STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

Amended Letter

Accepted 2/17/26 CTasley.

January 15, 2026

Originally sent on: September 5, 2023

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

Dear Ms. McKay:

An unannounced visit was made to Bridges By Epoch At Trumbull on August 10, 2023 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting investigations, and a state re-Licensure inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violation are not responded to by September 15, 2023 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

The Plan of Corrections is to be submitted, along with a copy of your original state violation letter to the department by September 15, 2023.

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 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;

DATE(S) OF VISIT: August 9, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

(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.

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

Respectfully,

Elizabeth T. Heiney BS RN BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ETH:

CT # 35243, 35244 and re-licensure

DATE(S) OF VISIT: August 9, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations 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 provided by an assisted living service agency (3) (C) (D) and/or (k) Client service record (2) (F) (H).

1. Based on clinical record reviews, interviews with agency personnel and review of agency policies for four of four clients in the survey sample (Client #1, #2, #3 and #4) who depended on the Assisted Living Services Agency (ALSA) for assistance with activities of daily living, medication management and nursing assessments. The agency's Licensed Practical Nurses (LPN) failed to notify a Registered Nurse (RN) of Clients' changes in condition, and the agency's LPN failed to follow the Death of a Client policy, and the agency's LPN failed to carry out job duties and responsibilities, and the agency failed to ensure and conduct an RN assessment following a change in a Client's condition, and failed to update Clients' service plans to reflect a change in condition and failed to ensure a Client had an comprehensive service plan with necessary interventions to minimize harm. The findings included:

a. Client #1 was admitted to the ALSA on 07/17/2023 with diagnosis that included Alzheimer's disease, spinal stenosis, and anxiety. The Client's service plan and 120-day assessment dated 07/17/2023, identified the Client required nursing assessments, medication administration, assistance with bathing, dressing, personal hygiene, and incontinence care. The advance directives on file, identified the Client had a Do Not Resuscitate order dated 07/14/2023.

Review of Client #1's LPN notes dated 07/28/2023 and 07/29/2023, identified the Client presented with congestion and a non-productive cough. On the morning of 07/29/2023, the Client was found lying on the floor without injuries and assisted off the floor. Additionally, during the dinner meal on 07/29/2023, staff attempted to wake the Client, but he/she remained asleep in a wheelchair and continued to present with congestion.

i. Interview and review of Client #1's clinical record with the Supervisor of Assisted Living Services Agency (SALSA) and RN Designee on 08/07/2023 at 10:15 AM, identified on 07/30/2023 around 05:00 AM, an ALSA aide found Client#1 unresponsive. LPN #1 proceeded to contact Advanced Practice Registered Nurse (APRN) #1, indicated the Client was absent of vital signs and had a DNR order. APRN #1 directed the LPN to call 911, notify the RN Designee and the Client's responsible party. LPN #1 failed to follow APRN #1's directives and failed to notify the SALSA or RN Designee of the Client's death. Client #1's body was released to the funeral home on 07/30/2023 around 11:00 AM. The funeral home contacted the RN Designee on 08/01/2023, to identify the agency released the Client's body on 07/30/2023 without a signed death certificate. Additionally, the agency's LPNs failed to report a change in Client #1's condition to the SALSA and/or RN Designee on 07/28 and 07/29/2023.

b. Client #2 was admitted to the ALSA on 05/31/2021 with diagnosis that include dementia, falls, weakness, osteoporosis, and weight loss. The Client's service plan and 120-day assessment dated 05/10/2023, identified the Client required nursing assessments, medication administration, assistance with bathing, dressing, personal hygiene, and incontinence care. The Client received home health care nursing services weekly for the treatment of a stage II pressure ulceration (partial thickness loss of dermis presenting as a shallow opened area) to the right hip.

