STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Community Health Services, Inc.
d/b/a Community Health Services
500 Albany Avenue
Hartford, CT 06120

CONSENT ORDER

WHEREAS, Community Health Services, Inc. ("Licensee") has been issued License No. 0293 to operate an Outpatient Clinic, ("Facility") under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and,

WHEREAS, the Department's Facility Licensing and Investigations Section ("FLIS") conducted unannounced inspections commencing on October 1, 2014 and concluding on November 18, 2014 for the purposes of conducting multiple investigations; and,

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in violation letters dated October 16, 2014, November 25, 2014, and March 3, 2015 (Exhibit A attached); and,

WHEREAS, office conferences regarding the violation letters were held between the Department and the Licensee on November 19, 2014 and November 25, 2014; and,

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein:

NOW THEREFORE, the Facility Licensing and Investigations Section of the Connecticut Department of Public Health, acting herein by and through Barbara Cass, its Section Chief, and the Licensee, acting herein by Robert Harris, its Board Chair, hereby stipulate and agree as follows:

1. In accordance with Connecticut General Statutes section 19a-494, the license of Community Health Services, Inc. located at 500 Albany Avenue, Hartford, CT is placed on probation for a period of one (1) year.

2. The Licensee shall execute a contract with an Infection Control Consultant ("ICC") approved in writing by the Department within two (2) weeks of the effective date of this Consent Order. The ICC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the ICC and any other costs associated with compliance with this Consent Order. Failure to pay the ICC in a timely basis and in accordance with the contract, as determined by the Department in its sole and absolute discretion, shall constitute a violation of this Consent Order. Failure to pay the costs associated with the ICC's duties may result in a fine not to exceed one thousand dollars ($1,000.00) per day until such costs are paid.

3. The ICC shall function in accordance with the FLIS's ICC Guidelines (Exhibit B - copy attached). The ICC shall be a registered nurse who holds a current and unrestricted license in Connecticut and who is credentialed in infection control. The ICC shall provide consulting services for a minimum of three (3) months at the Facility unless the Department identifies through inspections or any other information that the Department deems relevant that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The ICC shall arrange his/her schedule in order to be present at the Facility at various times on the day and evening shifts including holidays and weekends. The ICC shall be at the Facility for a total of eight (8) hours per month. The Department shall evaluate the hours of the ICC at the end of the three (3) month period and may, in its sole and absolute discretion, reduce or increase the hours of the ICC and/or the ICC's responsibilities, if the Department determines, based upon any information it deems relevant, that the reduction or increase is warranted. The terms of the contract executed with the ICC shall include all pertinent provisions contained in this Consent Order. The Department shall base any decision regarding a reduction in the hours of services of the ICC upon onsite inspections conducted by the Department and based on all other information the Department deems relevant.

4. The ICC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.

5. The ICC shall conduct and submit to the Department an assessment of the Facility's regulatory compliance with regard to the Facility's infection control program and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order. During the assessment, if the ICC identities any issues requiring immediate attention, she shall immediately notify the Department and the Licensee for appropriate response.

6. The Infection Control Consultant shall have the responsibility for:

   i. Assessing, monitoring, and evaluating the delivery of care as it relates to infection prevention and implementing prompt training and/or remediation in any area in which a staff member demonstrates a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
   ii. Recommending to the Department an increase in the ICC's contract hours if the ICC is unable to fulfill the responsibilities within the stipulated hours per month;
   iii. Monitoring the continued implementation of the infection control and prevention related components of the Licensee's plan of correction submitted in response to the violation letters dated November 19 and 25, 2014 and March 3, 2015. (Exhibit A);
   iv. Reviewing the Facility's infection control and prevention policies/procedures;
   v. Evaluating the implementation of the Facility's infection control policies and procedures;

vi. Determining compliance with the Facility's policies and procedures for management and appropriate isolation of patients with potentially communicable infections; and,

vii. Assessment of the implementation of infection control techniques of staff providing direct care.

7. The ICC shall confer with the Licensee's Chief Executive Officer (CEO), Chief Medical Officer ("CMO"), Chief Quality and Clinical Operations Improvement Officer ("CQCOIO") and other staff determined by the ICC to be necessary to the assessment of the infection control program and the Licensee's compliance with federal and state statutes and regulations.

8. The ICC shall make recommendations to the Licensee's CEO, CQCOIO and CMO for improvement in the infection control program in the Facility. If the ICC and the Licensee are unable to reach an agreement regarding the ICC's recommendation(s), the Department, after meeting with the Licensee and the ICC shall make a final determination, which shall be binding on the Licensee.

9. The ICC shall submit monthly written reports to the Department documenting:

   a. The ICC's assessment of the care and services provided with regards to infection prevention principles;
   b. Whether the Licensee is in compliance with applicable federal and state statutes and regulations; and
   c. Any recommendations made by the ICC and the Licensee's response and implementation of the recommendations.

10. Copies of all ICC reports shall be simultaneously provided to the CEO, CQCOIO, CMO and the Department.

11. The ICC, the Licensee's, CQCOIO, CMO and Chief Legal and Human Resource Officer shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and, if the Department determines that the ICC's engagement should be extended after the initial three month period, thereafter at six (6) week intervals throughout the tenure of the ICC. The purpose of the meetings shall be

the discussion of issues related to the infection control program, compliance with this Consent Order and the Licensee's compliance with applicable federal and state statutes and regulations.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the ICC and the Department, upon request.

13. The Department shall retain the authority to extend the period the ICC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and any other information the Department deems relevant.

14. The CQCOIO shall have responsibility for maintaining the Licensee's infection control and prevention, surveillance and control program which shall have as its purpose the protection of patients and personnel. The CQCOIO must hold a current and unrestricted registered nurse license in Connecticut and have expertise and experience specific to infection control. Should the CQCOIO lack professional work experience in the areas of infection control, the Licensee shall provide oversight by the Infection Control Consultant required by section two (2) of this Consent Order until such time as the CQCOIO receives proper credentialing and/or training, as determined by the Department, in infection control. The CQCOIO shall also be responsible for staff education in the area of infection control. The CQCOIO and CMO shall implement a mechanism to ensure that each patient with an infection is properly identified and receives the appropriate care and services pertinent to the identified infection. The CQCOIO shall ensure the following:

    i. Maintenance of an effective infection control program;
    ii. In conjunction with the CMO, ongoing review and revision, as necessary, of the Facility's policies/procedures related to infection control prevention, including, but not limited to:
        a. Infection control surveillance activities;
        b. Disinfection and/or sterilization of medical equipment;

c. Reporting reportable diseases;
d. Staff testing for tuberculosis;
e. Hand hygiene; and
f. Preventing the transmission of infectious disease.

iii. In-service of all staff regarding infection control principles and practices;
iv. Monitoring the effectiveness of patients triage and isolation process;
v. Development of policies and procedures relative to isolation protocols;
vi. Accurate line listings of patient infections to include date of onset of infection, type of infection, site of infection, treatment, room location and any culture/lab results;
vii. Appropriate recordkeeping of reportable diseases, in accordance with regulatory requirements; and,
viii. Ongoing monitoring of staff adherence to infection control policies and procedures.

