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

IN RE: Crossroads Inc.
54 East Ramsdell Street
New Haven, CT 06515

FIRST AMENDED CONSENT ORDER

WHEREAS, Crossroads Inc. ("Licensee") has been issued License No. SA-0086 to operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons located at 54 East Ramsdell Street in New Haven, Connecticut ("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 May 7, 14 and 27, 2015, at the Facility for the purposes of conducting multiple investigations; and,

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies ("Regulations") were identified in a violation letter dated June 11, 2015 (Exhibit A, attached); and,

WHEREAS, an office conference regarding the June 11, 2015 violation letter was held between the Department and the Licensee on June 30, 2015, and,

WHEREAS, the Licensee and the Department entered into a Consent Order on June 27, 2014, placed the Licensee's license on probation for a period of two years with various terms and conditions (Exhibit B, Consent Order, attached); and,

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

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department, acting herein by and through Barbara Cass, its Section Chief, and the Licensee, acting herein by Genoveva Palmieri, its Board of Directors Chairperson, hereby stipulate and agree as follows:

1. The Consent Order executed with the Department on June 27, 2014 shall be incorporated and made part of this Consent Order. To the extent that there is any conflict between the Consent Order executed in December of 2014, and this First Amended Consent Order, the terms of this First Amended Consent Order shall govern.
2. Within one (1) week of the effective date of this Consent Order, the Crossroads Board of Directors ("Board") on behalf of the Facility shall execute a contract with a Temporary Manager pre-approved in writing by the Department.
3. The terms of the contract executed with the Temporary Manager shall include all pertinent provisions contained in this Consent Order. The Temporary Manager's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur all costs associated with the hiring of the Temporary Manager. Any reports required by this Consent Order shall be mailed and/or emailed to Cher Michaud, R.N., Supervising Nurse Consultant at the address provided below and shall also be provided to the Board.
4. The Temporary Manager shall serve for a minimum of six (6) months unless the Department in its sole and absolute discretion identifies through inspections, reports from the Temporary Manager or any other information it deems relevant that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations.
5. The Department may, upon request of Crossroads, and in its sole and absolute discretion, reduce the length of service for the Temporary Manager based upon inspections, reports from the Temporary Manager or any other information it deems relevant. The Temporary Manager shall be physically present at the Facility an average of at least twenty four (24) hours per week and accessible telephonically at all times, unless the Department approves otherwise. When not physically present, the Temporary Manager shall designate a person in charge who shall oversee the operations of the Facility to ensure a safe environment providing quality care at all

times. The Temporary Manager shall arrange his/her schedule in order to be present at the Facility at various times during all operational hours including holidays and weekends. The Department shall evaluate the hours of the Temporary Manager at any time it deems appropriate and at the end of the six (6) month period and may, in its sole and absolute discretion, reduce or increase the hours of the Temporary Manager and/or his or her responsibilities, if the Department determines the reduction or increase is warranted.

6. The Temporary Manager shall act and perform the duties assigned herein at all times to serve the interest of the Department and Crossroads 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 Crossroads or its employees that will deter or interfere in fulfilling this obligation.
7. The Temporary Manager shall, in addition to the duties herein assigned in this Consent Order, serve as the Executive Director who is accountable to the governing authority and responsible for the management of the Facility until such time that the Executive Director position is filled by a new Executive Director.
8. The Temporary Manager shall oversee all areas of Facility compliance with state and federal laws to assure the health and safety of the patients is protected.
9. Within the first thirty (30) days of the effective date of this Consent Order, the Temporary Manager shall conduct a comprehensive review of the staffing at the Facility. Such review shall identify vacant positions that are funded but not filled and shall identify staffing needs. The Temporary Manager shall submit a separate report to the Department and the Board regarding staffing within forty-five (45) days of the effective date of this Consent Order. The Temporary Manager shall ensure that adequate and qualified staff are on site to meet the needs of the patients. The Temporary Manager shall be responsible for the recruitment and hiring of qualified staff in order to meet the needs of the patients.
10. Within thirty (30) days of the effective date of this Consent Order, the Temporary Manager shall also conduct an assessment of the equipment and supply needs of the Facility, and shall report his findings regarding this issue as part of his monthly reports.

The Temporary Manager shall have the authority to purchase supplies and equipment as he deems necessary to ensure that quality health care is provided at the Facility.

11. The Temporary Manager, with the approval of the Board of Directors, shall be responsible for evaluating and hiring the permanent appointments of the following full time positions:
    a. Executive Director; and
    b. Chief Clinical Director.
    c. In addition, the Temporary Manager may fill any of the above-listed positions as needed with a temporary appointment until such time as a permanent replacement is recruited and approved. Once permanent appointments of the positions listed above in this paragraph are made, the Temporary Manager shall inform the Department and the Board within three (3) business days if any of those positions become vacant, and if a Temporary Manager is no longer at the Facility, during the period of probation, the Executive Director shall inform the Department and the Board of such vacancies.
12. If there is any dispute between the Temporary Manager and the Board, the Board or the Temporary Manager may submit such dispute, including, but not limited to, disputes regarding financial expenditures, staffing, issues related to physical plant or compliance with state and federal statutes and regulations, to the Department, and the Department in its absolute and sole discretion, shall make a final decision with respect to such issue. Such decision shall be binding and not subject to appeal or challenge in any forum.
13. The Temporary Manager shall have the authority to take such actions as necessary to secure compliance with applicable federal and state regulatory requirements and the provision of care and services in accord with the standards of practice for such services and care.
14. The Temporary Manager shall conduct a comprehensive review of the behavioral health services provided by the Licensee. The Temporary Manager shall implement policies and/or procedures and take any other measures necessary to ensure that patients are being provided behavior health services consistent with all federal and state requirements and consistent with the standard of care. Within two months after the effective date of this Consent Order, the Temporary Manager shall issue a separate

report to the Department and the Board which details the Temporary Manager's findings and recommendations with respect to the provision of behavioral services.

15. The Temporary Manager shall have the authority to hire, terminate or reassign staff; obligate Facility funds; alter, develop and implement Facility policy and procedures; and otherwise manage the Facility. For the permanent positions of Executive Director and Chief Clinical Director, approval of the Board is required prior to hire.

16. The Temporary Manager shall be provided full access to and management of all the Facility bank accounts and/or internal controls related to billing/accounts receivable, cash receipts, accounts payable, cash disbursements, and payroll records. The Temporary Manager shall have access to all areas of the Facility at all times, seven days a week and twenty-four hours per day. The Licensee agrees to provide to the Temporary Manager all security codes, maintenance records, contracts and leases and any other documents or information the Temporary Manager requests. The Licensee agrees to cooperate with the Temporary Manager in all respects. The Temporary Manager shall be compensated by the Licensee at a rate agreed upon by the Temporary Manager and the Licensee. The Licensee agrees that the Temporary Manager, in addition to filing written reports required by this Consent Order, may also communicate with the Department by phone, email or in any other way chosen by the Temporary Manager and the Department. The Licensee agrees that the Temporary Manager will meet with the Department from time to time as the Temporary Manager and the Department deem necessary. Such meetings may be limited to the Temporary Manager and the Department.

17. The Temporary Manager shall assess the Facility's quality control program. A Quality Assessment Performance Improvement ("QAPI") Program shall be instituted by the Temporary Manager, which shall identify a QAPI Committee, consisting of, the Licensee's Executive Director, Chief Clinical Officer, Compliance Officer, and shall include any other persons deemed appropriate by the Temporary Manager. The QAPI Committee shall meet at least monthly and its responsibilities shall include reviewing all reports or complaints relating to patient care and compliance with federal state laws and regulations. The Temporary Manager shall attend and participate in all QAPI Committee meetings and evaluate and report on the design of the QAPI programs

implemented by the QAPI Committee. The activities of the QAPI Committee shall include, but not be limited to, assessing the patients of the Licensee to evaluate the appropriateness of care and services, determination and adoption of new policies to be implemented by Licensee's staff to improve patient care practices, and routine assessment of care and response to treatment of patients. Under the supervision and direction of the Temporary Manager, the QAPI Committee shall implement a QAPI program that will measure, track and report on compliance with the requirements of this Consent Order. Said report shall be provided to the Department and the Board. The QAPI Committee shall measure and track the implementation of any changes in the Licensee's policies, procedures, and allocation of resources recommended by the QAPI Committee or the Temporary Manager to determine compliance with and effectiveness of such changes. A record of QAPI meetings and subject matter discussed will be documented and available for review by the Department, the Board and the Temporary Manager. Minutes of all such meetings shall be maintained at the Facility for a minimum of five (5) years.

18. Within the first thirty (30) days of the effective date of this Consent Order, the Temporary Manager shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation.

19. The Temporary Manager shall regularly, and at least weekly, confer with and provide direction to the Licensee's Chief Clinical Officer and other staff determined by the Temporary Manager to be necessary to the assessment of and provision of quality care and the Licensee's compliance with federal and state statutes and regulations.

20. The Temporary Manager shall make written recommendations, at least every other month, to the Board for improvement in the delivery of direct patient care in the Facility. Such recommendations shall also be simultaneously provided to the Department. If the Temporary Manager and the Board are unable to reach an agreement regarding the Temporary Manager's recommendation(s), the Department shall make a final decision as specified above.

21. The Temporary Manager shall submit monthly written reports to the Department and the Board documenting:

a. The Temporary Manager's assessment of the care and services provided to patients; and,
b. The Licensee's compliance with applicable federal and state statutes and regulations; and
c. Programmatic changes and Facility process changes made by the Temporary Manager and the Licensee's response and outcomes relative to implementation of the changes; and,
d. Any and all other matters deemed relevant by the Temporary Manager.

22. The Temporary Manager shall contract with a company specializing in accounting to ensure that accounting services are provided and maintained in accordance with current accounting principles and practices. The scope of such services shall include, but not be limited to, the following:
a. Convert accounting transactions into an applicable general ledger accounting software to produce financial statements for Fiscal Year 2015 and forward;
b. Review current payroll processes and perform steps necessary to generate payroll on a every other week basis;
c. Review current accounts payable and receivable processes to ensure all invoices are processed in a timely fashion; and,
d. Reconcile all bank accounts and major general ledger accounts on a monthly basis.

23. The Temporary Manager shall consult with a Physical Plant Engineer who shall conduct a physical plant assessment and make recommendations to the Temporary Manager and Board. Should there be a dispute, as noted above, the Department in their absolute and sole discretion, shall make a final decision. Such decision shall be binding and not subject to appeal or challenge in any forum.

24. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, the Temporary Manager, the Executive Director and Clinical Director, shall ensure substantial compliance with the following:
a. Clean and safe environment;
b. Emergency response procedures;
c. Patient/Resident/Client safety with smoking;

d. Patient/Resident/Client safety including controls of sharps;

e. Resident assessment;

f. Comprehensive charting;

g. Comprehensive treatment planning, review, and revisions as necessary;

h. Protection of Resident/Client Rights;

i. Supervision of Residents;

j. Staffing supervision and communication;

k. Medication Storage;

l. Incident investigation and follow up; and

m. Patient/Resident/Client Resident leave of absence.

25. The Temporary Manager shall provide training to the Board which shall include, but not be limited to, the following:

a. Development of a mission, vision and goals of the organization;

b. Providing direction for the organization;

c. Establishing a policy based governance system;

d. Defining the rules of the organization and function of such;

e. Establishing policies on the rules;

f. How the board interacts with the organization's leadership team;

g. Fudiciary duties to protect the organizations assets; and

h. Define the Board's scope of duties and responsibilities.

26. The Temporary Manager shall make recommendations to the Board regarding appointments of additional members. Such recommendations shall include, but not be limited to, individuals whose experiences include skills that shall promote the mission, vision, and goals of the organization.

27. The Temporary Manager, Executive Director, if the position has been assumed and Chief Clinical Director shall meet with the Department every month for the first four (4) months after the effective date of this Consent Order and thereafter at least once every three months throughout the tenure of this Consent Order. The meetings shall include discussions of issues related to the care and services provided by the Licensee, the Licensee's compliance with applicable federal and state statutes and regulations and any other issues the Department deems relevant.

28. All 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 Temporary Manager and the Department, upon request.

29. All reports required by this document shall be directed to:

Cher Michaud, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308; MS #12FLIS
Hartford, CT 06134-0308
cher.michaud@ct.gov
Phone: (860) 509-7400

30. 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 or any other state or federal agency'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 requirements contained herein, 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 allegations and/or violations contained in Exhibit A shall be deemed true in any subsequent proceeding before the Department in which the Licensee's compliance with this Consent Order or state and federal law or regulations is at issue.

31. The execution of this Consent Order has no bearing on any state or federal 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 or the appropriate federal authorities.

32. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this Consent Order unless otherwise specified in this Consent Order.

33. The Licensee agrees 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.

34. 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.

35. 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 June 11, 2015 violation letter referenced in this Consent Order.

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

37. This Consent Order is effective on the date it is signed by the Department's representative.

IN 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.

CROSSROADS - LICENSEE

By: Genoveva I. Palmieri
Genoveva Palmieri
Board of Directors Chairperson

On this 21st day of August, 2015, before me, personally appeared Genoveva Palmieri who acknowledged herself to be the Chairperson of the Board of Directors for Crossroads, a corporation, and that she, as Chairperson, being authorized so to do, executed the foregoing Consent Order for the purposes therein contained, by signing the name of the corporation by herself as Executive Director.

My ~~Commission Expires~~: _____

~~Notary Public~~ Robert Phillips [ ]
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 26th day of August, 2015.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

June 11, 2015

Clifford H. Skolnick
Crossroads, Inc.
54 East Ramsdell Street
New Haven, CT 06515

Dear Mr. Skolnick:

Unannounced visits were made to Crossroads Inc. on May 7, 14 and 27, 2015 by a representative 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 June 3, 2015.

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.

An office conference has been scheduled for June 30, 2015 at 11:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Aveenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

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, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

c: Department of Mental Health and Addiction Services
Licensure File

CT-18345, CT-18146

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: May 7, 14 and 27, 2015

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 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (j) Environment (1)(D) General (i)(ii)and/or (F)(iv)(i)and/or (viii)(e).

1. Based on facility observation, and interview, the facility failed to maintain a clean and safe environment and/or in good state of repair to prevent and/or minimize all health hazards. The findings include:
    a. During a tour of the Women's facility on 5/7/15 with the Assistant Program Director at 9:00 AM the first floor daycare hallway floor was heavily soiled.
    b. The janitor closet on the second floor of the women's unit, was observed unlocked containing 2 large containers of Lysol all-purpose cleaner and 2 large dispensers of Lysol bathroom cleaner.
    c. The laundry room door was observed propped open with a large trash can and the room housing the copier was propped open with an open container of laundry detergent. Interview with the Women Services Program Director on 5/7/15 could not identify why these hazards were observed.
    d. During the tour of the west wing hall with the Program Manager on 5/14/15 identified a broken drawer in the medication room.
    e. The bathroom shared by Rooms #21 and #22 had the toilet seat that was missing and was observed on the floor next to toilet.
    f. Room #21, #22, #31, #32 and at the staff work station, all contained 16 ounce bottles of generic all-purpose cleaner labeled as containing bleach that were unattended.
    g. Room #3, #6, #7, #8, #9, #11, #17, #19, #20, #23, #24, #36 and #38, had closet veneers that were broken off in many areas.
    h. Room #7, #13, #17, #18, #23, #36, #38 base board heaters in the bathrooms and/or in the bedrooms were bent, some presenting sharp edges and rusted.
    i. Room #23 bathroom vents were laden with dust.
    j. Room #31 had a strong odor of cigarette smoke coming from the bathroom. Interview on 5/14/15 with the Program Director at 2:00 PM identified the Client had admitted to smoking in this bathroom.
    k. Room #32 had a hole in the bathroom door.
    l. The Emergency Exit doors in both the of the men's West and East wing were heavily soiled.
    m. The Mechanical room door vent was heavily laden with dust.
    Room #35 bed had an alternating air mattress, torn open, with air bladders exposed. The bath tub pertaining to this room, contained a black substance around the grout and the wall had peeling paint.
    n. The bathroom shared by Room # 36 and #38 had black substance around the tub area and a large water stain on the wall. Three broken floor tiles were observed in this bathroom.
    o. Room #38 had an electrical wall socket that was missing a cover and a bedside table was

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

observed broken.

p. The barber shop had 2 broken bedside tables with screws protruding from the sides. Subsequent to surveyor inquiry, the Program Manager removed them as they presented a hazard.
q. Room #2 bathroom had a broken paper towel dispenser lying on the floor. The inside of the tub was stained with black matter.
r. Room #3, #5 and #18 had bathroom and bedroom walls that the paint was peeling off.
s. Room #5 had a broken bedside table.
t. Room #6 had bed with a torn mattress. The bathroom tub related to this room was rusted and had dark substance around the grout.
u. Room #7 shared bathroom, had missing floor tiles and the floor was heavily soiled.
v. Room #9 and #10 shared bathroom had missing floor tiles and the bathroom sink fixture was coming off the wall.
w. Room #13 had wires taped to the wall that belonged to a CD player with connecting speakers. This room had a non-working call box that was lifted off from the wall. The base board heaters of this room were heavily soiled.
x. Room #19 had ceiling tiles that had brown dark stains.
y. The dining room walls were heavily soiled and had an unattended bucket with cleaning liquid solution left unattended outside of the kitchen.
z. The community shower room heat base boards were rusted, and one of the shower cubical lacked a shower curtain. The exterior of the shower had 1 broken tile and the interior of the shower had black matter in the grout.
aa. The resident's bedrooms all identified missing reading chairs, and reading lights. Interview with the CEO on 5/14/15 identified that a plan was in place for repairing and painting the entire men's unit both bathrooms and bedrooms but could not explain why this had not been done and that the Program Director should have followed up. These are repeated violations.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570) (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (j) Environment (1)(D) (i)(ii) and/or (3)(A)(iii).

2. Based on observation and interview the facility failed to maintain a clean and sanitary kitchen. The findings include:
   a. The kitchen, over the stove vents were heavily laden with dust. Interview with Kitchen Manager on 5/14/15 identified the vents were washed weekly.

DATES OF VISIT: May 7, 14 and 27, 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 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or(2) and/or (j) Environment (D)(i) and/or (2) Emergency and Disaster Procedures (A) (vi)and/or (m) Service Operations (7)(A).

3. Based on observation, a review of facility documentation and interviews, the facility failed to ensure monthly inventory and/or the documentation of first aid supplies. The findings include:
    a. During the tour on 5/7/15, the First Aid kit in the medication room of the Women's Unit was observed to lack a date and signature of when the kit had been checked for the contents and replacements on monthly bases. Interview with Women's Program Director identified that although she was aware of the monthly inspections for the first aid kit, the documentation could not be provided. This is a repeated violation.
    b. Observation on 5/14/15 in the two medication rooms on the Men's unit identified the First Aid kit and the biohazard spill kit lacked the appropriate contents and lacked the documentation of the date and initials of whom had monitored the kits on a monthly basis. Interview with the Assistant Program Director of the Men's unit identified although he was aware of the monthly checks, the e documentation could not be provided that monthly checks had been conducted. This is a repeated violation.
    c. Observation on 5/14/15 at 9:45 AM identified that fire and disaster diagrams for facility exit routes were not posted in the hall ways, resident rooms, common rooms and counselor's offices. Interview the Senior Maintenance person on 5/14/15, identified the fire and disaster diagrams for facility exit routes had been removed for the purpose of painting walls. Interview with the Executive Director on 5/14/15 further identified the painting had yet to be completed.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (j) Environment (D)(i) and/or (m) Service Operations (7)(A) and/or(10) (A)(iii) and/or (iv)(v) and/or (vi).

4. Based on pharmaceutical record review and interview, the facility failed to ensure medications vials were dated and/or the medications disposed in a safe manner. The findings include:
    a. Observation during the tour on 5/14/15 identified 4 expired Narcan vials. Interview with the Acting Program Director of the Men' unit identified that 2 of the vials had belonged to a resident that had been discharged on 4/6/15, and the other 2 expired Narcan vials had belonged to a client who had been discharged the previous month. Interview with the Staff Person #1 on 5/14/15 at 10:00 AM identified that the clients had turned over the Narcan when admitted, to the staff. Staff Person #1 further identified that the staff cannot administer the Narcan in this facility. Interview with Program Director on 5/14/15 at 1PM identified that staff not been trained to administer Narcan and the facility lacked a policy for this medication. This is a repeated violation.
    b. Observation identified one vial of Regular insulin and a vial of Humalog insulin that had

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

been opened but not dated as to when it had been opened. Interview with Staff Person #1 identified that he was not aware that insulin must be dated when opened and was unsure if there is a policy addressing insulin dating. Review of the facility's medication policy directed out-of-date and discontinued medications must be destroyed according to facility policy. The medication policy failed to address the integrity of medication once vials are opened. This is a repeated violation.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (j) Environment (D)(i) and/or (m) Service Operations (7)(A) and/or (C).

