

# 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

March 2, 2020

Julie Troy, Supervisor of Assisted Living Services Agency  
Brandywine Assisted Living At Litchfield  
19 Constitution Way  
Litchfield, CT 06759  
jtroy@brandycare.com

Dear Ms. Troy:

Unannounced visits were made to Brandywine Assisted Living At Litchfield on February 6, 2020 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 February 25, 2020.

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. The state violations cannot be edited by the provider in any way.

An office conference has been scheduled for March 17, 2020 at 1:00 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 identified with an asterisk. Should you wish 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 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 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. Please do not send another copy via US mail.

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.



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DATE(S) OF VISIT: January 22, 24 and February 6, 2020

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D 105 (d) Governing authority of an assisted living services agency (4)(A) and/or (F).

1. Based on clinical record review and staff interview, for one of one client (Client # 1) who eloped from the facility for six hours and continued with exit seeking behaviors in the weeks that followed, the Assisted Living Services Agency (ALSA) Governing Authority failed to ensure the development of comprehensive safety measures. The findings include:
  - a. Client #1 was admitted to the assisted living program on 10/27/19 at 5:45 pm with diagnoses that included prostate cancer, chronic obstructive pulmonary disease and dementia.

The client service program dated 10/27/19 identified independence with activities of daily living, and the need for medication administration by ALSA nurses.

The physician's note dated 10/15/19 indicated that Client #1 did not require a secured environment as a prevention measure to wandering.

According to the Executive Director in an interview on 2/28/2020, the facility glass sliding doors at the entrance (foyer doors) were secured with a keypad access code after 8PM. The Executive Director explained that without a passcode entered, the security system would alarm if the sliding doors were pushed in a lateral sliding fashion.

The Executive Director further indicated that on 10/27/19 at 8:45PM, a staff member pulled into the facility driveway to start a flu clinic, saw Client # 1 walking out the driveway but did not realize that was an elopement as Client # 1 was just admitted the same day and the staff had not met Client # 1.

When the staff arrived to the front door and saw that one of the sliding panels was pushed outward away from its sliding track (instead of in a side-to-side fashion that would have triggered the alarm), the staff immediately grabbed the "walkie" at the front desk and called the nursing staff in the facility to report an elopement.

The police was notified, and the ALSA staff initiated a search around the facility. The State police with search dogs brought Client # 1 back six hours later around 3AM.

The client exhibited minor scratches. The next-of-kin was notified and remained with Client # 1 for the rest of the night.

The ALSA documentation identified a meeting on 10/28/19 with Client # 1's next-of-kin, who was reluctant to see Client # 1 transferred to the secured unit (Memory care unit which was locked at all times).

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The plan of care was updated to reflect the need to monitor the client for exit seeking behaviors.

The ALSA documentation dated 11/4/19 indicated that Client #1 was found outside in the parking lot.

On 11/14/19 Client # 1 was found packing up belongings, preparing to leave, and was re-directed.

On 11/18/19 Client #1 packed up to leave for New Jersey, and the next-of-kin was notified.

On 11/21/19 and 11/23/19, Client # 1 attempted to leave the building and was re-directed at the front desk.

On 11/25/19 Client # 1 left the facility and was found in the middle of the road asking passing cars for a ride.

The next-of-kin came in and stayed with the client.

On 11/26/19 Client #1 was transferred to the Geriatric Psychiatric Hospital for evaluation.

On 12/19/19 Client # 1 was re-admitted to the facility.

The ALSA documentation dated 12/22/19, 12/23/19 and 12/26/19 indicated that Client # 1 was agitated and made multiple attempts to leave the facility.

Interview and review of the ALSA documentation, policies and procedures with the ALSA Executive Director and the Supervisor of Assisted Living Services Agency (SALSA) on 2/4/2020 failed to indicate that the Governing Authority had sufficient measures in place to ensure door safety prior to the six-hour elopement by Client # 1 on 10/27/2019.

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

2. Based on review of the clinical record and interview with agency personnel, for one of two clients (Client # 2) who received narcotics for symptom management, the Assisted Living Services Agency (ALSA) nurses failed to follow the agency policies, the Supervisor of Assisted Living Services Agency (SALSA) failed to provide oversight and education, and failed to complete a comprehensive investigation of narcotic discrepancies. The findings include:
  - a. Client #2 was admitted to the Memory Care unit on 6/28/19 with diagnoses that included subdural hemorrhage, hyperlipidemia, anemia, muscle weakness, and Alzheimer ' s Disease. Client # 2 elected the hospice benefit on 11/21/19.

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- i. Client # 2's medications included liquid Ativan by mouth and liquid Morphine by mouth.

The ALSA documentation indicated that the facility was staffed with three shifts of nurses, and the nurses documented on a "Narcotic Administration Record" sheet each time they took a dose of Morphine or Ativan to administer to Client # 2.

Interview with the SALSA on 1/20/2020 and review of the "Narcotic Administration Record" sheets for Client # 2's Morphine and Ativan dated 2019 and 2020 failed to identify a joint count of the narcotics at change of shift between the nurse leaving the shift (outgoing nurse) and the nurse arriving to work (oncoming nurse), in accordance with the ALSA policies.

