

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

Page 1 of 2

ALSA LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Masonicare at Ashlar Village
Pond Ridge ALSA
74 Cheshire Road, Wallingford, 06492
Tel: 203-679-6400

Signature of FLIS Staff

Nurse Consultant
Michael J. Smith, RN

okorytnyuk@masonicare.org

Licensure Category: ALSA 087

Census: 123 Capacity:

89A
L

Memory Care/Traditional

41 memory ☐

Date(s) of onsite inspection: 5/29/24, 5/30, and 6/3/2024

Date(s) additional information obtained: _____

Personnel contacted: Rachael Laudano ExDirector
rlaudano@masonicare.org

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

☒ Licensing Inspection ☐ Initial ☒ Renewal ☐ Other (e.g. strikes):

☐ Visit **OR** Revisit for the purpose of

☒ See Complaint Investigation CT# 38793

☒ Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 7/1/24

☐ Desk Audit ☐ Amended Letter: ☐ Original Ltr

☐ Citation # _____ was issued to this facility as a result of this inspection.

☐ Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

☐ Citation # _____ was/was not verified as corrected. See attached narrative report.

☒ Narrative report/additional information attached.

☐ See Certification File.

☐ Referral(s) to _____

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ALSO LISTED IN THE
ALBANY JOURNAL

Office of the Registrar of Births, Deaths and Marriages
Albany, New York
12242

For further information, please contact:
The Registrar of Births, Deaths and Marriages
Albany, New York
12242

ALBANY, NEW YORK

1. Name of the person: [Name]

2. Date of birth: [Date]
3. Place of birth: [Place]

4. Date of death: [Date]

5. Place of death: [Place]

6. Cause of death: [Cause]

7. Name of the physician: [Name]

8. Name of the hospital: [Name]

9. Name of the funeral home: [Name]

10. Name of the cemetery: [Name]

11. Name of the informant: [Name]

12. Name of the informant's address: [Address]

13. Name of the informant's telephone: [Phone]

14. Name of the informant's occupation: [Occupation]

15. Name of the informant's date of birth: [Date]

16. Name of the informant's sex: [Sex]

17. Name of the informant's race: [Race]

18. Name of the informant's religion: [Religion]

19. Name of the informant's marital status: [Status]

20. Name of the informant's education: [Education]

**STRIKE MONITORING SUPPLEMENT TO
LICENSING INSPECTION REPORT**

Page 2 of 2

- [xx] Verification of Alzheimer's special care units or programs or [] Not applicable
[xx] Part time Infection Prevention and Control Specialist and other requirements of P.A. 21-185

REPORT SUBMITTED BY: Michael J. Smith, RN **DATE OF REPORT:** 6/4/24

[X] Approval for issuance of license granted by: Elizabeth T. Wang **DATE:** 7/3/24
Supervisor/Title JNL

LICENSING INSPECTION NARRATIVE REPORT:

Re-Licensure survey consisted of a tour, review of Gov't Authority Minutes, Quality Assurance Meeting Minutes, Personnel folders, and Clinical Record Reviews.