5. Based on a review of facility documentation and interviews, for 7 of 8 sampled Incident /Accident /Grievance Reports reviewed, the facilities failed to follow-up and/or ensure supervisory oversight. The findings include:
   a. Review of facility Incident /Accident /Grievance Report dated 2/22/15 at 4:45 PM identified that during a tour of the East Unit, a client had an object and had shoved it down his/her pants. The report identified it was not known if it had been a weapon, or other object. It further identified the client refused to surrender the object. This report although signed by the CA, lacked the Supervisor of the Men's Unit/Unit Director signature for review as directed, and lacked the action taken by the facility and/or the follow-up.
   b. Review of facility Incident /Accident /Grievance Report dated 3/5/15 at 10:15 AM identified a counselor aid's had separated two clients involved in a fist fight. Further review identified that although the CA had documented the events, the Supervisor of the Men's/Unit Director lacked to complete and/or sign this report as directed. The documentation lacked identifying the action and/or follow-up taken by the facility and/or the follow-up.
   c. Review of facility Incident /Accident /Grievance Reports dated 5/1/15 at 9:00 PM identified that during the supervision of medications, the client had taken 2 pills instead of one 25mg Quinapine medication, and had verbalized he/she did not care. The report although completed and signed by the CA, lacked the Supervisor of the Men's Unit/Unit Director signature and review as directed, and lacked the action taken by the facility and/or the follow-up.
   d. Review of facility Incident /Accident /Grievance Report dated 5/4/15 at 6:30 PM identified a client had requested to go to the hospital for an injury. This documentation failed to identify the person who had completed it and lacked the Supervisor of the Men's Unit/Unit Director signature and review as directed, and lacked the action taken by the facility and/or the follow-up of this resident.
   e. Review of facility Incident /Accident /Grievance Reports dated 5/4/15 at 8:55 PM, 4/30/15 at 11:15 PM, 2/24/15, and 2/22/15 at 4:45 PM, identified these reports were completed by the staff and/or a client. These reports all lacked the Supervisor of the Men's Unit/Unit Director signature and review as directed and all lacked the action taken by the facility and/or the follow-up as further directed. Review of the facility

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

policy, for Incident, Accident and Grievance Reporting, directed that all would be reviewed to reduce the probability of reoccurrence of such events and improve agency practices. It further directed in part, the personnel document the action taken in a detailed manner, and given to the supervisor or Program Director. It further directed the Supervisor and/or the Program Director would document date and time it had been received and reviewed for clarity and completion. The policy directed the Supervisor contact the person making the report within 24 hours of the occurrence. This is a repeated violation.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570) (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (I) Accident or Incident Reports (1)(2) and/or (3)(A)(B)(C)(D)(C)(F)(G)(H) and/or (I) and/or (4)(5) and/or (6) and/or (m) Service Operations (3)(A) and/or (7)(A) and/or (C).

6. Based on clinical record review and interviews, the facility failed to notify the Department of a Class A incident and/or failed to report and/or investigate multiple smoking concerns and/or falls and/or suicidal attempts and/or ensure safety for 2 of 2 clients. The findings include:
   a. Client #1 was admitted to the facility on 1/13/15. Diagnoses included heroin and cocaine addiction, alcohol abuse and depression. Review of the record identified a progress note dated 1/14/15 by MSW (Master's Social Work) Intern #1 identifying an allegation that Client#1 had been smoking in his/her bathroom. Although the documentation identified Client #1 had denied this smoking allegation, no further incident report, investigation and/or intervention was documented in the record. Counselor #1's progress note dated 2/6/15 identified a meeting with Client #1 on 2/5/15, after a cigarette lighter was found on Client #1's possession after a search. The documentation further identified Client #1's orientation period would be extended by 7 days. Hospital emergency room documentation dated 2/13/15 identified a diagnosis of self-mutilation/ self-destructive behaviors, and a depressive disorder, after Client #1 had cut his/her arm. Client #1 returned to the facility on 2/14/15, with recommendations to follow up with the psychiatric provider within 7 days. Review of the record identified a Safety Treatment Contract dated 2/17/15 which identified the client would notify staff of thoughts or attempts of self-injurious behaviors by cutting. Psychiatrist consult note dated 2/18/15 identified the client denied suicidal ideation. Progress note dated 2/18/15 identified the client reported being called a "cry baby" by a staff member. No further investigation followed this allegation. Further review of this note identified the clinical team recommended the client be placed on a treatment contract. The record lacked this treatment contract.
   A memo to chart note dated 2/22/15 identified Client #1 being upset over wanting the items that he/she had brought into the facility without a store receipt, from a pass to the community. The documentation identified that the client referenced this is why these things happen, pointing to the old cutting marks on his/her wrist. A referral to hospital form, dated 2/23/15 identified Client #1had fallen out of bed diagnosed with a concussion. No

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

incident report, investigation and/or follow-up were found in the record. A memo to chart dated 2/24/15 identified an envelope with cigarettes and a lighter was found on Client #1 during a search of persons. An incident report, investigation and/or intervention were not found in the record. A memo to chart dated 2/26/15 identified Client #1 had been seen by the staff smoking out of his/her window in the facility. Review of the record lacked an investigation and/or follow-up or an intervention. Counselor #1 progress notes dated 3/1/15 identified Client #1 had been taken off the clonidine medication, and that Clonidine was found under Client #1's bed on rounds. No incident report, investigation, nor intervention was documented.

Memo to chart note dated 3/2/15 identified Client #1 was found lying across her bed, feet on floor with no clothes on. The note further identified that at 11:00 PM it took several calls for Client #1 to respond to staff when they were doing rounds. No incident report, investigation, nor intervention documented. Memo to chart note dated 3/3/15 identified that Client #1, was found sitting on the floor at 12:00 AM exhibiting questionable behavior. The note identified the CA indicated to the client, to speak with his/her counselor. Hospital emergency room documentation dated 3/3/15 identified Client #1 presented with a contusion to the left hand and allergic conjunctivitis. The record lacked documentation of an investigation and/or incident report and/or follow-up.
Facility Reportable Event form dated 3/6/15 at 1:00 AM identified Client#1 was found unresponsive, 911 called and the client transported to the emergency room. The report identified that Client #1's room had been searched and 3 bags containing a white powder like substance presumed to be drugs, a syringe, cigarette and a cigarette lighter was found. The documentation further identified twelve empty bags were also found. Memo to chart dated 3/6/13 identified CA#1 contacted the Clinical Director.
Interview on 5/8/15 at 7:30 AM with CA #1 identified when they searched Client #1's room on 3/6/15, after the emergency response team had removed Client #1, the staff found 1 syringe, 3 bags of white powder and a lighter and cigarette. She further identified that in Client's #1 closet, a clear 2x3 inch plastic pouch was found with 10 to 12 bags of white powder held together by a rubber band. It was further identified that the staff found, 10-12 stamped empty bags in the Client's trash can.
Review of emergency room Psychiatric Evaluation dated 3/6/15 identified the client had reported to the hospital Psychiatrist that he/she had injected 6 bags of heroin, 3 bags in the AM and 3 bags before going to bed, along with prescription medications, that included Methadone. Interview with Counselor #1 on 5/8/15 identified Client #1 had reported to the emergency room Psychiatrist on 3/6/15 that the hand contusion on the emergency visit on 3/2/15 had been from attempts to inject heroin into the right hand.
Interview with Women Services Program Director on 5/7/15 at 2:00 PM identified an Incident Reports should have been initiated for events dated

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2/5/15, 2/13/15, 2/18/15, 2/22/15, 2/24/15, 2/26/15, and 3/2/15 regarding Client #1. She further identified there was not an explanation as to why this had not occurred. The Program Director identified that during morning report she and the treatment team are made aware of incidences that occur with clients and reports regarding any incidents are requested. She further identified an action report and an intervention should have been followed. The Program Director further identified that searches take place on admission and whenever the Client's leave the building and upon their return. Documentation in clinical record identified another agency had been contacted 3/6/ 15 at 2:13 of this incident. The facility failed to notify the Department of Client #1's overdose in the facility on 3/6/15. Review of the facility's Critical Incident policy directed that the Executive Director is responsible for reporting any accident, incident within a Class A and/or a Class B immediately by telephone. It further directed a written report would be forwarded to the Department within 72 hours.

b. Client #3 was admitted to facility on 1/23/15 with diagnosis that included heroin, and cocaine dependences. Review of facility Reportable Event documentation dated 5/26/15 identified that Client #3 had reported that on 3/28/15 he/she had used heroin and had passed out in the bathroom. The report identified that several residents had performed CPR and had resuscitated him/her. The report further identified there had been no staff available at the time of the incident and no incident report completed. Review of the Discharge summary dated 5/23/15 identified that Client #3 had had two incidents of using drugs in the facility and/or premises. The note identified that on 3/25/15 Client #3 had been granted his/her first 8 hour pass and returned at 8:00 PM. The note further identified that Client #3 had brought extra clothes from home and upon searching his/her wardrobe had found a bag of heroin in the pockets. The note identified Client #3 had surrendered a urine to the facility and after having surrendered a urine decided to use the heroin and had no recollection after that. This discharge summary identified that during a session with another client, on 4/2/15 this other client was the one that reported Client #3's overdose and the excessive use of drugs within the facility.
Interview on 5/27/15 at 11:45 AM with Counselor #1, identified during a /her as Client #3 had overdosed on heroin in the bathroom of their room, and that Client#3 had turned blue and another client had done CPR and had revived him/her and that 2 other client had gone into the kitchen to get Client #3 milk and salt. Client #4 indicated h/she did not know where staff was during incident and that Client #3 had offered him/her heroin which is making it harder for h/her to stay clean. Counselor #1 further indicated, he told Counselor #2 of what Client #4 had revealed to him. Counselor #1 identified Counselor #2 had told him to Report this immediately to the Program Director which he identified he did. Counselor #1 identified that he was directed by the Program Director to get Client #3 and interview him/her about the incident. Counselor #1 identified Client #3 had identified he/she had fallen in the bathroom and hit his/her head after

