# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

December 30, 2020

Fontella Dubissette
Spring Village At Stratford Llc
6911 Main Street
Stratford, CT 06497

executivedirector@springvillagestratford.com

Dear Ms. Dubissette:

An unannounced visit was made to Spring Village At Stratford Llc on February 3, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit. The state violation cannot be edited by the provider in any way.

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 is to be submitted to the Department by January 10, 2021.**

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 Karen.Donato@ct.gov may be subject to disciplinary action. Please do not send another copy via US mail.

DATE(S) OF VISIT: February 3, 2020

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

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by January 10, 2021 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

If there are any questions, please do not hesitate to contact this office at Karen.Donato@ct.gov.

Respectfully,

Loan D Nguyen

Loan Nguyen MSN, RN, C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CT # 26888

DATE(S) OF VISIT: February 3, 2020

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing authority of an assisted living services agency (4) (A) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on clinical record review and staff interview, for one of one client (Client # 1) who eloped from the facility, the Assisted Living Services Agency (ALSA) staff failed to provide the safety of the client. The findings include:

   a. Client #1 was admitted to the ALSA program on 3/16/18 with diagnoses that included hypertension, dementia and aortic valve disorder. The client service program dated 10/08/19 identified the need for assistance with bathing, grooming and showering twice a week.

   The client ambulated independently with a walker and was at risk for falls.

   The ALSA Incident Report dated 1/28/2020 indicated that Client # 1 was not found in own bedroom while ALSA Aide #1 was completing safety rounds at 1:30 AM. ALSA Aide #1 checked the usual locations that Client #1 frequented and was not successful, then ALSA Aide #1 checked the parking lot and found Client # 1 still in pyjamas, holding a briefcase and trying to enter a locked car. Client #1 was escorted back into the building.

   Review of the clinical record with the SALSA on 2/03/2020 indicated that Client # 1 did not have a history of elopement, was placed on 10 minutes check until the day shift staff arrived at 7AM, when Client # 1 was transferred to the secured unit inside the assisted living facility.

   Interview and review of the care plan with the SALSA on 2/03/2020 identified a revision to the plan of care in the secured unit on 1/28/2020 which included safety checks every 30 minutes, however the records failed to identify the completion of safety checks every 30 minutes from 1/28/2020 to 2/03/2020 in the secured unit in accordance with the plan of care, and identified neglect of the client's safety after an incident of elopement.

Spring Village at Stratford
A WoodBine Senior Living Community

POC accepted 1/13/2021 LS

1-8-21

Plan of Correction for 12-30-20 Violation Report

(4) Responsibilities of the governing authority shall include, but not necessarily be limited to: (A) ensuring the quality of services provided by the agency and the quality of care rendered to clients; and/or (m) Client's bill of rights and responsibilities. An assisted living services agency shall have a written bill of rights and responsibilities governing agency services which shall be provided and explained to each client at the time of admission to the agency. Such explanation shall be documented in the client's service record. All clients shall receive a written copy of any changes made to the bill of rights. (5) right of the client to be free from physical and mental abuse and exploitation and to have personal property treated with respect;

Client #1 was admitted to our Assisted Living Community on 3-16-18. On 1-28-20, Client #1 was found in the parking lot and escorted back into the building. (Completed 1-28-20)

The SALSA determined that Client #1 needed to be moved immediately to Memory Care due to decline in cognitive ability. Client #1's Doctor agreed to the move and assessment. (Completed 1-28-20)

The SALSA/Designee is responsible for ensuring that all plans of care are followed and executed as written. In the Memory Care community at Spring Village at Stratford residents are under constant supervision due to their cognitive impairments.

The Administrator will oversee compliance. Any issues identified will be discussed and a plan implemented for correction.