Connecticut Department of Public Health

DEPARTMENT OF PUBLIC HEALTH INSPECTION OF WHITING FORENSIC HOSPITAL

Public Act 18-86

An Act Concerning Whiting Forensic Hospital And Connecticut Valley Hospital

Department of Public Health
Commissioner Raul Pino

In accordance with the provisions set forth in Public Act 18-86, the Department of Public Health hereby submits the attached information regarding the Department's on-site inspection and review of records at Whiting Forensic Hospital.

Section 4 of Public Act 18-86 requires the Department of Public Health to conduct an on-site inspection of Whiting Forensic Hospital and a review of Whiting Forensic Hospital records regarding the hospital's operating protocols and procedures, documentation of employee training, any complaints against the hospital or an employee of the hospital, and any allegations of abuse or neglect of a patient. The Public Act also requires the Department to report the outcome of the Department's inspection and review of records to the Whiting Forensic Hospital taskforce and the Public Health Committee.

On July 18, 2018, an initial licensure survey concluded at Whiting Forensic Hospital by the Connecticut Department of Public Health, Healthcare Quality and Safety Branch, Facility Licensing and Investigations Section. This initial survey was conducted to determine if the facility was in compliance with the Regulations of Connecticut State Agencies for the Licensure of Hospitals for Mentally Ill Persons, specifically section 17-227-14a to 17-227-14m.

The inspection team was comprised of two Supervising Nurse Consultants, three Nurse Consultants and one Building and Fire Safety Inspector. Inspection activities included, but were not limited to, a tour of the Whiting and Dutcher buildings, a review of 42 patient records, review of facility policy and procedures, review of the restraint and seclusion logs, review and observations of staffing patterns and staff engagement, observations of care and the quality of life, interviews with patients, and interviews with facility staff.

Written correspondence, dated August 15, 2018, has been sent to the facility. It summarized the following areas of noncompliance, which were identified during the course of inspection activities:

1. One of six patient clinical records reviewed for restraint use, documentation did not accurately reflect continued use of 4-point restraints in accordance with facility policies and procedures;
2. One of six patient clinical records reviewed for episodes of restraint/seclusion, the documentation did not accurately reflect an episode of seclusion;
3. Thirteen of nineteen patients receiving antipsychotic medications after 5/1/18, Abnormal Involuntary Movement Scale (AIMS) testing was not tracked and/or completed in accordance with policy and procedures;
4. One of eighteen patient clinical records reviewed for comprehensive treatment planning, the treatment plan was not comprehensive for a patient who was noted to have urinary incontinence;
5. One of nine patient clinical records reviewed for accuracy of physician orders, the record did not reflect a complete/accurate physician order for a patient who had an alteration in skin integrity;

6. Inaccurately dated expiration date on glucose monitoring solution was noted on one of five patient units;
7. Foul odors were noted in multiple bathrooms throughout the facility;
8. Mold was noted on shower curtains on multiple units in multiple shower areas;
9. The required hospital transfer agreement was not specific to Whiting Forensic Hospital;
10. Whiting Building:
    a. On three of the six units, broken floor and wall tiles were noted in the shower/toilet rooms,
    b. Heating/Ventilation/Air Conditioning (HVAC) diffusers on Unit 5A, were noted to be a ligature risk;
    c. Room lighting lens' in Unit/Room 5A were not of institutional design;
    d. Ventilation in the Unit 6 shower room was not adequate;
    e. Fire/smoke doors lacked adequate self-closing and positive latching throughout all basement areas;
    f. Voids and penetration were noted for the passage of wires and conduit throughout the basement fire and smoke barriers for corridors and storage rooms;
    g. The facility constructed a storage room in the corridor in the basement of Unit 3 that was not resistive to fire and smoke and lacked door closers and positive latching; and
    h. Basement mechanical, number 081 had broken and leaking steam drains and the main sprinkler valve for the partially sprinklered building was leaking; and
11. Dutcher Building:
    a. Unit three south, room 328, the door hardware and closure was not of an institutional design;
    b. Unit three north, room 341, the door hardware and closure was not of an institutional design;
    c. Unit two, south, room 226, the door hardware and closure was not of an institutional design;
    d. Unit two, north, room 239, the door hardware and closure was not of an institutional design;
    e. Unit one, south, stairwell doors east and west, the door hardware and closure were not of an institutional design; and
    f. Unit one, north, patient room 111, the HVAC system supply diffusers above the patient bed posed a ligature risk. Subsequent to surveyor notification, an immediate correction was made.