slipping on water.
Counselor #1 identified that later in the interview Client #3 reported having been on a pass and had found a bag of heroin in an old pair of pants and had brought the heroin back to facility, taping the bag to his/her body part, surrendering a urine and then using the heroin in his/her bathroom. Counselor #1 identified Client #3 identified that he/she that must have hit him/her hard because he/she could not remember anything after that, other than what the other clients had reported to him/her. Counselor #1 identified that he had reported this to the Program Director, along with Client #3.
Interview on 5/27/15 at 2:45 PM with Counselor #2 identified that on 4/2/15 Counselor #1 told her of an allegation that Client #3 had overdosed over the weekend and she immediately responded to Counselor #1 to report the incident to the Program Director to ensure he was made aware. Interview with Counselor #1 on 5/27/15 at 3:00 PM identified that he reported back to the Program Director, late in the day and that the Program Director directed him to go back and interview Client #3. Counselor #1 identified that he called Client #3's other agency referral to inform them of the overdose and that the Clinical Director wanted Client #3 discharged for using heroin in the facility. Counselor #1 indicated it was late in the day, Client #3 was allowed by the Clinical Director to remain in the program.
Interview 5/27/15 at 10:30 AM with the Clinical Director identified he was first made aware of Client #3's overdose on 5/28/15 when he had been informed by the CEO. The Clinical Director further identified that on 3/30/15 he was made aware by the Program Director that Counselor #1 had reported Client #1 had slipped in the bathroom and hit his/her head and had refused treatment, but had not been made aware of the alleged heroin overdose. He further identified he had informed the Program Director to write up an Incident report pertaining to the fall in bathroom. He further identified he had not follow up to see if that had been completed.
Interview on 5/27/15 at 3:30 PM with the evening Lead CA#1 who was on duty on 3/23/15 identified that he did not recall any incidents happening that evening. He further identified if they had been aware of an overdose and cardiac arrest he is certified to preform CPR, would have initiated CPR, called 911, the medical coordinator and his supervisor. Lead CA #1 Identified his staff always has 1 CA on a unit and the clients are never left unsupervised. Further interview identified if an event occurred he would have done an incident report and written it in the log book.
Interview on 5/27/15 at 3:45 PM with evening CA #2 identified he was unaware of any incident on the evening shift during the evening shift on 3/28/15. He identified he would have reported it and identified had been informed of the incident regarding Client #3 overdosing on 5/22/15 from the CEO.
Interview with CEO on 5/27/15 at 9:00 AM identified that the staff was unaware of the overdose until 5/22/15 when Client #4 revealed this incident in a counseling session with Counselor #1. He further identified that the Investigation of this incident was started on 5/22/15. CEO identified he has morning meetings

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daily with the Program Directors/Coordinators and Director of Clinical services and the report includes a review of Accident/Incidents /Grievances. He identified that as a result of this investigation the Program Director's employment had been terminated. The CEO further identified that in his investigation Client #4 had identified that there had not been staff on the west wing, where the incident had occurred. The CEO identified that a minimum of 1 staff person is expected to be on each wing at all times. The CEO identified the process as if there is a critical incident he is to be immediately notified and in this incident, the Program Director reported it to the Clinical Director and/ or the Clinical Director not reporting to the CEO.
Review of facility policy for Incident/Accident/Grievances reporting directed in part that all reports are written to investigate, review, and monitor all reported incidents to reduce the probability of a recurrence of such event and improve agency practices and notifying the appropriate personnel of facility and required state and federal agencies. It further directed that when a Critical Incidents occurs, the staff person on duty will immediately verbally notify the Supervisor / Program Director.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570) (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (m) Service Operations (3)(A) and/or (C)(i)(ii)(iii) and/or (F) and/or (6)(A)(i) and/or (7) (A) and/or (C).

7. Based on clinical record review and interviews, the facility failed to ensure that the treatment plans were comprehensive and/or revised and/or lacked clinical oversight. The findings include:
   a. Client #1 was admitted to the facility on 1/13/15. Diagnoses included heroin and cocaine addiction, alcohol abuse and depression. Review of the record identified a progress note dated 1/14/15 by MSW (Master's Social Work) Intern #1 identifying an allegation that Client#1 had been smoking in his/her bathroom. Although the documentation identified Client #1 had denied this smoking allegation, no further incident report, investigation and/or intervention was documented in the record. Review of the Recovery Treatment plan dated 1/28/15 lacked identifying a problem with smoking in his/her bathroom and/or interventions.
   Counselor #1's progress note dated 2/6/15 identified a meeting with Client #1 on 2/5/15, after a cigarette lighter was found on Client #1's possession after a search. The documentation further identified Client #1's orientation period would be extended by 7 days. Hospital emergency room documentation dated 2/13/15 identified the diagnosed with self-mutilation/ self-destructive behaviors, and a depressive disorder; after Client #1 had cut his/her arm. Client #1 returned to the facility on 2/14/15, with recommendations to follow up with the psychiatric provider within 7 days. Review of the record identified a Safety Treatment Contract dated 2/17/15 that identified the client would notify staff of thoughts or attempts of self-injurious behaviors by cutting. Psychiatrist consult note dated

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2/18/15 identified the client denied suicidal ideation. Progress note dated 2/18/15 identified the client reported being called a "cry baby" by a staff member. No further investigation followed this allegation. Further review of this note identified the clinical team recommended the client be placed on a treatment contract. The record lacked this treatment contract. Review of the Recovery treatment plan dated 2/6/15 lacked identifying any further revised problems and/or interventions to address Client #1's self-mutilation and/or self-destructive behaviors.

A memo to chart note dated 2/22/15 identified Client #1 being upset over wanting the items that he/she had brought into the facility without a store receipt, during a pass. The documentation identified that the client referenced this is why these things happen, pointing to the old cutting marks on his/her wrist. A referral to hospital form dated 2/23/15 identified Client #1had fallen out of bed and diagnosed with a concussion. No incident report, investigation and/or follow-up was found in the record. A memo to chart dated 2/24/15 identified an envelope with cigarettes and a lighter was found on Client #1 during a search of persons. An incident report, investigation and/or intervention were documented in the record. A memo to chart dated 2/26/15 identified Client #1 had been seen by the staff smoking out of his/her window in the facility. Review of the record lacked an investigation and/or follow-up or an intervention. Counselor #1 progress notes dated 3/1/15 identified Client #1 had been taken off the clonidine medication, and that Clonidine was found under Client #1's bed on rounds. No incident report, investigation, nor intervention was documented. Review of the Recovery treatment plan dated 2/6/15 lacked identifying any further revised problems and/or interventions to address Client #1's continued smoking and/or storage of medications in the room. Memo to chart note dated 3/2/15 identified Client #1 was found lying across her bed, feet on floor with no clothes on. The note further identified that at 11:00 PM it took several calls for Client #1 to respond to staff when they were doing rounds. An incident report, investigation, or intervention were not documented. Memo to chart note dated 3/3/15 identified that Client #1, was found sitting on the floor at 12:00 AM exhibiting questionable behavior. The note identified the CA indicated to the client, to speak with his/her counselor. Hospital emergency room documentation dated 3/3/15 identified Client #1 presented with a contusion to the left hand and allergic conjunctivitis. The record lacked documentation of an investigation and/or incident report and/or follow-up. Facility Reportable Event form dated 3/6/15 at 1:00 AM identified Client#1 was found unresponsive, 911 called and the client transported to the emergency room. The report identified that Client #1's room had been searched and 3 bags containing a white powder like substance presumed to be drugs, a syringe, cigarette and a cigarette lighter was found. The documentation further identified twelve empty bags were also found. Memo to chart dated 3/6/13 identified CA#1 contacted the Clinical Director.

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Interview on 5/8/15 at 7:30 AM with CA #1 identified when they searched Client #1's room on 3/6/15, after the emergency response team had removed Client #1, the staff found 1 syringe, 3 bags of white powder and a lighter and cigarette. She further identified that in Client's #1 closet, a clear 2x3 inch plastic pouch was found with 10 to 12 bags of white powder held together by a rubber band. It was further identified that the staff found, 10-12 stamped empty bags in the Client's trash can.

Review of emergency room Psychiatric Evaluation dated 3/6/15 identified the client had reported to the hospital Psychiatrist that he/she had injected 6 bags of heroin, 3 bags in the AM and 3 bags before going to bed, along with prescription medications, that included Methadone.

Interview with Counselor #1 on 5/8/15 identified Client #1 had reported to the emergency room Psychiatrist on 3/6/15 that the hand contusion on the emergency visit on 3/2/15 had been from attempts to inject heroin into the right hand. Further interview and review of the Client #1's record with Counselor #1, identified the Recovery Treatment plans dated 1/28/15 and 2/6/15 were the only treatment plans that had been completed without revision and/or reviews. This is a repeated violation.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (m) Service Operations (3) Client Records (H).

8. Based on observation, a review of facility documentation and interviews, the facility failed to provide safe storage of Client Medical Records. The findings include:
    a. Observation on facility tour on 5/14/15 at 9:30 AM of the medical records storage room identified 82 client medical records in manila envelopes stacked on top of file cabinets. This room was observed having a sprinkler system. Interview with the Program Director, identified the facility is in the middle of filing records and need more file cabinets which he was working on. He could not explain how the records, stored in the manila envelopes, on files would be maintain safe if the sprinkler system was activated.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) (j) Environment (1)(D)(i)(ii) and/or (m) Service Operations (7) Staffing (A) and/or (C).

9. Based on observation, a review of facility documentation and interviews, the facility failed to supervise and/or ensure safety for 2 of 2 records reviewed for smoking. The findings include:
    a. During the tour on 5/14/15 of the men's west wing, the bathroom between Room #31 and #32 identified a strong odor of cigarette smoke. Interview with the staff identified that Client #5, who was observed in his/her bed, could have been smoking in the bathroom. Review of Client #5's clinical record identified diagnosis that included opioid, alcohol, cocaine, cannabis, and tobacco dependencies. Interview with Men's

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Clinical Coordinator on 5/14/15 at 4:00 PM identified that Client #5 told him that he/she had been smoking in the bathroom because he/she did not feel well and could not go outside with the smoking group. The Clinical Coordinator further identified that the clients are not allowed to keep lighters and cigarettes and could not explain why Client #5 had a lighter and cigarettes on his/her possession. Review of the facility policy for monitoring clients in residential treatment, directed the facility provide clinical assessment and paraprofessional monitoring for signs and symptoms of distress in clients in residential addiction treatment to ensure the health and safety of residents. The facility lacked this supervision.

b. Client #2 was admitted to the facility on 1/23/15 with diagnosis that included heroin addiction, Post Traumatic Stress Disorder (PTSD), depression and anxiety disorder. Review of the record identified that on 2/10/15 Client #2 signed an admission No-Smoking policy and on 2/23/15 signed the Admission Acknowledgement of Consent to abide by program's no smoking policy. Progress note dated 4/29/15 identified Client # 2 had been observed smoking in the building and was placed on 30 day safety response. Interview with the Women Services Program Director on 5/7/15 at 11:00 AM identified the facility was unable to provide a written incident report addressing Client #2 smoking in the building. Review of facility smoking policy failed to direct a comprehensive plan to identify how staff would be monitoring to ensure safety regarding the smoking policy.

The following is a violation of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g) Executive Director (1) and/or (2) and/or (j) Environment (D)(i) (ii) and/or Service Operations (7)(A) and/or (C).

