UNITED STATES BANKRUPTCY COURT
DISTRICT OF CONNECTICUT
NEW HAVEN DIVISION

In re:	**Chapter 11**
AFFINITY HEALTH CARE MANAGEMENT, INC., *et al*,[1]	**Case No. 16-30043(JAM)**
	(Jointly Administered)
Debtors.	

REPORT OF PATIENT CARE OMBUDSMAN NANCY SHAFFER

TO: THE HONORABLE JULIE A. MANNING,
CHIEF UNITED STATES BANKRUPTCY JUDGE

The Patient Care Ombudsman provides this interim report to the Court regarding the status of Douglas Manor.

This report is submitted to the court subsequent to a notice received by the Ombudsman on Friday, July 7, 2017, from the Section Chief of Licensure and Certification, Connecticut Department of Public Health, Ms. Barbara Cass, regarding a preliminary Immediate Jeopardy situation at Affinity home, Douglas Manor. "Immediate Jeopardy" ("IJ") is a deficiency citation that involves a situation in which the health and safety of the individual and/or individuals is immediately jeopardized or in which the resident is actually harmed. In the Douglas Manor situation, as in all such instances, the Department of Public Health consults with the Centers for Medicare and Medicaid Services (CMS) prior to identifying an Immediate Jeopardy. Douglas Manor now has opportunity to file an "Allegation of Removal" plan which will describe its plan

[1] Affinity Health Care Management, Inc., Case No. 16-30044, Health Care Alliance, Inc. d/b/a Blair Manor, Case No. 16-30045, Health Care Assurance, L.L.C. d/b/a/ Douglas Manor, Case No. 16-30046, and Health Care Reliance, L.L.C. d/b/a Ellis Manor, Case No. 16-30047.

to correct deficient practices as described by the Department of Public Health.

The circumstances of this situation are in the area of neglect. The incident happened on June 4, 2017. In this case, it is alleged that the residents' plan of care was not appropriately followed and this contributed to the individual falling and sustaining a serious injury. DPH found that, although there were failures in the provision of services, the staff continued to work and was not provided suitable follow-up in-service training nor was any ongoing monitoring conducted.

In circumstances such as this, the nursing home has the opportunity to develop its plan of correction specific to the alleged deficiencies. This Allegation of Removal/Plan of Correction must be reviewed and approved by the Department of Public Health (DPH). The DPH will do a follow-up visit to determine whether the Plan of Correction has been achieved and if and when sanctions should be lifted. As in all these situations, these decisions are made in collaboration with the Center for Medicare and Medicaid Services.

The Regional Ombudsman, Mr. Pantaleo, received a complaint from a representative of the resident on June 26, 2017, and visited the resident on June 30th. At that time, the resident reported that she felt safe and confident with her care since the incident. Prior to receipt of the complaint the Office of the Ombudsman was not made aware that this event had occurred. The Regional Ombudsman and the Patient Care Ombudsman will remain available to the resident and representative.

Respectfully submitted,

Dated: July 11, 2017

Nancy Shaffer
Patient Care Ombudsman for
Affinity Health Care Management, Inc., et al
CT State Long Term Care Ombudsman
Department On Aging
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CERTIFICATION

I hereby certify that on this 11th day of July, 2017, a copy of the foregoing Interim Report regarding identification of Immediate Jeopardy at Douglas Manor is provided by the Patient Care Ombudsman, Nancy Shaffer, by first class mail, postage prepaid, to the following:

U.S. Trustee
Kim L. McCabe, Esq.
Steven E. Mackey, Esq.
Office of the United States Trustee
The Giaimo Federal Building
150 Court Street, Room 302
New Haven, CT 06510

/s/Karen S Haabestad
Karen S. Haabestad
Assistant Attorney General