Upon identification of non-compliance for items 1-9, the facility responded and immediate corrections to the issues of non-compliance were completed and verified by the inspection team through July 18, 2018. Items 10 and 11 required physical modifications to the environment, therefore, could not be completed immediately. A written plan of correction for items 10 and 11 was requested which was required to include the following elements:

- 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;
- The date each such corrective measure or change by the institution is effective;
- 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
- The title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

On August 20, 2018 a plan of correction was received and reviewed and approved on August 21, 2018.

Please find attached the following materials:

- Correspondence to the facility dated August 15, 2018
- Approved Plan of Correction dated August 21, 2018
- Copy of license for Hospital for Mentally Ill Persons issued to Whiting Forensic Hospital

In conclusion, the Department has received and approved a plan of correction that has been provided and the Department has issued a license as a Hospital for Mentally Ill Persons to Whiting Forensic Hospital effective August 21, 2018.

Substitute Senate Bill No. 404
Public Act No. 18-86

AN ACT CONCERNING WHITING FORENSIC HOSPITAL AND CONNECTICUT VALLEY HOSPITAL.

Section 1. (Effective from passage) (a) There is established a task force to (1) review and evaluate the operations, conditions, culture and finances of Connecticut Valley Hospital and Whiting Forensic Hospital, (2) evaluate the feasibility of creating an independent, stand-alone office of inspector general that shall be responsible for providing ongoing, independent oversight of Connecticut Valley Hospital and Whiting Forensic Hospital, including, but not limited to, receiving and investigating complaints concerning employees of Connecticut Valley Hospital and Whiting Forensic Hospital, (3) examine complaints and any other reports of discriminatory employment practices at said hospitals, except any information or documentation not subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes or any other federal or state confidentiality law, (4) assess the implications of a patient of Whiting Forensic Hospital being permitted to be present during a search of his or her possessions, (5) evaluate the membership of the advisory board for Whiting Forensic Hospital established pursuant to section 17a-565 of the general statutes, as amended by this act, (6) examine the role of the Psychiatric Security Review Board established pursuant to section 17a-581 of the general statutes, (7) evaluate the need to conduct a confidential survey regarding the employee work environment at Connecticut Valley Hospital and Whiting Forensic Hospital, including, but not limited to, worker morale, management and any incidences of bullying, intimidation or retribution, and (8) review the statutory definitions of abuse and neglect in the behavioral health context.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a senior administrator of a behavioral health facility, and one of whom shall have law enforcement or corrections experience or experience working in a secured facility;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a psychologist or psychiatrist with forensic experience, and one of whom shall be a person who has lived with or experienced mental illness;

(3) One appointed by the majority leader of the House of Representatives, who shall be a former or current administrator of a hospital with a bed capacity of at least two hundred;

(4) One appointed by the majority leader of the Senate, who shall be a patient advocate;

(5) One appointed by the minority leader of the House of Representatives, who shall have experience providing direct care services to persons with behavioral health disorders; and

(6) One appointed by the minority leader of the Senate, who shall have experience providing direct care services at a hospital.

(c) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The chairperson of the task force shall be selected from among its members. Such chairperson shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(f) In performing its review and evaluation under subsection (a) of this section, the task force may hold a public forum, which shall provide opportunity for public comment.