10. Based on review of facility documentation and interviews the facility failed to ensure the safety of the clients and/or failed to conduct weekly room searches as directed by facility policy. The findings include:

a. Review of facility documentation of the West Wing documentation log from 3/8/15 through 5/16/15 identified that on 3/8/15 the Counselor had requested a "cause search" of Room #24. On 4/17/15 Room #33 was searched after smoking was identified in the client's bathroom, this was identified as a "cause search". On 4/20/15 a Client returning from pass was found with cigarettes. The documentation identified that a strip search, for "cause search" was performed. On 4/24/15 at 7:36 AM Room #33 had a random search. At 10:30 AM Room # 31 was identified as randomly searched and was Rooms #22, #24, #34 and #3. On 5/14/15 a search of Room #24 took place for "cause" and on and 5/16/15 a "cause search" of Room #24was identified. A total of 6 rooms were documented as being randomly searched over a nine week period.

Interview on 6/1/15 at 9:35 AM with the Acting Program Director identified the only documentation of searches are in the unit specific logs and if contraband are found within these searches, an Incident Report is written. The Acting Program Director further identified that strip searches are done for cause and must be

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requested by Clinical Director, but that cavity searches are prohibited. Further

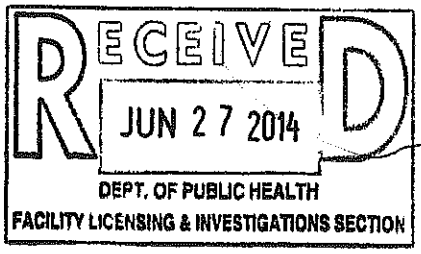
interview with the Acting Program Director identified that random searches of those referred by an outside agency may be part of weekly searches but are not selected just because the client are coming from a specific outside agency. He identified that the CA's perform 2 to 3 random room searches on a weekly basis. The Acting Program Director identified that he could not explain why only 6 rooms were searched over a period of 9 weeks.

Review of the facility policy on random searches directs that they are authorized by the Unit Director and conducted with no prior notification to the client. The policy further directed the room searches are conducted on a routine and random basis as well as "for cause" and that weekly searches are conducted with no prior notification, for clients referred by the criminal justice system, with documentation that the search had been conducted. Further indicates for clients who sought treatment voluntarily or have another referral source, random searches will be conducted according to the schedule determined by the Unit Director, if referral source has not stipulated a schedule. The policy further identified "cause searches" are conducted when staff observes client behavior that indicates possible presence of contraband in the program.

Exhibit B

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

IN RE: Crossroads Inc.
54 East Ramsdell Street
New Haven, CT 06515



CONSENT ORDER

WHEREAS, Crossroads Inc., ("Licensee") has been issued License No. SA-0086 to operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons, ("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 June 21, September 6 and November 14, 2013 at the Facility 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 August 23, 2013, October 15, 2013, and December 11, 2013 (Exhibit A attached); and,

WHEREAS, office conferences regarding the August 23, 2013, October 15, 2013, and December 11, 2013 violation letters were held between the Department and the Licensee on August 6, 2013, November 6, 2013, and November 20, 2013, and,

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

NOW THEREFORE, the FLIS of the Department, acting herein by and through Barbara Cass, its Section Chief, and the Licensee, acting herein by Genoveva Palmieri, its Chairperson of its Board of Directors, hereby stipulate and agree as follows:

1. In accordance with Connecticut General Statutes section 19a-494, the license of Crossroads, Inc. located at 54 East Ramsdell Street, New Haven, Connecticut is placed on probation for a period of two (2) years.
2. In accordance with Connecticut General Statutes sections 19a-494 (3) and 19a-494 (7) and 4-177(c), the Commissioner of Public Health hereby censures and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.
3. Within one week of the effective date of this Consent Order, the Board of Directors on behalf of the Facility shall execute a contract with an Independent Licensed Practitioner (ILP) approved by the Department. The duties of the ILP shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur all costs associated with compliance with this Consent Order. The ILPC shall function in accordance with the FLIS's ILP Guidelines (Exhibit B copy attached). The ILP shall be a licensed practitioner who holds a current and unrestricted license in Connecticut and has statutory authority to conduct psychosocial assessments.
4. The practitioner assuming the responsibility of the ILP shall not be included in meeting the staffing requirements of the Regulations of Connecticut State Agencies or set forth under this Consent Agreement or under any agreement with the Connecticut Department of Mental Health and Addiction Services.
5. The ILP shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identified through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal state statutes and regulations. The ILP shall be at the Facility for a total of thirty-two (32) hours per week.
6. The ILP shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate

the hours of the ILP at the end of the three (3) months and may, in its sole and absolute discretion, reduce or increase the hours of the ILP and/or the ILP's responsibilities, if the Department determines the reduction or increase is warranted based upon any information the Department deems relevant. The terms of the contract executed with the ILP shall include all pertinent provisions regarding the authority and duties of the ILP contained in this Consent Order and shall be submitted for approval by the Department upon the Department's request.

7. The ILP 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.
8. The ILP shall conduct and submit to the Department an initial assessment of the services provided by Crossroads, Inc. and shall review all of the deficiencies noted in the August 23, 2013, October 15, 2013, and December 11, 2013 violation letters and assess the Licensee's regulatory compliance which identifies areas requiring remediation. This written assessment shall be submitted to the Department and the Licensee within two (2) weeks after the execution of the ILP contract.
9. The ILP shall submit written reports every other week to the Department documenting:
    a. The ILP's assessment of the care and services provided to patient/residents/clients; and,
    b. Whether the Licensee is in substantial compliance with applicable federal and state statutes and regulations; and,
    c. Any recommendations made by the ILP and the Licensee's response to implementation of the recommendations.
10. Copies of all ILP reports shall be simultaneously provided to the Licensee and the Department.
11. The Department shall retain the authority to extend the period that the ILP services are required, should the Department determine, based upon any information it deems relevant, 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 on any other information the Department deems relevant.

12. The ILP shall make recommendations to the Licensee's Executive Director and Clinical Director, for improvement in the delivery of direct patient/client care in the Facility. If the ILP and the Licensee are unable to reach an agreement regarding the ILP's recommendation(s), the Department, after meeting with the Licensee and the ILP shall make a final determination, which shall be binding on the Licensee.

13. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, the Executive Director and Clinical Director, shall ensure substantial compliance with the following:

    a. Clean and safe environment;
    b. Emergency response procedures;
    c. Patient/Resident/Client safety with smoking;
    d. Patient/Resident/Client safety including controls of sharps;
    e. Resident assessment;
    f. Comprehensive charting;
    g. Comprehensive treatment planning, review, and revisions as necessary;
    h. Protection of Resident/Client Rights;
    i. Supervision of Residents;
    j. Staffing supervision and communication;
    k. Medication Storage;
    l. Incident investigation and follow up; and
    m. Patient/Resident/Client leave of Absence.

14. On or before July 31, 2014, the Executive Director and Clinical Director shall develop and/or review and revise, as necessary, policies and procedures related to areas noted in paragraph number thirteen (13).

15. On or before August 8, 2014, all Facility staff shall be in-serviced, to the policies and procedures identified in paragraph number thirteen (13).

16. The INC, the Licensee's Executive Director and Clinical Director shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

17. The Licensee shall ensure that qualified, licensed staff is designated to provide clinical supervision.

18. The Licensee shall notify the Department immediately of a vacancy or staffing change in the positions of Executive Director, Clinical Director, and Program Managers.

19. The Executive Director, Clinical Director, and Program Managers shall make random unannounced visits to the facility to observe care and services. These visits shall be inclusive of all three shifts, weekends, and holidays.

20. The Licensee shall conduct scheduled meetings every other week with patients/residents/clients and responsible parties which include at a minimum the Executive Director, Clinical Director, and Program Managers to address any patient/resident/client care issues.

21. A Quality Assurance Performance Improvement Program ("QAPI") shall be instituted, which will identify a QAPI Committee, consisting of, at least, the Facility's Executive Director, Clinical Director, and Program Managers. The QAPI Committee shall meet at least once every thirty (30) days to review all reports or complaints relating to resident care and compliance with federal and state laws and regulations. The activities of the QAPI Committee shall include, but not be limited to, assessing all patients/residents/clients in the Facility to identify appropriateness of care and services, determination and adoption of new policies to be implemented by Facility staff to improve care patient/resident/client practices, and routine assessing of care and response to treatment of same. In addition, this Committee shall review and revise all policies and

procedures and monitor their implementation. A record of QAPI meetings and subject matter discussed will be documented 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. The Independent Licensed Practitioner shall be given notice and invited to attend the monthly meetings.

22. The Facility shall assign an administrative staff member to oversee the implementation of the requirements of this document. Said individual shall submit monthly reports to the Department regarding the implementation of the Consent Order components.

23. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand five hundred dollars ($2,500.00) by money order or bank check payable to the "Treasurer of the State of Connecticut" and mailed to the Department at the time this signed Consent Order is submitted to the Department. The money penalty and any reports required by this document shall be directed to:

Cher Michaud, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 FLIS
Hartford, CT 06134-0308

24. 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. The allegations contained in the violation letters attached as Exhibit A shall be deemed true in any subsequent proceeding before in which compliance with its terms is at issue or

compliance with the federal or state statutes or regulations is at issue. The Licensee retains all of its rights under applicable law.

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 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 Act, Chapter 368a of the Statutes, Regulation that exist 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.
27. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this Consent Order.
28. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

IN 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.

CROSSROADS - LICENSEE

By: Genoveva I. Palmieri
Genoveva Palmieri
Board of Directors Chairperson

On this 27th day of June, 2014, before me, personally appeared Genoveva Palmieri who acknowledged herself to be the Board of Directors Chairperson, a corporation, and that she, as such Executive Director, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation ~~by himself~~ as Executive Director.

My Commission Expires: Feb. 28, 2018 Nereida Lumlano
Notary Public [✓]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

6.27.14
Date

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

RECEIVED
JUN 27 2014
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

August 23, 2013

Miguel Caldera
Crossroads Inc
54 East Ramsdell Street
New Haven, CT 06515

Dear Mr. Caldera:

An unannounced visit was made to Crossroads Inc on June 21, 2013 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through June 27, 2013.

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.

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 September 6, 2013 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.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Cher Michaud RN

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CM

c: Department of Mental Health and Addiction Services
Licensure File
CT15341

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: June 21, 2013

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 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1) and/or (2) and/or (j) Environment (D)(1)(i) and/or (m)Service Operations(7)(A)and/or(C).

1. Based on observation and interview, the facility failed to monitor and/or supervise for the safety of a child and/or provide a safe environment. The findings include:
   a. Observation at 10:35 AM (Friday) in the nursery playroom identified a client and identified a 5year old and two small toddlers. Interview with the client identified that he/she was watching the small toddlers for another client and the 5 year old belonged to her. She identified that usually there is staff to watch the kids in the playroom least 3 or 4 times a week, except on Wednesday's. She identified that on Wednesday's the clients either take their children to group or miss the group. This is a repeated violation.
   b. Observation of the nursery identified a child's plastic low bike that lacked a seat and a swing set that was not leveled to the floor. These swing sets had exposed coils at the site of insert where the batteries would go as they lack covers.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1) and/or (2) and/or(j)Environment(1)(D)(i)and/or(m)Service Operations(7)(A)and/or(10).

