Section 3

2017

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Brookdale West Hartford
22 Simsbury Road
West Hartford CT 06117
M:

Signature of FLIS Staff

Melissa J San Souci RN Nurse Consultant
Ph 860-523-9899
Fax - 860-523-9515

Licensure Category: Assisted Living Services

Licensed Bed/Bassinet Capacity: __ Census: 73

Date(s) of onsite inspection: 03/02/17; 03/03/17, 03/07/17, 03/09/17, 03/10/17, 04/28/17, 04/27/17

Date(s) additional information obtained: 03/13/17

Personnel contacted: Diane Vecchia, RN, SAMSA, Zoila Diaz Jones, RN Designee 3/2017, 4/27/17 Beata Kozubel RN SAMSA, Acting ED - Noreen Washburn, Annette Cochefski RN, BDCS, Todd Curtiss ED, Adrienne Perry, RN Case Manager

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[X] See Complaint Investigation # 21230, #19133, #20349, #18213, #21548

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated _____

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. 6-1-17

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Melissa J San Souci RN **DATE OF REPORT:** 03/30/17

Approval for issuance of license granted by: Joan D Nguyen **DATE:** 4-18-17
Supervisor/Title

DEPARTMENT OF PUBLIC HEALTH
HOSPITAL AND MEDICAL CARE DIVISION

INSPECTION MATERIALS CHECKLIST
ASSISTED LIVING SERVICES AGENCY

Assisted Living Services Agency Brookdale West Hartford

Address 22 Simsbury Road

City West Hartford State CT Zip Code 06117

The Inspection Materials Checklist is to be used to identify any new or revised agency materials since the last licensure inspection. Please complete as appropriate for your agency and have any materials so identified available for review.

Agency Materials	New	Revised
BY-LAWS OR RULES OF ORDER		
POLICIES/PROCEDURES		
Client Care Policies/Procedures		
o Admission		7/16
o Assisted Living Aide Program		
o Discharge		7/16
o Emergency		6/19
o Administration of Medications		10/15
o Complaint Procedure		10/15
Nursing Service		
PERSONNEL POLICIES-for the assisted living services agency		
Orientation		3/16
In-service education		N/A
Required health examinations		N/A
Annual performance evaluation policy		N/A
Job description-supervisor of assisted living services		N/A
Job description-assisted living aide		N/A
QUALITY ASSURANCE PROGRAM/PLAN		N/A
BILL OF RIGHTS		N/A
PUBLIC INFORMATION MATERIALS		

PLEASE IDENTIFY ANY OTHER NEW MATERIALS DEVELOPED Change of name on Collateral to Brookdale West Hartford, Hospice Guidlines revised 1/15, Courtyard safety Guidlines revised 7/15.

Supervisor of Assisted Living Services Signature: [signature]

Date: 3/9/17

0200N/3

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 1, 2017

Beata Kozubel, Supervisor of Assisted Living Services Agency
Brookdale West Hartford
22 Simsbury Road
West Hartford, CT 06117

Dear Ms. Kozubel:

Unannounced visits were made to Brookdale West Hartford on March 2, 3, 7, 9, 10, 2017 and April 27and 28, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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.

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 May 31, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);

2. Date corrective measure will be effected;

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. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are 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
CT # 18213, 19133, 20349, 21230, 21548

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATES OF VISIT: March 2, 3, 7, 9, 10 and April 28, 2017

THE FOLLOWING VIOLATIONS 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 D19-13-D105 (g) Supervisor of assisted living service (2)(A) and/or (B) and/or (h) Nursing services provided by an assisted living services agency(3)(J)(v).

1. Based on review of the clinical records and interview with agency personnel, for two of ten clients (Clients #6 and #10) in the survey sample, the agency failed to ensure effective communication and safe administration of medications. The findings include:
    a. Client #6 was admitted on 08/04/16 to the Memory Care Unit with diagnoses that included Alzheimer's dementia with behavioral disturbance and anxiety. Physician's Orders for the period of 02/14/17 to 03/13/17 included Gabapentin 200 mg by mouth three times a day, Trazodine 25 mg three times a day, and Trazadone 50 mg outh at bedtime.

        i. Interview and review of the medication administration record (MAR) on 03/10/17 of Client #6 with the Registered Nurse (RN) designee and the RN Case Manager failed to identify documentation of administration of the 5:00 pm doses of Gabapentin and Trazodone on 02/20/17, and the 8:00 pm dose of Trazodone on 02/20/17.

        ii. Further interview and review of the February 2017 staffing schedule with the Executive Director and Licensed Practical Nurse (LPN) #1 on 03/10/17 indicated that LPN #4 was scheduled to work on the Memory Care Unit from 4:30 to 8:00 pm on 2/20/17, however LPN #4 did not report to work as planned.

        ALSA aide #1 notified LPN #1 at 6:49 pm on 02/20/17 that there was no nurse on duty on the Memory Care Unit to administer medications.

        The aide further recalled seeing LPN #3 in the building earlier in the day and assumed LPN #3 was working that evening.

        In an interview on 03/10/17, LPN #2 indicated that LPN #2 was assigned to another unit outside of the Memory Care Unit from 2:00 pm until 7:00 pm on 02/20/17. LPN #2 was getting ready to leave at 7:00 pm on 02/20/17, when an aide reported the absence of nurse on the Memory Care Unit for medication administration. LPN #2 contacted the RN Designee who asked LPN #2 to stay and administer medications until a replacement nurse reported for duty.

        LPN #2 stated to the surveyor on 3/10/17 that LPN #2 agreed to stay because LPN #2 was the only nurse in the building, but was uncomfortable administering medications as LPN #2 had not received an orientation to the memory care unit.

        By the time LPN #2 received an orientation on 2/20/17 to the password codes and locks on the unit, LPN #3 arrived as the replacement nurse, and LPN #2 had not

administered any medications yet.

LPN #2 explained to the surveyor that LPN #2 reported off to LPN #3 by stating "Client #6 was all set" to signify that Client #6 was escorted back to the client's apartment, and failed to identify clear and effective communication of the client's status in order to meet the client's needs;

iii. In an interview on 03/10/17 LPN #3 stated LPN #2 reported off that Client #6 was "taken care of," and LPN #3 assumed that LPN #2 administered all medications to Client #6, but LPN #3 failed to establish contact with LPN #2 later in the shift upon seeing that the MAR was not signed for Client #6.

iv. Interview and review of Client #6's MAR with the RN Designee on 03/09/17 failed to identify awareness from the RN Designee of omitted medications for Client #6 on 2/20/17 until the surveyor's investigation, and failed to identify appropriate oversight of nursing practice.

The agency policy on Medication Administration Record (MAR) directed the completion of MAR documentation during the change of each shift and verification of medications administered by both the outgoing and oncoming staff;

v. Interview and review of the Controlled Substance tracking dated February 2017 with the RN Case Manager (RN #2) on 03/10/17 indicated that LPN #2 signed under "first staff signature," failed to identify a "second staff signature" by LPN #3 on 02/20/17 during the evening shift, as required on the agency pre-printed form, and failed to identify proper reconciliation of controlled substances;

vi. Interview and review of the Controlled Substance tracking dated February 2017 with RN #2 failed to identify a second staff signature on 02/13/17 during the evening shift, as required on the agency pre-printed form, and failed to identify proper reconciliation of controlled substances;

vii. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify a second staff signature and/or failed to identify documentation of an audit completed on 02/14/17 during the evening shift, in accordance with the agency requirements;

viii. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify an audit completed on 02/16/17 during the morning shift, in accordance with the agency requirements;

ix. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify a second staff signature on 02/21/17

during the morning and evening shifts, and/or failed to identify an audit completed on 02/21/17 during the evening shift, in accordance with the agency requirements.

b. Client #10 was admitted on 03/30/16 with diagnoses that included shortness of breath, congestive heart failure, essential hypertension, osteoarthritis, Alzheimer's dementia, urinary incontinence, depressive disorder, Vitamin D deficiency and a history of Guillain-Barre syndrome with residual weakness of the left leg.

