STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

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Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

May 20, 2019

Kaytee Slyman, Supervisor of Assisted Living Services Agency
Colebrook Village At Hebron
55 John E. Horton Blvd
Hebron, CT 06248

Dear Ms. Slyman:

Unannounced visits were made to Colebrook Village At Hebron on April 1, 2 and 3, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through May 14, 2019.

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 visits.

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 to the Department by June 2, 2019.

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 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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by June 2, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

DATES OF VISIT: April 1, 2 and 3, 2019

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

An office conference has been scheduled for June 5, 2019 at 10:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

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.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan D Nguyen

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

Complaint # 25153

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 (d) (4) (A) Governing Authority and/or (e) General requirements for an assisted living services agency (9) and/or (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (i) Assisted living aide services provided by an assisted living services agency (5) Supervision of assisted living aides (B) and/or (h) Nursing Services provided by an assisted living services agency (1) and/or (k) Client service record (2) (L) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on clinical record review and staff interview, for two of two clients (Clients # 1 and 2) with a history of elopements, the Assisted Living Services Agency/ALSA staff failed to update the plan of care after each incident of elopement, with interventions to prevent recurrence and ensure the client's safety. The findings include:

A. Client #1 was admitted to the assisted living services agency/ALSA program on 6/01/18 with diagnoses that included atrial fibrillation, Lewy Body dementia, hypertension and chronic kidney disease. The physician certification for chronic and stable status dated 10/11/18 indicated that Client # 1 "occasionally" wandered. The Client Service Plan dated 10/25/18 identified the need for assistance with bathing, medication reminders four times a day, safety checks daily and nightly with the goal that Client # 1 would remain "safe within the community."

i. Interview and review of the ALSA documentation on 4/02/19 with the Executive Director failed to identify specific recording by the ALSA aides of the daily and nightly safety checks completed for Client # 1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "Night Safety Checks") in accordance with the Client Service Plan;

Interview and review of agency documentation with the ED on 4/03/19 identified the use of flow sheets to record the daily and nightly checks on each ALSA client, but failed to identify the development of policies and/or specific instructions to the ALSA Aides on documentation requirements and compliance;

ii. The ALSA documentation dated 1/08/19 indicated that ALSA Aide #4 answered the front door of the building at 5:30 AM and saw Client # 1 in the company of the snow plow contractor who found Client # 1 in the rear driveway of the building. Client #1 was wearing a winter coat and shoes, did not know how long the client had been outside in the snow, and stated the client was outside "waiting for a ride to the lawyer's office."

The Executive Director developed a report on 1/09/19 that included an increase in safety checks until a Negotiated Risk Agreement was reached with the family.

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Interview and review of the ALSA documentation on 4/02/19 with the Executive Director failed to identify updates to the Client Service Plan to reflect the incident of elopement and the need to increase the safety checks;

iii. The ALSA documentation dated 1/17/19 indicated that the Director of Maintenance found Client # 1 in the back of the building at 4PM. Although the next-of-kin just dropped off Client # 1 at the facility an hour before the incident, Client # 1 told the Director of Maintenance that Client # 1 was standing outside the building waiting for pick-up by the next-of-kin.

An Elopement and Wanderer Risk Assessment dated 1/18/19 indicated that Client # 1 was found at the local pharmacy/drugstore, and concluded with a plan for more frequent safety checks.

Interview and review of the ALSA documentation on 4/02/19 with the Executive Director failed to identify specific recording by the ALSA aides of the increased daily and nightly safety checks completed for Client # 1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "Night Safety Checks") from 1/09/19 through 1/22/19 in response to the client's three incidences of elopement;

iv. From 1/23/19 through 1/28/19 the client's family placed a private sitter outside Client # 1's apartment from 7PM to 7AM to monitor and redirect Client # 1.

The ALSA documentation dated 1/27/19 indicated that overnight Client # 1 got up twice at 1:30AM and 4:30AM, got dressed and was ready to leave the apartment, when the private help reminded the client to stay in bed.