2. Based on observation and interview, the facility failed to safeguard and/or dispose of and/or observe the self-administration of medications in a safe manner. The findings include:
   a. Tour of the Women's unit at 10:00 AM identified the medication room was observed to have the door wide open with unlocked cabinets storing the medications. Also noted on the counter were stacks of medications cards. Observation identified no staff in the medication room but Care Assistant (CA) #2 outside the room in a desk area that is not connected to this med room. Interview with CA #1 identified that the medication cards on the counter were discontinued medications that needed to be recorded in a book and discarded by flushing them down the toilet. CA #2 was asked the reason for the unlocked cabinets and doors and identified she was right there. Review of the facility's medication management directed that non-controlled or over the counter expired medications will disposed of by the Unit Director and/or delegated staff who in the presence of another counselor would discard the medication in hazardous containers that meet OSHA standards.
   b. Observation at 11:40 AM identified the same medication room door was opened and unattended with cabinets unlocked. Interview with CA #2 identified that one of the cabinet doors have broken hinges therefore has remained unlocked. Review of the facility medication management policy directed the medication room door is never to be left unlocked if staff are not in the med room and identified Client's medication would be stored in cabinets with locked doors. This is a repeated

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

violation.

c. Interview with CA #1 identified that extra over the counter medications are stored in a box under the desk in the Director's office. Review of the facility policy directed that a locked medication room on each unit provides space for individual storage of prescribed medications and/or over the counter medications.

d. Review of the Client #2's Medication Administration Record (MAR) identified Methadone 60mg daily and identified it was signed out for Sundays. The record identified the client attended a clinic on a daily basis except on Sundays. Interview with CA #1 identified that the boxes stacked on the counter were for the clients who obtained their methadone for the Sunday dose from the clinic. She identified that the methadone is contained in these locked boxes and kept on the counter. Review of the medication policy directed that a separate non-portable locked container is provided for the storage of controlled substances. This is a repeated violation.

e. Observation at 10:10 AM identified CA #2 handing Client #2's bag of medications to the client and the client quickly popping the medications out of the card into his/her hand. CA #2 at no time checked prescribed med card name and/or verified the dose against the MAR. Review of the facility medication policy directed that the staff would ask to see the client's photo ID, and if no ID would check the photo kept in med room and set the medications on the counter to check for expirations dates. The policy directed the staff would ensure the client has taken the correct medication, the correct dose, and the correct amount as staff observes the client pour them in the paper medication cup. The facility failed to ensure that this had occured.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1) and/or(2) and/or (m)Service Operations(7)(A)and/or(10)(A)(vi).

3. Based on review of facility documentation and interview, the facility failed to provide at a minimum a semiannual education related to medications. The findings include:

a. Review of the facility's documentation of staff education related to medication identified an attendance sign in sheet with a pharmacy logo dated 9/21/09 and the word "training." These in-service training sheets had the signatures of the staff but failed to reflect the content of the in-service training that had been conducted. Interview with the Director of Clinical Services identified that it had been the pharmacy company that had come in to conduct the medication in-service and that no further in-service training related to medications had been conducted.

DATE(S) OF VISIT: June 21, 2013

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 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1)and/or(2) and/or(j)Environment(1)(D)(i)and/or(2)(A)(vi).

4. Based on observation, review of facility documentation, and interview, the facility failed to maintain the first aid kits. The findings include:
   a. Inspection of the first aid supplies on the Women and Children's unit identified that the unit lacked band aids. Interview with CA #7 identified they had run out about 1 week ago.
   b. Inspection of the first aid supplies on the Men's unit identified that one of the 2 men's unit lacked band aids in the supplies.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1)and/or(2) and/or(j)Environment(1)(D)and/or(3)(A)(viii).

5. Based on review of facility documentation and interview, the facility failed to monitor refrigerator temperatures. The findings include:
   a. During the tour of the children's playroom a small refrigerator stocked with yogurts, juices and milk was noted. Review of the refrigerator temperature log identified that it had only been checked on 6/1, 6/2 and 6/8/13. Interview with the staff identified that the kitchen staff monitors the temperatures.
   b. During the tour of the kitchen a malodourous gas type odor surrounded the kitchen and increased in the area of the Dietary Supervisor's office. Interview with the Dietary Supervisor confirmed the odor and identified the facility's maintenance personnel were aware of it and were checking it.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (g)Executive Director (2) and/or(i) Personnel Practices (1) and/or (3)(F).

6. Based on personnel file review, the facility lacked documentation for five of nine files reviewed that job performance evaluations had been completed and/or the staff maintained the credentials as noted in their job description. The findings include:
   a. Staff Person #1 was hired on 3/3/08. Review of the last job performance evaluation identified it was completed on 6/28/10. Another job performance evaluation was signed by the staff person on 6/20/12, however lacked the signature of the supervisor/evaluator and signature of Program Director/Coordinator as directed.
   b. Staff Person #2 was hired fulltime on 4/28/09. Review of the last job performance evaluation

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

identified it was completed on 6/28/10.

c. Staff Person #7 was hired on 3/08. Review of the last job performance evaluation identified it was completed on 7/27/10.

d. Staff Person #8 was hired fulltime on 9/28/08. Review of the last job performance evaluation identified it was completed on 7/27/10.

e. Staff Person #9 was hired on 10/30/02. Review of the last job performance evaluation identified it was completed on 6/30/10. Interview with the Director of Clinical Services identified that due to the lack of personnel some evaluations were not completed.

f. Additionally, Staff Person #1's new job description identified effective 12/27/11 he/she was a Senior Counselor Aide/Medication Supervision Support. Review of the job description directed certificates that included Adult Cardiopulmonary Resuscitation (CPR)and Medication Certification. The personnel file identified the Heart Saver First Aide that expired 9/2011 and a Medication Administration Certificate that expired on 4/7/08.

g. Staff Person #10 was hired on 5/1/13 as the Child Care Worker. Review of the job description directed the requirement of CPR certification for adults and children. No documentation was provided of the CPR training.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (g)Executive Director (2) and/or(m) Service Operations (3)(C) and/or (6)(A) and/or (7)Staffing(C).

7. Based on clinical record review and interview, for 4 of 5 records reviewed, the facility failed to provide treatment plans and/or clinical oversight of the treatment plans. The findings include:
   a. Client #1 was admitted to the residential facility on 11/6/12. Review of the treatment plans identified they were completed on 11/6/12, 12/4/12, 1/4/13 and the last one dated 3/6/13. The record lacked documentation of a 60 day treatment plan thereafter.
   b. Client #2 was admitted to the residential facility on 1/2/13. Review of the treatment plan reviews dated 2/4/13 and 3/4/13 lacked the signature of the client as directed. The record lacked documentation of a 60 day treatment plan thereafter.
   c. Client #4 was admitted on 6/4/13. Review of the Recovery plan for chemical dependence and for mental health dated 6/18/13 identified they both lacked the client's signature and the Director's signature as directed. Interview with the Director of Clinical Services identified that the treatment plans should have been signed and completed.

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 19a-495-570 (g)Executive Director (2) and/or (m) Service Operations (7) Staffing (C).

8. Based on record review and interview, the facility failed to conduct a risk assessment and/or psychiatric evaluation in a timely manner. The findings include:
a. Client #4 was admitted on 6/4/13. Review of the placement eligibility assessment dated 6/3/13 by a counselor in training (CIT) and signed as reviewed and approved for admission on 6/4/13 by the Director of Clinical Services identified the client had just been released from a hospital after being in for 12 days due to the voices getting worse and not being compliant with medications, and identified the diagnosis of Schizophrenia and medication for Haldol 5mg and Zyprexa 20mg. The assessment also identified that the client had an attempted hanging while in prison. Other placement eligibility assessment identified that during the interview the client had reported having a K2 dependence in the past year with the last date of using as 5/24/13. Review of the hospital documentation dated 5/24/13 – 6/3/13 identified the client treatment diagnosis had been psychosis. Review of other hospital information in the record identified the client had prior a admission to the hospital from 5/10/13 – 5/17/13 for the diagnosis of psychosis mood instability. Review of a facility medical referral dated 6/7/13 identified the client had gone into the emergency room. Review of hospital documentation dated 6/10/13 identified the client had drug induced hallucinations. Progress note dated 6/11/13 by the counselor identified it was the first contact with the client, reported not taking medications, and not attending groups. No further risk assessment was identified in the record. Facility psychiatric assessment dated 6/19/13 by Licensed Professional Counselor (LPC) #6 identified that the client was hearing voices compelling him/her to kill self and other people. The note identified the client was unable to connect with anyone and feeling extremely uncomfortable in groups because he/she cannot talk about the feelings because there is no group to address hallucinations and psychosis. The note concluded with the recommendation for a higher level of care where the psychiatric needs could be addressed and would benefit from medication management. Psychiatric consult with MD #1 identified a medication evaluation on 6/20/13 and increased the Zyprexa to 30mg with a follow-up in 30 days. The record identified an incomplete AIMS testing sheet. Interview with the Director of Clinical Services identified Client #4 had been admitted to the facility and shortly after had been transferred to the emergency room on several occasions and had been seen by the LPC on 6/19/13. The facility failed to ensure services were provided in a timely manner.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

October 15, 2013

Miguel Caldera
Crossroads Inc
54 East Ramsdell Street
New Haven, CT 06515

Dear Mr. Caldera:

An unannounced visit was made to Crossroads Inc on September 6, 2013 by 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, 2013.

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.

An office conference has been scheduled for October 29, 2013 at 10:00AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed 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.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

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

Respectfully,

Cher Michaud RN

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CM

c: Department of Mental Health and Addiction Services
Licensure File
CT15632, CT15637

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: September 6, 2013

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 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1) and/or (2) and/or (j)Environment(1)(D) and/or (F)(viii)(e) and/or (m)Service Operations(7)(A)and/or(C).

