CONNECTICUT Department of Public Health

HEALTHCARE QUALITY AND SAFETY BRANCH

Accepted 1/14/26 ET Healey SNC

December 18, 2025

Courtney Sylvain, Executive Director
The Residence at South Windsor Farms
200 Deming Street
South Windsor, CT 06074
Via Email: Csylvain@residencesouthwindsor.com

Dear Ms. Sylvain:

An unannounced visit was made to The Residence at South Windsor Farms on September 24, 2025 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 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 December 28, 2025

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 may be subject to disciplinary action.

CONNECTICUT
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

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 December 28, 2025 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant via email at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

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

Respectfully,

Elizabeth T. Heiney BS RN BC

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

ETH:brc

c. VL
Complaint #45364

The following is a violation of the Regulations of Connecticut State Agencies **Section 19-13-D105 (e) General requirements of an assisted living service agency (1), and (h)Nursing Services provided by an assisted living service agency (3)(B)(D)(G), and (m) Client Bill of Rights and Responsibilities to be free from harm (5).**

1. Based on review of agency documentation, interviews with agency personnel, and review of agency policy, for two of three clients (Client #1 and Client # 2) who resided in a Memory Care unit and received services from the Assisted Living Service Agency (ALSA), the agency failed to ensure the safety of a client that resulted in harm and injury. The findings include.

a. Client #1 had a move in date to the memory care assisted living community on 5/23/25, with the admitting diagnoses that included dementia, atrial fibrillation, hypertension, anxiety, diabetes mellitus and benign prostatic hyperplasia.

Review of the client service program dated 7/28/25 identified that Client #1 required assistance with bathing, dressing, grooming, ambulated with assistance of a walker and utilized a wheelchair for long distance, required assistance with toileting, and medication management.

b. Client #2 had a move in date to the memory care assisted living community on 1/28/23, with the admitting diagnoses that included Alzheimer's Disease, hypertension, progressive aphasia, history of aggressive behaviors and major neurocognitive disorder.

Review of the client service program dated 6/23/25 identified that Client #2 required complete assistance with bathing, dressing, grooming, toileting, and receives medication management.

Review of the agency documentation and investigation dated 9/2/25, on 9/24/25 at 9:00am identified Client #1 pushed his/her pendent for assistance and was found by aide staff in their apartment yelling for help, Client #1 reported that there was a man in the apartment going through his/her belongings. Client # 1 tried to tell the person to get out, but the person proceeded to "Attack" Client #1. Client #1 was assessed by the nursing staff and was noted to have areas of redness and scratches on the right side of their face. Client #1 indicated that staff would know the man that was in his/her apartment, because Client #1 scratched the back of the man's arm and made it bleed when he/she was struck.

Client #2 was found in his/her bathroom by agency staff trying to wash the blood

off of an injury to the left arm and appeared angry. 911-Emergency Services (EMS) was called and upon EMS arrived, Client # 2 was transported to Hospital #1 for a medical evaluation due to aggressive behavior.

Client #2 was discharged from the hospital and was returned to the Memory Care Unit by their spouse on 9/2/25 at 5:45pm. Client #2 appeared calm, with a dressing in place to the left arm and was diagnosed with a Urinary tract infection and was given an order for an antibiotic medication for 7 days. Upon the return of Client #2 to the facility, the client was placed on 15-minute staff checks for safety.

Review of the agency documentation and investigation dated 9/2/25, on 9/24/25 at 10:00am with the Executive Director (ED) and SALSA indicated Client #1 pushed his/her pendent for assistance and was found by aide staff in their apartment yelling for help, Client #1 reported that there was a man in the apartment going through his/her belongings. Client # 1 tried to tell the person to get out, but the person proceeded to "Attack" Client #1.

Client #1 was assessed by the nursing staff and was noted to have areas of redness and scratches on the right side of their face. Client #1 indicated that staff would know the man that was in his/her apartment, because Client #1 scratched the back of the man's arm and made it bleed when he/she was struck.

Client #2 was found in his/her bathroom by agency staff trying to wash the blood off of an injury to the left arm and appeared angry. 911-Emergency Services (EMS) was called and upon EMS arrived, Client # 2 was transported to Hospital #1 for a medical evaluation due to aggressive behavior.

Client #2 was discharged and was returned to the Memory Care Unit on 9/2/25 at 5:45pm. Client #2 appeared calm, with a dressing in place to the left arm and was diagnosed with a Urinary tract infection and was given an order for an antibiotic medication for 7 days. Upon the return of Client #2 to the facility, the client was placed on 15-minute staff checks for safety, and on 9/3/25 Client #2 was placed on constant observation with private duty staffing 24 hours per day. On 9/16/25 after no aggressive behaviors were identified by the agency staff, the hours for the private duty staff were changed to 12 hours per day, from 8am to 8pm, while Client #2 was awake.