The client's Personal Service Plan dated 04/15/17 identified the need for medication management and administration.

The physician's orders for the period of 03/14/17 to 04/10/17 included Melatonin 3 milligrams (mg) by mouth at bedtime (9:00 pm) and Trazodone 100 mg by mouth at bedtime (9:00 pm).

i. Interview and review of the medication administration record (MAR) with SALSA #2 on 04/27/17 failed to identify administration of the Trazodone and/or Melatonin on 03/14/17, 03/15/17, 03/16/17, 03/17/17, 03/18/17, 03/19/17, 03/20/17, 03/21/17, 03/22/17, 03/2317, 03/24/17, 03/25/17, 03/26/17, 03/27/17, 03/28/17, 03/29/17, 03/30/17, 03/31/17, 04/01/17, 04/02/17, 04/03/17, 04/04/17, 04/05/17. 04/06/17, 04/07/17, 04/08/17, 04/09/17 and 04/10/17; while the "medication exception and hold notes" section of the MAR indicated that the client refused and/or requested the medication be administered later (9:30 pm or 10:00 pm) on 03/14/17, 03/15/17, 03/16/17, 03/17/17, 03/18/17, 03/19/17, 03/21/17, 03/22/17, 03/29/17 and 04/01/17, the remaining dates lacked documentation of the reason for omitting the medications.

The agency policy on MAR directed the nurses to document explanations for medication refused and/or not given on the back of the MAR form.

ii. In an interview on 04/27/17 SALSA #2 indicated that there were no nurses in the facility after 8 PM, and Client #10 did not want the bedtime medications administered as early as 8 PM, therefore the ALSA nurses left the pre-packaged medications in a locked box for the ALSA aides to assist with self-administration when Client #10 requested the medications later at bedtime.

However, interview and review of the Client Service Plan and the ALSA aide documentation with SALSA #2 on 04/27/17 failed to identify a written plan for the aides to assist with bedtime medications, and/or failed to identify ALSA aide documentation of assisting with medications each time;

iii. In addition, the agency policy on Medication Administration/Assistance indicated that trained associates may assist the residents with medication management or medication administration as directed by the physician, that medications might not be pre-poured

or left for the residents to consume at a later time, and residents should be observed taking the medications.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (h) Nursing services provided by an assisted living services agency (3) (D) and/or (J) (v) and/or (4) (D) and/or (G) and/or (k) Client service record (2) (H) (v).

2. Based on review of the clinical record and interview with agency staff, for one of ten clients (Client #1) in the survey sample, the agency failed to coordinate services with the client, family and the physician. The findings include:
   a. Client #1 was admitted on 05/06/14 with diagnoses that included anxiety, depression, chronic kidney disease, hyperlipidemia, hypertension, osteoarthritis and osteopenia. Physician's orders dated 04/30/14 included self-administration of medications with staff supervision, oversight and cueing.

      Interview and review of the Personal Service Plan dated 11/17/16 with LPN #1 on 03/03/17 indicated that the client's family member pre-poured the client's medications three to four weeks at a time, the client self-administered medications and did not require prompting with medications.

      Interview and review of a form entitled "Self- Administration of Medication Review" dated 11/17/16 with the District Director of Clinical Services (DDCS) on 3/3/17 identified documentation from the ALSA nurse that Client #1 was fully capable to verbalize situations warranting the use of as-needed medications, demonstrated secure storage for medications kept in room, was to self-medicate "per physician's orders," but failed to identify awareness from the ALSA staff of a physician's order dated 04/30/14 to supervise and cue the client during self-administration, failed to identify nursing communication with the physician to clarify the order, and failed to identify a discussion with the family member regarding the physician's orders for medication supervision and cueing.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (c) Managed residential communities served by assisted living services agencies (5) (A)

3. Based on review of personnel files, agency documentation and interview with agency staff, the agency failed to document the employment of a Resident Service Coordinator. The findings include:
   a. Interview and review of the personnel file of the Executive Director (ED) with the ED and the Business/ Human Resource Director on 03/10/17 indicated that the ED (a

position not required by the regulations) was also employed as the Resident Service Coordinator (RSC), but failed to identify a written appointment letter of the ED to the position of RSC (a position required by the regulations).

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (h) Nursing Services provided by an assisted living services agency (3) (G) and/or (k) Client service record (H) and/or (m) Client's bill of rights and responsibilities (5).

4. Based on clinical record review, agency documentation and interview with agency personnel, for two of two clients (Clients #4 and #5) identified in an incident, the agency Supervisor of Assisted Living Services Agency (SALSA) #1 failed to ensure the client safety and/or failed to follow their own policy. The findings include:
   a. Client #4 was admitted to the memory care unit on 04/01/14 with diagnoses that included Alzheimer's dementia, hypertension and osteoporosis. Physician's orders dated 03/20/14 included Sertraline 25 milligrams (mg) by mouth daily, Donezepil 5 mg by mouth at bedtime and Trazodone 50 mg by mouth at bedtime.

      On 2/14/14, Client was evaluated by Advanced Practice Registered Nurse (APRN) #1 (Behavioral health) prior to admission to the memory care unit, and diagnosed with dementia without behavior disturbances, with recommendations to maintain Zoloft for depression, to consider adding Trazodone at bedtime to help sleep and stop the wandering, to monitor mood, affect, behavior, sleep, appetite, and to increase or decrease medications as needed.

      A Personal Service Plan dated 05/14/14 identified the addition of services from a private duty aide from 8:00 pm to 8:00 am as Client #4 was getting up at night to flushing items down the toilet.

      On 05/29/14 Trazodone was increased to 75 mg at bedtime for difficulty sleeping through the night. The diagnoses included dementia without behavior disorder and depressive disorder.

      On 06/24/14 the client was noted with continued weight loss, and adjustment disorder was added as a diagnosis.

      On 08/05/14 Client #4 was prescribed Remeron 7.5 mg by mouth at 8:00 pm for appetite

stimulation.

On 0916/14 Trazodone was increased to 150 mg at bedtime for sleep.

On 10/14/14 the client exhibited new nocturnal incontinence, and Trazodone was decreased to 75mg
at bedtime.

On 02/19/15, the minutes from a family meeting identified the need for physical assistance with showering and toileting, and indicated that the client was resisting care and refusing medications

A Personal Service Plan dated 05/15/15 indicated that Client #4 was seen by behavioral health for medication adjustment to manage the client's behavior, as the client demonstrated resistance to care, required constant redirection and an unusually large amount of time for assistance with activities of daily living.

On 06/02/15 the client pushed another client causing the other client to fall.

On 06/07/15 the client left the water running in the shower and flooded the apartment, causing leaks to the first floor below the apartment.

On 06/07/15 the client was found in another client's room using a coat hanger to pry the window open. The plan of care was updated to reflect frequent checks by the aides throughout the night.

i. On 07/16/15 the client was non-compliant with care and striking staff.

On 07/20/15 the physician directed to start Trazodone 50 mg. by mouth every six hours as needed for anxiety as evidenced by physical aggression, resistance to care and difficulty redirecting.