15. The CQCOIO shall be responsible for providing direction and leadership for nursing services to maintain high standards of care, collaborating with facility administration, departments, medical professionals, consultants, and organizations, to develop, support and coordinate patient care.

16. Within twenty-one (21) days of the effect of this Consent Order relevant Facility staff, including all nursing staff, shall be in-serviced, to the policies and procedures identified in paragraph fourteen (14), (ii) as appropriate to their role and function.

17. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, and CQCOIO, shall ensure substantial compliance with the following:
    a. Compliance with infection control policies and procedures and standards of care, including, but not limited to surveillance rounds.
    b. Compliance with sterilization and/or disinfection and/or reprocessing of medical instruments.
    c. In accordance with the facility policy and procedures, appropriate staff shall be fitted for N95 masks and provided with education regarding its use in preventing the transmission of airborne diseases.

18. The CQCOIO shall monitor the requirements of this Consent Order.

19. The CQCOIO shall provide monthly updates to the Licensee's Infection Control Committee regarding the status of remediation of infection control related issues identified in the November 19 and November 24, 2014 and March 3, 2015 violation letters and compliance with this Consent Order. The Infection Control Committee shall develop a method to monitor implementation of the requirements of the Consent Order and those recommendations implemented as a result of the ICC assessment. Membership of Licensee's Infection Control Committee shall include the CQCOIO and the CMO. The ICC shall have the right to attend and participate in all Committee meetings and to evaluate and report on the effectiveness of the Committee. The Licensee's Infection Control Committee shall monitor the implementation of any changes in the Licensee's policies, procedures, and allocation of resources recommended by the Committee and shall measure and track compliance with and effectiveness of such changes. A record of Infection Control Committee meetings and the subject matter discussed will be documented as minutes and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of five (5) years.

20. The Licensee shall maintain a Quality Assessment and Performance Improvement Committee (QAPIC). The QAPIC shall oversee systems and processes to assure that high quality care is provided to all patients. This includes the responsibility to identify when new policies and procedures are indicated to support delivery of high quality care and assure adoption of such policies and procedures. The scope of QAPIC shall include development of methods to measure, track, report and provide oversight of the status of remediation of all issues identified in the November 19 and November 24, 2014 and March 3, 2015 violation letters, as well as compliance with this Consent Order. Additionally, QAPIC shall review all reports and/or complaints related to the quality of care delivered to patients and compliance with federal and state laws and regulations. The QAPIC shall meet at least monthly and membership shall include CEO, CQCOIO, CMO and CLHRO. A record of QAPIC meetings and the subject matter discussed will be documented as minutes and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of five (5) years.

21. The Licensee agrees that this Consent Order does not limit any other agency or entity in any manner including but not limited to any actions taken in response to the factual basis of this Consent Order.

22. At the time the Licensee signs this Consent Order, it shall pay a monetary penalty to the Department in the amount of two thousand five dollars ($2,500.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the

Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Alice Martinez
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

23. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law. The allegations and findings contained in Exhibits A shall be deemed true in any subsequent proceeding in which the licensee's compliance with the Consent Order is at issue or the licensee's compliance with Connecticut statutes and regulations and/or with Federal statutes and regulations is at issue.

24. The Licensee understands that this Consent Order will be reported consistent with federal and state law and regulations and consistent with Department policy. In addition, the Licensee understands that this Consent Order will be posted on the Department's website.

25. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

26. The terms of this Consent Order shall remain in effect for a period of one year from the effective date of this Consent Order unless otherwise specified in this Consent Order.

27. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the November 19 and 25, 2014 and March 3, 2015 violation letters referenced in this Consent Order.

29. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

Robert Harris, Board Chair

On this 20th day of November, 2015, before me, personally appeared Robert Harris who acknowledged himself to be the Board Chair of Community Health Services, Inc. and that he, as such Board Chair being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by him as Board Chair.

My Commission Expires: May 31, 2017 Judy C. Cella
(If Notary Public) Notary Public [✓]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: Barbara Cass
Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section

Dated this 23rd day of November, 2015.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

October 16, 2014

Gregory L. Stanton
Community Health Service Inc
500 Albany Avenue
Hartford, CT 06120

Dear Mr.Stanton:

Unannounced visits were made to Community Health Service Inc on August 28, 29, September 3, 16 and October 1, 2014 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through October 1, 2014.

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 visits.

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 October 30, 2014 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7498.

Respectfully,

Alice M. Martinez

Alice M. Martinez, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c: Department of Mental Health and Addiction Services
Licensure File
CT-17232

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 the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b)and/or(c)and/or 19-13-D48 (b)(2)and/or 19-13-D50 Nursing personnel and/or19-13-D52 Maintenance.

1. Based on interview and a review of facility documentation, the facility failed to identify the staff person responsible for infection control to ensure compliance. The findings include:
   a. Review of the facility's infection control meetings documentation, chaired by Quality/ Compliance Officer (RN #1) identified meetings on 10/1/13, 10/16/14, 11/6/13, 12/11/13, 1/15/14, 3/12/14, 6/11/14 and 8/13/14. Interview with RN #1 on 8/28/14 at 2:00 PM identified that his role was Quality Compliance and he oversees the Infection Control Committee. RN #1 identified that the infection control meetings were held monthly but could not identify why the gap in the monthly infection control meetings. RN #1 identified that although he oversees infection control, he does not get involved in tracking the facility's infections and/or contagion diseases. RN #1 could not identify how the results of reportable diseases were followed-up and/or tracked by the facility, as no reports were generated to him. RN #1 identified that there had been a nurse who would have tracked and handled this type of information but had left in January or February of 2014, and did not know who followed-up. RN #1 identified that he is currently tracking the employee health part, but upon request by the surveyor, RN #1 was not able to generate a current staff list. Subsequent to surveyor inquiry the information requested was generated by Staff Person #2, who identified had pulled information from IT. Review of the documentation identified numerous front line staff persons and including new hires that were overdue on tuberculosis (TB) testing.
   b. Interview with the Chief Executive Officer on 8/28/14 at 4:00, as requested by the Department, identified in an action plan that the facility would identify all the current status of the staff requiring TB testing by 8/29/14 and complete all TB by 9/5/14. It further directed that a copy of the testing would be maintained in a centralized with the Infection Control Officer. The CEO identified that the facility's TB policy would be reviewed.
   Interview and review of facility documentation provided on 8/29/14 at 2:00 PM by the CEO failed to identify that the facility had identified current staff that required TB as identified on 8/28/14. Interview with APRN #1 identified that the facility would do bloodwork (Quantiferon) testing, as the lab was on the first floor and it was accessible to the staff. She further identified that she would be stepping in as the Infection Control Officer.
   Review of the facility roster for TB testing with the Infection Control Officer (APRN #1) on 9/16/14 at 9:40 AM identified that seven (7) staff members had no confirmation that the laboratory Quantiferon had been drawn. Although APRN #1 identified that remediation meetings including administrative and medical staff are held weekly to review progress of the corrective action plan, no further action was identified to determine the reason for the seven staff

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

members' noncompliance and/or address the staff that had not been tested.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b)and/or (c)and/or19-13-D48 Professional staff (b)(2) and/or19-13-D50 Nursing personnel and/or19-13-D52 Maintenance.