On 1/28/19, the client's responsible party entered a "negotiated risk agreement" with the ALSA, that addressed the client's preference to not live inside the secured unit, with an "agreed course of action" that included the hiring of a private duty staff from 7PM to 7AM (overnight) to watch the client "until negotiated risk agreement signed, or long-term solution in place," but the ALSA failed to include in the negotiated risk agreement any mutual plan to minimize the risk to the resident, as directed by the ALSA policy on Negotiated Risk Agreement on page 64, under Procedures (7);

v. After the negotiated risk agreement was signed on 1/28/19, Client # 1 was not assigned a private sitter, and the ALSA did not maintain documentation of daily safety checks on Client # 1.

The ALSA documentation dated 2/21/19 indicated that the Director of Maintenance found

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Client # 1 outside of the building at 7:00 AM near the memory care unit dressed with two shirts, shoes and no coat, standing in the middle of an icy field. Client # 1 stated the client was looking for "Allen," although there were no staff or family members by that name. Client # 1 was unable to move as the entire field was iced over, and the client was afraid of slipping on ice. The client's right hand was swollen, but the client denied falling. The agency investigation concluded that Client # 1 eloped through stairwell near the elevator on the East wing. The Executive Director documented that the client's wandering persisted "at dangerous level," with the next-of-kin agreeing to hire a private sitter during the hours of 7 PM to 7 AM from 2/21/19 through 2/25/19.

On 2/23/19 the client service program was updated to include safety checks every 1 to 2 hours during the night. Interview and review of the ALSA documentation with the Executive Director on 4/02/19 failed to identify specific recording by the ALSA aides of the increased daily and nightly safety checks completed for Client # 1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "Night Safety Checks") from 2/21/19 through 2/25/19 in response to the client's continued incidence of elopement;

vi. The ALSA documentation dated 2/25/19 indicated that Client # 1 was found outside the deck, inappropriately dressed for the cold winter weather. The ALSA notified the next-of-kin who agreed to put a lock on the door leading out to the deck.

On the same day 2/25/19 the physician's office certified Client # 1 as "chronic and stable," and appropriate for ALSA services. Interview with Advanced Practice Registered Nurse/APRN # 1 on 5/14/19 at 10:05 A.M. indicated that APRN # 1 was in charge of Client # 1's care in the physician's office, that the ALSA staff did not provide the APRN with the details of the multiple incidents of elopement, the ALSA did not explain to the APRN that the certification of "chronic and stable status" entitled the client to the ALSA services only and separately from residency rights in the Managed Residential Community/MRC, and the ALSA did not inform the APRN of the regulatory definition of "chronic and stable" that included stable mental health and cognitive functions.

Interview and review of the ALSA policies and procedures on 5/9/19 with the Executive Director failed to identify the development of policies and guidelines to address the criteria for discharging the clients from ALSA services (the services only, separately from residency status), including measures to address changes in condition when a client was no longer chronic and stable, in according with the State regulations.

B. Client #2 was admitted to the assisted living services agency/ALSA program on 6/27/18. The admitting diagnoses included dementia with depression, hypertension and glaucoma. The client service program dated 11/14/18 identified the need for assistance with bathing, dressing,

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medication reminders two times a day, safety checks daily and nightly.

i. Interview and review of the agency documentation dated 2/14/19 at 5:30 AM with ALSA Aide #4 on 4/03/19 identified that on rounds at 5 AM, Client #2 was not in the bedroom. The hallways and all of the rooms were searched and Client #2 was not located. ALSA Aide #4 drove around the building and found Client #2 sitting on a curb approximately 50 yards from the building wearing a coat and shoes, and exhibiting scrapes to the face. ALSA Aide #4 put the client in the car and drove to the front of the building. Review of the Accident Incident Injury Report and progress note dated 2/14/19 by the former SALSA indicated that Client #2 began to vomit once inside the building, and ALSA Aide #2 was instructed to call 911, but failed to identify an investigation with root cause analysis of the incident, to prevent recurrence of the incident and ensure the client safety;

