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

February 4, 2021

Patricia Keaney, Executive Director
Bridges By Epoch At Trumbull
2415 Reservoir Avenue
Trumbull, CT 06611
tkeaney@bridgesbyepoch.com

Dear Ms. Keaney:

An unannounced visit was made to Bridges By Epoch At Trumbull on October 1, 2019 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 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 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 16, 2021

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.

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 February 12, 2021 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 Section Chief via email at Donna.Ortelle@ct.gov or right fax number 860-622-2655. Please direct your questions concerning the instructions contained in this letter to the Section Chief at (860) 509-7400. Please do not send another copy via US mail.

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

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

Respectfully,

Donna Ortelle, RN, MSN
Section Chief
Facility Licensing and Investigations Section

DMO:lst

CT's 25988, 25989

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (k) Client service record (H)(i)(vi).

1. Based on clinical record review and interview with facility personnel for four of four clients (Clients #1, 2, 3 and #4) that had an incident, the facility failed to update the service plans and the Assisted living aides. The findings include:
   a. Client # 1 had a move in date of 1/31/19 with diagnosis that included dementia, hypertension, Alzheimer's dementia with behavioral disturbances, anxiety, and depression.

      Interview and review of the Service Plans dated 5/23/19 and 9/23/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #1 was independent with mobility and was physically aggressive at times when approached with new things or was getting an infection. Interventions included to approach calmly and explain what you are doing. The resident was socially inappropriate such as kissing others with an intervention to try and redirect and has sun downing.

      Interview and review of the Resident Notes dated 7/22/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that on 7/22/19, Client #1 accused the male caregiver of stealing things out of his/her room. Client #1 grabbed the paper towel holder and started to hit the female caregiver attempting to distract/calm him/her down and the male caregiver had to leave the client's room.

      The Resident Notes dated 7/31/19 at 2:17 AM identified that Client #1 was heard shouting at a female housekeeper who was cleaning, Client #1 shouted and the housekeeper called an assisted living aide to separate the client and diffuse the confrontation. When the assisted living aide tried to diffuse the situation Client #1 got angry and hit the assisted living aide on the arm and Client #1 was asked to sit in the room and relax.

      Review of the Resident Notes dated 7/31/19 at 1:57 AM identified that Client #1 was heard yelling at Client #2, the staff went to investigate what the argument was about and noted Client #1 on the floor on top of Client #2, Client #'1s hands were at Client #2's upper chest region/throat pinning Client #2 to the floor making it difficult for Client #2 to move or escape. The staff members pulled Client #1 off Client #2, the nurse was called into assess and found Client #1 to be confused, frightened/angry with red scratch marks on his/her nose, right cheek and forehead, Client #1 was sent to the hospital for an evaluation for his/her aggressive behavior towards staff and client.

      Interview and review of the facility documentation dated 7/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #1was heard by the staff yelling at a female client in the Television room, when the staff went to investigate, they noted Client #1 on the floor on top of Client #2, Client #1's hands were at Client #2's upper chest region/throat, Client #1 was given as needed medication and transferred to the hospital for an evaluation.

Further review of the clinical record at that time failed to identify documentation that the Service Plan dated 9/23/19 had been updated to include the incident that occurred on 7/30/19, the hospitalization and the interventions to prevent a reoccurrence.

Interview and review of the Service Recap Overall sheets for 8/1/19 through 8/31/19 and 9/1/19 to 9/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM failed to identify documentation that addressed the clients aggressive behaviors, the incident that occurred on 7/22/19, 7/31/19 at 2:17 AM and 7/31/19 at 1:57 AM that resulted in hospitalization or any interventions to prevent reoccurrences of his/her aggressive behaviors.

b. Client #2 had a move in date of 10/1/19 with diagnosis that included Alzheimer's dementia gastro-esophageal reflux, hypertension, and vitamin B1 deficiency.

Interview and review of the Service Plans dated 5/14/19 and 9/23/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #2 was independent with mobility and wandered in the unit, no attempts to leave, and no behavioral concerns.

The Resident Notes dated 7/31/19 at 1:57 AM identified that Client #1 was heard yelling at Client #2, the staff went to investigate and noted Client #1 on the floor on top of Client #2, Client #1's hands were at Client #2's upper chest region/throat pinning Client #2 to the floor making it difficult for Client #2 to move or escape, and the staff members pulled Client #1 off Client #2. The nurse was called into assess and found Client #1 to be confused, frightened/angry with red scratch marks on his/her nose, right cheek and forehead, Client #2 was sent to the hospital for an evaluation.

Interview and review of the facility documentation dated 7/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client # 1was heard by the staff yelling at a female client in the Television room, when the staff went to investigate what the argument was about they noted Client #1 on the floor on top of Client #2, Client #1's hands were at Client #2's upper chest region/throat, Client #1 was given as needed medication and Client #1 and Client #2 were transferred to the hospital for evaluations.

Further review of the clinical record at that time failed to identify documentation that the Service Plans dated 5/23/19 and 9/23/19 had been updated to include the incident that occurred on 7/30/19, the evaluation at the hospital and the interventions to prevent a reoccurrence.

