CONNECTICUT

Department of Public Health

HEALTHCARE QUALITY AND SAFETY BRANCH

January 13, 2026

Accepted
2/1/26
E Tetley SNC

Monica Morgan, Executive Director
The Cottage At Litchfield Hills
376 Goshen Road
Torrington, CT 06790
Via E-mail: mmorgan@cottagelitchfield.com

Dear Ms. Morgan:

An unannounced visit was made to The Cottage At Litchfield Hills on December 18, 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 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 January 23, 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.

CONNECTICUT
Public Health

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Affirmative Action/Equal Opportunity Employer

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 January 23, 2026 or if a request for a meeting is not made by the stipulated date, the violations 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.

If there are any questions, please do not hesitate to contact me office at (860) 509-8059.

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 #45752

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 (h) Nursing Services provided by an assisted living services agency (4)(A) and/or (m) Client's bill of rights and responsibilities (5).

1. Based on review of agency documentation, interviews with agency personnel and review of agency policies for one of two clients (Client #1) in the survey sample who were serviced by the Assisted Living Services Agency (ALSA), an agency professional failed to follow the Standard of Conduct and Performance, failed to follow the client's service plan, and failed to ensure clients' rights. The findings include:
    a. Client #1 was admitted to the ALSA on 10/27/2025, resided in the secure memory care unit with diagnoses of dementia, type II diabetes, cardiovascular disease, and muscle weakness. The Client's nursing assessment and service plan dated 11/26/2025, identified the Client required nursing assessments and medication administration by a nurse. Additionally, Client #1 required ALSA aide assistance with grooming, bathing, dressing, toileting and ambulation.

    Review of an agency investigation dated 12/07/2025, identified the Supervisor of Assisted Living Services Agency (SALSA) contacted the Executive Director on 12/07/2025 to report during Licensed Practical Nurse (LPN) #1 morning medication pass he/she presented with slurred speech, an unsteady gait and smelled of an alcohol type substance. ALSA aide #1 identified observing clients' unopened medication packs in the trash. LPN #1 was escorted out of the agency and terminated on 12/08/2025.

    Review of the agency's security camera footage on 12/18/2025 at 10:30 AM with the SALSA, identified on 12/07/2025 at 10:16 AM LPN #1 was working in the secure memory care unit, did not administer Client #1's medications, disposing the Client's medication pack in the trash and had an unsteady gait.

    Interview with LPN #2 on 12/18/2025 at 10:55 AM identified he/she worked the 07:00 AM to 3:00 PM shift on 12/07/2025, when ALSA aide #1 reported LPN #1 had presented with slurred speech, an unsteady gait and disposed of a medication pack in the trash. LPN #2 notified the SALSA and was instructed to escort LPN #1 from the agency.

    Interview with the Executive Director and SALSA on 12/18/2025 at 11:30 AM, identified LPN #1 failed to follow the agency's Standard of Conduct and Performance, failed to follow the client's service plan, and failed to ensure clients' rights.

    Review of the agency's Standard of Conduct and Performance identified some violations of company policies and procedures are so serious they would result in disciplinary action up to and including immediate termination. The following standards were neglect or abuse of a client, reporting to work under the influence of alcohol or drugs, willful disregard of safety rules/policies or failure to use prescribed safety equipment to the extent of endangering the wellbeing of clients.

Review of the agency's Nurse Administration policy, identified nurse administration would be completed by a Registered/Licensed Nurse, must be administered at the appropriate time, and the nurse would follow appropriate guidelines, standards and procedures by law when administering medications.

Review of the agency's Medication Errors policy identified any errors in medication administration would be documented as such by completing an incident report. This report would include wrong person, wrong route, wrong medication, wrong dose, wrong time, as well as omission-not given.

Plan of Correction to Violation #1:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirements for an assisted living services agency (1) and/or (g) Supervisor of assisted living services (2)(A) and/or (B) and/or (m) Client's bill of rights and responsibilities (5).

2. Based on review of clinical records, review of agency documentation, interviews with agency personnel and review of agency policies for one of two clients (Client #2) in the survey sample who were serviced by the Assisted Living Services Agency (ALSA), the agency failed to ensure a client's rights and safety. The findings include:
    a. Client #2 was admitted to the ALSA on 05/31/2019 and resided in the secure memory care unit with diagnoses of cognitive impairment, hypothyroidism and high cholesterol. The Client's 120-day nursing assessment and service plan dated 11/04/2025, identified the Client required nursing assessments and medication administration. Additionally, the Client required ALSA aide assistance with grooming, dressing, bathing, toileting and ambulation.

    Review of an agency investigation dated 11/11/2025, identified the Registered Nurse (RN) Designee reported that ALSA aide #3 restrained Client #2 in the presence of ALSA aide #2 on 11/07/2025. ALSA aide #3 was assisting ALSA aide #2 with toileting the Client when ALSA aide #3 tied the Client's sleeves together to prevent hitting. After Client #2 was toileted he/she cried. ALSA aide #2 reported the incident to the SALSA on 11/11/2025, ALSA aide #3 was removed from the schedule, an investigation was conducted, the Client was assessed by an RN, the Client's physician and responsible caregiver were notified. ALSA aide #3 was terminated on 11/14/2025.
    Interview with ALSA aide #2 on 12/18/2025 at 11:45 AM, identified on 11/07/2025 ALSA aide #3 was assisting with toileting Client #2 when ALSA aide #3 tied the Client's sleeves together to prevent the Client from hitting. ALSA aide #2 indicated the Client cried after the incident. ALSA aide #2 reported the incident upon returning to work on 11/11/2025.