ii. Interview and review of the agency policies and procedures on 4/03/19 with the Executive Director failed to identify polices and/or guidelines to direct the ALSA staff on the process of investigating incidents and accidents, to identify the root cause and develop interventions to prevent recurrence and keep the clients safe;

iii. Review of the clinical record on 4/03/19 with the Executive Director failed to identify updates to the service plan to reflect newly developed interventions after the elopement, with appropriately revised instructions for the ALSA aides.

On 2/14/19 at 6:10 AM, Client #2 was transferred via ambulance to the Emergency Department and admitted to Hospital #1 with sepsis due to pneumonia, facial laceration, accidental hypothermia, traumatic rhabdomyolysis and metabolic encephalopathy. The client was discharged from the hospital on 2/18/19 to a skilled nursing facility and returned to the facility on 3/1/19 with a 24-hour private sitter in place.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (h) Nursing Services provided by an assisted living services agency (1) and/or (4) (A) and/or (k) Client service record (5).

2. Based on review of the clinical record, agency documentation and interview with agency personnel, for one of one client (Client #3) who was prescribed controlled substances, the ALSA failed to provide the appropriate nursing management of the controlled substances. The findings include:

   Client #3 was admitted to the assisted living services agency/ALSA program on 6/30/18. The admitting diagnoses included coronary heart disease, back pain, anxiety and pleural plaque with presence of asbestos. The client service program dated 2/27/19 identified the need for medication

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reminders two times a day. Client #3's medications included a topical Fentanyl patch at 75 micrograms per hour to be replaced every 72 hours.

Interview and review of the clinical record with the interim SALSA on 4/02/19 indicated that that the next of kin pre-poured Client #3's medications and numbered the Fentanyl patches. The ALSA Aides subsequently handed the patch to the Client for self-application, after the client removed the old patch. The ALSA aide then initialed and dated the new Fentanyl patch, and discarded the old patch in a plastic container.

The ALSA policy directed the maintenance of a Narcotic Inventory Sheet for each narcotic in use, with the RN counting the quantity of narcotics and documenting in the "Amount Received" column with the date, time and signature of the RN.

Interview and review of the clinical documentation with the Executive Director on 4/02/19 failed to identify the inventory and utilization tracking by the ALSA nurses of the Fentanyl patches.

FACILITY: Colebrook Village at Hebron

DATES OF VISIT: April 1, 2 and 3, 2019

POC accepted 6-11-19 cmquyen

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 (d) (4) (A) Governing Authority and/or (e) General requirements for an assisted living services agency (9) and/or (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (i) Assisted living aide services provided by an assisted living services agency (5) Supervision of assisted living aides (B) and/or (h) Nursing Services provided by an assisted living services agency (1) and/or (k) Client service record (2) (L) and/or (m) Client's bill of rights and responsibilities (5).

This Plan of Correction is in response to your investigation of April 1-3, 2019. The Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. Colebrook Village at Hebron is committed to providing each client with the highest level of care in a safe and nurturing environment. This Plan of Correction is submitted to meet requirements established by state and federal law.

Violation #1, paragraphs 1, A, i, paragraph 1, A, iii, and paragraph 1, A, v

1.A.i. Executive Director failed to identify specific recording by the ALSA aides of the daily and nightly safety checks completed for Client #1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "Night Safety Checks") in accordance with the Client Service Plan…. (and) failed to identify the development of policies and/or specific instructions to the ALSA aides on documentation requirements and compliance.

1.A.iii. Executive Director failed to identify specific recording by the ALSA aides of the increased daily and nightly safety checks completed for Client #1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "night Safety Checks") from 1/09/19 through 1/22/19 in response to the client's three incidents of elopement.