1. Based on observation and interview, the facility failed to maintain a clean and/or sanitary and/or safe environment. The findings include:

a. Room #14 identified as a counselor office had ceiling tiles that were missing. Interview with Counselor #5 identified there had been some rewiring in effect.

b. Room #15 identified as a group room had a table covered with a table cloth that was soiled. The chairs contained foam protruding from the chairs and the base heater covers were falling off.

c. Room #13 bathroom and multiple other bathrooms (#18, #5, #3) had the door vents covered up with cardboard and/or paper towels. Additionally, entering in Room #13 the odor of cigarette smoke was evident (as was in Room #5, #17, #18 and #20). Interview with Counselor #5 identified that some clients are smoking in the bathrooms and it is an issue that the clients smuggle the cigarettes into the bathrooms to smoke. This is a repeated violation.

d. Room #16 and #18 bathroom doorframes were rusted.

e. Room #18 had two ripped mattresses on the beds.

f. In Room #9 shaving razors were noted on the dressers. Interview with Counselor #5 identified that the clients were allowed to keep them in the room. Interview with the Director of the men's unit on 9/6/13 identified the razors should have been given to the clients and taken away per the policy. Review of the sharps sign out/sign in form that was provided directed that when the clients are given a razor or scissor from the unit the staff would sign out the item and staff would ensure the item would be returned and signed backed in. Documentation was lacking that this had occurred.

g. Room #5's floor was observed to be heavily soiled and stained. The area had dirty drinking glasses and empty soda bottles around the bed area.

h. Room #4's bathroom mirror was cracked. This bathroom had a large area of the drywall that was peeling off. The ceiling tiles were noted to have large areas that were cracked off.

i. Room #3's bathroom sink fixture was detaching from the wall.

j. The barbershop room was observed to be utilized by a client who was cutting another client's hair. Interview with the client who was cutting hair identified that he/she uses the hand sanitizing liquid from the unit or an alcohol pad to clean the razor in between the haircuts. The facility lacked a policy to direct this practice and/or a practice to address the cleaning of equipmnt between clients.

k. Throughout the entire men's unit the handrails had large areas that had the paint peeling off and/or were barren exposing the chipped paint.

l. The blue hallway had dried soiled areas throughout the walls and the floors were stained and dirty. Interview with the Director identified that the maintenance staff should be going through the

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

units each day.

m. During the tour of the men's west wing hall walls were observed to be soiled and debris throughout the floors. Interview with Counselor #4 identified that it was a leisure day and that the clients would clean the areas later in that day.

n. Ceiling tiles throughout the unit were broken and/or not properly in place. Interview with Counselor #4 identified that the staff were to replace the tiles after contraband searches were completed.

o. The group room on the west wing had an open wall socket with exposed electrical wiring, identified as an intercom that had been removed.

p. Room #22 had a strong smell of cigarette smoke. Review of the facility men's unit log book from the period of 8/7/13 to 8/30/13 identified that smoking had been identified in Rooms #5, #21, #22, #31, #32, #37 and #38.

q. Observation during lunch serving in the kitchen on 9/6/13 identified several clients were entering the kitchen and passing through food prep areas to obtain cups and/or eating utensils. Interview with the staff in the kitchen identified that the clients are allowed to enter the kitchen when they need an item.

r. The refrigerator in the medication room that was utilized by the staff had debris and was soiled inside.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1) and/or (g)Executive Director (1) and/or(2) and/or(j)Environment (1)(D)(i) and/or (m) Service Operations (7)(A) and/or (10)(A).

2. Based on observation and interview, the facility failed to dispose of medications in a safe manner. The findings include:

a. The medication room contained two large garbage bags on top of the refrigerator. One contained Nicorette gum boxes and the other bag was full of medications cards. Interview with the staff person identified that these medications had been discontinued and they needed to be disposed. He identified that are usually disposed of on a month to month basis by the senior counselor aid. This is a repeated violation.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (g)Executive Director (2) and/or(i) Personnel Practices (3) (C)and/or(D)and/or(F) and/or (j)Environment (2)(A)(i)and/or(ii)and/or(iii).

DATE(S) OF VISIT: September 6, 2013

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

3. Based on a review personnel files, the facility lacked documentation of applications, evaluations, reference checks and/or an orientation to fire and safety practices. The findings include:
   a. Staff Person #1 was hired on 6/14/12. The personnel file lacked an application and an evaluation. The Licensed Alcohol and Drug Counselor (LADC) license on file had an expiration date on file of 5/31/13.
   b. Staff Person #4 was hired on 7/25/13. The personnel file lacked past employment reference checks and orientation to fire safety practices. The LADC license on file had an expiration date of 8/31/13.

The following are violations of the Connecticut General Statues Sec.17a-542 and the Regulations of Connecticut State Agencies Section 19a-495-570(g)Executive Director (2)

4. Based on review of facility documentation and interview, the facility failed to maintain the Client's Rights. The findings include:
   a. Facility documentation dated 9/4/13 by a client identified that on 9/3/13 the client had returned from a meeting and learned that Counselor #4 had ordered the telephones not to be given out. The documentation identified that the client understood there had been arguing among other clients over the phone but felt that he/she had been committed in obtaining privileges and felt punished over the mistakes of others. The documentation also identified that it had been signed by the Director of the men's unit who identified explaining to the client that he had authorized the phones to be removed. Interview with the Director on 9/5/13 identified that the phones were taken away that day as some clients did not have privledges.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (g)Executive Director (2) and/or (m)Service Operations (3)(A) and/or(B)(xiv)and/or(F)and/or(G)and/or(6)(A)(i)(a)(1)and/or(7)(A)an/or(C).

5. Based on record review and interview the facility failed to maintain completed records for 5 of 7 records reviewed. The findings include:
   a. Client #1 was admitted to the facility on 9/10/12 with a history of substance abuse and mood disorder. Review of the record identified psychiatric notes dated 9/18/12, 9/25/12 and 10/23/13 by Physician (MD) #2 that identified the self-report history of depression and that the client had not been interested in taking medications. It identified the recommendations that included one to one therapy. Review of psychotherapy progress notes dated 9/19/12, 9/26/12, 10/2/12 and 10/8/12 identified a report of no suicidal/homicidal ideations at that time. No notes for the months of November were identified. Psychotherapy note dated 12/18/12 identified that the client had discussed the transition to the new therapist and counselor and identified the stressors in the milieu and ways to cope. This note further identified the client reported cutting self in the past and

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

identified a follow-up in two weeks. The record lacked further documentation and lacked treatment plans, progress notes, and/or a discharge summary. Subsequent to surveyor inquiry on 10/1/13 a recovery plan dated 9/14/12 was send to the Department. This treatment plan lacked the signatures of the client, counselor, and the Director as directed. Review of the Discharge Summary dated 12/20/12 identified that the client had absconded and lacked the counselors and the Director's signatures as directed.

b. Client #2 was admitted to the facility on 11/12/12 with the history of opiate and alcohol dependence and a reported diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and anxiety and was discharged on 5/16/13. The record identified the client had consistent medication management consults with MD #1 from the period of 12/11/12 through 4/30/13. Review of the recovery plan problems #1, #2, #3 and #4 identified they were completed on 11/16/12. The record lacked the review of these recovery plans and/or further treatment plans.

c. Client #4 was admitted to the facility on 8/31/12 and discharged on 2/28/13. Diagnosis included the history of the opiate dependency and anxiety disorder. The record identified that the client had been seen by MD #1 for medication management and received psychotherapy sessions. Review of the Recovery Plans with problems #1, #2, #3 and #4 identified they were completed on 9/4/12. The record lacked the review of these recovery plans and/or and further treatment plans. A discharge summary was not identified in the record. Recovery progress notes from the period of 9/4/12 through 2/25/13 lacked the client's signature and the signature of the counselor as identified. Review of the Discharge Summary dated 2/28/13 identified that the client had successfully completed treatment goals and identified he/she was encouraged continuing recovery efforts in an outpatient setting. This discharge summary lacked the client's, the primary clinician's and the Director's signature as directed.

d. Client #5 was admitted to the facility on7/27/13 with diagnoses of opiate dependence and anxiety. The record identified that the client had been seen by MD #1 for medication management and received psychotherapy sessions. Review of the Recovery plans dated 7/27/12 identified Problem #1 for substance abuse and Problem #2 for mental health. The record lacked the review of these recovery plans and/or further treatment plans. Additionally a discharge summary was not identified in the record.

e. Client #6 was admitted to the facility on 3/1/13 for substance abuse treatment. The facility communication log book identified that on 9/5/13 at 8:55 AM Client #6 went out on job status. The log further identified that the facility received a call in the evening from a staff member that they saw Client #6 in an alleyway with another individual in an area known for drug dealing. The log further identified that Client #6 returned from the Emergency Room at 9:15 AM the following morning and signed out from the facility at 10:00 AM for a court visit. Interview with facility staff on 9/6/13 identified that they were unaware of the Client's whereabouts at that time. Review of the

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clinical record failed to reflect the client's absence and/or interventions related to such.

The following are violations of the Regulations of the Connecticut State Agencies Section 19a-495-570 (g)Executive Director (2)and/or(j)Environment (1)(D)and/or(l)Accident or Incident Reports(1)and/or(2)and/or(3).

6. Based on review of facility documentation and interview, the facility failed to notify the Department of a fire at the facility and/or failed to ensure client safety. The findings include:
a. Review of facility documentation dated 9/1/13 by Dietary Staff #1 identified that while using oil in a pot to fry potatoes the oil had boiled over when the frozen product had been poured into it and caused a grease fire. It further identified that the stove had been turned off and the fire extinguisher had been used to put out the fire. The documentation identified that maintenance had been called to assess the stove and that the kitchen had been cleaned up but that proper equipment was needed and that the fire department had been called. Other attached documentation dated 9/2/13 by a client identified there had been a fire behind the stove caused by grease on 9/1/13 and that the writer and another client had pulled the stove away from the wall in order to put the fire out. It identified that the two people took turns with the fire extinguisher until the fire had been completely out and that they had directed Kitchen Staff #1 to contact the Kitchen Supervisor. Interview with the Dietary Supervisor on 9/6/13 identified that the fire had started during breakfast from the overflowing contents from the pan onto the stove which caused the grease fire. He identified that two clients had moved the stove to put out the fire and that the fire department had been called one and a half to two hours later. He identified that the oven thermostat had been damaged during the fire and a new one would be replaced.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

December 11, 2013

Miguel Caldera
Crossroads Inc
54 East Ramsdell Street
New Haven, CT 06515

Dear Mr. Caldera:

An unannounced visits was made to Crossroads Inc on November 14, 2013 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through November 20, 2013.

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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 25, 2013 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.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Cher Michaud RN BSN

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CM

c: Department of Mental Health and Addiction Services
Licensure File
CT16104

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

FACILITY: Crossroads Inc

DATE(S) OF VISIT: November 14, 2013

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 19a-495-570(g) Executive Director (2) and/or (m)Service Operations (7)(A).