On 07/27/15 the client punched an aide in the throat requiring evaluation of the aide at the hospital.
An "as needed" Trazodone medication was administered to the client, the family member was notified however the nursing documentation failed to identify notification to the physician of the client's behavior, in accordance with the

agency policies;

ii. On 07/25/17 the client was found in another client's room and refused medications.

On 07/30/15 the client was found in another resident room and refused medications.

On 08/02/15 the client refused medications, however the nursing documentation failed to identify notification to the family member and/or the physician of the client's behavior;

iii. On 08/03/15 the client was found on the floor and was transported to the hospital via ambulance and returned to the facility on the same day with no new orders.

On 08/04/15 at 1:30 pm the client lost balance and fell to one knee.
On the same day 08/04/15 at 4:45 pm the client was found on the floor in another client's apartment and was transported to the hospital via ambulance. The client returned at 9:15 pm on 08/04/15 with a fractured left shoulder in a sling and was non-compliant with wearing the sling.

On 08/05/15 the client was found in another client's room.

On 08/05/15 the physician ordered a physical therapy evaluation and Acetaminophen 325 mg by mouth every twelve hours as needed for pain.

On 08/06/15 the client was found on the dining room floor by an aide and was transported to the hospital via ambulance.
The client returned from the hospital the following day 08/07/15 with a lacerated lip, bruises to the right eye and cheek, and pain to the left shoulder from he previous left shoulder fracture.

On 08/29/15 the client was found in another room, lying in bed while the other client was also in the bed.
Later on the same day 8/29/15 Client # 4 was found in the roommate's bed.

On 09/30/15 the client was non-compliant with taking medications and scratched

an aide.

On 10/21/15 the client was aggressive, hitting staff, non-compliant and refused medications. The physician was notified and a psychiatric evaluation was requested.

On 10/27/15 the physician ordered Risperdal 0.5 mg daily at 4:00 pm and discontinued the Donezipil 5 mg.

On 10/31/15 the client was combative, hitting staff and intrusive with another client. The client was placed on 1:1 with an aide, the client's family and the psychiatrist were notified and the Risperdal was increased to twice a day.

On 11/04/15 Client #4 was found in Client #5's room.
Client #5 was on the floor, covered in blood, and both clients were transported via ambulance to the hospital.

According to the Manager of the Memory Care Unit in an interview on 03/07/17 at 2:25 pm, the Manager of the Memory Care Unit heard on 11/04/15 someone calling for help from Client #5's room. The Manager of the Memory Care Unit responded and found Client #5 bleeding on the floor. The Manager of the Memory Care Unit indicated that Client #4 was also in Client #5's room; Client #4 appeared "shocked and frightened."

The Manager of the Memory Care Unit indicated that Client # 4 used to occupy a one-bedroom apartment until 7/21/15 when Client # 4 was transferred to a shared two-bedroom apartment at the family's request. Since then Client # 4 had exhibited increased confusion regarding own room.

The Memory Care Unit Manager indicated that at times the agency provided 1:1 aide coverage and/or the client had a private duty aide from an outside agency.

The Memory Care Unit Manager further indicated on 03/16/17 that on the day of the incident 11/04/17, Client #4 did not receive 1:1 aide coverage and/or a private duty aide, and wandered in other client's rooms/apartments.

Interview and review of the ALSA documentation with the Executive Director

on 03/30/17 failed to identify review and revision to Client # 4's personal service plan since 5/15/15 to reflect the client 's room change, lack of private duty aide or 1:1 coverage, changes in condition, worsening behavior and necessary interventions .

The next update took place on 11/5/15, one day after the incident in Client #5's room.

b. Client #5 was admitted to the Memeory Care Unit on 06/02/15 with diagnoses that included dementia with behavioral disturbances. A physician note dated 09/24/15 identified progressive dementia with significant decline since last seen in February of 2015 and a weight loss of eight pounds. Physician's orders dated 10/01/15 included Memantine hydrochloride 5 mg by mouth twice a day until 10/26/15, then Namenda XR 28 mg by mouth daily starting 10/27/15 and Risperidone 0.25 mg by mouth as needed every six hours for anxiety.

The nursing notes from 06/02/15 to 11/04/15 did not identify any behavioral issues.

On 11/04/15 the nurse ALSA nurse documented a response to a call from Client #5's room, and found Client #5 sitting on the floor with the back against the bureau drawer. The nurse lifted the shirt sleeve and noticed blood extending down the left arm. The client was transported by ambulance to the hospital.

The inter-agency patient referral report (Form W-10) from the hospital dated 11/05/15 indicated that Client #4 presented as an "assault victim," lived in a locked dementia unit where the client was assaulted by another client. Client #4 complained of head and neck pain, was admitted to the trauma unit for close observation overnight, diagnosed with laceration of the left upper extremity and received sutures.
Client #4 was discharged back to the ALSA on 11/05/15 with orders that included home care services for daily wound care to the left arm using xeroform gauze and clean gauze.

i. Interview and review of the agency policy on Abuse, Neglect and Exploitation with the Executive Director on 3/16/17 indicated that the ALSA had a written commitment towards the safety of the clients, but failed to identify a safe environment provided to Client # 5 on 11/4/15;

ii. Interview and review of the agency policy on Abuse, Neglect and Exploitation with the Executive Director on 3/16/17 indicated that the Executive Director was to initiate an internal investigation of each

incident of abuse and maintain a written record of the investigation, but failed to identify the completion of an investigation of the incident involving Clients # 4 and # 5 on 11/4/15.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (f) Personnel policies for an assisted living services agency (1) (D) and/or (E) and/or (2) (B) and/or (D) and/or (g) Supervisor of assisted living services (2)(C).

5. Based on review of employee personnel files and interview with agency personnel, for five of five personnel files (the files of ALSA Aides #1, #2, #3, #4 and #5) the agency failed to ensure the proper documentation. The findings include:
    a. SALSA #1 had a hire date of 11/10/14 as the RN designee and an appointment date of 09/25/16 as the SALSA. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a pre-employment physical examination, tuberculin testing record, documentation that the employee was free from communicable disease and/or an annual performance evaluation.
    b. The RN Designee had a hire date of 09/19/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 identified a tuberculin (TB) test dated 05/16/16 but failed to identify a physician's signature on the form, and failed to identify documentation that the employee was free from communicable disease.
    c. SALSA #3 had a hire date of 03/21/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a physical examination, TB testing, documentation that the employee was free from communicable disease, an appointment letter and/or a job description.
    d. Aide #1 had a hire date of 06/23/10. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence and/or annual performance evaluations for 2014, 2015, and or 2016.
    e. Aide #2 had a hire date of 04/16/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence and/or annual performance evaluation for 2016.
    f. Aide #3 had a hire date of 10/07/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a statement that the employee was free from communicable disease, failed to identify an evaluation of clinical competence and/or annual performance evaluation for 2016.
    g. Aide #4 had a hire date of 12/06/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence.

h. Aide #5 had a hire date of 08/25/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an annual performance evaluation for 2016.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (d) Governing authority of an assisted living services agency (3) (A) and/or (4) (A) and/or (B) and/or (l) Quality assurance program for an assisted living service agency (2) and/or (10).