2. Based on interview and facility documentation the facility failed to conduct surveillance rounds and/or ensure staff competencies and/or staff inservicing. The findings include:
   a. Interview with RN #1 on 8/28/14 identified that he did not do surveillance rounds and that competencies with staff and have not been done since September 2013. He identified that Medical Assistants are reviewed by the senior MA #1, and he does not get involved. RN #1 identified that technically there was not a staff person overseeing the nurses but that RN #2 is considered a team leader. The facility failed to ensure what staff person is responsible for staff competencies.
   b. Review of facility hazard surveillance/risk assessment reports from the period of January 2014 through July 2014, identified May and June's were not completed and/or signed. Review of this documentation identified infection control monitoring questions that included the monitoring of staff to see if utilizing appropriate preventative personal protection (PPE) and it questioned the staff regarding infectious patients and how monitored and how to proceed to minimize risk of infections. Interview with the Facilities Manager on 8/29/14 identified these rounds were conducted by a facilities person and issues regarding nursing and medical should be addressed and communicated to the Quality/ Compliance Officer (RN#1) for follow-up. He further identified the July's surveillance rounds had been conducted by RN #1 and issues should have been followed up and/or addressed by him.
   c. Interview with APRN #1, the Director of Adult Medicine, specializing in Infectious Diseases on 8/28/14 identified that she does not attend the Infection Control Meetings. She identified that there is not a specific log that would identify the tracking of patients with reportable such as TB and other diseases identified, but that the providers should be identifying that in the clinical notes and should be reporting to the Department. Interview with the CEO on 8/28/14 identified an action plan requested by the Department that by 8/29/14 the facility would identify a nurse in each department that would report communicable diseases as mandated. Interview on 8/29/14 with the CEO and the interim CMO failed to identify that the facility had corrected this concern. The action plan further identified that the staff would be trained by 9/2/14. Interview with the CEO on 9/3/14 failed to identify that in servicing had occurred to address the follow-up and/or the reporting of communicable diseases. Although the interim CMO identified that adolescence unit was reporting, no further evidence was provided that other departments including adult medicine and/woman's' unit.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or19-13-D52 Maintenance.

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

3. Based on review of personnel files, review of facility policy and staff interview for 7 of 11 personnel files, the facility failed to ensure staff periodic physical examinations for the purpose of preventing infection or contagion from communicable disease and/or a yearly job performance evaluations and/or ensure oversight compliance. The findings include:

a. RN #1 was hired on 9/3/13. Review of the personnel files on 8/28/14 identified that RN #1 (Clinical/Quality Compliance Manager) lacked a medical statement that the employee had been tested for tuberculosis (TB).

b. Medical Assistant #1 was hired on 10/25/04. Review of the personnel files on lacked identifying a medical statement that the employee had been tested for TB.

c. Dental Assistant #1 was hired on 9/5/95. Review of the personnel files on lacked identifying a medical statement that the employee had been tested for TB.

d. Interim Chief Medical Officer was hired on 10/7/13. Review of the personnel file lacked identifying a medical statement to identify that the employee had been tested for TB. Review of facility policy for employee health files, in part, directs that personnel files contain the result of annual TB testing.

e. APRN #1 was hired on 12/9/08. Review of the personnel file lacked a job performance evaluation and current credentials for the prescribing of medications.

f. APRN #2 was hired on 5/31/15. Review of the personnel file lacked a job performance evaluation. These are repeated violations.

g. Physician Assistant #1 was hired on 3/5/12. Review of the personnel file lacked a job performance evaluation. Interview with Staff Person #1 on 8/28/14 identified there is no one to do the providers evaluations as the interim Chief Medical Officer is just temporary in that position. Interview with the CEO on 8/28/14 at 4:00 PM further identified that presently no staff person is in the Human Resource position who would be responsible to audit and follow-up with the personnel files.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c)and/or19-13-D48 Professional staff (b)(2) and/or19-13 D50 Nursing personnel and/or19-13-D52 Maintenance.

4. Based on personnel file record review and interview the facility lacked RN supervision for nursing services and/or infection control compliance. The findings include:

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

a. Review of MA #6 personnel file identified an evaluation and a written warning completed by MA #1. Interview with RN #1 identified that the medical assistants supervised by MA #1, therefore she would complete their evaluations and adress the issues.

b. Review of the facility schedule for the period of July 4, 2014 through 8/15/14, identified that the Quality/Compliance Manger RN #1 had not been in the facility for that period of time. Interview with Staff Person #1 on 8/29/14 at 10:50 AM identified the facility lacked infection control coverage for that time and when RN #1 is out, no RN covers that position. She identified further identified if issues arise within the nursing department, the staff reports to the CEO.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(2)and/or 19-13 D50 Nursing personnel and/or19-13-D52 Maintenance.

5. Based on review of personnel files, facility documentation and staff interviews the facility failed to appoint a qualified Quality Compliance Officer. The findings include:

a. Review of RN#1's personnel file identified the job description for Quality/Clinical Manager directing the major responsibilities that included Staff Infectious Disease Committee in overseeing Infection control plan and activities at the health center. Review of the personnel file identified RN #1 was offered the position as Quality/Clinical Manger on 8/28/13 and accepted by signature on 9/3/13. Interview with RN #1 on 8/28/14 identified he had no system of tracking of client infectious diseases, had not overseen any infection control training of staff, other than a hand washing in-service in May 2014. RN #1 further identified that he had not conducted any surveillance of staff practice of infection control.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(2)and/or 19-13-D52 Maintenance.

6. Based on observation, review of facility documentation, review of facility policies and staff interview, the facility failed to follow acceptable standards for reprocessing of instruments utilized in the dental, adolescent, women's and podiatry clinics and/or failed to perform adequate sterilization monitoring and/or sterilization practices. The findings include:

a. Observation on 8/28/14 at 9:30 AM identified Dental Assistant #2 inserting biological indicator strips into the cassettes with the dental instruments, then wrapping with the cassettes in blue paper and sealing with autoclave tape. Dental Assistant #2 then placed the date and his initials, before placing into the autoclave. Observation of the sterilized dental instrument pouches in the clean room identified that they lacked having the biological indicator test strips inside. Interview with Dental Assistant #2 identified that these test strips are placed in the cassettes only but not in the pouches. He identified these pouches have external and internal indicators that change from pink to brown when sterilized. Review of the Community Health Center instrument sterilization flowchart directed the instruments be placed in individual autoclave bags with a temperature indicator strip.

