STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

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Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

Accepted 9/19/25 ET Hearing SDC

September 9, 2025

Terry Jackson, Executive Director
Charter Senior Living Of Brookfield
291 Federal Road
Brookfield, CT 06804
Via E-mail: TJackson@charterofbrookfield.com

Dear Terry Jackson:

An unannounced visit was made to Charter Senior Living Of Brookfield on August 18, 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 September 19, 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

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Public Health

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(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 **September 19, 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 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.

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

Respectfully,

Elizabeth T. Heiney BSN RN BC

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

ETH:lst

c. VL
Complaint CT #45299

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (g) Supervisor of assisted living services (2)(A) and/or (B) and/or (h) Nursing Services provided by an assisted living service agency (3)(C) and/or (D) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on review of clinical records, agency documentation, an agency incident report, interviews with agency personnel and agency policies for one of three clients (Client #1) in the survey sample with a change in condition, the Assisted Living Service Agency (ALSA) failed to follow agency policies, failed to identify a Client's change in condition timely and failed to ensure the Client's rights. The findings include:
    a. Client #1 was admitted to the ALSA on 07/21/2024 and resided in the secure memory care unit with diagnoses of cognitive decline, restlessness, agitation and chronic kidney disease. The Client's 120-day nursing assessment and service plan dated 07/29/2025, identified the Client required nursing services for assessments and medication administration. Additionally, the Client required ALSA aide assistance with bathing, grooming, dressing, incontinence care, toileting, ambulation with a walker, safety checks twice per shift and housekeeping.

    Review of Licensed Practical Nurse (LPN) #1's nursing note dated 08/04/2025 at 10:31 AM, identified Client #1 was transferred to the emergency department during the 11:00 PM to 07:00 AM shift for complaints of pain. The Client returned to the agency on the morning of 08/04/2025 with a diagnosis of an inguinal hernia pain and scans were negative for fractures.

    Review of an incident report dated 08/04/2025 at 2:05 PM by LPN #1, identified ALSA aide #1 called LPN #1 to Client #1's apartment. LPN #1 identified the Client was on the floor and laying on his/her right side. The Client indicated he/she was transferring out of his/her wheelchair and landed on the floor. Client #1 reported pain, and Acetaminophen was offered but declined. The Client required the assistance of three (3) staff members to transfer from the floor.

    Review of LPN #1's nursing note dated 08/04/2025 at 2:32 PM, identified Client #1 complained of pain but declined Acetaminophen 325 milligrams (mg) and requested to be transferred to the hospital. LPN #1 identified the Client did not present with signs or symptoms that would require a hospital evaluation.

    Review of a nursing note dated 08/05/2025 at 10:08 PM, identified Client #1 complained of pain during transfers.

    Review of a nursing note dated 08/06/2025 at 11:39 AM, identified Client #1 declined to get out of his/her reclining chair due to pain and did not eat breakfast.

    Review of a nursing note dated 08/10/2025 at 4:57 PM, identified Client #1 reported full-body pain and requested to be transferred to the hospital. The Client's responsible caregiver was consulted, and the Client was transported to the hospital.

Review of a nursing note dated 08/10/2025 at 10:31 PM, identified Client #1 was admitted to the hospital for a right femoral neck fracture.

Interview and review of Client #1's clinical documentation and incident report with the Registered Nurse (RN) Designee on 08/18/2025 at 12:15 PM, failed to identify the ALSA staff followed the Change in Condition policy by recognizing a change in condition timely resulting in a delay in appropriate treatment, failed to provide an RN assessment to the Client following the Client's reports of increased pain after an unwitnessed fall, failed to provide and failed to follow the agency's Incident/Unusual Occurrence policy by failing to immediately notify the Supervisor of Assisted Living Services Agency (SALSA) or RN Designee, the client's physician and responsible party of the Client's unwitnessed fall and moving the Client without activating 911.

Review of the agency's Change in Condition policy, identified a change in condition would include complaints of pain and/or decreased mobility and it would be the responsibility of the staff to provide care and notify the Health and Wellness Director immediately whenever there was a change in a client's status. Additionally, the client's physician and responsible party would be notified of a change in condition and if needed 911 would be activated.

Review of the agency's Incident/Unusual Occurrence policy identified an incident form would be filled out completely for any incident or unusual occurrence. The Wellness Director will be notified of the incident immediately and report any significant injuries such as complaints of pain or obvious broken bones or dislocations. If falls witnessed or unwitnessed occurred, do not move the client unless there is imminent danger to the client or staff. The staff would call 911 emergency services, and the client or client's responsible party can refuse the emergency service once they arrive, but the agency must call for evaluation even if the client and/or responsible party does not want the service.

Plan of Correction to Violation #1:

Rec'd 9/10/25 Accepted Telemy SWC

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH PLAN OF CORRECTION
CHARTER OF BROOKFIELD
VISIT CONCLUDED: AUGUST 18TH, 2025

Regulation/Finding	*Corrective Action Plan*	*Compliance Date*	*Person(s) Responsible*
Section 19-13-D105 Assisted Living Services Agency (g) Supervisor of assisted living services (2)(A) and/or (B) and/or (h) Nursing Services (3)(C) and/or (D) and/or (m) Client's bill of rights and responsibilities (5) The Assisted Living Services Agency (ALSA) failed to follow agency policies, failed to identify a Client's Change in condition timely, and failed to ensure the Client's rights.	**Please note that the filing of this plan does not constitute any admission as to the alleged deficiencies set forth in the letter of violation. This plan of correction is being filed as required by applicable law and as evidence of the community's commitment to quality care.** • LPN #1 is no longer a Charter of Brookfield associate. • Licensed nursing associates including the SALSA and RN designee were re-educated on **policy HW-033 Change in Condition** and **RSK -003 Incident/Unusual Occurrence Policy**, with emphasis on recognizing a change in condition timely, providing an RN assessment, when to notify the physician/responsible party, and to call 911. • Licensed nurse associates were re-educated on resident rights, including the right to timely evaluation and care.	_01/30/2026_ 01/30/2026	SALSA

	• Audits will be conducted on 25% of ALSA residents with documented change in condition, falls, or pain complaints to verify RN assessments were completed, appropriate parties were notified, and 911 was activated as needed. Audits will be conducted weekly for 4 weeks, and then monthly for 3 months or until compliance is reached	01/30/2026	SALSA / ED
	• Incident reports will be reviewed weekly for 4 weeks, then monthly for 3 months for adherence to **policy HW-033 Change in Condition and RSK - 003 Incident/Unusual Occurrence Policy**, or until compliance is reached	01/30/2026	
	• All findings will be brought to the Quality Assurance Committee for Review.		

In-services will be conducted at each upcoming meeting, including the Nurses' Meeting, CNA Meeting, and Monthly Team Meeting, to reiterate and reinforce the Resident Bill of Rights.