6. Based on review of the agency documentation and interview with agency personnel, the ALSA failed to hold meetings as required and maintain appropriate documentation. The findings include:
   a. Interview and review of the agency documentation with the Executive Director (ED) on 03/10/17 identified meetings held by the governing authority on 06/02/16 and 01/05/17 and failed to identify a minimum of two meetings per year.
   b. Interview and review of the Quality Assurance (QA) documentation for 2015 with the ED on 03/10/17 identified QA committee meetings held on 02/04/15 and 06/11/15, and failed to identify QA meetings every 120 days.
   c. Interview and review of the QA documentation with the ED on 03/10/17 failed to identify annual reports for the years 2014, 2015 and/or 2016.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B).

7. Based on review of the clinical record, agency documentation and staff interview, for one of ten clients (Client #10) in the survey sample, the agency failed to respond to the client's emergency pendant alarm in a reasonable amount of time. The findings include:
   a. Client #10 was admitted to the ALSA on 03/30/16 with diagnoses that included congestive heart failure, essential hypertension, osteoarthritis, Alzheimer's dementia, urinary incontinence, depressive disorder, Vitamin D deficiency and history of Guillain-Barre syndrome with residual weakness of the left leg.

      The client's Personal Service Plan dated 04/15/17 identified the need for medication management and administration.

      Interview and review of the "Alarm Response Report" with the SALSA and the Human Resource Director indicated that on 04/17/17 Client #10 activated the emergency pendant for assistance at 7:07 am, identified a response time of one hour and nine minutes, and failed to identify a response to the emergency call bell in a reasonable time

frame.

The agency policy on emergency pendant call directed the ALSA staff to respond to call alerts in a reasonable and timely manner and if unable to respond, the staff should request assistance from another staff member.

The Human Resource Director indicated that the two ALSA aides assigned to Client #10 on 04/17/17 received disciplinary action for not responding in a reasonable and timely manner.

Copy

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Brookdale West Hartford
22 Simsbury Road
West Hartford CT 06117

M:

Signature of FLIS Staff

Melissa J. San Souci RN Nurse Consultant
Ph 860-523-9899
Fax - 860-523-9515

Licensure Category: Assisted Living Services

Licensed Bed/Bassinet Capacity: ___ Census: 73

Date(s) of onsite inspection: 03/02/17, 03/03/17, 03/07/17, 03/09/17, 03/10/17

Date(s) additional information obtained: 03/13/17

Personnel contacted: Diane Voccia, RN, SALSA, Zoila Diaz Jones, RN Designee, Annette Cochefski, RN, DDCS, Todd Curtiss ED, Adrienne Perry, RN Case Manager

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes):* ___

[ ] Visit **OR** Revisit for the purpose of ___

[X] See Complaint Investigation # 21230, #19133, #20349, #18213

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ___

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Melissa J. San Souci RN **DATE OF REPORT:** 03/30/17

[ ] Approval for issuance of license granted by: Joan D Nguyen **DATE:** 4-18-17
Supervisor/Title

s:flis\hsr\FACESHEETS
Revised 12/2016

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Chris

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 1, 2017

Beata Kozubel, Supervisor of Assisted Living Services Agency
Brookdale West Hartford
22 Simsbury Road
West Hartford, CT 06117

Dear Ms. Kozubel:

Unannounced visits were made to Brookdale West Hartford on March 2, 3, 7, 9, 10, 2017 and April 27and 28, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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.

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 May 31, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);

2. Date corrective measure will be effected;

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. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are 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
CT # 18213, 19133, 20349, 21230, 21548

DATES OF VISIT: March 2, 3, 7, 9, 10 and April 28, 2017

THE FOLLOWING VIOLATIONS 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 D19-13-D105 (g) Supervisor of assisted living service (2)(A) and/or (B) and/or (h) Nursing services provided by an assisted living services agency(3)(J)(v).

1. Based on review of the clinical records and interview with agency personnel, for two of ten clients (Clients #6 and #10) in the survey sample, the agency failed to ensure effective communication and safe administration of medications. The findings include:
    a. Client #6 was admitted on 08/04/16 to the Memory Care Unit with diagnoses that included Alzheimer's dementia with behavioral disturbance and anxiety. Physician's Orders for the period of 02/14/17 to 03/13/17 included Gabapentin 200 mg by mouth three times a day, Trazodine 25 mg three times a day, and Trazadone 50 mg outh at bedtime.

        i. Interview and review of the medication administration record (MAR) on 03/10/17 of Client #6 with the Registered Nurse (RN) designee and the RN Case Manager failed to identify documentation of administration of the 5:00 pm doses of Gabapentin and Trazodone on 02/20/17, and the 8:00 pm dose of Trazodone on 02/20/17.

        ii. Further interview and review of the February 2017 staffing schedule with the Executive Director and Licensed Practical Nurse (LPN) #1 on 03/10/17 indicated that LPN #4 was scheduled to work on the Memory Care Unit from 4:30 to 8:00 pm on 2/20/17, however LPN #4 did not report to work as planned.

        ALSA aide #1 notified LPN #1 at 6:49 pm on 02/20/17 that there was no nurse on duty on the Memory Care Unit to administer medications.

        The aide further recalled seeing LPN #3 in the building earlier in the day and assumed LPN #3 was working that evening.

        In an interview on 03/10/17, LPN #2 indicated that LPN #2 was assigned to another unit outside of the Memory Care Unit from 2:00 pm until 7:00 pm on 02/20/17. LPN #2 was getting ready to leave at 7:00 pm on 02/20/17, when an aide reported the absence of nurse on the Memory Care Unit for medication administration. LPN #2 contacted the RN Designee who asked LPN #2 to stay and administer medications until a replacement nurse reported for duty.

        LPN #2 stated to the surveyor on 3/10/17 that LPN #2 agreed to stay because LPN #2 was the only nurse in the building, but was uncomfortable administering medications as LPN #2 had not received an orientation to the memory care unit.

        By the time LPN #2 received an orientation on 2/20/17 to the password codes and locks on the unit, LPN #3 arrived as the replacement nurse, and LPN #2 had not

administered any medications yet.

LPN #2 explained to the surveyor that LPN #2 reported off to LPN #3 by stating "Client #6 was all set" to signify that Client #6 was escorted back to the client's apartment, and failed to identify clear and effective communication of the client's status in order to meet the client's needs;

iii. In an interview on 03/10/17 LPN #3 stated LPN #2 reported off that Client #6 was "taken care of," and LPN #3 assumed that LPN #2 administered all medications to Client #6, but LPN #3 failed to establish contact with LPN #2 later in the shift upon seeing that the MAR was not signed for Client #6.

iv. Interview and review of Client #6's MAR with the RN Designee on 03/09/17 failed to identify awareness from the RN Designee of omitted medications for Client #6 on 2/20/17 until the surveyor's investigation, and failed to identify appropriate oversight of nursing practice.

The agency policy on Medication Administration Record (MAR) directed the completion of MAR documentation during the change of each shift and verification of medications administered by both the outgoing and oncoming staff;

v. Interview and review of the Controlled Substance tracking dated February 2017 with the RN Case Manager (RN #2) on 03/10/17 indicated that LPN #2 signed under "first staff signature," failed to identify a "second staff signature" by LPN #3 on 02/20/17 during the evening shift, as required on the agency pre-printed form, and failed to identify proper reconciliation of controlled substances;

vi. Interview and review of the Controlled Substance tracking dated February 2017 with RN #2 failed to identify a second staff signature on 02/13/17 during the evening shift, as required on the agency pre-printed form, and failed to identify proper reconciliation of controlled substances;

vii. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify a second staff signature and/or failed to identify documentation of an audit completed on 02/14/17 during the evening shift, in accordance with the agency requirements;

viii. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify an audit completed on 02/16/17 during the morning shift, in accordance with the agency requirements;

ix. Interview and review of the MAR Controlled Substance/MAR Change of Shift Audit dated February 2017 with RN #2 failed to identify a second staff signature on 02/21/17

during the morning and evening shifts, and/or failed to identify an audit completed on 02/21/17 during the evening shift, in accordance with the agency requirements.

b. Client #10 was admitted on 03/30/16 with diagnoses that included shortness of breath, congestive heart failure, essential hypertension, osteoarthritis, Alzheimer's dementia, urinary incontinence, depressive disorder, Vitamin D deficiency and a history of Guillain-Barre syndrome with residual weakness of the left leg.

