THE RESIDENCE at Westport
Independent & Assisted Living | Reflections Memory Care
1141 Post Road East | Westport, CT 06880
www.residencewestport.com

Accepted eTheiney SNC 9/1/24

July 19, 2024

Elizabeth Heiney, B.S., R.N., B.C.

Facility and Licensing Investigations Section

State of Connecticut

Department of Public Health

Dear Ms. Heiney,

The following plan of correction is being submitted on behalf of The Residence at Westport in response to an unannounced visit by your department on June 20, 2024 for the purpose of conducting a licensure renewal inspection. Your department has found the following violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living services agency (J) (vi) and/or (i) Assisted living aide services provided by an assisted living services agency (5)(B).

Based on the review of clinical records, agency documentation, interviews with personnel and review of policies, your findings show The Assisted Living Services Agency (ALSA) failed to follow the Missing Resident Response policy to ensure client safety.

Plan of correction

(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.

In response to the April 18, 2024, elopement, the community provided mandatory in-service/training to all associates on proper elopement procedures. In addition to this, the individuals involved were provided corrective action and individual re-educations.

Subsequent elopement drills were conducted to examine the effectiveness of set procedures/policies on 4/25/2024 and 5/22/2024.

(2) The date each such corrective measure of change by the institution is effective.
Re-education completed on 4/18/2024, 4/25/2024, 5/22/2024 and monthly for the next 6 months.

(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.
Elopement drills will be conducted monthly to ensure education was effective and proper procedures are followed in accordance with LCB policies.
Documentation will be completed and filed in the Reflections Director's office.

(4) The title of the institution's staff member that is responsible to ensuring the institution's compliance.

Nicole Ashby, RN, Resident Care Director

Addie Ricci, Executive Director

Deanna Dunning, Reflections Director

Sincerely,

Addie Ricci

Executive Director, The Residence at Westport

Nicole Ashby, RN

Resident Care Director, The Residence at Westport

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

HEALTHCARE QUALITY AND SAFETY BRANCH

July 16, 2024

Addie Ricci, Executive Director
The Residence At Westport
1141 Post Road East
Westport, CT 06880
Via Email: Aricci@residencewestport.com

Dear Ms. Ricci:

This is an amended edition of the violation letter originally sent on July 15, 2024.

An unannounced visit was made to The Residence At Westport on June 20, 2024 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure renewal inspection.

Attached is a 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, along with your original state violation letter, to the Department by July 26, 2024.

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.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATE(S) OF VISIT: June 20, 2024

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

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

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 may be subject to disciplinary action.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation not responded to by July 26, 2024, or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail.

Respectfully,

Elizabeth T. Heiney BS RN BC.

Elizabeth Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ETH:lst

c: VL

DATE(S) OF VISIT: June 20, 2024

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 (g) Supervisor of assisted living services (2)(A)(B) and/or (h) Nursing Services provided by an assisted living services agency (J)(vi) and/or (i) Assisted living aide services provided by an assisted living services agency (5)(B).

1. Based on review of clinical records, agency documentation, interviews with personnel, and review of policies for one of three clients (Client #1) in the survey sample, who resided in the secured memory care unit. The Assisted Living Services Agency (ALSA) failed to follow the Missing Resident Response policy to ensure client safety. The findings include:

   a. Client #1 was admitted to the Assisted Living Services Agency (ALSA) on 02/08/2024 and resided in the secured memory care unit with diagnoses of dementia, hearing loss and bilateral cataracts. The Client's 120-day nursing assessment and service plan dated 04/19/2024, identified the Client required nursing assessments and medication administration by a nurse. The Client required assistance from ALSA aides with bathing, grooming, dressing, and toileting. Additionally, the Client was at risk for elopements and required safety checks, engagement in purposeful activities daily and increased social interactions to prevent elopement.

   Review of Client #1's clinical record and the agency's investigation for an elopement dated 04/18/2024, identified on 04/18/2024 at 11:15 AM on the memory care unit, ALSA aide #1 heard a stairway door alarm. ALSA aide #1 asked ALSA aide #2 to check the stairway door and reset the alarm. ALSA aide #2 proceeded to reset the alarm. The agency's investigation identified at 11:16 AM, Client #1 opened a stairway door which set off an alarm, proceeded to leave the agency and was seen at 11:29 AM boarding a city bus by a private duty aide who was driving to the agency. The private duty aide directed the Client off the bus, called the memory care unit to report Client #1 had eloped and requested assistance. The Client was escorted back at 11:32 AM.

   Interview with the Supervisor of Assisted Living Services Agency (SALSA) on 06/20/2024 at 12:15 PM, identified the agency personnel failed to follow the Missing Resident Response policy by not immediately searching the stairwell, the area adjacent to the door, and perform an immediate head count once a door alarm was activated.

   Review of the agency's Missing Resident Response policy identified when a door alarm was activated, the staff would search the immediate area adjacent to the door (inside and outside) and initiate a headcount. The practice would ensure that even if a client was found at the door or in the immediate vicinity, another client did not go out unnoticed.

   Plan of Correction to Violation #1: