

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

IN RE: High Chase, LLC of Willington, CT
d/b/a High Chase, LLC
140 River Road
Willington, CT 06279

CONSENT ORDER

WHEREAS, High Chase, LLC of Willington, CT d/b/a High Chase, LLC ("Licensee"), has been issued License No. 1892 to operate a Residential Care Home known as High Chase located at 140 River Road in Willington, Connecticut ("Facility") under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department");

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted an inspection of the Facility on or about December 6, 2016;

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies, and the Department issued an Amended Citation (No. 2017-01) to the Licensee on or about January 23, 2017. (The Amended Citation 2017-01 is attached as Exhibit A to this Consent Order).

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, its Section Chief, and the Licensee, acting herein and through Kuldip Bhogal, M.D., the General Partner and Person-In-Charge of the Licensee, hereby stipulate and agree as follows:

1. The Licensee denies the allegations in the Amended Citation, but, by the signing of this Consent Order agrees that the Licensee's challenge to the Amended Citation is

withdrawn, and that the Amended Citation remains. In addition, the Licensee agrees that the allegations contained in the Amended Citation shall be deemed true in any subsequent proceeding before the Department in which its compliance with this Consent Order or the statutes and regulations pertaining to Residential Care Homes are at issue.

2. The Person-In-Charge of the Licensee shall amend its policies and procedures as necessary to ensure the safety of residents in its home with respect to the issue of identifying when residents are missing and how and when such issues are reported. The Person-In-Charge shall conduct training and/or retraining to all staff regarding its policies and procedures described above within two weeks of the effective date of this Consent Order. The Licensee shall have all staff sign the policies and procedures as described above within two weeks of the effective date of this Consent Order. The signed policies and procedures shall remain at the Facility permanently, and shall be available for the Department to review upon request.
3. Within three weeks from the effective date of this Consent Order, the Person-In-Charge shall provide written confirmation to the Department that the provisions of paragraph 2 above have been completed.
4. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the Department, upon request.
5. At the time of signing this Consent Order, the Licensee shall pay a monetary penalty to the Department in the amount of one thousand five hundred (\$1,500.00) dollars by bank check payable to "Treasurer, State of Connecticut" and mailed to the Department with the signed Consent Order. The money penalty and any reports required by this document shall be directed to:

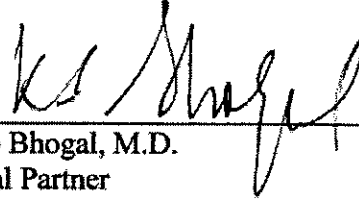
Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

6. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for

violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

7. The Licensee agrees that this Consent Order will be reported consistent with federal and state law and regulations and consistent with Department policy. In addition, the Licensee agrees that this Consent Order will be posted on the Department's website.
8. The Licensee agrees that this Consent Order does not limit any other agency or entity in any manner including but not limited to any actions taken in response to the factual basis of this Consent Order.
9. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
10. The Licensee agrees that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
11. Should the Licensee not be able to maintain substantial compliance with the requirements of this Consent Order and the requirements of the statutes and regulations related to residential care homes, the Department retains the right to issue charges including charges related to the allegations identified in the Exhibit A.
12. The Licensee has had the opportunity to consult with its attorney prior to the execution of this Consent Order.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below. I, Kuldip Bhogal, affirm that I am a General Partner and Person-In-Charge of the Licensee, and I am authorized to enter into this Consent Order on behalf of the Licensee.

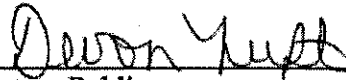


Kuldip Bhogal, M.D.
General Partner
Person-In-Charge

On this 13th day of April, 2017, before me, personally appeared Kuldip Bhogal, M.D., who acknowledged himself to be the General Partner and Person-In-Charge of the Licensee and that he, as such General Partner and Person-In-Charge, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by himself as General Partner and Person-In-Charge.

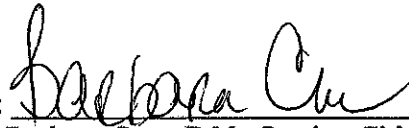
My Commission Expires: _____
(If Notary Public)

Devon Luth
NOTARY PUBLIC
CONNECTICUT
MY COMMISSION EXPIRES MAY 31st, 2020



Notary Public []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: 

Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section

April 13, 2017.

CERTIFIED MAIL

CITATION

AMENDED

In Re Citation No. 2017-01

**Classification of Violation
Pursuant to Connecticut
General Statutes Section 19a-527**

Date: January 23, 2017

**Class: B
Bed Capacity: 36-RCH
License Number: 1892**

Licensee: High Chase, LLC
Facility Name: High Chase, LLC
Facility Address: 140 River Road
Willington, CT 06279

The following citation is issued pursuant to Sections 19a-524 through 19a-528, inclusive of the Connecticut General Statutes:

A. Nature and Scope of Violations:

1. An inspection of this facility concluded on December 6, 2016 revealed the following:
 - a. R# 1's diagnoses included Major Depression and a history of Suicidal Ideation. Review of facility documentation (not dated) identified Resident # 1 returned to the facility from a leave of absence on 11/26/16 at approximately 10:30AM, and was last seen by staff smoking outside that day around 8:00PM. Documentation further identified that on Sunday morning (11/27/16) staff went to get the resident for breakfast because he/she did not come down to the dining room. The resident was not in his/her room and staff did not see the resident all day Sunday. On 11/28/16 (Monday), the documentation identified residents were questioned and family was contacted to ascertain the resident's whereabouts. The documentation further identified that after the family had not seen or heard from the resident, the facility contacted the police department and reported Resident # 1 as a missing person. The documentation further identified that although the facility is independent living and residents are free to come and go, it was "out of the ordinary" for Resident # 1 not to notify staff or sign out for a full day.

