CONNECTICUT Department of Public Health

HEALTHCARE QUALITY AND SAFETY BRANCH

January 14, 2026

Accepted
1/28/26
CTHeelthy SNC

Whitney Zajac, SALSA
Elmbrook Village
380 Salem Turnpike
Bozrah, CT 06334-1539
Via Email: WZajac@elmbrookvillage.com

Dear Ms. Zajac:

An unannounced visit was made to Elmbrook Village on January 6, 2026 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 January 24, 2026.

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 January 24, 2026 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 #45791

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 (3) (C) .**

1. Based on review of agency documentation, staff interviews, and review of agency policies for one of six clients (Client #3) in the sample survey, the Assisted Living Service Agency (ALSA) failed to identify a client's significant change in condition timely and failed to ensure client safety. The findings include:

a. Client #3 was admitted to the ALSA on 03/17/2025 and resided in the secure memory care unit with diagnoses of dementia, falls, type II diabetes, urinary tract infections and cardiac disease. The Client's 120-day nursing assessment and service plan dated 11/02/2025, identified the Client required nursing assessments and medication administration by a nurse. Additionally, the Client required ALSA aide assistance with bathing, grooming, oral care, dressing, toileting, incontinence care, ambulation with a walker and wheelchair mobility.

Review of an incident report dated 11/09/2025, identified Client #3 was found on the floor of his/her bedroom around 09:28 AM and had no visible injuries.

Review of a nursing note dated 11/09/2025, identified Client #3 had no ill effects from his/her fall on 11/09/2025.

Review of Licensed Practical Nurse (LPN) #2's nursing note dated 11/15/2025 at 03:56 AM, identified around 03:00 AM ALSA aide #4 was performing hourly safety checks when she observed Client #3 was drooling, had facial twitching and reported the observation to LPN #2. LPN #2 identified Client #3 was lying in bed on his/her left side, with repeated facial twitching and was foaming at the mouth. LPN #2 cleaned the Client's mouth, obtaining his/her vital signs and activated 911.

Review of the ambulance transportation report dated 11/15/2025, identified emergency medical services (EMS) personnel arrived at the ALSA at 03:33 AM. The report identified Client #3 was received in a wheelchair, presented with full body seizures and was unresponsive with bloody sputum coming from his/her mouth. The ALSA staff identified around 03:00 AM, Client #3 was unresponsive with jerking motions throughout his/her body which progressed over thirty (30) minutes and 911 was activated when the Client's condition worsen. Additionally, light blue bruising was present to Client #3's forehead with a bleeding abrasion and a pink/purple mark to the left cheekbone.

i. Interview with LPN #2 on 01/06/2026 at 11:45 AM, identified on 11/15/2025 at 03:00 AM she observed Client #3 lying in bed with facial twitching and was foaming at the mouth. LPN #2 identified cleaning the Client's mouth, obtaining vital signs and calling 911. LPN #2 and ALSA aide #4, transferred the Client into a wheelchair when EMS arrived. LPN #2 denied the Client had a fall on 11/15/2025 but indicated the Client fell on 11/09/2025 causing the bruising to the Client's forehead and left cheekbone.

ii. Interview with the Supervisor of Assisted Living Services Agency (SALSA) on 01/06/2026 at 1:00 PM, failed to identify staff detected Client #3's significant change in condition in a timely manner resulting in a delay in emergency medical care and failed to ensure Client #3's safety by transferring the Client into a wheelchair while seizing.

Review of the Change in Condition policy, identified the ALSA staff would be trained to be competent to make appropriate reports of change in baseline condition of the client. ALSA staff would know that when detecting moderately worsening symptoms of known chronic illnesses, to note the issue, report the change to a supervisor and if the supervisor was not available to call 911 immediately.

Plan of Correction for Violation 1:

Elmbrook Village
at Bozrah
An Everbrook Senior Living Community
380 Salem Turnpike • Bozrah, CT 06334

Accepted
1/29/26
CT Heiney SNC

January 19, 2026

Elizabeth Heiney

Supervising Nursing Consultant

Facility Licensing and Investigation Section

410 Capitol Avenue

P.O. Box 340308

Hartford, Connecticut 06134-0308

Dear Ms. Heiney,

Attached is the plan of correction for the violation regarding the visit from the Facility Licensing and Investigation Section of the Department of Public Health on January 6, 2026.