(g) Not later than January 1, 2019, the task force shall submit a preliminary report, in accordance with the provisions of section 11-4a of the general statutes, on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Not later than January 1, 2021, the task force shall submit a final report on its findings and recommendations to said joint standing committee. The task force shall terminate on the date that it submits such final report or January 1, 2021, whichever is later.

Sec. 4. (Effective July 1, 2018) (a) On or before January 1, 2019, the Department of Public Health shall conduct an on-site inspection of Whiting Forensic Hospital and a review of Whiting Forensic Hospital records, including, but not limited to, (1) the hospital's operating protocols and procedures, (2) documentation of employee training, (3) any complaints against the hospital or an employee of the hospital, and (4) any allegations of abuse or neglect of a patient.

(b) Not later than thirty days after completing the on-site inspection and review of hospital records conducted under subsection (a) of this section, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, to the task force established under section 1 of this act and to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the outcome of the on-site inspection and review.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Facility Licensing and Investigations Section

August 15, 2018

Hal Smith, Chief Executive Officer
Whiting Forensic Hospital
P.O. Box 70
Middletown, Connecticut 06457

Dear Mr. Smith:

In accordance with Public Act 18-86, the Department of Public Health conducted on-site inspections of Whiting Forensic Hospital. The inspection included a review of Whiting Forensic Hospital records regarding the hospital's operating protocols and procedures, documentation of employee training, any complaints against the hospital or an employee of the hospital, and any allegations of abuse or neglect of a patient. Additionally, inspection activities included, but was not limited to, a tour of the facility, review of clinical records, a review of the restraint and seclusion logs, review and observations of staffing patterns and staff engagement, observations of care and the quality of life, interviews with patients, and interviews with facility staff.

On July 18, 2018, an initial licensure survey concluded at Whiting Forensic Hospital by the Connecticut Department of Public Health, Healthcare Quality and Safety Branch, Facility Licensing and Investigations Section. This initial survey was conducted to determine if your facility is in compliance with the Regulations of Connecticut State Agencies for the Licensure of Hospitals for Mentally Ill Persons, specifically section 17-227-14a to 17-227-14m.

The following areas of noncompliance were identified during the course of inspection activities:

1. One of six patient clinical records reviewed for restraint use, the documentation did not accurately reflect continued use of 4-point restraints in accordance with facility policies and procedures;
2. One of six patient clinical records reviewed for episodes of restraint/seclusion, the documentation did not accurately reflect an episode of seclusion;

Connecticut Department of Public Health

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3. Thirteen of nineteen clinical records reviewed for patients receiving antipsychotic medications after 5/1/18, Abnormal Involuntary Movement Scale (AIMS) testing was not tracked and/or completed in accordance with policy and procedures;
4. One of eighteen patient clinical records reviewed for comprehensive treatment planning, the treatment plan was not comprehensive for a patient who was noted to have urinary incontinence;
5. One of nine patient clinical records reviewed for accuracy of physician orders, the record did not reflect a complete/accurate physician order for a patient who had an alteration in skin integrity;
6. Inaccurately dated expiration date on glucose monitoring solution was noted on one of five patient units;
7. Foul odors were noted in multiple bathrooms throughout the facility;
8. Mold was noted on shower curtains on multiple units in multiple shower areas;
9. The required hospital transfer agreement was not specific to Whiting Forensic Hospital;
10. Whiting Building:
    a. On three of the six units, broken floor and wall tiles were noted in the shower/toilet rooms,
    b. Heating/Ventilation/Air Conditioning (HVAC) diffusers on Unit 5A, were noted to be a ligature risk;
    c. Room lighting lens' in Unit/Room 5A were not of institutional design;
    d. Ventilation in the Unit 6 shower room was not adequate;
    e. Fire/smoke doors lacked adequate self-closing and positive latching throughout all basement areas;
    f. Voids and penetration were noted for the passage of wires and conduit throughout the basement fire and smoke barriers for corridors and storage rooms;
    g. The facility constructed a storage room in the corridor in the basement of Unit 3 that was not resistive to fire and smoke and lacked door closers and positive latching; and
    h. Basement mechanical, number 081had broken and leaking steam drains and the main sprinkler valve for the partially sprinklered building was leaking; and
11. Dutcher Building:
    a. Unit three south, room 328, the door hardware and closure was not of an institutional design;
    b. Unit three north, room 341, the door hardware and closure was not of an institutional design;
    c. Unit two, south, room 226, the door hardware and closure was not of an institutional design;
    d. Unit two, south, room 226, the door hardware and closure was not of an institutional design;
    e. Unit two, north, room 239, the door hardware and closure was not of an institutional design;
    f. Unit one, south, stairwell doors east and west, the door hardware and closure were not of an institutional design; and
    g. Unit one, north, patient room 111, the HVAC system supply diffusers above the patient bed posed a ligature risk. Subsequent to surveyor notification, an immediate correction was made.

