2016/2017

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION

LICENSING INSPECTION REPORT

Name and Address of Entity

The Residence at South Windsor Farms
200 Deming ST
South Windsor, CT
06074

Signature of DHSR Staff

Robin Sarrasin nurse consultant

Licensure Category: Assisted Living

Licensed Capacity: Census

Licensed Capacity: Census:

Dates of Onsite Inspection: 11-16-16

Date(s) Additional Information Obtained: 11/28/16

Personnel Contacted: Amy Page SALSA Joseph Dellapucca

REVIEW/FINDINGS/PROCESS (complete all applicable)

[ ] Licensing Inspection: [ ] *Initial* [X] *Renewal* [ ] *Other:*

Revisit for the Purpose of

[■] See Complaint Investigation # 20399

[ ] See Reportable Event Investigation #

[ ] See Certification file.

[X] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.
See violation letter dated 4/10/17

[ ] Citation # was issued to this facility as a result of this inspection.

[ ] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # was verified as corrected was notified that the licensee was no longer required to post Citation (see narrative).

[ ] Citation # was not corrected (see narrative).

[X] Narrative Report / Additional Information Attached.

[ ] Referral(s) to:

REPORT SUBMITTED BY Robin Sarrasin DATE OF REPORT 11-16-16

[X] Approval for Issuance of License granted by: Loan D Nguyen 2-8-17
Supervisor / Title Date

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

April 7, 2017

Amy Page, Supervisor of Assisted Living Services Agency
The Residence At South Windsor Farms
200 Deming Street
South Windsor, CT 06074

Dear Ms. Page:

An unannounced visit was made to The Residence At South Windsor Farms on November 16, 2016 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 received through November 28, 2016.

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 April 19, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);

2. Date corrective measure will be effected;

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. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Loan Nguyen

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

CT # 20399

DATE(S) OF VISIT: November 16, 2016

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 19-13-D 105 (k) Client service record (2) (H) (i) and/or (ii) and/or (vi) and/or (m) Client's bill of rights and responsibilities (5)

1. Based on review of the clinical records, agency documentation and interviews with agency staff, for two of two clients (Clients #1 and #2) with specific needs, the Assisted Living Services Agency (ALSA) failed to update the Client Service Plan with interventions to address the client's needs. The findings include:

A. Client #1 was admitted to the ALSA on 11/19/15 with diagnoses that included dementia, anxiety disorder, hyperlipidemia and osteoarthritis. The service plan dated 3/23/16 identified the need for limited assistance with bathing, supervision and verbal cueing with dressing, and monitoring during ambulation, with reminders to use the rollator walker.

Client # 2 was admitted to the ALSA on 4/25/16 with diagnoses that included coronary artery disease, edema, enlarged prostate, essential hypertension and dementia without behavioral disturbance. The service plan dated 4/25/16 identified the need for limited physical assistance with activities of daily living, and the need for supervision and/or cue with mobility.

i. Prior to admission to the ALSA, Client # 2 was treated at an inpatient behavioral health facility for increased agitation, agression and impulsivity. The discharge instructions fron the inpatient facility included recommendations for caregivers of the same gender as Client # 2 was resistive to care. Review of the Client Service Plan at the ALSA failed to identify inclusion of the discharge recommendations;

ii. The ALSA documentation dated 5/3/16 identified an initial assesment by the psychiatrist for behaviors and medications at 10 AM. The patient was diagnosed with very significant dementia and/or dementia with behavioral disturbance, ongoing for some time, with a possible degree of depression, and unclear effect of medications. The psychiatrist recommended the addition of an anti-depressant, and an increase in the current dose of the antipsychotic medication.

On the evening of the same day 5/3/16 at 9PM, the ALSA staff documented that Client # 1 was agressive, attempted to hit Client # 3, the ALSA aides tried to redirect Client # 2, but Client # 2 became combative and abusive. The documentation further indicated that Client # 2 continued to go in and out of other client's apartments, and was extremely difficult to redirect.

DATE(S) OF VISIT: November 16, 2016

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

Review of the Client Service Plan updated on 5/18/16 failed to identify notification to the physician after 9PM on 5/3/16 of Client # 1's agressive behaviors, revisions to the plan of care with interventions that addressed the client's behaviors and needs, and specific instructions for the ALSA aides to monitor the client's behavior;

iii. The facility documentation dated 7/20/16 indicated that on 7/20/16 at 12:30 AM two aides heard the alarm in the public rest room and responded, to find Client # 1 and Client # 2 in the hallway.

The aides indicated they saw Client # 2 grab Client # 1 and "throw" Client # 1 on the floor with force.

Client # 1 verbalized to the aides that Client # 2 previously wandered into Client # 1's room, and Client # 1 asked Client # 2 to leave the room. Client # 1 subsequently heard the alarm go off, came out of the room and found Client # 2 in the hallway by the public restroom. Client # 1 began yelling for help, and told Client # 2 to go away.

Client # 2, on the other hand, told the aides that Client # 1 was hitting and yelling at Client # 2, and Client # 2 "had no option" other than to grab Client # 1 and "throw" Client # 1 on the floor.

Following the incident Client #1 complained of severe pain to left hip, was hospitalized on the same day and diagnosed with a comminuted fracture of the left hip.

Interview and review of the agency documentation with the SALSA on 11/16/16 failed to identify observance of Client # 1's right to be free of physical abuse.

The hospital record indicated that Client # 1 underwent an open reduction and internal fixation of the left comminuted intertrochanteric hip fracture in the operating room on the same day, 7/20/16.

The ALSA Progress Notes dated 7/20/16 at 7:00 PM indicated that Client #2 remained under 1:1 observation by a private duty aide; on 7/21/16 Client #2 was evaluated by the physician and discharged to an inpatient behavioral health facility.

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Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

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Respectfully,

Loan D Nguyen

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

CT # 20399

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATE(S) OF VISIT: November 16, 2016

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DATE(S) OF VISIT: November 16, 2016

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THE RESIDENCE at South Windsor Farms

200 Deming St.
South Windsor, CT 06074
T 860-432-2911
F 860-432-2279

April 20, 2017

Loan Nguyen, Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134-0308

Dear Ms. Nguyen:

Please accept our response to your letter dated April 7, 2017. As requested, we have included measures to prevent recurrence, date measures will be effective, our plan to monitor corrective processes are sustained and who is responsible for monitoring each plan. We have addressed each violation with our plan of correction below:

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

i. All discharge instructions will be reviewed and items identified as pertinent to services provided by the ALSA will be added to the service plan. Ongoing resident's that have had inpatient stays at hospitals, SNF's or other will have discharge instructions reviewed by the Wellness Nurse. Any areas identified that pertain to ALSA services or special instructions for ALSA Aides will be documented on the resident's service plan. All nurses will be inserviced by 5/1/17. The Supervisor of Assisted Living Service Agency (SALSA) is responsible to monitor that the Service Plan has interventions to meet the resident's needs.

ii. It is our policy that physicians are notified for any change in condition. All nurses will be inserviced on incident reporting and physician notification by 5/1/17. The SALSA will monitor that physician notification occurs for changes in condition through the incident reporting.

iii. Interventions to prevent [future incidents] will be noted on resident's service plans as well as any special instructions for ALSA Aides to monitor client's behaviors. Service plans will be reviewed and updated as needed to include specific and individualized behavior techniques as indicated. All service plans will be updated by 5/1/17.

Additionally, all ALSA associates will be required to review the Behavior Policy (see attached) by 5/31/17. The SALSA is responsible to monitor that residents service plans are individualized and meet the resident's needs. The SALSA will also verify that all ALSA associates review the Behavior Policy.

accepted plan as written 5/23/17 11:18 am

If you have any questions or require any additional details, please do not hesitate to contact me at (860) 432-2911.

Sincerely,

Amy Page, B.S.N., R.N.
Resident Care Director
Supervisor for Assisted Living Agency