The client's Personal Service Plan dated 04/15/17 identified the need for medication management and administration.

The physician's orders for the period of 03/14/17 to 04/10/17 included Melatonin 3 milligrams (mg) by mouth at bedtime (9:00 pm) and Trazodone 100 mg by mouth at bedtime (9:00 pm).

i. Interview and review of the medication administration record (MAR) with SALSA #2 on 04/27/17 failed to identify administration of the Trazodone and/or Melatonin on 03/14/17, 03/15/17, 03/16/17, 03/17/17, 03/18/17, 03/19/17, 03/20/17, 03/21/17, 03/22/17, 03/2317, 03/24/17, 03/25/17, 03/26/17, 03/27/17, 03/28/17, 03/29/17, 03/30/17, 03/31/17, 04/01/17, 04/02/17, 04/03/17, 04/04/17, 04/05/17. 04/06/17, 04/07/17, 04/08/17, 04/09/17 and 04/10/17; while the "medication exception and hold notes" section of the MAR indicated that the client refused and/or requested the medication be administered later (9:30 pm or 10:00 pm) on 03/14/17, 03/15/17, 03/16/17, 03/17/17, 03/18/17, 03/19/17, 03/21/17, 03/22/17, 03/29/17 and 04/01/17, the remaining dates lacked documentation of the reason for omitting the medications.

The agency policy on MAR directed the nurses to document explanations for medication refused and/or not given on the back of the MAR form.

ii. In an interview on 04/27/17 SALSA #2 indicated that there were no nurses in the facility after 8 PM, and Client #10 did not want the bedtime medications administered as early as 8 PM, therefore the ALSA nurses left the pre-packaged medications in a locked box for the ALSA aides to assist with self-administration when Client #10 requested the medications later at bedtime.

However, interview and review of the Client Service Plan and the ALSA aide documentation with SALSA #2 on 04/27/17 failed to identify a written plan for the aides to assist with bedtime medications, and/or failed to identify ALSA aide documentation of assisting with medications each time;

iii. In addition, the agency policy on Medication Administration/Assistance indicated that trained associates may assist the residents with medication management or medication administration as directed by the physician, that medications might not be pre-poured

or left for the residents to consume at a later time, and residents should be observed taking the medications.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (h) Nursing services provided by an assisted living services agency (3) (D) and/or (J) (v) and/or (4) (D) and/or (G) and/or (k) Client service record (2) (H) (v).

2. Based on review of the clinical record and interview with agency staff, for one of ten clients (Client #1) in the survey sample, the agency failed to coordinate services with the client, family and the physician. The findings include:
   a. Client #1 was admitted on 05/06/14 with diagnoses that included anxiety, depression, chronic kidney disease, hyperlipidemia, hypertension, osteoarthritis and osteopenia. Physician's orders dated 04/30/14 included self-administration of medications with staff supervision, oversight and cueing.

      Interview and review of the Personal Service Plan dated 11/17/16 with LPN #1 on 03/03/17 indicated that the client's family member pre-poured the client's medications three to four weeks at a time, the client self-administered medications and did not require prompting with medications.

      Interview and review of a form entitled "Self- Administration of Medication Review" dated 11/17/16 with the District Director of Clinical Services (DDCS) on 3/3/17 identified documentation from the ALSA nurse that Client #1 was fully capable to verbalize situations warranting the use of as-needed medications, demonstrated secure storage for medications kept in room, was to self-medicate "per physician's orders," but failed to identify awareness from the ALSA staff of a physician's order dated 04/30/14 to supervise and cue the client during self-administration, failed to identify nursing communication with the physician to clarify the order, and failed to identify a discussion with the family member regarding the physician's orders for medication supervision and cueing.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (c) Managed residential communities served by assisted living services agencies (5) (A)

3. Based on review of personnel files, agency documentation and interview with agency staff, the agency failed to document the employment of a Resident Service Coordinator. The findings include:
   a. Interview and review of the personnel file of the Executive Director (ED) with the ED and the Business/ Human Resource Director on 03/10/17 indicated that the ED (a

position not required by the regulations) was also employed as the Resident Service Coordinator (RSC), but failed to identify a written appointment letter of the ED to the position of RSC (a position required by the regulations).

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (h) Nursing Services provided by an assisted living services agency (3) (G) and/or (k) Client service record (H) and/or (m) Client's bill of rights and responsibilities (5).

4. Based on clinical record review, agency documentation and interview with agency personnel, for two of two clients (Clients #4 and #5) identified in an incident, the agency Supervisor of Assisted Living Services Agency (SALSA) #1 failed to ensure the client safety and/or failed to follow their own policy. The findings include:
   a. Client #4 was admitted to the memory care unit on 04/01/14 with diagnoses that included Alzheimer's dementia, hypertension and osteoporosis. Physician's orders dated 03/20/14 included Sertraline 25 milligrams (mg) by mouth daily, Donezepil 5 mg by mouth at bedtime and Trazodone 50 mg by mouth at bedtime.

      On 2/14/14, Client was evaluated by Advanced Practice Registered Nurse (APRN) #1 (Behavioral health) prior to admission to the memory care unit, and diagnosed with dementia without behavior disturbances, with recommendations to maintain Zoloft for depression, to consider adding Trazodone at bedtime to help sleep and stop the wandering, to monitor mood, affect, behavior, sleep, appetite, and to increase or decrease medications as needed.

      A Personal Service Plan dated 05/14/14 identified the addition of services from a private duty aide from 8:00 pm to 8:00 am as Client #4 was getting up at night to flushing items down the toilet.

      On 05/29/14 Trazodone was increased to 75 mg at bedtime for difficulty sleeping through the night. The diagnoses included dementia without behavior disorder and depressive disorder.

      On 06/24/14 the client was noted with continued weight loss, and adjustment disorder was added as a diagnosis.

      On 08/05/14 Client #4 was prescribed Remeron 7.5 mg by mouth at 8:00 pm for appetite

stimulation.

On 0916/14 Trazodone was increased to 150 mg at bedtime for sleep.

On 10/14/14 the client exhibited new nocturnal incontinence, and Trazodone was decreased to 75mg
at bedtime.

On 02/19/15, the minutes from a family meeting identified the need for physical assistance with showering and toileting, and indicated that the client was resisting care and refusing medications

A Personal Service Plan dated 05/15/15 indicated that Client #4 was seen by behavioral health for medication adjustment to manage the client's behavior, as the client demonstrated resistance to care, required constant redirection and an unusually large amount of time for assistance with activities of daily living.

On 06/02/15 the client pushed another client causing the other client to fall.

On 06/07/15 the client left the water running in the shower and flooded the apartment, causing leaks to the first floor below the apartment.

On 06/07/15 the client was found in another client's room using a coat hanger to pry the window open. The plan of care was updated to reflect frequent checks by the aides throughout the night.

i. On 07/16/15 the client was non-compliant with care and striking staff.