Further review of the agency documents dated 8/24/25 at 9:26pm, on 9/24/25 indicated a prior incident involving Client #2 and Client #1. Client #1 reported that Client #2 entered his/her apartment and walked into the bathroom. When Client #1 attempted to stop Client #2, Client #1 was struck in the face and sustained scratches on the face and right eye. Client # 1 activated the emergency call bell, where the aid staff responded and found Client # 1 sitting in their

wheelchair with injuries to their face and area near the right eye, and was evaluated by the nursing staff for the injuries sustained in the incident.

Client # 2 was found in their room by agency staff attempting to wash an injury to their left arm. 911 was activated police and emergency service (EMS) personnel responded to the facility, and Client # 2 was transported to the hospital for a medical evaluation related to their injury and to aggressive behavior.

Review of the agency documentation and investigation dated 8/24/25 at 9:26pm, with the Executive Director (ED), and Memory Care Director (MCD) on 9/24/25 at 10am, indicated that on 8/24/25 at 9:26pm, Client #1 reported that Client #2 entered his/her apartment and went into the bathroom, and when Client #1 attempted to stop him/her, Client #2 turned around and hit Client #1 in the face.

Interview with the Supervisor of Assisted Living (SALSA) on 9/24/25 at 12pm indicated that after the incident on 8/24/25, updates to the client care plan identified Client #2 was placed on 15-minute safety checks by staff to ensure the safety of all clients.

Furthermore, following a meeting on 8/26/25 with Client # 1's family representative, Client #1's representative agreed to have the door locked on the outside of Client #1's room to prevent Client #2 from entering the incorrect room. The agency ensured Client #1 could leave the apartment as he/she wanted and would be let back in by staff upon returning.

Interview with Police identified an investigation involving 2 incidents of wandering and aggressive behavior by Client #2 on 8/24/25 and a 2nd on 9/2/25 that involved injury to Client #1 who resided in the Memory Care Unit. No criminal charges were brought forth on either client.

Interview with the agency ED and SALSA on 9/24/25 failed to identify an effective plan for the assurance of the safety of Client #1 and failed to ensure a safe living environment free from harm, neglect and injuries in a locked Memory Care unit.

Review of the agency policy on Abuse- Self Neglect/Neglect identified client living in our communities have the right to be free of abuse. Abuse is an intentional act, or failure to act, by a caregiver, or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.

Self-Neglect/Neglect identifies the failure by a caregiver or other responsible

person to protect an elder from harm, or the failure to meet the needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and safety. Examples include not providing adequate nutrition, hygiene, clothing, shelter, or access to necessary health care, or failure to prevent exposure to unsafe activities and environments.

Plan of Correction for Violation #1:

THE RESIDENCE at South Windsor Farms
Independent, Assisted & Memory Care Living

200 Deming Street
South Windsor, CT 06074
T 860-432-2911
F 860-432-2279
www.residencesouthwindsor.com

Accepted
1/14/26
E T Heiney SNC

December 26, 2025

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

Supervising Nurse Consultant
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 South Windsor Farms in response to an unannounced visit by your department on September 24, 2025, for the purpose of an investigation related to a complaint. The Plan of Correction set forth is not an admission of any wrongdoing, but rather, an opportunity to comply with the alleged violations.

The Residence at South Windsor Farms
Plan of Correction
December 26, 2025

The following is a violation of the Regulations of Connecticut State Agencies **Section 19-13-D105 (e) General requirements of an assisted living service agency (1), and (h)Nursing Services provided by an assisted living service agency (3)(B)(D)(G), and (m) Client Bill of Rights and Responsibilities to be free from harm (5).**

1. **The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of the identified issue of noncompliance.**

In response to the finding that the agency failed to ensure a safe living environment free from harm, neglect and injuries in a locked Memory Care Unit. The community will provide mandatory in-service education for Care Associates, LPNs and RNs on the agencies policy on Abuse-Self Neglect.

The community will provide mandatory in-service education on the reporting of incidents and the notification of ALSA RN of the behavior, which should also include notifying the on-call RN promptly.

THE RESIDENCE at South Windsor Farms

The Community will provide mandatory in-service education on Resident's Rights Bill of Rights and Responsibilities to be free from harm.

1. **The date each corrective measure or change by the institution is effective.**

Education will begin immediately and be completed by January 15, 2026.

2. **The institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained.**

As part of the Quality Assurance and Performance Improvement process, training effectiveness will be monitored through daily review of incidents via the incident dashboard and quarterly analysis at Safety Committee meetings to ensure sustained compliance with reporting requirements and resident safety.

3. **The title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.**

    1. The Resident Care Director (SALSA)
    2. The RN Designee
    3. Executive Director

Sincerely,

Amy Lombardi

Amy Lombardi, BSN, RN
Resident Care Director