ii. Interview and review of Client #2's clinical record on 08/09/2023 at 10:25 AM with the SALSA and RN Designee, identified in December of 2022 the Client's weight was 87 lbs., 83.4 lbs.in February 2023, 76.6 lbs. in March 2023, 70 lbs. in April 2023, 73.2 lbs. in May 2023 and 74 lbs. in June 2023 resulting in a thirteen-pound

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weight loss. The RN Designee failed to identify the Client was weighed with increased frequency due to a thirteen-pound weight loss. On 05/05/2023, the Client's responsible party agreed to hospice services but declined hospice on 05/12/2023. On 07/02/2023, Client #2 developed a rash and itching to the left arm, left axillary, and left flank. On 07/05/2023, the SALSA identified the rash appeared scabbed, with oozing drainage and had spread, therefore, the Client's physician prescribed an oral medication to treat shingles (a virus in the body causing a painful rash). Furthermore on 07/05/2023, the Client's responsible party agreed to hospice services starting on 07/08/2023. On 07/07/2023 the Client's home health LPN #1, identified the Client's rash spread, had a foul odor with bloody drainage, and the Client appeared to be in pain. Home health LPN #1 notified the RN Designee and Client #2's physician. The Client's physician directed for the Client to remain at the facility and ordered Morphine 5 milligrams every three hours as needed for pain. On 07/08/2023, the Client's responsible party requested the Client be transferred to the hospital and declined hospice services. Client #2 was transferred to the hospital and expired on 07/12/2023. The SALSA and/or RN Designee failed to conduct a change in condition assessment and develop a comprehensive change in condition service plan with updated interventions to minimize harm to the Client.

c. Client #3 was admitted to the ALSA on 06/21/2021 with diagnosis that included dementia, weakness, and cardiac disease. The Client's service plan and 120-day assessment dated 06/27/2023, identified the Client required nursing assessments, medication administration, assistance with bathing, dressing, personal hygiene, and incontinence care. The Client was non-ambulatory and required a Hoyer lift transfer (mechanical lift) from the bed to a wheelchair.

iii. Interview and review of Client #3's clinical record with the SALSA and RN Designee on 08/09/2023 at 11:30 AM, identified LPN #2 and #3 documented on 02/13/2023 and 02/14/2023 that Client #3 had bruising of an unknown origin to the right arm but failed to notify the SALSA or RN Designee until 02/21/2023. The SALSA assessed the Client on 02/23/2023 and identified Client #3 had bruises of an unknown origin to the right arm, under the breasts, rib cage, and to the left side of the Client's back. The Client was transferred to the hospital on 02/24/2023, and an agency investigation was conducted, with Client #3 returning to the agency on 03/01/2023. The SALSA and/or RN Designee failed to identify a change in condition assessment and service plan was completed upon the Client's discharge from the hospital and return to the agency.

d. Client #4 was admitted to the ALSA on 06/03/2021 with diagnosis that included dementia, type II diabetes mellitus and cardiac disease. The Client's service plan and 120-day assessment dated 06/23/2023, identified the Client required nursing assessments, medication administration, assistance with bathing, dressing, personal hygiene, and incontinence care.

iv. Interview and review of the Client's clinical record with the SALSA and RN Designee on 08/09/2023 at 11:50 AM, identified on 08/06/2023 the Client's adult brief was saturated with blood. LPN #1 contacted the RN Designee who directed the LPN to notify the on-call APRN and the Client's responsible party. LPN #1 indicated she was unable to reach the APRN, therefore, the RN Designee directed LPN #1 to call 911. LPN #1 called 911, instructed an ALSA aide to call the Client's responsible person and proceeded to leave the Client area. LPN #1 was unavailable to assist with Client #4's transfer to the hospital. The SALSA and RN Designee identified LPN #1 failed to carry out her assigned job duties and responsibilities. LPN #1 was terminated by the agency on 08/09/2023.