1.A.v. Executive Director failed to identify specific recording by the ALSA aides of the increased daily and nightly safety checks completed for Client #1 (in the pre-printed flow sheets next to the prompts "Safety Checks" and "night Safety Checks") from 2/21/19 through 2/25/19 in response to the client's continued incidence of elopement

- Documentation of interventions, including safety checks by nursing staff (C.NA.s) is now completed in real time on a computerized tablet. Revised protocol to be developed by 6/11/19 regarding safety check requirements and documentation of safety checks.
- Staff re-education about the policies and procedures of ALSA program regarding safety check requirements and documentation of same will be completed by 6/30/19 and added to new-hire orientation.
- RNs review and initial the completion of documentation by CNAs per regulations.
- Staff who fail to properly document safety checks as outlined on the individualized resident care/service plans will be disciplined pursuant to Colebrook Village's disciplinary procedure.
- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

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POC accepted 6-11-19 LNguyen

Violation #1, paragraph 1, paragraph 1, A, ii and paragraph 1, B, iii

1. *ALSA staff failed to update the plan of care after each incident of elopement with interventions to prevent recurrence and ensure the client's safety.*

1.A.ii. *Executive Director failed to identify updates to the Client Service Plan to reflect the incident of elopement and the need to increase safety checks.*

1.B.iii. *Executive Director failed to identify updates to the service plan to reflect newly developed interventions after the elopement, with appropriately revised instructions to the ALSA aides.*

- Supplemental Policy and Procedure for Elopement Prevention and Elopement Recovery to be developed by 6/11/19.
- Individualized service plan will be updated to reflect changes of condition and modified safety measure interventions for the protection of the resident, with appropriately revised instructions for the ALSA aides.
- Residents who elope shall be provided with an increase in safety checks to every-one-hour for up to three (3) days, while investigation is conducted by SALSA/Designee.
- Staff will be educated regarding new policy, need to update service plans, and need to provide revised instructions on updated service plans by 6/30/19.
- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

Violation #1, paragraph 1, A, iv

1.A.iv. *The ALSA failed to include in the negotiated risk agreement any mutual plan to minimize the risk to the resident, as directed by the ALSA policy on Negotiated Risk Agreement on page 64, under Procedures (7)*

- The SALSA/Designee drafts the negotiated risk agreement and ensure it includes a mutual plan to minimize the risk to the resident and/or others while still acknowledging and protecting the resident's rights.
- Negotiated Risk Agreements are reviewed by Chief Risk Officer at corporate level prior to final implementation to ensure an appropriate mutual plan has been implemented to reduce risk to residents while maintaining resident rights.
- Policy and procedures on Negotiated Risk Agreement is to be amended by 6/11/19 to include interventions in cases where Negotiated Risk Agreement is not followed or no longer remains appropriate.
- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

Violation #1, paragraph 1, A, vi

1.A.vi. *ALSA staff did not provide the APRN with the details of the multiple incidents of elopement, the ALSA did not explain to the APRN that the certification of "chronic and stable status" entitled the client to the ALSA services only and separately from residency rights in the Managed Residential Community/MRC, and the ALSA did not inform the APRN of the regulatory definition of "chronic and stable" that included stable mental health and cognitive functions…..Executive Director failed to identify the development of policies and guidelines to address the criteria for discharging the clients from ALSA services (the services only, separately from residency status), including measures to*

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address changes in condition when a client was no longer chronic and stable, in according with the State regulations.

- Elopements are considered changes of condition and therefore will be reported to the physician or appropriate medical personnel immediately.
- SALSA/Designee will modify individualized service plan to reflect incident of elopement and new interventions to protect the resident's safety. The SALSA/Designee will request medical personnel to execute new service plan authorization including review of changes to the services, level of care, medication plan, and/or additional services.
- By 6/11/19, policy and procedures will be added to ALSA/Health Services Policy & Procedure manual to include measures to address changes in condition when a client is no longer chronic and stable as well as criteria for discharge from ALSA services, explaining that the client can arrange for their own home care services and that the discontinuation of ALSA services will not affect the client's residency in the MRC.
- The nurses will be given re-education about this policy and procedure and its inclusion in Health Services Policy manual by 6/30/19.
- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

Violation #1, paragraph 1, B, i, and B, ii.