Please feel free to contact myself or Kristin Mangual the Executive Director if any other information is needed.

Respectfully,

Whitney Zajac RN

Whitney Zajac, RN, SALSA

Elmbrook Village

380 Salem Turnpike

Bozrah, CT 06334

Telephone: 860-861-9704

Fax: 860-934-5336

The following is the Plan of Correction for **Elmbrook Village** regarding the Statement of Deficiencies dated **January 14, 2026**. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Unannounced visit was made to **Elmbrook Village** on **Janauary 6, 2026** by a representative of the Facility Licensing and Invesitgation Section of the Department of Public Health for the purposes of conducting an investigation. The findings are as follows:

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 (3) (C) .

1. Based on review of agency documentation, staff interviews, and review of agency policies for one of six clients (Client #3) in the sample survey, the Assisted Living Service Agency (ALSA) failed to identify a client's significant change in condition timely and failed to ensure client safety. The findings include:

a. Client #3 was admitted to the ALSA on 03/17/2025 and resided in the secure memory care unit with diagnoses of dementia, falls, type II diabetes, urinary tract infections and cardiac disease. The Client's 120-day nursing assessment and service plan dated 11/02/2025, identified the Client required nursing assessments and medication administration by a nurse. Additionally, the Client required ALSA aide assistance with bathing, grooming, oral care, dressing, toileting, incontinence care, ambulation with a walker and wheelchair mobility.

Review of an incident report dated 11/09/2025, identified Client #3 was found on the floor of his/her bedroom around 09:28 AM and had no visible injuries. Review of a nursing note dated 11/09/2025, identified Client #3 had no ill effects from his/her fall on 11/09/2025.

Review of Licensed Practical Nurse (LPN) #2's nursing note dated 11/15/2025 at 03:56 AM, identified around 03:00 AM ALSA aide #4 was performing hourly safety checks when she observed Client #3 was drooling, had facial twitching and reported the observation to LPN #2. LPN #2 identified Client #3 was lying in bed on his/her left side, with repeated facial twitching and was foaming at the

mouth. LPN #2 cleaned the Client's mouth, obtaining his/her vital signs and activated 911.

Review of the ambulance transportation report dated 11/15/2025, identified emergency medical services (EMS) personnel arrived at the ALSA at 03:33 AM. The report identified Client #3 was received in a wheelchair, presented with full body seizures and was unresponsive with bloody sputum coming from his/her mouth. The ALSA staff identified around 03:00 AM, Client #3 was unresponsive with jerking motions throughout his/her body which progressed over thirty (30) minutes and 911 was activated when the Client's condition worsen. Additionally, light blue bruising was present to Client #3's forehead with a bleeding abrasion and a pink/purple mark to the left cheekbone. **(Please see attached report obtained from CRISP Shared Services – CONNIE)**

i. Interview with LPN #2 on 01/06/2026 at 11:45 AM, identified on 11/15/2025 at 03:00 AM she observed Client #3 lying in bed with facial twitching and was foaming at the mouth. LPN #2 identified cleaning the Client's mouth, obtaining vital signs and calling 911. LPN #2 and ALSA aide #4, transferred the Client into a wheelchair when EMS arrived. LPN #2 denied the Client had a fall on 11/15/2025 but indicated the Client fell on 11/09/2025 causing the bruising to the Client's forehead and left cheekbone.

ii. Interview with the Supervisor of Assisted Living Services Agency (SALSA) on 01/06/2026 at 1:00 PM, failed to identify staff detected Client #3's significant change in condition in a timely manner resulting in a delay in emergency medical care and failed to ensure Client #3's safety by transferring the Client into a wheelchair while seizing.

Review of the Change in Condition policy, identified the ALSA staff would be trained to be competent to make appropriate reports of change in baseline condition of the client. ALSA staff would know that when detecting moderately worsening symptoms of known chronic illnesses, to note the issue, report the change to a supervisor and if the supervisor was not available to call 911 immediately.