Upon identification of non-compliance for items 1-9, the facility responded and immediate correction to the issues of non-compliance were completed and verified by the inspection team through July 18, 2018, therefore a written plan of correction will not be required. Items 10 and 11 require physical plant corrections which involve physical modifications to the environment that could not be completed

immediately. Therefore, a written plan of correction for items 10 and 11 is required. Such plan shall include the following elements:

- 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;
- The date each such corrective measure or change by the institution is effective;
- 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
- The title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

Upon receipt of an acceptable plan of correction attesting that all corrections shall be made, a license to operate a Hospital for Mentally Ill Persons shall be issued. Please be aware and in accordance with the Regulations of the Connecticut State Agencies, specifically, section 17-227-14bC, Issuance of license, the license shall be posted in a conspicuous place in the hospital.

Please be advised in accordance with Public Act 18-86, the Department is required to report the outcome of the Department's inspection and review of the records to the Whiting Forensic Hospital Taskforce and the Public Health Committee.

If you have any questions regarding this matter, please contact me at (860) 509-7609. Thank you.

Respectfully,

Barbara Cass, R.N.
Branch Chief
Healthcare Quality and Safety Branch

C.C.: Donna Ortelle, Public Health Services Manager
Kim Hriceniak, Public Health Services Manager
Susan Newton, Supervising Nurse Consultant
Rose McLellan, Licensing Processing Supervisor
Anthony M. Bruno, Building and Fire Safety Supervisor

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

WHITING FORENSIC HOSPITAL

August 17, 2018

Barbara Cass, Branch Chief
Department of Public Health
410 Capital Avenue
Hartford, CT 06134

Dear Ms. Cass:

Attached, please find the Whiting Forensic Hospital response to the licensing survey conducted on July 18, 2018, attesting to corrective action completed and scheduled; processes to prevent reoccurrence and mitigation; as well as our monitoring plan.

Please also find supplemental documentation, including service records and photographs.

My thanks to you and your team for the collaborative approach during this process and we look forward to working with you in the future.

Respectfully,

Hal Smith, MPS
CEO, Whiting Forensic Hospital

CC: Miriam Delphin-Rittmon, DMHAS, Commissioner
Paul Dileo, DMHAS, Chief Operating Officer
Donna Ortelle, Public Health Services Manager
Kim Hriceniak, Public Health Services Manager
Susan Newton, Supervising Nurse Consultant
Rose McLellan, Licensing Processing Supervisor
Anthony M. Bruno, Building and Fire Safety Supervisor