1, B i *ALSA aide #2 …failed to identify an investigation with root cause analysis of the incident to prevent recurrence of the incident and ensure the client safety*

1, B, ii *Executive Director failed to identify policies and/ or guidelines to direct the ALSA staff on the process of investigating incidents and accidents, to identify the root cause and develop interventions to prevent recurrence and keep the clients safe*

- Incident reporting and investigation policy will be added to the ALSA/Health Services Policy & Procedure Manual by 6/11/19, detailing the process of investigating incidents and accidents, identifying root cause, and developing interventions to prevent recurrence and keep clients safe.
- The SALSA/Designee completes an incident report with root cause analysis, action item interventions. The incident report is submitted to the Executive Director who reviews the root cause analysis and the action items listed to ensure adequacy and prevent further recurrences and ensure client safety.
- Following the completion of an incident report, the SALSA/Designee will update the client service plan to include the new interventions after the elopement.
- Action items, interventions, and updates to individualized service plans are initiated by the SALSA/Designee.
- Nursing staff will communicate revised instructions to CNAs based on the updated client service plan.
- Per Resident Occupancy Policy & Procedure Manual, copies of incident reports are to be maintained in resident's administrative file and a copy in the Incident report log in the Executive Director's office.
- Nursing staff will be re-educated about the policies and procedures for incident reporting, documentation and investigations by 6/30/19.

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- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B) and/or (h) Nursing Services provided by an assisted living services agency (1) and/or (4) (A) and/or (k) Client service record (5).

Violation #2, paragraph 1

The ALSA failed to provide the appropriate nursing management of the controlled substances…Executive Director failed to identify the inventory and utilization tracking by the ALSA nurses of the Fentanyl patches.

- Narcotics Inventory Sheets are obtained from our contracted pharmacy for each narcotic in use, with the RN/LPN counting the quantity of narcotics and documenting the "amount received" column with the date, time and signature of the RN/LPN.
- For residents who self-administer narcotics/controlled substances schedule II and III, the nurse aides will not assist residents except by verbal cueing and will have no knowledge of the type of medication being cued.
- For residents who are unable to self-administer narcotics, nurse administration is required, and will be documented.
- Inventory tracking sheets are stored in the resident's locked medication box in the resident's apartment and are completed by the nurse.
- Nursing staff will be re-educated by the SALSA/Designee on proper documenting of controlled substances for residents who self-administer by 6/30/19.
- By 6/30/19, 24-hour nursing coverage will be implemented.
- SALSA/Designee will be responsible for ensuring the organization's compliance with this Plan of Correction.

Audits:

1. **All audits will be conducted by the SALSA/Designee monthly and will continue for 6 months.**
2. **A summary of audit results will be reported by the SALSA/Designee to the Quality Assurance Committee.**

- An audit of 60% charts, randomly selected, will be conducted monthly for six months with goal of 90%+ compliance with C.NA documentation expectations.
- All (100%) of new elopement incident reports will be reviewed by SALSA/Designee monthly for six months for root cause analysis, interventions/action items to prevent recurrence, updates to care/service plans, aide documentation of safety checks, RN updates to aide instruction sheets, implementation of the new ALSA policy on discharge from ALSA services including measures to address changes in condition when a client was no longer chronic and stable, physician notification, implementation, and negotiated risk agreements, with goal of 90% compliance.
- A monthly audit of all (100%) charts of resident receiving narcotic medications, including inventory of narcotics and tracking of utilization, will be conducted for six months with goal of 100%+ compliance with documentation expectations.

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- Once compliance goals are met for each separate audit, the audit will then continue quarterly ongoing.