Farmington Station

A SENIOR LIVING RESIDENCE (SLR)

Accepted 4/10/25 L Tetreault RN SWC

April 7, 2025

Elizabeth Heiney
DPH Supervising Nurse Consultant
410 Capitol Avenue P.O. Box 340308
Hartford, CT 06134-0308

Via email: elizabeth.heiney@ct.gov
Complaint #42348

Dear Ms. Heiney,

Below is Farmington Station's response to your visit dated January 7, 2025 for purposes of conducting an investigation on Complaint #42348.

DOH of associate 11/15/22, no disciplinary action during her employment except for 3 med errors (7/2/23, 6/16/24, 8/20/24). Competencies were performed, yearly in-services on Elder Abuse were complete. Incident occurred 12/5/24, RCD notified 12/6/24 and associate was immediately suspended. She was terminated 12/11/24 following the conclusion of the investigation.

1. The agency failed to ensure the supervision of the agency aide staff in the performance of their care and services to the clients and failed to safeguard the client from abuse from a facility aide staff member.

   A. CNA competencies will continue to occur every 120 days
   - This will be performed by monitoring the CNA during care
   - This will be performed by nurses
   - RCD responsible to ensure timely completion

   B. In-service on Elder Abuse and signs to report will continue to occur yearly
   - This will be performed during monthly staff in-services
   - This will be performed by managers
   - RCD responsible to ensure CNAs attend/complete

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During the investigation and interviews with other staff members, there was no reason to suspect any prior abuse from this associate toward any resident. We feel we took the necessary steps to safeguard the resident against abuse from the associate and took appropriate actions once an incident was reported. Our competency training and yearly in-services will continue, and we will continue to emphasize with staff the possible signs of abuse to report if noticed.

Should you have any additional questions please feel free to reach out to us at 860-284-0505 or you may email me at lmiller@farmingtonslr.com

Respectfully,

Lindsay Miller, Executive Director
Farmington Station Assisted Living

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

March 24, 2025

Lindsay Miller, Executive Director
Farmington Station A Senior Living Residence
111 Scott Swamp Road
Farmington, CT 06032
Via E-mail: lmiller@farmingtonSLR.com; mcarney@farmingtonSLR.com

Dear Lindsay Miller:

An unannounced visit was made to Farmington Station A Senior Living Residence on January 7, 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 a 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 April 3, 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 **April 3, 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.

Respectfully,

Elizabeth T. Heiney SNC

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

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c. VL
Complaint # 42348

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General Requirement for an assisted living service agency and/or (g) Supervisor of assisted living services (2)(B) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on review of agency documentation, review of the agency investigation, clinical record review, review of aide personnel record, interviews with agency personnel and review of the agency policy, for one of two client (Client #1) serviced by the Assisted Living Service Agency (ALSA), the agency failed to assure the protection of a client's rights and safety and failed to ensure supervision of the agency aides in care and services performed to the agency clients. The findings include:

   a. Client #1 had a move in date of 1/16/23 to the memory care unit with diagnoses of Alzheimer's disease, seizures, chronic obstructive pulmonary disease, amnesia. Review of the Clients 120-day assessment and service plan dated 1/1/25 required nursing assistance with bathing, dressing and grooming, incontinence care, assistance with transfers and ambulation, supervision with escorts, cuing for eating, and medication management and administration.

   Interview and review of the agency investigation dated 12/6/25 at 11:15am with the Executive Director (ED) on 1/7/25 at 10:30 identified that on 12/6/24 a facility staff member reported that on 12/5/24 as she was leaving the parking lot after work, she observed through the facility window an aide staff member grab the front of a clients clothes, pull him/her to a sitting position in bed, then stand them up and push them toward the room door to the facility hallway. The staff member identified the aide staff member as a black female with 2 braids and a white sweatshirt later identified as Aide #1.

   Review of the agency video surveillance dated 12/5/25 by the ED identified at approximately 5:00pm the agency aide and client # 1 were observed exiting the client's room, with the aide slamming the client's walker down in front of her and then rushing the client down the hallway in an unsafe manner. The ED identified from the video, the aide as Aide #1 and the client as Client #1.

   Interview with staff member #1 (SM #1) on 1/7/25 at 12:10pm identified, as she was leaving the facility for the day on 12/5/24 at about 5:00pm, and driving through the facility parking lot, "something caught her eye" in one of the first-floor apartments. As SM #1 drove by the window, she observed a staff member and an unidentified person lying in bed, pulling and pushing at each other, then the staff member grabbed the clothing near the neck of the client and pull the client to a seated position, and then pulled him/her to a standing position and pushed them forcefully toward the room -hall doorway.

   Review of the agency policy on Allegations of Abuse policy and Procedure, identified if any associate witnessed or received information that could be considered abuse, an investigation

is initiated and completed with outcomes and a plan of action.

The agency failed to ensure the supervision of the agency aide staff in the performance of their care and services to the clients and failed to safeguard the client from abuse from a facility aide staff member.

As a result of the agencies investigation, ALSA aide #1 was terminated on 12/11/24.

**Plan of Correction for Violation #1:**