2018

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

January 25, 2018

Susan Marcoux Klehm, Supervisor of Assited Living Services Agency
Brookdale Wilton
96 Danbury Road
Wilton, CT 06897

Dear Ms. Klehm:

An unannounced visit was made to Brookdale Wilton on July 17, 2017 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 obtained through July 21, 2018.

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 visit.

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 February 8, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

DATE(S) OF VISIT: July 17, 2017

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

Respectfully,

Loan D Nguyen

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

CT # 20888

LN:mb

DATE(S) OF VISIT: July 17, 2017

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

The following are violations of the Regulations of Connecticut State Agencies Section D19-13-D105. Assisted living services agency (e) General requirements for an assisted living services agency (13) and/or (m) Client's bill or rights and responsibilities (6) and/or (9).

1. Based on review of the clinical record, agency documentation and interview with agency personnel, for one of one client (Client #1) with a complaint, the agency failed to conduct a comprehensive investigation of a complaint and/or failed to ensure patient's consent to disclosure of private information. The findings include:
   a. Client #1 had a start of care date of 01/22/14 and diagnoses that included non-insulin dependent diabetes mellitus, hypertension, hypothyroidism, anemia, chronic diastolic heart failure, glaucoma, rheumatic rhabdomyolysis, basal cell skin carcinoma, hyperlipidemia, esophageal reflux and abnormal gait. On 04/08/16 the client complained of left shoulder pain with subsequent swelling that was evaluated and diagnosed as effusion with compression of the venous and lymphatic drainage and secondary swelling. The client was alert and oriented.
   The Client Service Plan dated 03/03/16 identified the need for assistance with showering and toileting at times.

   i. Interview and review of the nursing notes with the Assisted Living Services Agency (ALSA) Director of Clinical Services (DCS) identified a complaint on 04/22/16 from Client # 1 regarding ALSA Aide "being rough and not listening to resident needs" and Client # 1 requested that ALSA Aide # 1 no longer be assigned.
   Interview and review of the agency's complaint log with the DCS identified documentation of the complaint, but failed to identify an investigation of the complaint.
   The agency policy entitled "Grievance Policy – RR-3" directed the Executive Director (ED) of District and/or the Regional Director of Operations to document actions following receipt of the complaint, such as contact with family, dates of contact, and interventions implemented in response to the grievance;

   ii. Interview and review of the agency's complaint log with the DCS identified documentation of the date of Client #1's complaint, however failed to identify a complete date including the year, for a total of 58 complaints in the complaint log;

   iii. The ALSA documentation indicated that the client was hospitalized on 03/31/15, transferred to a skilled nursing facility (SNF) and re-admitted to the ALSA program on 5/14/15.
   The legal designation of power-of-attorney dated 9/9/09 identified Family Member # 1 and Family Member # 2 as having power-of-attorney to act jointly on all matters on behalf of Client # 1, with no documentation found in the ALSA record of a rescission of the granting of power-of-attorney.
   The ALSA note dated 05/14/15 identified Person #4 as Client # 1's privately hired "case manager" and that the "case manager" would pre-pour the client's medications.

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Interview with the Executive Director on 07/18/17 indicated that the ALSA Emergency Contact form listed Person # 4 twice, as the first person to contact and again as the third person to contact, with no identification of Family Member # 1 or Family Member # 2 as contact persons, and failed to identify verification from the ALSA of the appropriateness of the listing;

iv. Subsequent ALSA notes identified numerous phone calls and/or electronic messages from the ALSA staff to Person #4 from 05/14/15 to 08/09/16 with updates on the client's status, changes of condition.
Interview with the SALSA on 07/20/17 failed to identify written consent from Client # 1 to share personal and/or health information with Person #4 prior to updating Person # 4 on Client # 1's status;

v. Interview with the SALSA on 07/20/17 and review of the ALSA documentation dated 07/07/15, 03/02/16 and 06/23/16 indicated that Person #4 attended family meetings with Client # 1, and failed to identify written consent from Client # 1 prior to allowing Person # 4 in family meetings where Client # 1's health and living arrangements were discussed;

vi. Interview and review of the Client Service Plans dated 06/17/15 and 10/29/15 with the Executive Director on 07/18/17 indicated that the Client service Plans were signed by Person #4, but failed to identify legal documentation of the appointment of Person # 4 as the healthcare agent for Client # 1, prior to signing Client Service Plans on behalf of Client # 1.

