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

IN RE: Connecticut Renaissance, Inc. of Bridgeport, CT
d/b/a Renaissance East
31 Wolcott Street
Waterbury, CT 06702

CONSENT ORDER

WHEREAS, Connecticut Renaissance, Inc. of Bridgeport, CT, ("Licensee") has been issued License No. SA-0056 to operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons, ("Facility") known as Renaissance East under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted an unannounced inspection on January 30, 2015; and,

WHEREAS, the Department during the course of the aforementioned inspections, identified violations of the Regulations of Connecticut State Agencies in a violation letter dated February 24, 2015 (Exhibit A attached); and,

WHEREAS, an office conferences regarding the February 24, 2015 violation letter was held between the Department and the Licensee on February 26, 2015; and,

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

NOW THEREFORE, the FLIS acting herein by and through Barbara Cass, its Section Chief, and the Licensee, acting herein by and through Marly Le Beau, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Licensed Practitioner ("ILP") pre-approved in writing by the Department by June 1, 2015. The Licensee shall incur the cost of the ILP and any other costs associated with compliance with this Consent Order. Failure to pay the ILP in a timely basis and in accordance with the contract, as determined by the Department in its sole and absolute discretion, shall constitute a violation of this Consent Order. Failure to pay the costs associated with the ILP's duties may result in a fine not to exceed one thousand ($1,000.00) dollars per day until such costs are paid.
2. The duties of the ILP shall be performed by a single individual unless otherwise approved by the Department. The ILP shall function in accordance with the FLIS' 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.
3. 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 Order or under any agreement with the Connecticut Department of Mental Health and Addiction Services.
4. The ILP shall provide consulting services for a minimum of four (4) months at the Facility unless the Department identified through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal or state statutes and regulations. The ILP shall be at the Facility for a total of sixteen (16) hours per week.
5. The ILP shall arrange his/her schedule in order to be present at the Facility at various times on all shifts including holidays and weekends, as applicable. The Department shall evaluate the hours of the ILP at the end of the four (4) 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, based upon any information it deems relevant, that the reduction or increase is warranted. The terms of the contract executed with the ILP shall include all pertinent provisions contained in this Consent Order and shall be submitted for approval by the Department.

6. 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.
7. The ILP shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the hiring of the ILP. During the initial assessment, if the ILP identifies any issues requiring immediate attention, he/she shall immediately notify the Department and the Licensee for appropriate response.
8. The ILP shall confer with the Licensee's Executive Director, Medical Director, Clinical Director and other staff determined by the ILP to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
9. The ILP shall submit written reports every two weeks to the Department documenting:
    a. The ILP's assessment of the care and services provided to patient/residents/clients and recommendations;
    b. The ILP's assessment of the physical environment of care and recommendations;
    c. Whether the Licensee's is in substantial compliance with applicable federal and state statutes and regulations; and,
    d. 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 Executive Director and the Department.
11. The Department, in its absolute and sole discretion, shall retain the authority to extend the period that the ILP services are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of whether the Licensee is able to maintain substantial compliance will be based on the results of the on-site survey inspection and/or

complaint investigations by the Department, the ILP's reports, meetings with the Licensee, other information provided by Licensee and 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. Medication Administration;
    e. Medication Storage;
    f. Resident assessment;
    g. Comprehensive charting;
    h. Comprehensive treatment planning, review, and revisions as necessary;
    i. Protection of Resident/Client Rights;
    j. Supervision of Residents;
    k. Staffing supervision and communication;
    l. Incident investigation and follow up; and
    m. Patient/Resident/Client Resident leave of Absence.

14. No later than June 1, 2015, 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) above.

15. No later than June 15, 2015, all Facility staff shall be in-serviced regarding the policies and procedures identified in paragraph number thirteen (13) above.

16. The ILP, 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 ILP. 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 changes 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 shifts, weekends, and holidays, as applicable.
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 ILP 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 Consent Order. Said individual shall submit monthly reports to the Department regarding the implementation of the Consent Order.

23. The Licensee shall pay a monetary penalty to the Department in the amount of one thousand dollars ($1,000.00) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department with the signed original Consent Order. The money penalty and any reports required by this Consent Order shall be directed to:

Alice Martinez, 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. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law. The allegations and findings contained in Exhibit A shall be deemed true in any subsequent proceeding in which the licensee's compliance with the Consent Order is at issue or the licensee's compliance with Connecticut statutes and regulations and/or with federal statutes and regulations is at issue.

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

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

27. 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 February 24 and March 4, 2015 violation letters referenced in this Consent Order.

28. 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.

29. 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.

30. 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.

31. The Licensee had the opportunity to consult with an 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.

Connecticut Renaissance, Inc. - LICENSEE

By: Marly LeBeau
Marly Le Beau
Chair, Board of Directors

On this 6th day of May, 2015, before me, personally appeared Marly Le Beau who acknowledged herself to be the Chair of the Board of Directors of Connecticut Renaissance, Inc., a corporation, and that she, as such President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by herself as President.