1. Based on review of facility documentation and staff interview, the facility failed to ensure 26 Clients were supervised when on a leave from the facility. The findings include:
a. Review of facility documentation dated 11/8/13 identified that Client #1 reported that on 11/5/13 at approximately 7:00pm she and 10 other female clients were taken by limousine to City Hall to vote. The documentation identified that inside the vehicle were alcoholic beverages which some of the clients consumed, and no staff accompanied the clients. Additionally, the documentation identified clients stated that Board Member #1 came onto the women's units and asked if anyone would like to vote, and the clients went with the board member. Further documentation identified that the Clients felt it "strange" and felt uncomfortable that they were being videotaped while getting out of limousine. The investigation further identified that that the Executive Director authorized a Board member to transport clients to voting polls and that some of the clients did not sign out as per facility policy. Documentation dated 11/19/13 identified 13 male clients were taken to vote in a limousine, and that upon return although they were searched per facility policy the Clinical Aides failed to perform a urine screen. Further documentation dated 11/19/13 identified that the female clients who got into the limousine after the male clients, stated some of the male clients smelled of alcohol and some of them appeared under the influence.
Interview with the Director of Clinical Services on 11/14/13 at 10:10am identified that it was reported to Client #1's counselor that the client and others were taken to vote by a board member and that alcohol was in the limousine which a couple of the clients drank. Additionally, the Director of Clinical Services stated that during their investigation it was identified that a couple of the clients were observed drinking, and when the clients got to the polling stations they were being videotaped and some clients had expressed feeling uncomfortable with this.
The Director of Clinical Services stated that although the facility's policy is when a client is on a leave of absence (LOA) upon return a physical search and urine test are to be completed, only 5 of the 11 female clients who went to vote had a urine test completed on 11/7/13 (2 days after being on LOA), and the 2 clients that were alleged drinking were not tested until 11/8/13 (3 days after LOA). The Director of Clinical Services stated that urine screens should have been completed upon the return from voting on 11/5/13. Additionally, the Director of Clinical Services stated she did not speak to any staff that worked that evening because "too much was going on right now."
Interview with Staff Person #2 on 11/14/13 at 10:30am identified that she was aware that clients were going to vote on 11/5/13, but was only made aware that the male clients had gone out prior to the women, when the female clients reported that. Staff Person #2 further stated that she did not perform urine tests on the clients upon return because they had just gone out to vote, but did report it to the Director of Clinical Services, Women's unit.

FACILITY: Crossroads Inc

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Interview with the Executive Director on 11/14/13 at 11:30am identified that a board member arranged transportation as "a last minute thing" for clients to go out to vote, and he felt it was fine. He further stated 13 men went to vote, and all had signed out and that no staff member went with the clients. Although the clients were searched upon return, no urine tests were completed. Additionally, the Executive Director stated that although he asked the board member to check the limousine and van for any contraband and they assured him that there was none, he did not physically check this himself. He stated it was a really bad judgment call on his part and that this should have been planned weeks in advance. Additionally, he stated that it was reported that the Limousine driver had been videotaping the female clients and the Board of Directors spoke to the company that posted the footage online and had it deleted, because no female clients gave permission to be videotaped.

Review of the Men's unit Sign Out log dated 11/5/13 identified 14 men signed out to vote, 1 male client failed to sign back in, and 4 clients returned 2 hours or later from voting. Review of the women's unit (upstairs) Sign Out log failed to reflect that any of the 7 clients signed out. Review of the Amethyst house Sign Out log identified 4 women signed out at 7:00pm and returned at 8:35pm. Interview with Executive Director at 11:30am identified that he did not know why the 4 clients who returned after being out for greater than 2 hours, and the one client who did not sign in, did not have a urine screen completed.

Interview with Staff Person #5 on 11/14/13 at 2:05pm identified that although she did not see the clients leave on the downstairs unit, she did see the clients return. Additionally, Staff Person #5 stated the clients were searched per facility policy but were not given urine tests because the Executive Director set it up and felt it was fine.

Interview with Staff Person #6 on 11/14/13 at 2:40pm identified that the Executive Director called the unit and said the clients were going to go out to vote, whoever wanted to, and that a member of the board was taking them. Staff Person #6 further stated that the Executive Director did not say how the clients were getting there and who was going with them. Additionally, Staff Person #6 said that she brought the female clients to the men's unit and left them with the board member. Staff Person #6 stated she did not see how they were being transported, or who was going with them. Staff Person #6 further stated that, although the clients were searched upon return, no urine tests were completed, because policy states if a client is gone longer than 2 hours, if requested or staff feels it needs to be done. Staff Person #6 stated she did not search any clients. The facility lacked evidence that the clients were appropriately supervised prior to or during the out trip to vote and/or that the clients were searched and/or assessed upon return.

DATE(S) OF VISIT: November 14, 2013

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The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570(g) Executive Director (2) and/or (m) Service Operations (2)(A).

2. Based on review of facility documentation and staff interview, the facility failed to ensure the client's rights were protected. The findings include:
   a. Review of facility documentation dated 11/8/13 identified that Client #1 reported that on 11/5/13 at approximately 7:00pm, she and 10 other female clients were taken by Limousine to City Hall to vote. Further documentation identified that the Clients felt it "strange" and felt uncomfortable that they were being videotaped while getting out of limousine.
   Interview with the Director of Clinical Services on 11/14/13 at 10:10am identified that all female clients confirmed that they were being videotaped while getting in/out of the limousine and that they felt uncomfortable about it. Additionally, the Director of Clinical Services stated one client had a protective order in place. The Director of Clinical Services stated that when the facility found out that the client's pictures were posted on an internet newspaper, they were notified and asked that the client's pictures were removed.
   Interview with the Executive Director on 11/14/13 at 11:30am identified that the limousine driver was the person videotaping the clients and that they did not obtain permission to do so. He stated when he was made aware of the posting on the internet newspaper, he was assured by a board member that the pictures were removed. The facility failed to protect the privacy of the clients.

The Following are violations of Regulations of Connecticut State Agencies Section19a-495-570(m) Service Operations (3)(A) and/or (7)(A).

3. Based on clinical record review, review of facility documentation, and staff interview for 25 of 25 clients who went on an LOA the facility failed to ensure the clients were assessed upon return. The findings include:
   a. Review of facility documentation dated 11/8/13 identified that Client # 1 reported that on 11/5/13 at approximately 7:00pm she and 10 other female clients were taken by Limousine to City Hall to vote. The documentation identified that inside the vehicle was alcoholic beverages which some of the clients consumed, and no staff had accompanied the clients. Additionally, the documentation identified clients stated that a Board Member came onto the women's unit and asked if anyone would like to vote, and the clients went with the board member. The investigation further identified that that the Executive Director authorized a Board member to transport clients to voting polls without staff supervision and that some of the clients did not sign out as per facility policy. Additionally, upon the client's unsupervised return, urine screenings were not immediately performed.
   Review of the facility policy and procedure for "Urine Drug Testing", stated drug testing will be

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conducted on a routine and random basis as well as for cause. Additionally, the policy identified all clients returning to the residential unit from a pass will be routinely asked to provide staff with a urine specimen.

Interview with Director of Clinical Services on 11/14/13 at 10:10am identified that during the investigation with the female clients, it was discovered that 14 male clients also had been taken to the voting polls. She further stated that although, facility policy is to perform urine test upon client's return to the facility, no clients received urine testing until 2 days after the clients went on a LOA, when staff began investigating the allegation of alcohol consumption in the limousine. Additionally, the Director of Clinical Services also stated that no male clients were tested following the out trip. She also stated that the 2 clients, who were identified as drinking, were not tested until 11/8/13, 3 days after the LOA.

Interview with Staff Person #2 on 11/14/13 at 12:10pm identified that when the female clients returned from voting, they said the male clients had gone out before. Additionally, Staff Person #2 stated that no urine testing was completed after the clients came back because they had just gone to vote.

Interview with Staff Person #5 on 11/14/13 at 2:05pm stated identified urine testing was not performed on the female clients upon return because the Executive Director set up the outing and figured it was okay.

Interview with the Executive Director on 11/14/13 at 11:30am identified that although the policy is upon return from an LOA, a urine test will be completed, urine testing was not completed on the male clients because they were only out for a short time to vote. The facility failed to ensure testing was completed upon the clients returning from an out trip.

The facility failed to ensure the clients were assessed upon return from the LOA.

The following are violations of Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operations(3)(A) and/or (F) and/or (7)(A).

4. Based on review of facility documentation, clinical record review, and interview, the facility failed to assess clients and/or revise the treatment plan as necessary, following an incident at the facility. The findings include:

a. Review of facility documentation dated 11/8/13 identified that Client #1 reported that on 11/5/13 at approximately 7:00 pm she and 11 other female clients were taken by Limousine to City Hall to vote. The documentation identified that inside the vehicle were alcoholic beverages which some of the clients consumed, and that no staff accompanied the clients. Interview with the Director of Clinical Services and the Executive Director on 11/14/13 at 11:30am identified that 14 men also had traveled in the van and/or limousine that evening. Review of the clinical records of Clients #6 and #7 failed to reflect an assessment and/or revisions of the treatment plan following the alleged

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consumption of alcoholic beverages. Additionally, review of the clinical records for Clients #1, 2, 3, 4, 5, 8, 9, 10,11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25, failed to reflect an assessment and/or revisions of the treatment plan following the exposure to alcoholic beverages.

The Following are violations of Regulations of Connecticut State Agencies Section19a-495-570(g) Executive Director (2) and/or (m) Service Operations (3)(A).

5. Based on review of facility documentation and staff interview, the facility failed to ensure a complete investigation was conducted following an incident. The findings include:
a. Review of facility documentation dated 11/8/13 identified that Client #1 reported that on 11/5/13 at approximately 7:00 pm she and 10 other female clients were taken by Limousine to City Hall to vote. The documentation identified that inside the vehicle were alcoholic beverages which some of the clients consumed, and no staff accompanied the clients. Additionally, the documentation identified clients stated that Board Member #1 came onto the women's units and asked if anyone would like to vote, and the clients went with the board member. Further documentation identified that the clients felt it "strange" and felt uncomfortable that they were being videotaped while getting out of limousine. The investigation further identified that that the Executive Director authorized a Board member to transport clients to voting polls and that some of the clients did not sign out as per facility policy. Documentation dated 11/19/13 identified 13 male clients were taken to vote in a limousine, and that upon return although they were searched per facility policy the Clinical Aides failed to perform a urine screen. Further documentation dated 11/19/13 identified that the female clients who got into the limousine after the male clients, stated some of the male clients smelled of alcohol and some of them appeared under the influence.
Interview with the Director of Clinical Services on 11/14/13 at 10:10am identified that she did not interview staff, and/or investigate the male clients going out because there was too much going on. Interview with the Executive Director on 11/14/13 at 11:30am identified that he did not feel an investigation was warranted because clients go to vote every year and the Board member stated there was no alcohol in the vehicles. The facility failed to ensure a complete investigation was conducted.