CONNECTICUT

Department of Public Health

HEALTHCARE QUALITY AND SAFETY BRANCH

Reviewed & Accepted 6/5/26 LMES

December 15, 2025

Patricia Strickland, Executive Director
Harborchase Of Branford
173 Alps Road
Branford, CT 06405
Via E-mail: pstrickland@harborchase.com

Dear Ms. Strickland:

An unannounced visit was made to Harborchase Of Branford on December 1, 2025 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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. 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 December 25, 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 violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 25, 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 BS RN BC

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

ETH:lst

c. VL
Complaint CT #45598, 45632

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 (C) and/or (h) Nursing Services (3)(C) and/or (F) and/or (i) Assisted living aide services provided by an assisted living services agency (2) and/or (5)(B) and/or (k) Client service record (2)(I).

1. Based on clinical record reviews, staff interviews, agency documentation, video observation, and agency policies for one of two clients (Client #1) in the survey sample, the Assisted Living Service Agency (ALSA) failed to ensure client safety, to provide in-service training on equipment use, complete an incident report, conduct a complete investigation and failed to identify timely emergent care was provided to the Client. The findings include:
    a. Client #1 was admitted to the ALSA in January of 2024 with diagnosis that included hypothyroidism, high blood pressure, arthritis, and lymphedema. The Client's 120-day nursing assessment and service plan dated 09/03/2025, identified Client #1 required nursing assessments. Additionally, the Client required extensive ALSA aide assistance for bathing, dressing, grooming and incontinence care. Client #1 was non-ambulatory, required mobility assistance with his/her tilt-in-space wheelchair (a mobility device that tilts the entire seat and backrest as a single unit) and required two (2) person assistance with transfers with a Hoyer lift (mechanical lift device) from the wheelchair to bed.

    Review of Licensed Practical Nurse (LPN) #3's nursing note dated 10/29/2025 at 10:11 PM, identified Client #1 was observed in his/her tilt-in-space wheelchair tilted forward toward the ground. ALSA aide #3 and #4 identified the wheelchair was unable to recline. LPN #3 was able to recline the wheelchair back and Client #1 assisted with a Hoyer lift device into bed. The Client identified pain to his/her feet but had no opened areas. LPN #3 notified the Supervisor of Assisted Living Services Agency (SALSA) and the Client's responsible caregiver.

    Review of a nursing note dated 10/30/2025, identified Client #1 was transported to the hospital for significant shortness of breath and complaints of bilateral leg pain.

    Review of emergency medical services (EMS) report dated 10/30/2025 at 06:08 AM, identified EMS was dispatched to Client #1 after a report of a fall on 10/29/2025 and the onset of shortness of breath. Client #1 was received in a hospital bed, warm to touch, short of breath and complained of leg pain. EMS identified at 10:30 PM on 10/29/2025, Client #1 was transferred out of a wheelchair to bed when the Client fell during the process and was placed into bed. Furthermore, EMS identified the morning shift LPN checked on the Client and found him/her to be short of breath and 911 was initiated.

    Review of Client #1's hospital emergency department summary dated 10/30/2025, identified Client #1's chief complaint, as a fall at the ALSA on 10/29/2025 at 10:00 PM while being transferred out of a wheelchair. On the morning of 10/30/2025, the Client was found to be pale, short of breath and complained of leg pain. The Client's responsible caregiver identified the Client did not fall to the ground, but his/her wheelchair abruptly tilted forward to the ground when the Client was being transferred by ALSA staff.

Review of a nursing note dated 11/06/2025 at 10:04 PM, identified Client #1 was admitted to the hospital since 10/30/2025, treated for a urinary tract infection and returned to the agency on 11/06/2025.

Review of the ALSA's in-service documentation prior to the 10/29/2025 incident, failed to identify the ALSA nurses and aides were trained on the use of tilt-in-space wheelchairs. Subsequent to the incident, ALSA staff were provided with in-service training on the use of a tilt-in-space wheelchair.

Review of Client #1's in-room camera footage on 12/01/2025 for 10/29/2025, identified ALSA aide #3 and #4 were attempting to transfer the Client from his/her tilt-in-space wheelchair to the bed. ALSA #4 tilted the wheelchair back when the wheelchair abruptly tilted forward to the ground. Client #1 yelled out, indicting pain to his/her legs and the ALSA aides called for LPN #3. ALSA aide #3 and #4 indicated to the Client that they would not be able to move him/her, and assistance was on the way. LPN #3 arrived six (6) minutes after the initial call for assist, tilted the wheelchair back, assisted with transferring the Client to bed and conducted a brief evaluation.

Interview with ALSA aide #3 on 12/01/2025 at 12:20 PM, identified on 10/29/2025 around 10:00 PM she was orienting ALSA aide #4 to Client #1's bedtime care, as ALSA aide #4 had not previously cared for the Client. ALSA aide #4 attempted to recline the Client's tilt-in-space wheelchair back to transfer him/her into bed when the wheelchair abruptly tilted forward to the ground. ALSA aide #3 identified the Client remained in the wheelchair and complained of pain to his/her legs. ALSA aide #3 and #4 called for LPN #3 for assistance. LPN #3 was able to recline the chair back, and the Client was transferred to bed.

Interview with the former Executive Director (the SALSA was on vacation) on 12/01/2025 at 12:40 PM, failed to identify nursing staff documented a description of the 10/29/2025 incident in an incident report, failed to conduct a complete investigation of the incident, failed to provide ALSA aides with in-service training on the use of Client #1's tilt-in-space wheelchairs prior to the incident on 10/29/2025, and failed to identify timely emergent care was provided to the Client resulting in a delay in a hospital evaluation until 10/30/2025.