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

Review of the dental policy lacked to reflect that a temperature indicators be placed in these pouches. According to the Center for Disease Control (CDC) guidelines dated 2008 identified that chemical indicators affixed to the outside of each pack to show that the package has been processed through the sterilization cycle, but these indicators do not prove sterilization has been achieved. It directed that chemical indicators should also be placed on the inside of each pack to verify sterilant penetration.

Interview with DA #1 on 8/28/14 identified that all three M11 autoclaves of the dental department are not equipped to provide the indicated batch number when the instruments are being sterilized to ensure a tracking of the instruments. Review of the documentation identified that although biological spore testing monitoring log was maintained, a sterilization log that would indicate the time, the load number, temperature and number of instruments sterilized in each batch was not. Review of the facility Sterilization Policy identified to log all load items with a log number, time and date. The load number, time, date and temperature are required to enable the recall of items if the temperature or weekly/ monthly biological testing so indicates. Review of the facility dental policy on sterilization failed to reflect the logging of items with a log number, date and time and temperature monitoring.

b. Observation of instruments autoclaved in the dental clinic on 8/28/14 at 12:15 PM identified that sterilized dental instruments packages had pencil and/or pen markings of a date and the number of the autoclave that were not legible and/or had faded. Interview with DA #1 identified the dental department does not identify what instruments go in the autoclaves. Review of the Sterilization Log identified a load identifiers were not adequate for tracking of batched instruments processed by autoclave load.

c. Observations and review of the sterilization logs in the podiatry clinic on 8/28/14 at 12:15 PM with MA #2 identified instruments in pouches that included nail clippers, mallets and spurs that had labeled sticker rendering unreadable. MA #2 identified that the date is placed on the sticker as well as his extension. The sterilization log for this podiatry autoclave failed to identify a system of load identification for tracking instruments that had been processed in each batch.

d. Observation and review of the Adolescent/Pediatric clinic sterilization log dated 8/4/14, 8/11/14, 8/18/14 and 8/25/14 identified that load identification was not completed and temperature of the cycle was not recorded. Review of the facility policy and procedure for Infection Control and Sterilization identified test date, sterilizer identifier, load identifier, biological identifier, lot number, and expiration dates, date and time in (to the sterilizer) with initials, date/time out (of the sterilizer), type of sterilization, cycle length and temperature, test results and control results be documented. Center for Disease Control guidelines dated 2008 directed that sterilization process should be monitored and record by time temperature and assessment of the pressure gauge. Chemical indicators should be used with biological testing.

e. Observation and interview with MA #5 in the utility room on the Women's Health unit on 8/28/14 at 10:00 AM identified sterilizing equipment located on the counter with a sink located in the middle of the counter. MA #5 indicated the sink is the first step in the sterilization process. The soiled instruments are cleaned using a medal brush to remove any debris and then soaked in a

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

basin of Normal Saline and anti-bacterial/microbial cleanser. The basin was noted on the left side of the counter directly next to the sink. The Maxi-sweep ionizer was located on the right side of the sink. According to MA #5 the Maxi-sweep ionizer is the next step of the instrument cleaning process. When the clean instruments are removed from the ionizer they are placed on the counter on a clean pad to air dry. The area the clean instruments are placed to air dry is located immediately adjacent to the sink used to clean the soiled instruments. MA #5 opened the sterilizer (autoclave) and seven (7) sterilized kits were noted in the sterilizer. The kits were stacked in multiple layers on top of each other in the autoclave chamber. Once the sterilized kits were removed by MA #5, they were stacked on top of each other in a small area between the autoclave and the wall. Observation of the sterilization area with MA #5 failed to ensure there was appropriate separation between soiled and clean areas. Further observation, identified specimen cups that contained urine for testing on the left side of the counter next to the cleansing basin. Interview with MA #5 at the time identified the clean and soiled areas on the counter were close together and lacked separation because there was no other area to complete the sterilization process or to conduct the urine tests. MA #5 further indicated she was unaware of the manufacturer's instructions for placement of kits for sterilization in the autoclave. Review of the facility Sterilization Policy directs to conduct all steam sterilization in a soiled utility area, prior to placement in the autoclave. Washing must be done in a soiled utility area to prevent splattering or contaminating clean supplies or areas. The policy further directed to separate items or arrange them loosely in the autoclave chamber.

f. Review of facility documentation and interview with MA #5 failed to reflect the facility maintained a sterilization log that identified the date, load number, temperature and number of instruments sterilized in each batch. Interview with MA #5 at the time identified she was not aware a sterilization log was required to be maintained. MA #5 identified the number of sterilizations conducted each day varied, however, noted at least one sterilization was conducted each day. Review of the facility Sterilization Policy identified to log all load items with a log number, time and date. The load number, time, date and temperature are required to enable the recall of items if the temperature or weekly/ monthly biological testing so indicates.

g .Review of the Biological Monitoring Log used to document spore testing failed to reflect consistent weekly spore testing was conducted on the autoclave that was used on a daily basis per the facility policy. Additionally, the facility was unable to provide documentation of how often and when the autoclave was cleaned. MA #5 indicated the autoclave in use on the Women's Health unit was a loaner from the supplier because the unit autoclave was being repaired. MA #5 indicated the unit autoclave had been in for repair several times in the past six months and currently was still not available. MA #5 was unsure why weekly spore testing was not conducted and was unable to locate the manufacturer's manual. Review of the facility Sterilization Policy identified autoclaves used daily should be monitored with biological testing for live spores on a weekly basis. Results are to be recorded and maintained by the department with the autoclaves. Additionally, autoclaves should be cleaned on a weekly basis or as outlined in the manufacturer's manual and recorded.

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 the Connecticut State Agencies Section 19-13-46 Building and equipment (d) and/or Section 19-13 D47 Governing Board, administrator (b) and/or(c) and/or 19-13-D48 Professional staff (b)(2) and/or 19-13-D52 Maintenance.

