, 2025