Whiting Forensic Hospital Plan of Correction 8/20/18

NON-COMPLIANCE ITEM	CORRECTIVE ACTION	STEPS TO PREVENT REOCCURENCE/MITIGATION	MONITORING PLAN/STAFF RESPONSIBLE
Whiting Building			
a. On three of the six units, broken floor and wall tiles were noted in the shower/toilet rooms	Broken and missing tiles were replaced on or before 6//20/18	Housekeepers have been instructed to report broken or missing tiles found while performing daily shower room cleaning to WFH maintenance department	Building Superintendent 1 will make random monthly checks of shower rooms to ensure housekeeper reporting is taking place
b. Heating/Ventilation/Air Condition (HVAC) diffusers on Unit 5A, were noted to be a ligature risk	Diffusers replaced with 3/16" perforated metal on 8/9/18, no longer ligature risk	All future HVAC diffusers installed will be 3/16" perforated metal to meet anti-ligature requirements	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature
c. Room Lighting lens' in Unit/Room 5A were not of institutional design	Shatterproof Lexan installed to cover lenses on 8/9/18	All patient areas will have shatter proof lens cover	During environmental rounds, the multi-disciplinary team will check to ensure all light fixtures in patient areas have shatterproof lenses, Maintenance Supervisor 1 will submit work order as necessary, documented on rounds checklist, and reviewed by MEC Committee monthly to ensure issue addressed
d. Ventilation in the Unit 6 shower room was not adequate	Motor on ventilation system replaced on 7/15/18	Housekeepers have been instructed to report shower ventilation issues found while performing daily shower room cleaning to WFH maintenance department	During environmental rounds, the multi-disciplinary team will check to ensure no ventilation issues exist, Maintenance Supervisor 1 will submit work order as necessary, document on rounds checklist, and review by MEC Committee monthly to ensure issue addressed
e. Fire/smoke doors lacked adequate self-closing and positive latching throughout all basement areas	Door closures on all doors throughout basement concourse have been repaired or replaced to ensure self-closing and positive latching of doors – completion of project 7/27/18	Annual Fire Door inspection was instituted in 2018 at WFH	Maintenance Supervisor 1 will conduct Annual Fire Door Inspection, as part of inspection will ensure all fire door close and latch
f. Voids and penetration were noted for the passage of wires and conduit throughout the basement fire and smoke barriers for corridors and storage rooms	All basement voids and penetrations inspected by WFH maintenance staff. All void and penetrations identified filled with STI fire caulk- project completed 7/25/18	WFH has instituted a fire barrier penetration policy which requires a permit for any penetration of a fire barrier	Plant Facility Engineer 2 or Plant Facility Engineer 1 will issue a permit any time a fire barrier penetration is necessary and will only sign off on completion upon inspection of area

NON-COMPLIANCE ITEM	CORRECTIVE ACTION TAKEN	STEP TO PREVENT REOCCURENCE/MITIGATION	MONITORING PLAN/STAFF RESPONSIBLE
g. The facility constructed a storage room in the corridor in the basement of Unit 3 that was not resistive to fire and smoke and lacked door closers and positive latching	Exposed lumber covered with 5/8" fire rated sheet rock – project completed by 7/23/18 Door closures installed on basement storage room to ensure self-closing and positive latching of doors – completion of project 7/27/18	All future construction at WFH will comply with building safety code. Fire Marshall will inspect construction project as dictated by scope of the project.	Plant Facility Engineer 2 or Plant Facility Engineer 1 will schedule Fire Marshall for necessary consultation and inspection as necessary
h. Basement mechanical, number 08 had broken and leaking steam drains and the main sprinkler valve for the partially sprinkled building was leaking	WFH plumbing department replaced leaking steam condensate line- completed 7/26/18 Leaking sprinkler valve repaired by Simplex Grinnell on 7/17/18	Sprinkler valves inspected quarterly. All identified deficiencies will be repaired by contractor	Plant Facility Engineer 2 schedules and reviews quarterly inspection
Dutcher Building			
a. Unit three south, room 328, the door hardware and closure was not of an institutional design	Door closure moved to inside of room on or before 6/22/18. Door hardware ordered, install date no later than 8/25/18	Current WFH standard operating procedure is to install anti-ligature door hardware for any patient areas not visible by line of sight All door hardware in patient areas at WFH is included on Environmental Safety Rounds, which are conducted continuously throughout the day	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature Nurse Executive monitors Environmental Safety Rounds documentation daily and follows up on any identified safety issues
b. Unit three north, room 341, the door hardware and closure was not of an institutional design	New door and hardware ordered, install date no later than 8/25/18	Current WFH standard operating procedure is to install anti-ligature door hardware for any patient areas not visible by line of sight All door hardware in patient areas at WFH is included on Environmental Safety Rounds, which are conducted continuously throughout the day	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature Nurse Executive monitors Environmental Safety Rounds documentation daily and follows up on any identified safety issues
c. Unit two, south, room 226, the door hardware and closure was not of an institutional design	Door closure moved to inside of room on or before 6/22/18 Door hardware ordered, install date no later than 8/25/18	Current WFH standard operating procedure is to install anti-ligature door hardware for any patient areas not visible by line of sight All door hardware in patient areas at WFH is included on Environmental Safety Rounds, which are conducted continuously throughout the day	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature Nurse Executive monitors Environmental Safety Rounds documentation daily and follows up on any identified safety issues