Review of the agency's Death of a Client policy and procedure identified staff would follow specific rules and regulations as to the proper notification procedures. The procedure directed if a client was found with the absence of vital signs, check DNR status, call 911 if indicated, and the SALSA and/or RN Designee on duty. The staff would note the time of death or the time the client was discovered to be absent of vital signs, notify the

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client's family and notify the Executive Director of the client's death.
Review of the agency's Change in Status policy and procedure identified when there was a noticeable change in the client's mental, medical, or functional status, the SALSA or RN Designee would assess the client and document the findings in the clinical record. The client's responsible party and physician would be notified as well to determine if transfer or discharge was needed. A change in the client's condition would require a change in the service plan and a complete assessment update. The agency would arrange for a meeting, if needed, with the client/responsible party to include ancillary providers and revise the client's service plan if indicated.
Review of the agency's Client Assessment policy, identified an RN assessment and service plan would be completed pre-admission to the agency, reassessed every 120-days and after a significant change in condition. A client maybe reassessed at any time.
Review of the agency's LPN job description identified the primary purpose of the LPN's job was to be responsible for providing client care under the medical directions and supervision of the client's attending physician, ensuring the client remained as independent as possible and assist the client in maintaining physical and emotional health. The LPN would communicate with community healthcare professionals on the care needs of all clients, maintain a safe environment for the clients and follow the agency's policies and procedures.

Plan of Correction for Violation #1

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of the Assisted Living Service Agency (1), and (e) General Requirements of the Assisted Living Service Agency (1), and CT Public Act 21-185 (1)(2)(b) Nursing Home and Dementia Special Care Units.

2. Based on interviews with agency personnel, and review of agency personnel documentation, the agency failed to employ a full - time Infection Preventionist in accordance with the Public Acts of the Connecticut State Agencies, for the facility surveillance component of the infection prevention and control program. The findings include:

Interview and review of the agency documentation with the Executive Director (E.D.) Supervisor of Assisted Living Services Agency (SALSA), and RN Designee on 8-9-23 at 11:00am, identified the Assisted Living Service Agency services agency has four locked Memory Care Units, with a total capacity for 78 clients, and a current census (as of 8/7/23), of 59 clients in the building.
Review of the agency personnel roster with the ED and SALSA on 8/9/24 at 11:00am failed to identify the ALSA has a full-time Infection Control Preventionist on staff. The agency SALSA further identified there had not been an Infection Preventionist in the building since her start at the facility on 10/20/22. The SALSA also identified she had completed the training/requirements as an Infection Control Preventionist but failed to identify she was

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assigned to fulfill the role for the agency. The Connecticut Public Act identified a dementia special care unit with more than sixty residents would employ a full-time infection prevention and control specialist, and a dementia special care unit with sixty clients or less, would employ a part-time infection prevention and control specialist.

Plan of Correction for Violation #2

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of the Assisted Living Service Agency (1) and (e) General Requirements of the Assisted Living Service Agency (1), and (f) Personnel Policies for an Assisted Living Service Agency (1) (E) (2)

3. Based on interviews with agency personnel, and review of agency documentation, the Assisted Living Service Agency (ALSA) failed to ensure completion of the required annual Tuberculin (TB) Testing and/or Screening requirement for two (2) out of seven (7) direct care staff members.

Review of the agency personnel records, and interview with the Executive Director (ED) and Supervisor of Assisted Living Service Agency (SALSA) on 8/9/24 at 12:00pm, failed to identified completion of an employee TB test and/or TB screening tool document for two out of seven direct care staff members reviewed.

Plan of Correction for Violation #3

DATE(S) OF VISIT: August 9, 2023

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of the Assisted Living Service Agency (1), and (g) Supervisor of assisted living services (2) (G)(H)

4. Based on interviews with agency personnel, and review of agency documentation, the Assisted Living Service Agency (ALSA) failed to ensure the completion of the weekly and monthly meetings between the Supervisor of Assisted Living Service Agency (SALSA), and the Facility Service Coordinator.
Review of the agency organizational records with the Executive Director (ED) and Supervisor of Assisted Living Service Agency on 8/9/23 at 12:00pm, failed to identify weekly and monthly meeting minutes between the ED/Service Coordinator and SALSA for the last licensure period dates of 8/31/21 through 4/23/23.