Chris

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Connecticut Department of Public Health

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Affirmative Action/Equal Opportunity Employer

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iv. Subsequent ALSA notes identified numerous phone calls and/or electronic messages from the ALSA staff to Person #4 from 05/14/15 to 08/09/16 with updates on the client's status, changes of condition.
Interview with the SALSA on 07/20/17 failed to identify written consent from Client # 1 to share personal and/or health information with Person #4 prior to updating Person # 4 on Client # 1's status;

v. Interview with the SALSA on 07/20/17 and review of the ALSA documentation dated 07/07/15, 03/02/16 and 06/23/16 indicated that Person #4 attended family meetings with Client # 1, and failed to identify written consent from Client # 1 prior to allowing Person # 4 in family meetings where Client # 1's health and living arrangements were discussed;

vi. Interview and review of the Client Service Plans dated 06/17/15 and 10/29/15 with the Executive Director on 07/18/17 indicated that the Client service Plans were signed by Person #4, but failed to identify legal documentation of the appointment of Person # 4 as the healthcare agent for Client # 1, prior to signing Client Service Plans on behalf of Client # 1.

POC Approved
3/9/18
M. San Souci RN

BROOKDALE PLACE
WILTON
BROOKDALE SENIOR LIVING

The following is the Plan of Correction for **Brookdale Wilton** regarding the Statement of Deficiencies dated **January 25, 2018**. 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 Wilton on July 17, 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. Assisted living services agency (e)General requirments for an assisted living service agency (13) and/or (m) Client's bill of rights and responsibilities (6) and/or (9).

1.a.i. Agency on 04/08/16 failed to conduct a comprehensive investigation of a complaint
1.a.ii. Agency failed to identify a complete date including the year, for a total of 58 complaints in the complaint Log

A Corrective Action:
1. District Director of Clinical Services (DDCS) reviewed and re-educated Supervisor of Assisted Living Services (SALSA) and Executive Director (ED) on Grievance Policy – RR-3 following exit interview on July 17, 2017
2. District Director of Clinical Services (DDCS) will review and re-educate all Supervisor of Assisted Living Services (SALSA), Executive Directors (ED), and Resident Service Coordinators (RSC) on Grievance Policy – RR-3.

B. Completion Date: Re-education Grievance Policy – RR-3 will be completed on or before February 28, 2018

C. Ongoing Quality Assessment and Performance Improvement Process:
1. ED will audit Grievance Log on a weekly basis for at least a four month period or until such time as a 90% compliance is achieved to verify proper documentation procedures and timely resolution of complaints.
2. DDCS will monitor Grievance Log on a quarterly basis to verify proper documentation procedures and timely resolution of complaints with an expectation of a 95% compliance.

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

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POC Approval
3/9/18
M San Souci RN

1.a.iii. Agency failed to reconcile and identify Emergency Contacts

1.a.iv. Agency failed to identify written consent from Client and share personal and/or health information

1.a.v. ALSA failed to identify written consent from Client prior to allowing person in family meeting where Client health and living arrangements were discussed

1.a.vi. Agency failed to identify legal documentation of the appointment of person as the healthcare agent for Client prior to signing Client Service Plans on behalf of Client.

A Corrective Action:

1. District Director of Clinical Services (DDCS) reviewed and re-educated Supervisor of Assisted Living Services (SALSA) and Executive Director (ED) on HIPAA: Authorization to Use or Disclose PHI Policy following exit interview on July 17, 2017
2. District Director of Clinical Services (DDCS) will review and re-educate Supervisor of Assisted Living Services (SALSA), Executive Director (ED), and Resident Service Coordinator (RSC) on HIPAA: Authorization to Use or Disclose PHI Policy.
3. District Director of Clinical Services (DDCS) will review and re-educate SALSA, ED, and RSC on Resident Information Sheet Policy MIMO-3
4. ED and SALSA will conduct an audit of 100% of Resident Clinical and Financial Records for valid Health Care Representative documents and update Face Sheets accordingly.

B. Completion Date:

1. Re-education for HIPAA: Authorization to Use or Disclose PHI Policy will be completed on or before February 28, 2018.
2. Re-education for HIPAA: Resident Information Sheet Policy MIMO-3 will be completed on or before February 28, 2018.
3. Audit or Clinical Records and Financial Records will be completed by March 31, 2018.

C. Ongoing Quality Assessment and Performance Improvement Process:

1. SALSA will review 25% of Clinical Records for accuracy of Resident Face Sheet quarterly for a one year period of at least one year or until such time as a 90% accuracy is achieved.

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