NON-COMPLIANCE ITEM	CORRECTIVE ACTION TAKEN	STEP TO PREVENT REOCCURENCE/MITIGATION	MONITORING PLAN/STAFF RESPONSIBLE
d. Unit two, south, room 226, the door hardware and closure was not of an institutional design	Item duplicate to above, per Sue Newton on 8/20/18	N/A	N/A
e. Unit two, north, room 239, the door hardware and closure was not of an institutional design	Door closure moved to inside of room on or before 6/22/18 Door hardware ordered, install date no later than 8/25/18	Current WFH standard operating procedure is to install anti-ligature door hardware for any patient areas not visible by line of sight All door hardware in patient areas at WFH is included on Environmental Safety Rounds, which are conducted continuously throughout the day	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature Nurse Executive monitors Environmental Safety Rounds documentation and follows up on any identified safety issues.
f. Unit one, south, stairwell doors east and west, the door hardware and closure were not of institutional design	Door closures moved to inside of stairwell on or before 6/22/18 Door hardware ordered, install date no later than 8/25/18	Current WFH standard operating procedure is to install anti-ligature door hardware for any patient areas not visible by line of sight All door hardware in patient areas at WFH is included on Environmental Safety Rounds, which are conducted continuously throughout the day	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature Nurse Executive monitors Environmental Safety Rounds documentation and follows up on any identified safety issues.
g. Unit one, north, patient room 111, the HVAC system supply diffusers above the patient bed posed a ligature risk.	Per DPH report, subsequent to surveyor notification, immediate correction was made.	All future HVAC diffusers installed will be 3/16" perforated metal to meet anti-ligature requirements	Plant Facility Engineer 2 will ensure only ligature resistant material is ordered and installed via PO approval process which requires his signature

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0074

Hospital for Mentally Ill Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

State of CT, Department of Mental Health and Addiction Services of Hartford, CT d/b/a Whiting Forensic Hospital is hereby licensed to maintain and operate a Hospital for Mentally Ill Persons.

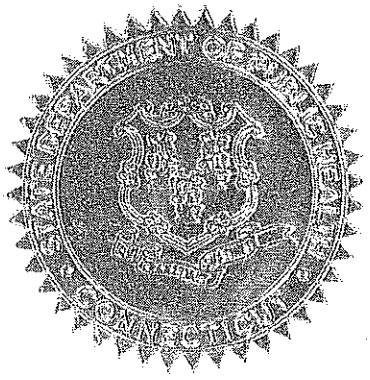
Whiting Forensic Hospital is located at 70 O'Brien Drive, Middletown, CT 06457-3945.

The maximum number of beds shall not exceed at any time:

229 General Hospital Beds

This license expires **June 30, 2020** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, August 21, 2018. INITIAL.



Raul Pino, MD, MPH
Commissioner