The ALSA policies directed the oncoming nurse and the outgoing nurse to visually count the controlled substances at the change of shift, with the oncoming nurse counting and the outgoing nurse verifying the count against the actual declining inventory sheet;

- ii. Interview with the SALSA and the Executive Director on 2/4/2020 failed to identify nursing oversight of the process of tracking narcotics through counts and documentation, including the review of completed narcotic sheets by the SALSA, to ensure conformance with the agency policies and/or timely identification of narcotic discrepancies;

- iii. Interview with Licensed Practical Nurses (LPN) # 1 through 7 on 02/06/2020 indicated that each nurse counted the narcotics alone during their respective shift, as the nurses were not aware of a policy that required joint counting at the change of shift, and the nurses had not received in-service regarding that policy.

Interview with the Supervisor of Assisted Living Services (SALSA) and the Executive Director on 2/4/2020 failed to identify the provision of in-service or any other form of communication to the ALSA nurses regarding the policy on joint count of narcotics at change of shift to ensure medication accuracy, protection of the client's property, and to identify the exact timing of any narcotic discrepancy;

- iv. The ALSA documentation indicated that on 1/5/2020 LPN # 1 worked the 3PM to 11PM shift, administered Morphine liquid to Client # 2 as ordered, documented the balance on the narcotic count sheet and left work. The oncoming nurse (Registered Nurse/RN) # 1 reported on the next day 1/6/2020 to the Executive Director and the SALSA that 9 milliliters (ml) were missing from the bottle of liquid Morphine and the count documented by LPN # 1 was not correct.

Interview with the SALSA and the Executive Director on 2/4/2020 indicated that in the absence of joint counts of narcotics at each change of shift, it was impossible to determine whether the discrepancy was caused by the outgoing nurse or the oncoming

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nurse, or whether the incorrect count had been carried over from shift to shift with no exact tracing back to the exact time the discrepancy took place.

Interview with the SALSA and the Executive Director on 2/4/2020 failed to identify a comprehensive investigation of the incident, to include data collection, timeline of the events, statements, root cause analysis, conclusions derived from the investigation, and interventions developed to prevent recurrence;

- v. The ALSA documentation also indicated that on 1/5/2020 LPN # 1 worked the 3PM to 11PM shift and administered liquid Ativan to Client # 2. LPN # 1 documented the balance without a joint count with the oncoming nurse, and left work at 11PM. The night shift nurse (11PM to 7AM) did not document any Ativan administration.

LPN # 4 worked the morning shift (7AM to 3PM) and reported at 10AM that 7ml of Ativan were missing from the bottle.

The ALSA subsequently terminated LPN # 1 based on the reports from RN # 1 and LPN # 4.

Interview with the SALSA and the Executive Director on 2/4/2020 indicated that in the absence of joint counts of narcotics at each change of shift, it was impossible to determine whether the discrepancy was caused by the outgoing nurse or the oncoming nurse, or whether the incorrect count had been carried over from shift to shift with no exact tracing back to the exact time the discrepancy took place.

Interview with the SALSA and the Executive Director on 2/4/2020 failed to identify a comprehensive investigation of the incident, to include data collection, timeline of the events, statements, root cause analysis, conclusions derived from the investigation, and interventions developed to prevent recurrence.



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March 10, 2020

Loan Nguyen, M.S.N., R.N., C.  
Supervising Nurse Consultant  
State of Connecticut  
Department of Public Health  
Facility Licensing and Investigations Section  
410 Capitol Avenue, PO Box 340308  
Hartford, CT 06134-0308

**RE: Response to the State of Connecticut Violation**

Dear Ms. Nguyen,

This letter is in response to the State of Connecticut Violation letter dated March 2, 2020. Please find the Plans of Correction for each Violation and appropriate attachments.

Violation 1: Section 19-13-D105(d) Governing Authority of an assisted living services agencies (4) (A) and /or (F)

1. The Governing Authority of the institution implemented and made systemic changes to ensure comprehensive safety measures to prevent a recurrence of elopement by a Resident of the institution. The measure implemented by the institution includes initiation of a new door alarm policy, the purchase and installation of door alarms on egress doors and key pads and alarms on non-egress doors.
2. The completion date of door alarm education was 2/14/20. The written policy and procedure was completed on 3/1/20.
3. All door alarms are tested each week on the 1030p-630am shift by the Director of Environmental services.
4. The logs are printed and reviewed daily by the Director of Environmental services and during his absence (days off, sick or vacation days) by either the Executive Director, Wellness Director, or the Designee.

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Violation 2: Section 19-13-D105(g) Supervisor of assisted living services  
(A) and/or (B) and/or (C) and/or (D) and or (h) Nursing Services provided by an assisted living  
agency (1) and or (k) Client service record (2)(J)

1. This institution implemented a controlled substance inventory and tracking system that includes a narcotic count at the change of each shift utilizing the Narcotic Count Records completed by the oncoming and outgoing nurses, documentation of the controlled substance on the Master Controlled Substances Tracking Record, and the Controlled Substance Tracking Record- Additions to Stock, consistent with the Brandywine Controlled Substances Inventory and Tracking Policy.
2. The corrective action measure went into effect February 7, 2020. Nurse education for narcotic counts and policy enforcement was completed February 13, 2020.
3. Narcotic audit reviews 100% of the narcotic count sheets each week for 6 months. After 6 months of successful audits (90% satisfaction) subsequent audits will occur quarterly.
4. The Director of Wellness or the Designee will review narcotic sheets each week on random days. Irregularities will be reported verbally when they are found by the oncoming and outgoing nurses to the Director of Wellness or Designee. An investigation will ensue by the Director of Wellness or Designee to determine why the count is incorrect and all parties will be interviewed and a corresponding report will be made.

Sincerely,

Julie Troy R.N., B.S.N.  
Wellness Director  
Enclosures

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