On 07/20/15 the physician directed to start Trazodone 50 mg. by mouth every six hours as needed for anxiety as evidenced by physical aggression, resistance to care and difficulty redirecting.

On 07/27/15 the client punched an aide in the throat requiring evaluation of the aide at the hospital.
An "as needed" Trazodone medication was administered to the client, the family member was notified however the nursing documentation failed to identify notification to the physician of the client's behavior, in accordance with the

agency policies;

ii. On 07/25/17 the client was found in another client's room and refused medications.

On 07/30/15 the client was found in another resident room and refused medications.

On 08/02/15 the client refused medications, however the nursing documentation failed to identify notification to the family member and/or the physician of the client's behavior;

iii. On 08/03/15 the client was found on the floor and was transported to the hospital via ambulance and returned to the facility on the same day with no new orders.

On 08/04/15 at 1:30 pm the client lost balance and fell to one knee.
On the same day 08/04/15 at 4:45 pm the client was found on the floor in another client's apartment and was transported to the hospital via ambulance. The client returned at 9:15 pm on 08/04/15 with a fractured left shoulder in a sling and was non-compliant with wearing the sling.

On 08/05/15 the client was found in another client's room.

On 08/05/15 the physician ordered a physical therapy evaluation and Acetaminophen 325 mg by mouth every twelve hours as needed for pain.

On 08/06/15 the client was found on the dining room floor by an aide and was transported to the hospital via ambulance.
The client returned from the hospital the following day 08/07/15 with a lacerated lip, bruises to the right eye and cheek, and pain to the left shoulder from he previous left shoulder fracture.

On 08/29/15 the client was found in another room, lying in bed while the other client was also in the bed.
Later on the same day 8/29/15 Client # 4 was found in the roommate's bed.

On 09/30/15 the client was non-compliant with taking medications and scratched

an aide.

On 10/21/15 the client was aggressive, hitting staff, non-compliant and refused medications. The physician was notified and a psychiatric evaluation was requested.

On 10/27/15 the physician ordered Risperdal 0.5 mg daily at 4:00 pm and discontinued the Donezipil 5 mg.

On 10/31/15 the client was combative, hitting staff and intrusive with another client. The client was placed on 1:1 with an aide, the client's family and the psychiatrist were notified and the Risperdal was increased to twice a day.

On 11/04/15 Client #4 was found in Client #5's room.
Client #5 was on the floor, covered in blood, and both clients were transported via ambulance to the hospital.

According to the Manager of the Memory Care Unit in an interview on 03/07/17 at 2:25 pm, the Manager of the Memory Care Unit heard on 11/04/15 someone calling for help from Client #5's room. The Manager of the Memory Care Unit responded and found Client #5 bleeding on the floor. The Manager of the Memory Care Unit indicated that Client #4 was also in Client #5's room; Client #4 appeared "shocked and frightened."

The Manager of the Memory Care Unit indicated that Client # 4 used to occupy a one-bedroom apartment until 7/21/15 when Client # 4 was transferred to a shared two-bedroom apartment at the family's request. Since then Client # 4 had exhibited increased confusion regarding own room.

The Memory Care Unit Manager indicated that at times the agency provided 1:1 aide coverage and/or the client had a private duty aide from an outside agency.

The Memory Care Unit Manager further indicated on 03/16/17 that on the day of the incident 11/04/17, Client #4 did not receive 1:1 aide coverage and/or a private duty aide, and wandered in other client's rooms/apartments.

Interview and review of the ALSA documentation with the Executive Director

on 03/30/17 failed to identify review and revision to Client # 4's personal service plan since 5/15/15 to reflect the client 's room change, lack of private duty aide or 1:1 coverage, changes in condition, worsening behavior and necessary interventions .

The next update took place on 11/5/15, one day after the incident in Client #5's room.

b. Client #5 was admitted to the Memeory Care Unit on 06/02/15 with diagnoses that included dementia with behavioral disturbances. A physician note dated 09/24/15 identified progressive dementia with significant decline since last seen in February of 2015 and a weight loss of eight pounds. Physician's orders dated 10/01/15 included Memantine hydrochloride 5 mg by mouth twice a day until 10/26/15, then Namenda XR 28 mg by mouth daily starting 10/27/15 and Risperidone 0.25 mg by mouth as needed every six hours for anxiety.

The nursing notes from 06/02/15 to 11/04/15 did not identify any behavioral issues.

On 11/04/15 the nurse ALSA nurse documented a response to a call from Client #5's room, and found Client #5 sitting on the floor with the back against the bureau drawer. The nurse lifted the shirt sleeve and noticed blood extending down the left arm. The client was transported by ambulance to the hospital.

The inter-agency patient referral report (Form W-10) from the hospital dated 11/05/15 indicated that Client #4 presented as an "assault victim," lived in a locked dementia unit where the client was assaulted by another client. Client #4 complained of head and neck pain, was admitted to the trauma unit for close observation overnight, diagnosed with laceration of the left upper extremity and received sutures. Client #4 was discharged back to the ALSA on 11/05/15 with orders that included home care services for daily wound care to the left arm using xeroform gauze and clean gauze.

i. Interview and review of the agency policy on Abuse, Neglect and Exploitation with the Executive Director on 3/16/17 indicated that the ALSA had a written commitment towards the safety of the clients, but failed to identify a safe environment provided to Client # 5 on 11/4/15;

ii. Interview and review of the agency policy on Abuse, Neglect and Exploitation with the Executive Director on 3/16/17 indicated that the Executive Director was to initiate an internal investigation of each

incident of abuse and maintain a written record of the investigation, but failed to identify the completion of an investigation of the incident involving Clients # 4 and # 5 on 11/4/15.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (f) Personnel policies for an assisted living services agency (1) (D) and/or (E) and/or (2) (B) and/or (D) and/or (g) Supervisor of assisted living services (2)(C).

5. Based on review of employee personnel files and interview with agency personnel, for five of five personnel files (the files of ALSA Aides #1, #2, #3, #4 and #5) the agency failed to ensure the proper documentation. The findings include:
    a. SALSA #1 had a hire date of 11/10/14 as the RN designee and an appointment date of 09/25/16 as the SALSA. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a pre-employment physical examination, tuberculin testing record, documentation that the employee was free from communicable disease and/or an annual performance evaluation.
    b. The RN Designee had a hire date of 09/19/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 identified a tuberculin (TB) test dated 05/16/16 but failed to identify a physician's signature on the form, and failed to identify documentation that the employee was free from communicable disease.
    c. SALSA #3 had a hire date of 03/21/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a physical examination, TB testing, documentation that the employee was free from communicable disease, an appointment letter and/or a job description.
    d. Aide #1 had a hire date of 06/23/10. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence and/or annual performance evaluations for 2014, 2015, and or 2016.
    e. Aide #2 had a hire date of 04/16/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence and/or annual performance evaluation for 2016.
    f. Aide #3 had a hire date of 10/07/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify a statement that the employee was free from communicable disease, failed to identify an evaluation of clinical competence and/or annual performance evaluation for 2016.
    g. Aide #4 had a hire date of 12/06/16. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an evaluation of clinical competence.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

h. Aide #5 had a hire date of 08/25/15. Interview and review of the personnel file with the Business and Human Resource Director on 03/10/17 failed to identify an annual performance evaluation for 2016.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (d) Governing authority of an assisted living services agency (3) (A) and/or (4) (A) and/or (B) and/or (l) Quality assurance program for an assisted living service agency (2) and/or (10).