7. Based on interviews, the facility failed to ensure that equipment was maintained and/or expired instruments removed. The findings include:
   a. Interview on 8/28/14 at 12:20 PM with MA #3 of the walk-in primary care area, identified that the glucometers are cleaned every Friday, but it is not documented. She further identified that Hemacue biological control testing of equipment #1, #2, #3, #8 and #9, are checked and documented daily, but the weekly cleaning is not documented.
   b. Interview with DA #1 on 8/28/14 at 1:00 PM identified that the autoclaves: M11 #1, M11 #2, M11 #3 and the Statin 5000 in the dental area, are cleaned on a monthly basis, but he does not document this on the log. Review of the Infection Control and Sterilization policy (dental) directed the completion of monthly log of autoclave cleaning located on a clip board in the sterilization room. Review of the dental department autoclave monthly cleaning maintenance log identified that in the months of April and July 2013, there lacked documentation that the autoclaves were cleaned. Review of the facility's Instrument Sterilization policy directed that autoclaves should be cleaned on a weekly basis. The facility failed to have a uniform policy as discrepancies were identified in these two sterilization policies.
   c. Observation on 9/3/14 in the adolescent nursing desk area identified a drawer containing approximately six sterilized bag that contained female speculums, with dates of 1/2/13 and another one identified cleaned on 1/13/14 with an expiration date of 7/13/14. Interview with MA #4 identified that the facility no longer use these types but the disposable speculums. The facility failed to ensure that expired sterilized and/or unused instruments were removed.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(2) and/or 19-13-D50 Nursing personnel and/or19-13-D52 Maintenance.

8. Based on observation, review of facility policy and staff interview for respiratory precautions, the facility failed to ensure that personnel had been test fitted for N-95 mask and/or lacked awareness of their location. The findings include:
   a. Interview with the Quality/Clinical Manager (RN#1), identified there has not been N95 fit testing in the facility, while employed in that role, including him. He further identified that he had no documentation of any staff that has been fitted and/or of who has one. RN #1 further failed to identify awareness of where the facility had a supply of N-95 masks, if any. Further interviews with random nursing staff, that included APRN #1, who is the Director of Primary Care, with the primary focus in infectious diseases, lacked identifying the awareness of where and if any N-95

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

masks were stored at the facility. Interview with MD #1, (identified by Staff Person #1), as the interim Infectious Disease Physician identified that he had been fitted elsewhere and does have an N-95 mask and would not see potential patients without it. MD #1 further identified that he was not the interim ID physician. Interview with MA #1 on 8/28/14 identified that a supply of N-95 masks are stored in a closet labeled Emergency Preparedness. Review of a box of these masks, identified meeting the guidelines for CDC N95 respirators, but they lacked identifying the size of them. MA #1 further identified that she had been fitted more than two years ago. According to the CDC guidelines for the Respiratory Protection in Health Care Setting directed the most critical elements of a respiratory protection program include the assignment of responsibility, training and fit testing. It directed fit testing be performed during the initial respiratory protection program training and periodically thereafter.

Interview with the Chief Executive Officer (CEO)on 8/28/14 at 4:00PM as directed in an action plan by the Department that a list of staff in each department who have fitted for the N-95would be generated to the Department on 8/29/14.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(2) and/or 19-13-D50 Pharmaceuticals (4)and/or19-13-D52 Maintenance.

9. Based on observation and interview the facility failed to secure medications in a safe manner. The findings include:

   a. During tour of the dental operatories on 8/28/14 at 9:00 AM, Room #4 was observed to have two Lidocaine vials in this unattended operatory. This same room contained an unlocked cabinet storing 118 Benzo-gel containers, 30 Lidocaine vials and needles.

   b. Room #14's unlocked cabinet and unattended operatory, contained 7 Carbocaine cartridges and a 50 vial box of Carbocaine, 38 boxes of Lidocaine vials and a box of needles and a container of Benzo-gel topical anesthetic. Interview with Dental Assistant #1 identified that medications should not have been unattended and the cabinets storing the medications should be locked at all times.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or19-13-D48 Professional staff (b)(2) and/or 19-13-D49 Records (b) and/or 19-13-D50 Nursing personnel and/or19-13-D52 Maintenance.

10. Based on review of the clinical record and staff interview the facility failed to ensure a referral had been obtained and/or lacked ensuring that infection control precautions had been followed and/or the staff in-serviced. The findings include:

    a. Review of Patient #2 clinical record identified he/she presented to the clinic on 5/21/14 with a cough and difficulty breathing. The note identified the patient started having a productive cough two months ago, fever, chills night sweats and progressive shortness of breath. The note further identified the patient reported having been treated in the past at the hospital for pneumonia and

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evaluated for TB, which was negative. The record identified the patient was moved to a negative pressure room at this visit and transferred to the hospital. Interview and review of the record with MD #1 on 8/28/14 identified that after the 5/21/14 visit the patient presented to the clinic on 6/18/14 with a diagnosis of pneumonia. The note identified that a cardiology consult would be ordered once the labs were drawn. The record identified the patient returned to the clinic on 6/25/14 for medication refill and a cough and would follow-up with cardiology. The visit on 7/16/14 identified the patient presented for a follow-up and would be referred to a cardiologist. A note dated 7/18/14 identified the patient had been admitted to the hospital for chest pain and on 7/22/14 had called to speak to MD #1 to report he/she had a heart attack. MD #1 identified he had called the hospital on 7/28/14 and was informed by hospital that the patient had been in ICU for right sided hemiplegia. A note dated 8/14/14 identified the patient was on life support and subsequently passed away on 8/18/14. Review of the record and interview with MD #1 identified that a referral to the cardiologist could not be located in the record.

b. Review of Patient #3 record identified the patient presented to the urgent care on 8/6/14 at 4:30 PM with heartburn. The record identified vital signs documentation taken by MA #6, indicating a temperature of 98.4 and the patient having a pain scale of 8 out of 10. Physician Assistant #1assessment note identified the patient had presented with a two week history of constant abdominal pain in the right and upper quadrant and lower quadrant. The note identified the patient reported intermittent fever and burning in his/her chest, with some sporadic nausea, vomiting, decreased appetite and constipation. The documentation identified PA #1 had discussed this patient with MD #1, and a mask had been placed on Patient #3 and was told to follow-up in the emergency room (ER) immediately due to concern for health of patient and public health. The note further identified PA #1 explained the possibility of Ebola infection and the importance of wearing a mask and being evaluated in the ER. The note identified that Patient #3's family member translated the conversation to the patient and verbalized understanding and identified would drive the patient to the hospital. PA #1's note further identified that she had contacted the hospital to give report and was told by the hospital that Patient #1 had not arrived. The note identified that PA #1 contacted the patient at home several times and had encouraged him/her to go to ER. The note further identified that the hospital had informed PA #1 that Patient #3 had presented to the hospital without a mask. Interview with PA #1 on 9/2/14 identified that Patient #3 had reported that he/she had developed these same symptoms about a year ago after a cesarean section. PA #1 identified that the patient had been treated two weeks ago in the country of Africa and placed on antibiotics, but felt it was not working. PA #1 reported that the patient had reported no sick contact, presented to the clinic, and well hydrated and had been alert and orientated. PA #1 identified that after she had evaluated the patient she had discussed Patient #3 with MD #1 because the patient had indicated coming from West Africa. PA #1 identified that they had concluded if it was Ebola it was at the very end stage, because he/she would have presented sicker, but was ill enough to be evaluated in the ER. She identified that she placed a mask on Patient #3 and told the family member that an ambulance would be called but that the patient had refused. PA #1 identified she did not place the patient in an isolation room. She further identified that the patient had not gone directly to the

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

hospital as both the patient and family member were instructed, because when she had called the hospital to give report, the hospital contact said that the patient had not presented to the hospital. PA #1 identified that it was then when she contacted the patient at home to instruct him/her to be taken to the ER as they had been instructed earlier. PA #1 further identified that between 7:30 PM -8:00PM the hospital had called the clinic to report that the Patient #3 had walked throughout hospital looking for the ER without a mask in place. PA #1 identified that she should have called an ambulance for the patient and had the patient transferred to the hospital.

