STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

Accepted
10/16/25
ETKeaney SNCRN

September 18, 2025

Trish Keaney, Executive Director
Bridges By Epoch at Trumbull
2415 Reservoir Avenue
Trumbull, CT 06611
Via Email: Tkeaney@bridgesbyepoch.com

Dear Ms. Keaney:

An unannounced visit was made to Bridges By Epoch at Trumbull on August 25, 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 28, 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
(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 28, 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 the Supervising Nurse Consultant via email at dph.flisadmin@ct.gov or right fax number 860-622-2655. 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 #44239

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 (m) Client's bill of rights and responsibilities (5).

1. Based on review of clinical records, agency documentation, an agency investigation, 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 secure memory care ALSA on 01/03/2025 with diagnoses of vascular dementia, osteoporosis and arthritis. The Client's 120-day nursing assessment and service plan dated 02/25/2025, identified the Client required nursing services for assessments and medication administration. Additionally, the Client required ALSA aide assistance with bathing, grooming, oral care, dressing, incontinence care, toileting, hourly safety checks and housekeeping. The Client was independent with ambulation and transfers.

    Review of Licensed Practical Nurse (LPN)# 1's nursing note dated 04/19/2025, identified being called to Client #1's apartment at 08:40 AM and the Client reported pain to his/her right hip. ALSA aide #1 identified the Client had fallen around 06:30 AM on 04/19/2025 in another Client's apartment and indicated the Client was transferred back to bed. LPN #1 notified the Client's responsible party, physician and the Supervisor of Assisted Living Services Agency (SALSA) of the incident. Client #1 was transferred to the hospital.

    Review of Client #1's hourly safety checks dated 04/19/2025, identified Client #1's safety checks were conducted.

    Review of LPN #1's nursing note dated 04/20/2025, identified contacting Client #1's responsible party who reported that Client #1 had a right hip fracture and required surgery.

    Review of the agency's investigation dated 04/21/2025, identified on 04/19/2025 the on-call SALSA received a phone call reporting that Client #1 had fallen. The on-call SALSA directed ALSA aide #2 and #3 to transfer the Client back to bed and notify the on-coming 07:00 AM nurse of the fall. The on-call SALSA further identified not notify the Client's responsible party or physician. Additionally, ALSA aide #2 identified finding Client #1 on the floor of another client's apartment around 06:30 AM on 04/19/2025. ALSA aide #2 called the on-call SALSA who directed ALSA aide #2 and #3 to transfer the Client into bed and notify the on-coming 07:00 AM nurse of the Client's fall. ALSA aide #2 reported the Client's fall to on-coming

ALSA aide #1.

b. Interview and review of Client #1's clinical documentation with the Executive Director on 08/25/2025 at 1:30 PM, identify the ALSA staff failed to follow the agency's Fall Protocol policy, failed to identify the Client's change in condition timely, failed to provide appropriate care and treatment timely and failed to ensure the Client was free from neglect.

Review of the agency's Fall Protocol policy identified when a client falls or is found on the floor, the staff would not move the client and notify the nurse on duty immediately. The wellness staff would check for life threatening injuries and activate 911 immediately when indicated. Additionally, the client's family or responsible party would be promptly notified, and an incident report would be filled out.

Review of the agency's Change in Status policy identified when there was a noticeable change in the clients' mental, medical or functional status, the Wellness Director would assess the client's condition and document the findings in the client's record. If the change was an emergency, emergency procedures would be followed, and the Wellness Director and/or Executive Director would be notified as soon as possible. Along with the client's physician on record, and family.

Review of the agency's Client Abuse Policy identified neglect was the failure to provide goods and services necessary to avoid physical harm, mental anguish and mental illness. A client had been neglected if an individual had failed to provide appropriate care, treatment or services to the client and the individual's failure to provide the treatment, care or service to the client is either intentional or the result of carelessness and as a result of the failure to provide the treatment, care, or services, the individual had failed to maintain the health or safety of the client, as evidenced by harm to the client, or a deterioration in the client's physical, mental or emotional condition.

Plan of Correction for violation #1:

Bridges
BY EPOCH
MEMORY CARE ASSISTED LIVING
AT TRUMBULL

Rec'd
10/2/25
Accepted
10/10/25
ETHeiney, RN

September 22, 2025

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

Re: 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 provided by an assisted living service agency (3) (C) (D) and/or (m) Client's bill of rights and responsibilities (5).

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 25, 2025.

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 Executive Director are notified as soon as possible in a change of condition for a client. The client's responsible party and physician should be notified immediately and 911 called if deemed necessary. The on-call SALSA failed to contact the client's family and physician after receiving notice of client's fall.

(2) On April 24, 2025 an inservice was held with the SALSA, Executive Director, RN Designee and LPN's re: Policy No. 203. An audit of all service plans was conducted for 30 days to ensure compliance. Change in condition policy to be reviewed at every 120 day assessment. Quality Assurance Committee to provide oversight on a quarterly basis to ensure 100% compliance.

(3) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 407) protocol when a fall occurs. When a client is found on the floor a nurse is to be notified immediately and the client is not to be moved. After a wellness check for life threatening injuries it may be deemed necessary to call 911, client responsible party and physician being notified as well. The on-call SALSA failed to initiate a Tembo wellness visit when being notified of the client fall, failed to notify the responsible party and physician while instructing the ALSA aide to pick client up off the floor.

(4) On April 24, 2025 an inservice was held with SALSA, Executive Director, RN Designee, LPN's and ALSA aides to review policy no. 407. All falls are to be reviewed at monthly safety committee meetings and quarterly quality assurance reviews to ensure 100% compliance. Falls will also

be addressed at weekly tracking meetings with the Executive Director, SALSA and RN Designee.

(5) Bridges by Epoch at Trumbull will follow its Wellness Policy and Procedure (Policy No. 111) client abuse. Client did not receive appropriate care in a timely manner. On-call SALSA instructed ALSA aide to have the oncoming nurse follow-up with a client fall that had been reported.

(6) On April 29, 2025 an inservice was held with the SALSA, RN Designee, Executive Director, LPN's and ALSA aides re: policy no. 111. Client abuse policies are part of new hire orientation and held annually. All allegations of client abuse and or neglect will be investigated under the direction of the Executive Director and in accordance with the state law.

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

Respectfully Submitted,

Patricia Keaney
Executive Director