6. Based on review of the agency documentation and interview with agency personnel, the ALSA failed to hold meetings as required and maintain appropriate documentation. The findings include:
   a. Interview and review of the agency documentation with the Executive Director (ED) on 03/10/17 identified meetings held by the governing authority on 06/02/16 and 01/05/17 and failed to identify a minimum of two meetings per year.
   b. Interview and review of the Quality Assurance (QA) documentation for 2015 with the ED on 03/10/17 identified QA committee meetings held on 02/04/15 and 06/11/15, and failed to identify QA meetings every 120 days.
   c. Interview and review of the QA documentation with the ED on 03/10/17 failed to identify annual reports for the years 2014, 2015 and/or 2016.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B).

7. Based on review of the clinical record, agency documentation and staff interview, for one of ten clients (Client #10) in the survey sample, the agency failed to respond to the client's emergency pendant alarm in a reasonable amount of time. The findings include:
   a. Client #10 was admitted to the ALSA on 03/30/16 with diagnoses that included congestive heart failure, essential hypertension, osteoarthritis, Alzheimer's dementia, urinary incontinence, depressive disorder, Vitamin D deficiency and history of Guillain-Barre syndrome with residual weakness of the left leg.

      The client's Personal Service Plan dated 04/15/17 identified the need for medication management and administration.

      Interview and review of the "Alarm Response Report" with the SALSA and the Human Resource Director indicated that on 04/17/17 Client #10 activated the emergency pendant for assistance at 7:07 am, identified a response time of one hour and nine minutes, and failed to identify a response to the emergency call bell in a reasonable time

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

frame.

The agency policy on emergency pendant call directed the ALSA staff to respond to call alerts in a reasonable and timely manner and if unable to respond, the staff should request assistance from another staff member.

The Human Resource Director indicated that the two ALSA aides assigned to Client #10 on 04/17/17 received disciplinary action for not responding in a reasonable and timely manner.

POC Approved
9/7/17
M Sarbonetti RS

BROOKDALE
WEST HARTFORD
SENIOR LIVING SOLUTIONS

The following is the Plan of Correction for **Brookdale West Hartford** regarding the Statement of Deficiencies dated **June 1, 2017**. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Unannounced visit was made to Brookdale West Hatford on March 2, 3, 7, 9, 10, 2017 and April 27 and 28, 2017 by a representative of the Facility Licensing and Invesitgation Section of the Department of Public Health for the purposes of conducting an investigation. The findings are as follows:

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (g) Supervisor of assisted living service (2) (A) and/or (B) and/or (h) Nursing services provided by an assisted living service agency (3)(J)(v).

1.a.i. Agency on 2/20/17 failed to ensure effective communication and safe administration of medications.

1.a.ii. LPN #2 on 2/20/17 failed to identify clear and effective communication of the client's status in order to meet the client's needs.

1.a.iii. LPN #3on 2/20/17 failed to establish contact with LPN #2 later in the shift upon seeing the MAR was not signed for Client #6

1.a.iv. RN Designee on 2/20/17 failed to identify appropriate oversight of nursing practice.

A Corrective Action:
1. SALSA will review and re-educate nursing staff on Medication Administration Services Policy.
2. SALSA will review and re-educate nursing staff on Medication Administration Record Audit Policy CS-40-9

B. Completion Date: Re-education of nursing staff will be completed on or before July 15, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
1. SALSA or RN Designee will audit 50 % of MARs on a weekly basis on a weekly basis for a four month period to verify proper documentation procedures are followed. The expectation is 95% accuracy.
2. Ongoing audits will be conducted on 5% of clinical records during routine Quality Assurance at a minimum of every 120 Days

D. SALSA will be responsible for the ongoing monitoring of this plan

22 Simsbury Road
West Hartford, CT 06117
brookdale.com

POC Approved
9/7/17
M. Sanchez RN

1.a.v. LPN #2 on 2/20/17 failed to identify a "second staff signature" by LPN #3, and failed to identify proper reconciliation of controlled substances.

1.a.vi. RN #2 failed to identify a second staff signature on 2/13/17, and failed to identify proper reconciliation of controlled substances.

1.a.vii. RN #2 failed to identify documentation of Controlled Substance/MAR Change of Shift audit completed on 2/14/17

1.a.viii RN #2 failed to identify documentation Controlled Substance/MAR Change of Shift audit completed on 2/16/17

1.a.ix. RN #2 failed to identify a second staff signature on 2/21/17, and/or failed to identify an audit completed on 2/21/17

A Corrective Action:

1. SALSA/RN Designee has completed an audit of current Controlled Substance Records to identify if other residents may have been affected by the alleged deficient practice.
2. SALSA will review and re-educate nursing staff on Medication & Treatments Controlled Substances Count CS-40-4.

B. Completion Date: Re-education of nursing staff will be completed on or before Jul 15, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:

1. SALSA or RN Designee will audit 100% Controlled Substance Count Sheets on a weekly basis for a four month period to verify compliance with proper documentation procedures. The expectation is a 95% compliance rate. Additional corrective action will be taken by the SALSA, as indicated by audit findings.

D. SALSA will be responsible for the ongoing monitoring of this plan

1.b.i. Review of Client #10 MAR failed to identify administration of Trazodone and/or Melatonin on 3/14/17 – 4/10/17

1.b.ii. SALSA #2 on 4/27/17 failed to identify a written plan for the aides to assist with bedtime medications, and/or failed to identify ALSA aide documentation of assisting with medications each time.

1.b.iii. Agency failed to comply with Medication Administration / Assistance Policy

A Corrective Action:

1. SALSA will review and re-educate nursing staff on Medication & Treatments – Medication Administration Record CS-40-8
2. SALSA or RN Designee will reeducate and complete a Resident Assistant Medication Reminder Skills Checklist on all Resident Assistants that are responsible for medication reminders.

B. Completion Date:

1. Re-education of nursing staff will be completed on or before July 15, 2017
2. Re-education and Skills validation will be completed on or before July 1, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:

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9/7/17
M Sansouci RN

B. Completion Date: Letter of appointment will be completed on or before September 30, 2017 for all RSC.

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. District Director of Clinical Services will audit 100% of personnel records of all Resident Service Coordinators to assure letter of appointment is present.
   2. District Director of Operations will have accountability to initiate letter of appointment to all new RSC.

D. District Director of Clinical Services will be responsible for the ongoing monitoring of this plan

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (h) Nursing Services provided by an assisted living services agency (3) (G) and/or (k) Client services record (H) and/or (m) Client's bill of rights and responsibilities (5).

4.a.i. SALSA #1 failed to ensure the client safety and/or failed to follow their own policy. Nursing documentation failed to identify notification to the physician of the client's behavior, in accordance with the agency policies.

4.a.ii. Client #1 refused medications, however the nursing documentation failed to identify notification to the family member and/or the physician of the client's behavior.

4.a.iii. ALSA documentation failed to identify review and revision to Client #4's personal service plan since 5/15/15 to reflect the client's room change, lack of private duty aide or 1:1 coverage, changes in condition, worsening behavior and necessary interventions.

A Corrective Action:
   1. SALSA will review and re-educate nursing staff on Change of Condition/Notification Policy CT-4

B. Completion Date: Re-education of nursing staff will be completed on or before July 15, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. SALSA or RN Designee will audit 25% of all medical records on a weekly basis for a four month period to verify documentation on condition change is complete in resident record as well as Resident Service Plan. A 95% compliance is the expectation.
   2. SALSA, along with the interdisciplinary team, will review all residents on a bi-monthly basis, for a period of four months, using the Collaborative Care Meeting Process to identify residents who may have a change in condition or changes in orders warranting additional communication to physician, responsible party and other associates.