Interview with MD #1 on 8/28/14 at 10:30 AM identified that PA #1 had expressed concerns after Patient #3 had left to the emergency room. He identified that he had found out the morning after that the patient had not gone directly to the ER. MD #1 identified that an Ebola policy was drafted to be presented to the staff because the facility did not know how to handle this case and that there were specific CDC recommendations. Review of the facility policy with MD #1 for the recommendations of patients with suspected Ebola Virus Infection included the recommendations for patient's management and transportation. This policy lacked identifying if having been approved by the Board. Interview with the interim CMO on 8/29/14 at 4:00 PM identified that MD #1 did get together with the CEO to create a policy for the staff to follow on Ebola.

Interview with RN #1 identified that he had not been made aware of any issues with a suspected case and/or had not done and/or partaken in any in-servicing to the staff regarding the Ebola policy. He reiterated that the only in-servicing he had completed with staff was in May 2014 that had to do with handwashing.

Interview with APRN #1 identified that there had not been a formal in-service on the Ebola policy that had been drafted. She identified that the staff had been gathered and the policy had been reviewed. She further identified that the facility had placed signs near the elevators, entrance doors and front receptionist regarding the signs and symptoms.

Additionally, PA #1 identified that she does not remember when she had been fitted for the N-95 mask and did not know her size and where she would locate them in the facility if needed them.

The following are violations of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(2) and/or 19-13-D49 Records (b) and/or 19-13-D50 Nursing personnel and/or19-13-D52 Maintenance.

11. Based on review of the clinical record and staff interview the facility failed to notify the patients of positive test results and/or failed to report incidents of infectious diseases in a timely manner. The findings include:

a. Patient #1 had a visit on 8/28/14 with APRN #1, with a history that included tuberculosis (TB) of the lung. The progress note dated 8/28/14 identified that the patient had completed the treatment for active TB from June 2013 through February 2014. The note further identified the treatment had been extended as the patient had not returned for follow-up and a chest x-ray to stop treatment. The record identified a chest x-ray on 3/19/14 indicating a right apical scarring without evidence for active disease. Interview ARPN #1 on 8/28/14 identified that the facility does Quantiferon testing for suspected communicable infections. Interview with RN #1 identified that a

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

log and/or list is not maintained regarding patient positive and/or on treatment but should be indicated in the record of any communicable diseases and/or the reporting.
Interview with the CEO, interim CMO and APRN #1 on 8/28/14 at 4:00 identified that by 8/29/24 the Infection Control officer would utilize and/or create a system to log management treatment and follow-up of communicable diseases. The CEO present two separate lists of patients of whom had Quantiferon testing and/or PPD testing, dating back from 6/13 to 8 /14 that had been generated on 8/29/14 by the IT department. Review of those lists lacked identifying the follow-up and/or treatment to the patients identified as positive and lacked identifying Patient #1.

b. Review of Patient's #30's clinical record identified laboratory testing dated 7/15/14 with positive results for gonorrhea. The note further identified that a call had been received from the laboratory indicating this positive report. Review of the clinical record and interview with RN #4 on 10/2/13 at 1:15 PM identified she had attempted to telephone the patient regarding the laboratory results but had been unable to reach Patient #30 on 7/15/14. RN #4 identified that she had notified MD #1 of the patient's positive test results, using the task program in the electronic system. Interview with MD #1 on 10/2/14 at 12:45 PM identified that he had also attempted to contact the patient by phone on 7/15/14. The record lacked additional attempts to contact Patient #30, until 8/4/14 at 3:02 PM. The telephone notes identified the patient had verbalized understanding and would come to the walk in clinic the following day. A note dated 9/3/14 at 10:40 AM identified the patient had been contacted several times but had failed to return to the clinic. The treatment note dated 9/10/14 at 1:00 PM identified the patient had been administered Ceftriaxone 250 mg intramuscularly and Azithromycin 1 Gram by mouth and directed to return to the clinic with any further /unrelieved symptoms. Interview with APRN #1 on 10/1/14 at 1:00 PM identified, Patient #30 should have been notified by the next working day with positive test results on 7/15/14.

c. Review of Patient #34's clinical record identified laboratory results dated 9/8/14 that were positive for syphilis. Review of records and interview with APRN #1 on 10/2/14 at 3:00 PM identified Patient #34 was administered antibiotic treatment on 9/16, 9/23 and 9/29/14. Review of the facility documentation Adult Medicine State Reportable Log identified the laboratory results for Patient #34 was reported on 9/11/14.

d. Review of Patient #39's clinical record identified laboratory results dated 9/11/14 was positive for chlamydia. Review of the record and interview with APRN #1 on 10/2/14 at 3:00 PM identified Patient #39 was administered antibiotic treatment on 9/15/14. Review of the facility documentation for Sexually Transmitted Disease Log identified the laboratory results for Patient #39 were reported on 9/11/14. Interview with APRN #1 on 10/1/14 at 1:00 PM identified the facility practice of reporting infectious diseases remains unit based and in-service was in process to standardize the reporting practice on each unit.

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

November 25, 2014

Gregory Stanton
Community Health Service Inc
500 Albany Avenue
Hartford, CT 06120

Dear Mr.Stanton:

Unannounced visits were made to Community Health Service Inc on November 17 and 18, 2014 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, with additional information received through November 21, 2014.

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 visits.

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 9, 2014 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Alice M. Martinez

Alice M. Martinez, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c: Department of Mental Health and Addiction Services
Licensure File
CT-17584, CT-17507

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DATE(S) OF VISIT: November 17 and 18, 2014

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 19-13-46.Bulding and equipment and/or19-13-D47 Governing board, administrator (b) and/or (c)and/or19-13-D48.Professional staff (b) and/or19-13-D50.Nursing personnel and/or19-13-D52 Maintenance.

