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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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Healthcare Quality and Safety Branch

January 31, 2024

Eileen Moore, Executive Director
The Residence At South Windsor Farms
200 Deming Street
South Windsor, CT 06074
Via Email: emoore@residencesouthwindsor.com

Dear Ms. Moore:

Unannounced visit was made to The Residence At South Windsor Farms on November 28, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a complaint 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 violations 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 February 10, 2023.

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (k)(2)(H)(i)(ii) Client Service Program.

1. Based on clinical record review, review of agency documentation, and interviews with facility personnel, for one (1) of one (1) client residing in the memory care unit of the Assisted Living Service Agency (ALSA), the agency failed to ensure adherence to the client specific care plan for the management of end-of-life care needs, and failed to ensure care coordination with the hospice agency for the management of client's skin integrity and the prevention of pressure injuries.
   a. Client #1 had a move in date to the memory care assisted living community on 8/26/20, with diagnoses that included Dementia, Confusion, transient ischemic attack, and hypertension.

      Review of the Client's service program dated 8/11/23 identified Client #1 required assistance with personal hygiene, dressing, escorts to meals in wheelchair, repositioning every 2 hours for pressure relief to skin, assistance with toileting, bathing, and medication management. Client #1 had a 12-hour private care giver from 7p to 7a daily and was currently on Hospice services for end-of-life care.

      Interview with Family Member #1 on 11/28/23 at 11:06am identified, while Client #1 was residing at the ALSA, Hospice services were being provided for end-of-life care needs. Family member identified that the ALSA community was coordinating care with the Hospice services, but while on hospice services, the Client had developed a pressure sore on his/her lower back.

      Review of the agency clinical documentation and Client # 1's Interdisciplinary notes dated August 6, 2023, identified Client #1 was to be repositioned every 2 hours by ALSA aide and/or nursing staff, for the prevention of pressure injuries. Family member further identified they were notified by the ALSA community, that client had developed a wound to his/her back on August 8, 2023. Client #1's Family member verbalized concern that the ALSA staff were not repositioning client every 2 hours or using the client pressure relief cushion to the back, when client was in their wheelchair, per the hospice plan of care, that resulted in a wound to the client's back.

      Interview with the Former SALSA on 11/28/23 at 12:05 noon, identified following a case conference with Client #1's Family member, to discuss the care being provided by the ALSA and the hospice service, resulting in a pressure wound to Client #1, a request was made to transfer Client #1 to another hospice agency, and every 2-hour repositioning and use of the pressure relief pillow by the ALSA staff. The ALSA staff failed to ensure compliance with the client's plan of care and failed to ensure clients' safety, resulting in an injury.

Plan of Correction for Violation #1:

Facility Plan of Corrections

Plan of corrections Accepted 4/11/24 CT Tolland SNC

Healthcare Quality and Safety Branch,

An unannounced visit was made to The Residence at South Windsor Farms by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Complaint Investigation Survey. An Immediate Action Plan was asked to be created in response to the complaint being investigated.

Immediate Action Plan for The Residence at South Windsor Farms Investigation:

At The Residence at South Windsor Farms, the safety and well-being of our residents are our top priorities. In light of the recent investigation findings and concerns raised, we are committed to taking immediate action to enhance our resident care and safety standards. This document outlines the steps we will take to address these issues promptly and effectively. The following measures will be implemented, starting on February 13, 2024.

I. The measures that The Residence at South Windsor Farms will implement to prevent recurrence of the identified violation are as follows:

1. Completion of MOU (Memo of Understanding) with initiation of care services from an outside Agency.
    - The MOU will clearly define what services and care will be provided by the ALSA staff and what will be provided by the outside Hospice Agency staff which will include any and all care services to be provided specific to the resident's care needs.
    - The MOU form will either be outside agency specific or The Residence at South Windsor Farms MOU form.
    - Scheduled communication of care and resident's clinical status from the outside agency to the ALSA, will be as dictated in the MOU.
2. Retraining on the MOU form for Nursing staff (RN and LPN).
3. Retraining of RCAs to follow the plan of care pertaining to assistive devices with cushions.
4. Care Planning for the resident will mirror the delegation of care responsibilities that is described in the MOU.
5. Care planning will include any specific documentation regarding the use of a cushion in an assistive device when necessary.
6. Care and monitoring of open areas will continue to be provided by outside agency services, per protocol.

II. The corrective measures by The Residence as South Windsor Farms will be effective as of February 13,2024.

III. This audit process will occur with a sampling of 20% of residents receiving outside services requiring an MOU monthly for a total of 60 days. Once compliance has been established the audit process will move to a quarterly 10% sample for the next 90 days.

IV. The Residence at South Windsor Farms will ensure that once the education process is completed, that the RCD or Designee will audit adherence to established policies and procedures.

In conclusion, the immediate action plan outlined in this document reflects our commitment to addressing the concerns raised and maintaining the highest standards of resident care and safety at The

Residence at South Windsor Farms.