Review of the agency's Client Accident Standard/Head Injury policy identified the community shall provide care and service appropriate to the needs of clients accepted for admission to the residence. These services would be specific to individual state regulations and guidelines. Community staff would be trained in accordance with requirements. First aid would be offered post incident and clients requiring emergency services would be transported via ambulance or medical transport.

Review of the agency's Incident Report and Risk Management Report policy, identified the company to have an incident reporting system that applied to incidents, events, unusual occurrences and situations involving injury and the potential for injury. The incident reporting system is considered an internal company communication system

where facts and information can be found regarding a particular incident, event or occurrence. The following incidents rise to the level of significant events major property or equipment damage or failure.

Plan of Correction to Violation #1:

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 (C) and/or (h) Nursing Services (3)(F) and/or (i) Assisted living aide services provided by an assisted living services agency (3)(A).

2. Based on agency documentation review and staff interviews, for one of two clients (Client #1) in the survey sample, the Assisted Living Service Agency (ALSA) failed to update a client's services to reflect individual care needs, failed to ensure care was provided timely and failed to ensure department access to agency report documentation upon request. The findings include:
    a. Client #1 was admitted to the ALSA in January of 2024 with diagnosis that included hypothyroidism, high blood pressure, arthritis, and lymphedema. The Client's 120-day nursing assessment and service plan dated 09/03/2025, identified Client #1 required nursing assessments. Additionally, the Client required extensive ALSA aide assistance for bathing, dressing, grooming and incontinence care. Client #1 was non-ambulatory, required mobility assistance with his/her tilt-in-space wheelchair (a mobility device that tilts the entire seat and backrest as a single unit) and required two (2) person assistance with transfers with a Hoyer lift (mechanical lift device) from the wheelchair to bed.

    Review of Client #1's service plan dated 09/03/2025 and ALSA care logs identified the Client required extensive assistance with toileting, incontinence management and/or has special requirements. Additionally, the Client would remain safe while toileting and would receive assistance with managing incontinent supplies as needed.

    Review of Client #1's clinical record identified the Client was treated for Urinary Tract Infections on 08/28/2025, 10/30/2025 and 11/27/2025.

    Review of Client #1's alarm calls for service report for 11/01/2025 to 12/01/2025 identified the Client's wait time for a response was five (5) minutes and thirty-two (32) seconds and eleven (11) minutes and fifty-five (55) seconds on 12/01/2025.

    Interview with the former Executive Director on 12/01/2025 at 1:25 PM, failed to identify Client #1's service plans were updated after the Client's identified Urinary Tract Infections but identified the ALSA aides expected response time for alarm calls for service was six (6) minutes.

Although requested by the surveyor on 12/01/2025, the ALSA failed to provide Client #1's alarm calls for service report for 09/01/2025 to 10/31/2025.

Plan of Correction to Violation #2:

HARBORCHASE OF BRANFORD PLAN OF CORRECTION FOR VISIT OF DECEMBER 1, 2025 VIOLATION: SECTION 19-13-D105 (G) SALSA (2) (A) (B)(C) AND (H) NURSING SERVICES PROVIDED BY ALSA (3) (F)(I) ALSA (3)(A)

MEASURE IMPLEMENTED	DATE OF COMPLETION	HOW COMMUNITY IS TO MONITOR MEASURE IMPLEMENTED	TITLE OF PERSON/PERSONS RESPONSIBLE FOR COMPLETING AUDIT/COMPLETION
IN-SERVICE LPN'S/RN'S REGARDING UPDATING OF A CLIENT'S SERVICES TO REFLECT INDIVIDUAL CARE NEEDS, ENSURE CARE IS PROVIDED TIMELY, AS WELL AS DPH SURVEY/COMPLAINT VISITS AND PROCESS TO ENSURE TIMELY RECEIPT OF INFORMATION REQUESTED	January 15, 2026	Complete in-service sign in sheet and put a copy in each nursing staff's employee file	Kristin Giuliano- DRC Phil Noto-ED
Audit of 4 ALSA Residents weekly x 4 weeks then bi-weekly x 4 weeks then monthly x 2 to ensure 1. Clients services reflect individual care needs 2. Physicians' orders followed 3. Residents' status assessed appropriately and reported to SALSA, MD and family timely. 4. Resident needs are met timely	START DATE: January 5, 2026 END DATE: APRIL 5, 2026	Internal audit tools completed by Kristin Giuliano-DRC in time frame stated to ensure client services reflect individual care needs, Physicians orders followed, Residents status assessed appropriately and reported to SALSA, MD and family timely Ensure residents' needs met timely	Kristin Giuliano-DRC for accuracy Patricia Strickland-SED for timeliness

HARBORCHASE OF BRANFORD PLAN OF CORRECTION FOR VISIT OF DECEMBER 1, 2025 VIOLATION: SECTION 19-13-D105 (G) SALSA (2) (A) (B)(C) AND (H) NURSING SERVICES PROVIDED BY ALSA (3) (F)(I) ALSA (3)(A)

Community will print and keep on file 30-day alarm logs to ensure service reports when requested are available as RFT failed to email DPH or ED after 3 separate requests	January 5, 2026	Every 30 days call log will be printed and reviewed by ED and kept in a binder in the ED office	Phil Noto-ED