1. Based on review of facility documentation and staff interview of infection control surveillance the facility failed to provide evidence that infection control surveillance was conducted. The findings include:
   a. Interview with Medical Assistant (MA) #1 on 11/17/14 identified the intra-vaginal Transducer ultra sound probe was not in use because it had been identified as being disinfected with a low level disinfectant. Review of the Infection Control (IC) minutes dated 11/12/14 identified that an outside agency had identified concerns regarding processing of the intra-vaginal Transducer ultra sound probe. The IC minutes further identified that the standard department practices of infection surveillance based on the American Congress of Obstetrics and Gynecologists guidelines was one layer of early detection. According to the Center for Disease Control Guidelines for Disinfection and Sterilization (2008) a vaginal probe used in sonographic scanning should be high level disinfected between examinations. Interview on 11/17/14 with the CEO identified that the change in disinfecting requirements had not been identified by the facility. Further interview identified that a chart audit, completed by the Interim Director of Women's Health, had reviewed 92 patients at risk for cross contamination from use of the inappropriately disinfected intra-vaginal Transducer ultra sound probe.
   b. Observation with the Facilities Manager on 11/17/14, identified the sink in the client restroom in the Adult clinic, had one water control that was pushed downward to initiate the flow of the water. When pushed downward, the water flowed for less than 3 seconds before the water shut off. Interview with the Facilities Manager identified that the timing of the water flow was not adequate for hand washing and would need to be adjusted by a plumber. Further interview identified that surveillance monitoring of the hand washing facilities was not conducted.
   c. Observation on 11/17/14 of three of the vital signs machines on the Adult Medicine walk-in clinic were observed to be soiled. Subsequent to surveyor inquiry, the Facilities Manager directed housekeeping to clean the bases of the vital signs machines. Interview with MA #2 on 11/17/14 identified that the vital signs machine was supposed to be wiped down with Sani Wipes between patients. The facility failed to ensure that surveillance monitoring of patient care equipment was conducted.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D46 Building and equipment (d)and/or19-13-D47 Governing board, administrator (b) and/or 19-13-D48 Professonal staff (b) and/or19-13-D50 Nursing personnel and/or 19-13-D52 Maintenance.

2. Based on review of interview and facility documentation in Women's Health, the facility failed to maintain diagnostic equipment according to required standards of disinfection. The findings include:
   a. Interview with MA #1 on 11/17/14 identified the intra-vaginal Transducer ultra sound probe was not in use because it had been identified as disinfected with a low level disinfectant. Review of the Infection Control (IC)

minutes dated 11/12/14 identified that an outside agency had identified concerns regarding processing of the intra-vaginal Transducer ultra sound probe. The IC minutes further identified that the standard department

DATE(S) OF VISIT: November 17 and 18, 2014

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

practices of infection surveillance based on the American Congress of Obstetrics and Gynecologists guidelines was one layer of early detection. According to the Center for Disease Control Guidelines for Disinfection and Sterilization (2008) a vaginal probe used in sonographic scanning should be high level disinfected between examinations. Interview on 11/17/14 with the CEO identified that the change in disinfecting requirements had not been identified by the facility. The interview also identified that a chart audit, completed by the Interim Director of Women's Health, reviewed 92 patients at risk for cross contamination from use of the inappropriately disinfected vaginal probe.

The following are violations of the Regulations of Connecticut State Agencies Section 9-13-D47 Governing board, administrator (b) and/or 19-13-D48 Professional staff (b) and/or19-13-D50 Nursing personnel and/or 19-13-D52 Maintenance.

3. Based on review of the facility documentation and staff interview, the facility failed to report Reportable Disease log information to the Infection Control Committee and/or failed to ensure that staff education of this log. The findings include:
   a. Review of the Reportable Disease Log on 11/18/14 identified that 27 cases of Hepatitis C had been reported to the Department of Public Health since 10/3/14. Interview with RN #1 on 11/20/14 identified that he/she had not reviewed the Hepatitis C data from the Adult Medicine State Reportable Log at the Infection Control meeting agenda on 11/12/14 because he/she was not comfortable to bring up issues at the meeting. Interview on 11/19/14 at 3:30 PM with The CEO and the Chief Medical Officer identified that they were unaware of the number of recently reported Hepatitis C cases. Further interview identified that information in the Reportable Disease logs is not centrally reported to the Infection Control Committee.
   b. Review of the Adult Clinic Reportable Disease Log on 11/18/14 identified that from 10/3/14 to 11/18/14, twenty seven new cases had been reported to the Department of Public Health Epidemiology. Review of the log on 11/20/14 with RN #1 identified that he/she had not completed the treatment date and type of treatment for the infectious disease because completion of that information was not within the scope of his/her job.

The following is a violation of the Regulations of Connecticut State Agencies Section 9-13-D47 Governing board, administrator (b) and/or 19-13-D48 Professional staff (b) and/or19-13-D50 Nursing personnel and/or 19-13-D52 Maintenance.

4. Based on review of facility documentation and staff interview of the annually required staff tuberculosis testing, the facility failed to develop a system of accountability for staff compliance with the requirement. The findings include:
   a. Review of the facility documentation failed to identify that the facility implemented a system to identify and notify staff when annual tuberculin testing was due. Interview on 11/18/14 with the CEO identified that the Clinical Directors had been asked to make recommendation but the CEO had not heard any response. Further interview identified that although tuberculosis testing had increased compliance in September 2014 subsequent to surveyor inquiry, the facility had no current plan to maintain compliance until a new consultant who was recently contracted made a facility assessment and recommendations. Review of the new consultant's communication with the facility identified that a meeting was held on 11/5/14 and the next

DATE(S) OF VISIT: November 17 and 18, 2014

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

visit will be held at the start of December.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D46 Building and equipment and/or 19-13-D47 Governing board, administrator (b) and/or 19-13-D52 Maintenance.

5. Based on observation and staff interview, the facility failed to provide adequate hand washing equipment and/or failed to ensure equipment was maintained clean. The findings include:
   a. Observation with the Facilities Manager on 11/17/14, identified the sink in the client restroom in the Adult clinic, had one water control that was pushed downward to initiate the flow of the water. When pushed downward, the water flowed for less than 3 seconds before the water shut off. Interview with the Facilities Manager identified that the timing of the water flow was not adequate for hand washing and would need to be adjusted by a plumber.
   b. Observation on 11/17/14 of three of the vital signs machines on the Adult Medicine walk-in clinic were observed to be soiled. Subsequent to surveyor inquiry, the Facilities Manager directed housekeeping to clean the bases of the vital signs machines.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

March 3, 2015

Gregory Stanton
Community Health Service Inc
500 Albany Avenue
Hartford, CT 06120

Dear Mr.Stanton:

An unannounced visit was made to Community Health Service Inc on February 6, 2015 by a representatives 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 visits.