Interview with the ED/Service Coordinator on 8/9/23 at 12:00pm, failed to identify the occurrence of weekly and monthly meetings, from 8/31/21 through 4/23/23, between herself, the previous SALSA, or with the current SALSA, until being notified of the regulatory requirement in April of 2023.
Interview with the SALSA on 8/9/23 at 12:00pm, failed to identify the occurrence of weekly and monthly meetings until April 23, 2023, when the SALSA was told of the requirement. The SALSA further identified from her employment start date of 10/24/22, she had not met with the ED/Service Coordinator for the required weekly and monthly meetings, until 4/23/23.

Plan of Correction for Violation #4

Resent · Received 1/30/26

Bridges®
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

Alerted
2/2/26
CT+Henry SNC

January 29, 2026

Elizabeth T. Heiney, B.S., R.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
Dph.flisadmin@ct.gov

Dear Ms. Heiney:
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 August 10, 2023. (Amended letter sent January 15, 2026)

Re: Violations 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 provided by an assisted living service agency (3) (C) (D) and/or (k) Client service record (2) (F) (H).

Remarkable people.
Exceptional care.

Plan of Correction:

(1) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 203) change of condition. The SALSA and/or RN Designee will complete an assessment on all residents that return from the hospital to the agency. If a change of condition is identified an updated service plan will be completed to reflect the changes. The client's family and physician will be notified, with a copy of the updated service plan provided to the responsible party. Clients returning from the hospital will be reviewed at weekly morning meeting with IP, SALSA, Service Coordinator and/or RN Designee. Change in condition policy to be reviewed at every 120 day assessment with Quality Assurance Committee providing oversight on a quarterly basis to ensure 100% compliance.

Re: Violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of the Assisted Living Service Agency (1), and (e) General Requirements of the Assisted Living Service Agency (1), and CT Public Act 21-85 (1)(2)(b) Nursing Home and Dementia Care Units.

(1) Bridges by Epoch at Trumbull hired a full-time Infection Preventionist on 10/1/23 in accordance with the Public Acts of the Connecticut State Agencies, for the facility surveillance component of the infection prevention and control program. This position has been filled by the same individual from 10/1/23 to current.

Re: Violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (d) Governing Authority of the Assisted Living Service Agency (1), and (f) Personnel Policies for an Assisted Living Service Agency (1) (E) (2)

(1) Bridges by EPOCH at Trumbull will follow Policy SVIII:9 Workplace Health and Safety TB Screening for Team Members. Each team member will be screened annually utilizing the Tuberculosis Screening Questionnaire. The SALSA, RN Designee and/or Service Coordinator will be responsible for compliance by issuing the TB Screening at all annual reviews. Team Members files will be audited quarterly by the Business Office Manager to ensure this screening has been utilized to meet regulations.

Re: Violations of the Regulations of Connecticut State Agencies Section 19-15-D105 (d) Governing Authority of the Assisted Living Agency (1), and (g) Supervisor of assisted living services (2) (G) (H)

(1) Bridges by Epoch at Trumbull will follow its Policy No: 501A Wellness Policy Report. The SALSA will complete the weekly report and submit to the Service Coordinator every Thursday. The weekly report will be sent to the Vice President of Wellness every Thursday. The monthly report will be completed by the SALSA and submitted to the Service Coordinator and the VP of Wellness by the 5th of every month. Information for the weekly and monthly reports are gathered during weekly meetings between the SALSA and Service Coordinator. Meeting minutes will be recorded and kept in the Managers Morning Meeting binder. The minutes will include census, move-ins and outs, incidents, services provided, acute transfer information as well as residents at risk. Quality Assurance will audit the weekly and monthly meetings to ensure compliance.

Respectfully Submitted,

Patricia Keaney
Executive Director