A. Corrective Action:
    a. LPN # 2 & ALSA aide #4 provided re-education on Change in Condition Policy.
    b. SALSA to provide re-education to CNA staff on Change in Condition Policy
    c. SALSA to provide re-education to LPN staff on Change in Condition Policy

B. Completion Date:
    a. Completed – 01/20/26
    b. On going – CNA Meeting Scheduled for 01/22/26
    c. On going – LPN Meeting Scheduled for 01/27/26

C. SALSA will be responsible for ongoing monitoring of this plan.

This serves as a verbal 1:1 education with Shirley Litton CNA.

When there is a change in condition with a resident, the resident is to remain where they are found. Residents should not be moved when an acute change in condition is occurring. The policy for Procedure for Recognizing Changes in Condition as well as Procedures for Attending Medical Emergencies has been provided to me for my review.

I, Shirley Litton acknowledge the above and will not move resident from location found when there is an acute change in condition and understand policy and procedure for resident Change in Condition as well as Attending Medical Emergencies.

X _____ DATE: 1-20-26

This serves as a verbal 1:1 education with Diana Lazare LPN.

When there is a change in condition with a resident, the resident is to remain where they are found. Residents should not be moved when an acute change in condition is occurring. The policy for Procedure for Recognizing Changes in Condition as well as Procedures for Attending Medical Emergencies has been provided to me for my review.

I, Diana Lazare acknowledge the above and will not move resident from location found when there is an acute change in condition and understand policy and procedure for resident Change in Condition as well as Attending Medical Emergencies.

X _____ DATE: 1/20/26

Patient Demographics

[redacted]

ED Prov Note

Source: [redacted]
Provide[redacted]
Date Collected [redacted]

Health Records

History
No chief complaint on file.

HPI:

I reviewed any nurses notes, vital signs, home medication list, other history or pertinent diagnostic tests available

History provided by: The EMS personnel and the nursing home
Chief Complaint: Seizure
Duration: This morning
Context: No prior history
Relieved by: Still focal seizing after 10 mg of Versed
Associated symptoms and Additional history: Patient is an 82-year-old female with history of dementia brought in by EMS actively seizing at the nursing home. Received in Versed and now chest eye and mouth twitching. No recorded history of trauma. EMS saw evidence of an older head injury nothing looked acute to me. Patient was seen here recently after several episodes of unresponsiveness at the nursing home and perhaps these were seizures as well. She was diagnosed with UTI and discharged back to the SNF.

Additional HPI

Past Medical History:
Diagnosis Date
Diabetes mellitus (HCC)
DM (diabetes mellitus) (HCC)
Hyperlipidemia
Hypertension

No past surgical history on file.

No family history on file.

Social History
Social History
Tobacco Use

[redacted]

[redacted]

Patient Demographics

CRISP Shared Services

[redacted]

Smoking status: Former
Types: Cigarettes
Smokeless tobacco: Never
Vaping Use
Vaping status: Never Used
Substance Use Topics
Alcohol use: Never
Drug use: Never

Review of Systems
Unable to perform ROS due to urgency/altered mental status

Physical Exam
There were no vitals taken for this visit.

Physical Exam
Vitals and nursing note reviewed.
Constitutional:
Patient is seizing. She is twitching mouth and eyes but no grand mal activity as paramedics reported earlier.
HENT:
Nose: Nose normal.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds.
Patient placed on O2 as she had been sedated with 10 of Versed 5 of Valium
Neurological:
Twitching of mouth and eyes

ED Course
Final diagnoses:
None

MDM:
Number and Complexity of Problems Addressed

MDM Detail: Twitching eventually stopped and patient made some voluntary movements. CAT scan done and we are awaiting the report.
Seizure activity terminated after 5 mg Valium and 2 g of Keppra.
Discussed with teleradiology. Patient has a left cerebral parenchymal hemorrhage with surrounding edema.
Discussed with [redacted] TT who said patient is not surgical and should be admitted to neurology.
She sent to neurologist on-call and awaiting his evaluation of this patient to

[redacted]

[redacted]

determine whether she needs to be admitted here or transferred.

Amount and Complexity of Data

Discussion with Other Healthcare Provider:

[redacted]

Risk of Complications and/or Morbidity or Mortality of Patient Management

Critical Care

CT Head w/o contrast (Results Pending)

[redacted]

[redacted]