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Facility Documentation dated 11/27/16 at 9:00AM identified Resident # 1 had not come down for medications so staff went to check on resident and he/she wasn't in the facility. The documentation further identified that the staff spoke to other residents and staff and they reported not seeing the resident since Saturday morning (11/26/16). There was no documentation to reflect that staff followed up on the resident's whereabouts. On 11/29/16, the resident was found deceased in an area pond.

Review of the daily log/Census identified Resident # 1 was marked as returning to the facility on 11/26/16 and being "out" on 11/27/16 and 11/28/16.

Review of the Resident sign in/out sheets for November 2016 failed to identify that Resident # 1 signed in or out on 11/27/16 or 11/28/16.

Review of Resident # 1's Medication Administration Record for November 2016 identified the resident last received his/her medications on 11/26/16 at 8:00PM. Further review noted that for 11/27/16 and 11/28/16 the resident was marked as "out" or a "no show" for all medication times. There was no documentation to reflect that staff followed up on the resident's whereabouts.

Interview with Staff # 1 (worked 7-3 on 11/26/16) on 12/6/16 at 2:25PM stated that the resident returned from an LOA between 9:30-10:30AM on 11/26/16. Staff # 1 further stated that the resident came down for lunch that day but did not see him/her after that.

Interview with Staff # 2 (worked 3-11 on 11/27/16) on 12/9/16 at 10:44AM stated he last saw the resident Saturday night (11/26/16) in the dining room playing a game with other residents. Staff # 2 stated that the day staff on Sunday (11/27/16) reported to him that they hadn't seen the resident all day. Additionally, there was no documentation to reflect that any action was taken when Resident # 1 was not in the facility.

Interview with Staff # 3 (worked 11-7 on 11/27/16) on 12/9/16 at 10:05AM stated he works the 11-7 shift and does not check on residents or do a head count at night. Staff # 3 further stated that he was unsure what to do if a resident was missing.

Interview with Staff # 4 on 12/6/16 at 10:30AM stated that she worked on Sunday (11/27/16) the 7-3 shift and when the resident did not come down for his/her medications so she went up to check the room and noted the resident was not there. Staff # 4 stated that she asked the resident's roommate if he/she had seen the resident and was told the last time was the night before. Staff # 4 stated that she read that the resident returned Saturday, but when she was unable to locate the resident on Sunday she was concerned and completed an incident report, reported to the evening shift that the resident had not been seen, but did not notify anyone in administration. Staff # 4 further stated that she was not aware of the facilities Policy Procedure/ Practices on missing persons.

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Interview with the Administrator on 12/6/16 at 9:00AM stated that staff does not check on residents in timed increments but staff are supposed to do a head count every morning. The Administrator stated that although she spoke/interviewed all staff who worked on 11/26/16, 11/27/16 and 11/28/16 she did not document any staff statements or implement any interventions/ education to staff on missing residents. She stated that the last time the resident was seen was around 8:00PM Saturday night. The Administrator stated that when a resident is missing for 24 hours the police are to be notified. Additionally, the Administrator stated that although there is no policy for staff to follow on missing person they should know what to do.

B. Statutes and/or Regulations Violated:

Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D6 (c)(1).

C. Classification of Violations

Class B in accordance with Section 19a-527 (K)(2)(D) of the Regulations of Connecticut State Agencies.

D. Amount of Civil Penalty to be imposed in accordance with Connecticut General Statutes Sections 19a-527 and 19a-528: \$3,000.00

NOTIFICATION OF ELECTION TO CONTEST CITATION

If the licensee wishes to contest this Citation, the administrator or his designee must within three days, excluding Saturdays, Sundays and holidays, of receipt of the Citation by the licensee, shall notify the Supervising Nurse Consultant who signed the citation by contacting the Facility Licensing and Investigations Section (FLIS), Department of Public Health, 410 Capitol Avenue, MS#12 HSR, P.O. Box 340308, Hartford, Connecticut 06134-0308, telephone number (860) 509-7400 or any Supervising Nurse Consultant within FLIS (same address, same telephone number):

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ELECTION NOT TO CONTEST CITATION

Should the licensee not wish to contest this Citation and pay the civil penalty, check or money order should be made payable to: Treasurer, State of Connecticut, attention Donna Ortelle, PHSM and sent to the above identified address.

IF THE ADMINISTRATOR FAILS TO SO NOTIFY THE DEPARTMENT, THE CITATION SHALL BE DEEMED A FINAL ORDER OF THE COMMISSIONER OF PUBLIC HEALTH, EFFECTIVE UPON THE EXPIRATION OF THE THREE DAY PERIOD REFERENCED ABOVE. CONNECTICUT GENERAL STATUTES SECTION 19a-525(a).

INFORMAL CONFERENCE

If the administrator has notified the Department in accordance with the procedure set forth above, an informal conference will be conducted as required by Section 19a-525(b) between the licensee and the Commissioner or his designee. The facility may wish to be represented by an attorney.

POSTING REQUIREMENT

Each Class A or Class B Citation shall be prominently posted in the nursing home cited so as to be visible to any resident, including those in wheelchairs and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the Commissioner of Public Health or the

Citation has been vacated by the Commissioner. Failure to comply with this requirement constitutes a violation of Connecticut General Statutes Section 19a-540.

Exhibit A

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Signature: Donna Ortelle, R.N. MSW

Date: 4/23/17

DMO:mb:

cc: Dr. Kuldip Bhogal, Person-Charge
Barbara S. Cass, Section Chief
Donna Ortelle, Public Health Services Manager
Denise Soja, Nurse Consultant
LaRonda, Leggett, Office Assistant