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 March 17, 2015 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Alice M. Martinez

Alice M. Martinez, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c: Licensure File
CT-17851

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DATE(S) OF VISIT: February 6, 2015

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

The following is a violation of the Regulations of the Connecticut State Agencies Section 19-13 D47 Governing Board, Administrator (b) and/or (c) and/or 19-13-D48 (b)(2) and/or 19-13-D50 Nursing Personnel or 19-13-D52 Maintenance.

1. Based on review of facility policy, and staff interviews for one of one patient who presented with symptoms of a communicable disease the facility failed to ensure that a medical staff person responded in a timely manner. The findings include:

   a. Patient #1 presented to the urgent care clinic on 1/16/15 for hemoptysis and weight loss. Interview on 2/6/15 with Receptionist #1 at 4:20 PM identified that Patient #1 came to the reception window of the urgent care/walk in Adult clinic at the facility and identified he/she had symptoms of coughing up blood. Receptionist #1 identified she immediately directed Patient #1 to put on a face mask and sit in an area of the waiting room away from other patients. Receptionist #1 identified RN #1 was notified and directed to have the patient put on a mask and go to the Appointment Adult Clinic where he/she would be seen. Receptionist #1 identified she told the patient that he/she would need to be seen in the Adult Appointment Clinic on the same floor of the building but in a different area. Interview on 2/6/15 with Receptionist #2 at 4:29 PM identified she observed Patient #1 entering the waiting room in the Appointment Adult Clinic carrying a clipboard and face mask in his/her hand. Receptionist #2 identified that Patient #1 proceeded toward the waiting room chairs. Receptionist #2 further identified that she came from behind the reception desk and directed Patient #1 to put the face mask on and then escorted the patient into the negative pressure isolation room adjacent to the waiting area. Interview on 2/6/15 with RN #1 (Infection Control Liaison for the Adult Clinic) at 4:42 PM identified he was notified by Receptionist #1 and informed that Patient #1was at the Walk In desk with symptoms of coughing up blood and weight loss. RN #1 directed Receptionist #1 to have Patient #1 put on a face mask. RN #1 identified that he was unsure how Patient #1 went from the Urgent Care/Walk In clinic to the Adult Appointment Clinic. Furthermore, RN #1 identified he did not go to the Urgent Care/Walk In clinic to ensure Patient #1 went directly to the negative pressure isolation room because he was donning his personnel protection equipment. RN #1 identified that he donned his gown in the hallway and went to the bathroom to look in the mirror to check the fit of the N95 mask. RN #1 also identified he did not see Patient #1 until he entered the isolation room and Patient #1 was there. Although, RN#1 was the only RN that had been informed by Receptionist #1 of Patient #1's symptoms, he failed to immediately respond to ensure that Patient #1 followed the direction of putting on the face mask and was escorted to the negative pressure isolation room. Review of the facility Tuberculosis (TB) Exposure Control Plan included TB Exposure Control Procedures for Suspected or known active TB cases, that directed the person/patient be ask to cover his/her nose and mouth, provide a surgical mask for the person to wear to contain droplets, isolate

DATE(S) OF VISIT: February 6, 2015

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

from other visitors and/or employees and if available place patient in negative pressure room.

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2. Based on review of facility policy, and staff interviews the facility failed to ensure the facility policy identified who the designated medical staff person would respond with a suspected case of a communicable disease. The findings include:

   a. Patient #1 was seen at the urgent care clinic on 1/16/15 for hemoptysis and weight loss. Interview on 2/6/15 with Receptionist #1at 4:20 PM identified that Patient #1 presented to the reception window of the urgent care/ walk in Adult clinic at the facility and identified that he/she had symptoms of coughing up blood. Receptionist #1 identified that she had immediately directed Patient #1 to put on a face mask and sit in an area of the waiting room away from other patients. Receptionist #1 also identified that she telephoned RN #1 and was directed to have the patient put on and mask and direct Patient #1 to the Appointment Adult Clinic where he/she would be seen. Receptionist #1 identified that she told the patient that he/she would be need to be seen in the Adult Appointment Clinic on the same floor of the building but in a different area.
   Interview on 2/6/15 with Receptionist #2 at 4:29 PM identified that she observed Patient #1 entering the waiting room in the Appointment Adult Clinic carrying a clipboard and face mask in his/her hand. Receptionist #2 identified that Patient #1 proceeded toward the waiting room chairs. Receptionist #2 further identified that she came from behind the reception desk and directed Patient #1 to put the face mask on and then escorted the patient into the negative pressure isolation room adjacent to the waiting area.
   Interview on 2/6/15 with RN #1 (Infection Control Liaison for the Adult Clinic) at 4:42 PM identified that although he had been called by Receptionist #1 and informed that an urgent care patient was at the Walk In desk and had symptoms of coughing up blood and weight loss, and had directed Receptionist #1 to have Patient #1 put on a face mask. RN #1 identified that he was unsure how Patient #1 got from the Urgent Care/Walk in clinic to the Adult Appointment Clinic. Further interview with RN #1 identified that he had not gone to the Urgent Care/Walk in clinic to ensure Patient #1 came directly to the negative pressure isolation room because he had been donning his personnel protection equipment. RN #1 identified that he had donned his gown in the hallway and had gone into the bathroom to look in the mirror to check the fit of his N95 mask. RN #1 also identified that he had not seen Patient #1 until he entered the isolation room and Patient #1 was there. Although, RN#1 was the only RN that had been informed by Receptionist #1 of Patient #1's symptoms and he failed to ensure that Patient #1 followed the direction of putting on the face mask and

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

be escorted to the negative pressure isolation room.

Review of the facility Tuberculosis (TB) Exposure Control Plan included TB Exposure Control Procedures for Suspected or known active TB cases, that directed the person/patient be ask to cover his/her nose and mouth, provide a surgical mask for the person to wear to contain droplets, isolate from other visitors and/or employees and if available place patient in negative pressure room. The facility policy failed to address what medical staff person would immediately respond if a suspected case of any communicable disease presented to the receptionist area.

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3. Based on review of personnel files, review of facility policies and procedures and interviews with facility personnel, the facility failed to ensure that employees who have direct care with patients were fit tested with respirators.

a. Review of 3 of 4 personnel files on 2/6/15 identified that 3 medical receptionists were hired in 11/2014. Review of the job description for a medical receptionist indicates that they would be escorting patients to exam rooms, assisting to determine medical problems, takes vital signs and assisting providers/nurses with procedures and treatments as directed. Review of facility policy identified that fit testing will be limited to personnel who require the use of respirators. These personnel will be limited to location where known or suspected patients with TB are most concentrated (Reception, Security, Clinical Operations). Interview with the Director of Adult on Medicine on 2/6/15 at 5:00 PM identified that the 3 medical receptionists that were hired in 11/2014 had not been fit tested and the process of fit testing started in 1/2015 (2 months after hire).