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

October 26, 2020

Fontella Dubissette, Supervisor of Assisted Living Services
Spring Village At Stratford LLC
6911 Main Street
Stratford, CT 06497

don@springvillagestratford.com

Dear Ms. Dubissette:

Unannounced visits were made to Spring Village At Stratford LLC on September 28 and 30, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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 visits. 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 November 5, 2020.

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. Please do not send another copy via US mail.

DATE(S) OF VISIT: September 28 and 30, 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 November 5, 2020 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 Loan.Nguyen@ct.gov.

Respectfully,

Loan D Nguyen

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

CT # 28583, 28562

DATE(S) OF VISIT: September 28 and 30, 2020

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D 105 (k) Client service record (2) (H) (i) and/or (m) Client's bill of rights and responsibilities (5)

1. Based on review of the clinical record, agency documentation and staff interview, for one of one client (Client # 1) who eloped, the Assisted Living Services Agency (ALSA) neglected to provide for the client's safety in accordance with the service plan. The findings include:

Client #1 was admitted to the assisted living program on 9/2/2020, with the diagnoses that included Wernicke-Korsakoff Syndrome, and a history of anxiety secondary to non-ambulatory status.

The client service program dated 9/2/2020 identified the need for assistance with dressing, incontinence care, bathing, the use of wheelchair for mobility, medication pre-pouring by the Assisted Living Services Agency (ALSA) nurse, and medication reminders from the ALSA aides.

Client # 1's service plan also included the need for safety checks from the ALSA aides every two hours.

The ALSA documentation indicated that the Executive Director found Client #1 outside the main front door on 9/9/2020 at 8:30AM. According to the ALSA documentation, Client #1 recalled crawling to the apartment door (instead of using the wheelchair to self-propel), sliding down the stairs in a sitting position then crawling out of the main exit door.

The surveyor was unable to obtain a clear account from the client during the onsite visit of 9/28/2020, regarding the distance traveled and the amount of time spent outside the building while crawling on 9/9/2020 before Client # 1 returned to the facility and was found by the Executive Director at the main door. Client # 1 verbalized no recollection of the 9/9/2020 elopement when interviewed by the surveyor on 9/28/2020.

Interview and review of the ALSA documentation with the Executive Director on 9/28/2020 failed to identify documentation by the ALSA aides of safety checks completed every two hours for Client # 1 in accordance with the plan of care, from the admission date on 9/2/2020 to the elopement date 9/9/2020.

According to the Executive Director in an interview on 9/28/2020 at 10 AM, Client #1 verbalized anxiety on 9/9/2020 when the Executive Director found the client.

Client # 1 reported that three men were after Client # 1 and the client called a family member called, but the client felt that the family member should go to jail. The Executive Director notified the emergency responders and Client #1 was transferred to Hospital #1 for a psychiatric evaluation.

The ALSA note dated 9/9/2020 indicated that Client #1 was discharged from the Emergency Department back to the assisted living facility on the same day, and Client # 1 was transferred to the Memory Care unit inside the

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facility. Client #1 was calm and cooperative, acknowledged that the client was previously hallucinating and regretted the behavior.

Acceptance
3/31/2021
IE

Spring Village at Stratford
A WoodBine Senior Living Community

3-19-21 Plan of Correction for 10-26-20 Violation Report

(H) a client service program, completed by a registered nurse in consultation with the client, family and others involved in the care of the client, within seven (7) days of the client's admission to the agency, which shall be reviewed as often as the client's condition requires but not less than once every one hundred and twenty (120) days, shall be explained to, reviewed with and agreed to by the client or his or her representative, shall reflect the client's or his or her representative's or family's preferences and choices regarding client services, and shall include but not necessarily be limited to: (i) identification of client's problems and needs;

Client #1 was admitted to our Assisted Living Community on 9-2-20 in the non-secured, non-memory care section of the community. All residents are free to come and go as they see fit in the assisted living section of our community.

Client #1 was anxious and had an episode of hallucinations that caused him to believe multiple men were "out to get him". He exited the community via a stairwell and stairwell door on 9-9-20. A staff member found Client #1 outside looking for help, brought them back into the community, and called the nurse to assist. The nursing department evaluated Client #1 and determined it would be best to send them to a psychiatric evaluation. On return from the evaluation, Client #1 was moved to our Memory Care Community.

Client #1 was not a memory care resident at the time of incident. They were free to come and go as they pleased. Due to the hallucinations on 9-9-20, and new risk of poor judgment of surroundings, the community, staff, doctors, and family determined that Client #1 should reside in Memory Care based on their needs.

The SALSA and family 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 9-9-20)

Spring Village at Stratford's standard for all residents, regardless of cognitive abilities, are 2 hour around the clock checks. Historically, SVS does not log every 2 hour check. SVS will eliminate 2 hour checks from the resident service plans, although they will still be a standard.

The SALSA/Designee will audit all current resident charts for individual needs to ensure that everyone is receiving appropriate assistance.

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.