Interview with the Executive Director and SALSA on 12/18/2025 at 12:15 PM, identified ALSA aide #3 failed to follow the agency's Standard of Conduct and Performance, failed to follow the Restraints policy, and failed to ensure the client's rights. Additionally, ALSA aide #2 failed to report an allegation of abuse timely, and the agency failed to report an allegation of abuse to a state regulatory agency.

Review of the agency's Standard of Conduct and Performance identified some violations of company policies and procedures are so serious they would result in disciplinary action up to and including immediate termination. The following standards were neglect or abuse of a client, reporting to work under the influence of alcohol or drugs, willful disregard of safety rules/policies or failure to use prescribed safety equipment to the extent of endangering the wellbeing of clients.

Review of the agency's Restraints policy identified no client of the community would be restrained by any method, to include physical, chemical, psychological or mechanical.

Review of the agency's Reporting Client Abuse, Neglect or Exploitation policy identified the purpose of the policy was to guide employees of the community in the timely, accurate reporting of any suspicion of abuse, neglect or exploitation of any elder person. Any employee of the community is a mandated reporter and would report abuse.

Review of the Incident Report policy identified all incident reports need to be completed as soon as possible following the incident. The Executive Director would sign and approve the incident report, and the Executive Director would communicate any serious incident to the owner and would follow the state regulatory reporting requirements.

Plan of Correction to Violation #2:

Rec'd 1/20/26

Heiney, Elizabeth T

From: Monica Morgan <mmorgan@cottagelitchfield.com>
Sent: Tuesday, January 20, 2026 1:40 PM
To: Therrien, Laronda
Cc: Heiney, Elizabeth T; Corrina Kwasnick
Subject: RE: Violation letter - The Cottage At Litchfield Hills - EID 12-18-25
Attachments: Elder Abuse Triage Flow Chart.pdf; Restraints.pdf; POLICY - Reporting Resident Abuse Neglect or Exploitation.pdf; Resident Rights CT.pdf; PROCEDURE - Incident Report.pdf; Medication Errors.pdf; Medication Error Report.pdf; PROCEDURE - Nurse Administration.pdf; Standards of Conduct.pdf

Reviewed 2/1/26 Accepted CT Heiney GWL

Importance: High

Dear Department Officials,

Please find below the formal Plan of Correction (POC) for the findings identified during the recent survey. This POC is being submitted to the Department prior to the required date of January 23, 2026, and serves as our representation of compliance with the identified state statutes and regulations.

Plan of Correction for The Cottage at Litchfield Hills

Violation #1: LPN Impairment, Medication Omission, and Failure to Follow Service Plan/Client Rights (19-13-D105 (g), (h), (m))

Corrective Measures and Systemic Changes:
Staff Re-training and Protocol: All clinical and direct care staff will receive mandatory re-training on the Agency's Standard of Conduct (specifically policies regarding working under the influence and client neglect/abuse), the Nurse Administration Policy (including error/omission documentation), and the Client's Bill of Rights.

Changes to Existing Protocol: Suspected Staff Impairment will be added to the Agency's Standard of Conduct protocol which will require immediate notification to the Executive Director and SALSA when any staff suspect another staff member of being impaired during their assigned shift. The Executive Director and SALSA will investigate the report. Should the report be found substantiated, the information would be forwarded to the Ombudsperson and/or Elder Abuse Hotline as deemed appropriate by the Executive Director.

Effective Date:
The re-training and protocol changes/ implementation will be started effective immediately and will be ongoing to ensure completion with an end date of March 31, 2026. This will include a signature log of all staff attendance for re-training.

Monitoring (Quality Assessment and Performance Improvement):
The Assistant Resident Care Director will conduct unannounced spot checks of the medication administration process across all shifts for a minimum of 60 days. This will be overseen by the Resident Care Director for completion.

Responsible Staff Title:
Executive Director, Resident Care Director, Assistant Resident Care Director

Violation #2: Unauthorized Client Restraint, Untimely Staff Reporting, and Failure to Report Allegation to State Regulatory Agency (19-13-D105 (e), (g), (m))

Corrective Measures and Systemic Changes:
Staff Re-training: All ALSA staff (Aides, Nurses, Supervisors) will receive mandatory re-training focused on the Restraints Policy (zero tolerance), the Reporting Client Abuse, Neglect or Exploitation Policy (emphasizing mandated reporter status and the *immediate* reporting requirement), and the Incident Report Policy.

Changes to Existing Protocol: A new "Abuse/Neglect Concern Triage" flow chart will be posted and implemented to ensure staff notify all responsible parties immediately and the Executive Director reports all allegations to the proper state regulatory agency within 24 hours of discovery, as required.

Effective Date:
The re-training and Triage Flow Chart implementation will be started effective immediately and training will be ongoing to ensure completion with an end date of March 31, 2026. This will include a signature log of all staff attendance for re-training.

Monitoring (Quality Assessment and Performance Improvement):
The Resident Care Director will audit all incident reports weekly for a minimum of 90 days to ensure timely documentation, immediate staff reporting, and compliance with state regulatory reporting procedures.
The Assistant Resident Care Director will incorporate scenarios on unauthorized restraints and timely reporting into monthly staff in-service training.

Responsible Staff Title:
Executive Director, Resident Care Director, Assistant Resident Care Director

Please feel free to contact me with any questions.

Monica A. Morgan
Executive Director
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