Interview and review of the Service Recap Overall sheets for 8/1/19 through 8/31/19 and 9/1/19 to 9/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM failed to identify documentation that addressed the incident that occurred on 7/31/19 that resulted in a hospital evaluation and interventions to prevent reoccurrences.

c. Client #3 had a move in date of 7/28/17 with diagnosis that included major cognitive disorder, Alzheimer's dementia, hypertension, anxiety, hallucinations and delusions.

Interview and review of the Service Plans dated 4/22/19 and 8/9/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #3 was independent with mobility, used an assistive walking device for long distances and no behaviors of concern.

Review of the Resident Notes dated 7/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #4 wandered into Client #3's room and was punched by Client #3 a few times in her/his back. Client #3 shouted at Client #4 you are invading my privacy, Client #4 was immediately removed from Client #3's room, Client #3 was assessed no injury noted and Client #3 denies pain.

Interview and review of the facility documentation dated 7/29/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #4 wandered into Client #3's room and was punched by Client #3 a few times in the back, Client #3 shouted at Client #4 you are invading my privacy, Client #4 was immediately removed from Client #3's room by the staff nurse.

Further review of the clinical record at that time failed to identify documentation that the service Plans dated 5/23/19 and 9/23/19 had been updated to include the incident that occurred on 7/30/19, the evaluation at the hospital and the interventions to prevent a reoccurrence.

Interview and review of the Service Recap Overall sheets for 8/1/19 through 8/31/19 and 9/1/19 to 9/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM failed to identify documentation that addressed the clients behavior, the incident that occurred on 7/29/19, and interventions to prevent reoccurrences of his/her behaviors.

d. Client #4 had a move in date of 9/4/18 with diagnosis that included dementia with behavioral disturbances, hypertension, hypercholesterolemia and paranoia.

Interview and review of the Service Plans dated 5/24/19 and 9/20/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #4 had a history of paranoia and aggressive behaviors, was independent with mobility, can be physically aggressive at times, resistive to care and wanders inside the common areas but does not leave the building.

Review of the Resident Notes dated 7/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #4 wandered into Client #3's room and was punched in the back by Client #3 who shouted at the Client. Client #4 was immediately removed from Client #3's room by the staff, the nurse was notified and assessed Client #4, no injury was noted and Client #4 denied pain.

Interview and review of the facility documentation dated 7/29/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM identified that Client #4 wandered into Client #3's room and was punched by Client #3 a few times in the back, Client #3 shouted

at Client #4, Client #4 was immediately removed from Client #3's room by the staff nurse, and Client #4 was assessed by the nurse.

Further review of the clinical record at that time failed to identify documentation that the Service Plan dated 9/20/19 had been updated to include the incident that occurred on 7/29/19 and interventions to prevent a reoccurrence.

Interview and review of the Service Recap Overall sheets for 8/1/19 through 8/31/19 and 9/1/19 to 9/30/19 with the Executive Director and the SALSA on 10/1/19 at 2:30 PM failed to identify documentation that addressed the clients behavior, the incident that occurred on 7/29/19, and interventions to prevent reoccurrences of his/her behaviors.

Bridges
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

POC accepted
2/17/2021
LD

February 16, 2021

Donna Ortelle, RN, MSN
Section Chief
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
Donna.Ortelle@ct.gov

Re: Violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (k) Client service record (H)(i)(vi).

Dear Ms. Ortelle:

Please see below the Plan of Correction submitted by Bridges by Epoch at Trumbull as a result of an unannounced visit to the Community on October 1, 2019. The visit ensued a violation stating the Community failed to update the service plans and the Assisted Living aides for 4 out of 4 clients that had an incident.

Plan of Correction:

(1) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 410) for developing and maintaining an individualized service plan for each client.

Remarkable people.
Exceptional care.

Bridges
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

POC accepted 8/17/2021 ebs

The service plan will be reviewed every 120 days and with a significant change by the SALSA (Supervisor of Assisted Living Services Agency). If the client has a significant change in status, a new service plan will be completed with associated interventions and reviewed with the SALSA, the clients Responsible party and the Assisted Living aides. A service plan can be revised at any time to reflect an episodic event. Service plans have been revised for client 1, 2, 3 and 4.

(2) Effective August 3, 2020 Bridges by Epoch at Trumbull hired a new Wellness Director (SALSA). Policies and Procedures were reviewed during orientation including Policy No. 410 re: Service Plans.

(3) An audit of all service plans took place starting November 1, 2020 as a result of multiple violations related to service plans from March 2018 through March 2020. The audit was over a 30 day period with all client service plans reaching 100% compliance. In addition, service plans will be reviewed at each Quarterly review meeting moving forward to ensure 100% compliance is being upheld.

(4) The Executive Director will ensure Community compliance by monthly tracking meetings with the SALSA and the RN Designee. Resident changes will be discussed and identified with service plans and the Assisted Living aides updated as needed.

Please do not hesitate to contact me if you have any questions at 203-397-6800.

Respectfully Submitted,

Patricia Keaney
Executive Director

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