D. SALSA will be responsible for the ongoing monitoring of this plan

4.b.i. ALSA failed to identify a safe environment provided to Clients #5 on 11/4/15

A Corrective Action:
   1. SALSA will review and re-educate nursing staff on Change of Condition/Notification Policy CT-4
   2. All nursing staff and Resident Care Associates will complete re-education on Managing Aggressive Residents

POC Approved 9/7/17 M. Sullivan

1. SALSA or RN Designee will audit 50% of MAR's and MOR's on a weekly basis for a four month period to verify proper documentation procedures are followed, expectation rate is 95% compliance
2. Ongoing audits will be conducted on 5% of clinical records during routine Quality Assurance at a minimum of every 120 Days

D. SALSA will be responsible for the ongoing monitoring of this plan

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (h) Nursing services provided by an assisted living services agency (3) (D) and/or (J) (v) and/or (4) (D) and/or (G) and/or (k) Client service record (2) (H) (v).

2.a. Agency failed to coordinate services with Client #1, family, and the physician. Agency failed to identify nursing communication with the physician to clarify the order, and failed to identify a discussion with the family member regarding the physician's orders for medication supervision and cueing.

A Corrective Action:

1. SALSA will review and re-educate nursing staff on Change of Condition/Notification Policy CT-4

B. Completion Date: Re-education of nursing staff will be completed on or before July 15, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:

1. SALSA or RN Designee will audit 25% of all medical records on a weekly basis for a four month period to verify documentation on condition change is complete in resident record as well as Resident Service Plan compliance expectation is 95%.
2. SALSA, along with the interdisciplinary team will review all residents on a bi-monthly basis, using the Collaborative Care Meeting Process to identify residents who may have a change in condition or changes in orders warranting additional communication to physician, responsible party and other associates.

D. SALSA will be responsible for the ongoing monitoring of this plan.

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (c) Managed residential communities served by assisted living services agencies (5) (A).

3.a. Agency failed to document the employment of a Resident Service Coordinator, failed to identify a written appointment letter of the ED to the position of RSC

A Corrective Action:

1. All Resident Service Coordinators will have a letter of appointment detailing responsibilities upon assuming role.

POC Approved 9/7/17 M Santoro RN

B. Completion Date: Re-education of nursing staff and Resident Care Associates will be completed on or before July 30, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. SALSA or RN Designee will audit 25% of all medical records on a weekly basis for a four month period to verify documentation on condition change is complete in resident record as well as Resident Service Plan. A 95% compliance is the expectation.
   2. SALSA, along with the interdisciplinary team will review all residents on a bi-monthly basis, using the Collaborative Care Meeting Process to identify residents who may have a change in condition or changes in orders warranting additional communication to physician, responsible party and other associates

D. SALSA will be responsible for the ongoing monitoring of this plan

4.b.ii. Executive Director failed to identify the completion of an investigation of the incident involving Clients #4 and #5 on 11/4/15.

A Corrective Action:
   1. District Director of Clinical Services will review and re-educate Executive Directors on conducting investigations

B. Completion Date: Re-education of nursing staff will be completed on or before July 30, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. District Director of Clinical Services will audit 50% of all investigations for a four month period to verify completion and resolution of investigation. All reportable incidents are reported to DDCS on a weekly basis by SALSA on weekly report. Expectation is 95% compliance with all investigations.
   2. SALSA, along with the interdisciplinary team will review all residents on a bi-monthly basis, using the Collaborative Care Meeting Process to identify residents who may have a change in condition or changes in orders warranting additional communication to physician, responsible party and other associates

D. DDCS will be responsible for the ongoing monitoring of this plan

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (f) Personnel policies for an assisted living services agency (1) (D) and/or (E) and/or (2) (B) and/or (D) and/or (g) Supervisor of assisted living services (2) (C).

5.a. Personnel file failed to identify a pre-employment physical examination, tuberculin testing record, documentation that the employee was free from communicable disease and/or an annual performance evaluation for SALSA #1.

5.b. Personnel file failed to identify physician's signature on the tuberculin testing form, documentation that the employee was free from communicable disease and/or an annual performance evaluation for RN Designee.

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9/7/17
M Sunbourne RN

5.c. Personnel file failed to identify a pre-employment physical examination, tuberculin testing record, documentation that the employee was free from communicable disease an appointment letter and/or job description SALSA #3.

5.d. Personnel file failed to identify an evaluation of clinical competence and/or annual performance evaluations for 2014,2015,2016 for Aide #1.

5.e. Personnel file failed to identify an evaluation of clinical competence and/or annual performance evaluations for 2016 for Aide #2.

5.f. Personnel file failed to identify statement that the employee was free from communicable disease and evaluation of clinical competence and/or annual performance evaluations for 2016 for Aide #3.

5.g. Personnel file failed to identify evaluation of clinical competence for Aide #4.

5.h. Personnel file failed to identify annual performance evaluations for 2016 for Aide #5.

A Corrective Action:

1. District Director of Clinical Services will review and re-educate Executive Director, Business Office Manager, and SALSA on policy 402 Associate Physicals
2. District Director of Clinical Services will review and re-educate SALSA on completing Skills Competency during orientation and annually.
3. District Director of Operations will review and re-educate Executive Director, Business Office Manager, and SALSA on Associate Annual Review process

B. Completion Date: will be completed on or before September 30, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:

1. Business Office Manager will conduct an audit of 25% of the associate personnel files weekly for a period of 4 months to ensure completeness and bring all items out of compliance into compliance.

D. Executive Director will be responsible for the ongoing monitoring of this plan

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (d) Governing authority of an assisted living services agency (3) (A) and/or (4) (A) and/or (B) and/or (1) Quality assurance program for an assisted living service agency (2) and/or (10).

6.a. Review of agency documentation for 2016 failed to identify a minimum of two meetings per year for the governing authority.

6.b. Review of agency documentation for 2015 failed to identify QA meetings every 120 days.

6.c. Review of agency documentation failed to identify annual reports for the years 2014, 2015, 2016.

A Corrective Action:

1. District Director of Clinical Services will review and re-educate SALSA and RSC on Quality Assurance Policy – CT -7
2. District Director of Clinical Services will review and re-educate SALSA and RSC on Governing Authority Process.

POC Approved
9/7/17
M Sanchez

3. District Director of Clinical Services will review and re-educate SALSA and RSC on Quality Assurance Annual Report.

B. Completion Date: will be completed on or before July 30, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. SALSA will advise District Director of Clinical Services of the dates for Quality Assurance Meeting and Governing Authority Meeting
   2. SALSA will send a copy of the completed minutes of QA and GA meetings and the Annual Report to District Director of Clinical Services

D. District Director of Clinical Services will be responsible for the ongoing monitoring of this plan

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105 (g) Supervisor of assisted living services (2) (A) and/or (B).

7.a. Agency failed to respond to the client's emergency pendent alarm in a reasonable amount of time.

A Corrective Action:
   1. SALSA will review and re-educate all nurses and resident care staff on Resident Call System and Door Alarm Response – SE-14

B. Completion Date: will be completed on or before July 30, 2017

C. Ongoing Quality Assessment and Performance Improvement Process:
   1. SALSA or designated manager will review Pendent Response Report on a daily basis for a period of four months
   2. All response time greater than ten minutes will be reviewed with assigned care giver. Additional corrective action will be taken at the discretion of the SALSA, as indicated by audit findings.

D. SALSA will be responsible for the ongoing monitoring of this plan