My Commission Expires: April 30, 2017

Notary Public [ ]
Commissioner of the Superior Court [ ]

HOWARD E KELLY JR
Notary Public
Connecticut
My Commission Expires Apr 30, 2017

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

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

Dated this 7th day of May, 2015.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

February 24, 2015

Rachael A. Petitti
Renaissance East
31 Wolcott Street
Waterbury, CT 06702

Dear Ms. Petitti:

An unannounced visit was made to Renaissance East on January 30, 2015 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a review of care and services, with additional information received through February 4, 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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 11, 2015 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

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

2. Date corrective measure will be effected.

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

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

Respectfully,

Alice M. Martinez

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

c: Department of Mental Health and Addiction Services
Licensure File

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 OF VISIT: January 30, 2015

THE FOLLOWING VIOLATIONS 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 (1)(A) Physical Plant (D) General (i)(ii) and/or (F)(viii)(b).

1. Based on review of facility documentation, observation and staff interview for hot water temperatures, the facility failed to ensure the temperatures were maintained safely at 110-120 degrees Fahrenheit. The findings include:
   a. Review of the Facility Inspection Checklists dated 11/22/14, 11/29/14, 12/5/14, 12/12/14, 12/19/14, 12/26/14, 1/2/15, 1/9/15 and 1/16/15 all identified that water temperatures in the dorm restroom were recorded at 178 and 184 degrees Fahrenheit, the second floor client restroom were recorded at 166 and 175 degrees Fahrenheit and the third floor client restroom were recorded as 173, 175 and 176 degrees Fahrenheit.
   Observation of the water temperatures on 1/30/15 at 1:30 PM identified water temperatures of 101 degrees Fahrenheit in the second floor bathroom and 104 degrees Fahrenheit in the third floor bathroom. Interview on 2/3/15 at 2:30 PM with the Director of Quality Improvement identified that she had reviewed the high water temperatures with the Maintenance person and the water temperatures had been adjusted, however the temperature's continued to vary. The Director of Quality Improvement further identified that the documentation indicating that there had been communication with the Maintenance person and the adjustments made to the correct the hot water temperatures could not be provided. The facility failed to maintain hot water temperatures at a safe level. This is a repeated violation from violation letter dated 1/16/14.

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)(viii)(e).

2. Based on observation, and interview, the facility failed to ensure a safe environment and/or maintained the facility in good repair to prevent and minimize all health hazards. The findings include:
   a. During the tour on 1/30/15 with the Program Director the following was identified:

      Broken and/or missing blinds were observed in Rooms #15 and #19 on the third floor.

   b. The second floor in Rooms #1, #2, #3 and #7 were observed to have broken blinds and/or lacked window blinds.

   c. Room #20 was observed to have wall damage and had white compound on the walls, without paint covering.

   d. Room #6 was observed to have a large crack in the wall.

DATE OF VISIT: January 30, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

e. The hallways in the first and second floor had holes in the walls, as did on the second floor stairway landing and the wall to the right side of the back door in the kitchen.

f. Loose wallpaper was identified in hallway near Room #17 on the third floor over the radiator.

g. Room #18 had a hole in the closet door.

h. Bannister rails were missing between the second and third floors.

i. The Group room on second floor had sofa's and twelve chairs that were observed having cushions covered with vinyl, that were split and/or torn.

j. Room #9 on the second floor, had nails that were sticking out of the wall.

k. Review of the Facility Inspection Checklist's identified that holes in the walls, furniture needing repair and/or handrails were included in the facility checklist to be inspected. Review of the documented responses from the period of 11/22/14, 11/29/14, 12/5/14, 12/12/14, 12/19/14, 12/26/14, 1/2/15, 1/9/15 and 1/16/15 identified that although these areas were listed on the checklist to be inspected, the staff that had completed the checklist and had written no and/or yes as requiring repair, but lacked the documentation that the repairs were corrected. Interview with the Program Director on 1/30/15 at 3:00 PM identified these weekly rounds were to be completed and sent to the central office for review. Interview with the Director of Quality Improvement on 2/3/15 at 2:30 PM identified that the Program Director should be completing the facility inspection checklist and should be reviewed by the Director of Residential Care to ensure that this checklist is being completed and followed-up. She further identified this checklist should be reviewed in the quarterly safety meetings.

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

3. Based on observation and interview, the facility failed to maintain the medication room in a sanitary manner and/or failed to ensure the integrity of the medications in the refrigerator. The findings include:
    a. During the tour of the medication room the medication refrigerator was observed unlocked and having a heavy accumulation of semi-liquid matter in the bottom of the refrigerator.
    b. The medication refrigerator lacked a thermometer and the documentation for the monitoring of the temperatures could not be provided.
    c. Two vials of Lantus Regular Insulin for Client #4 and #5, who were identified by staff as having been discharged from the facility were stored in this refrigerator. The refrigerator

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

contained 3 vials of Novolin Regular Insulin that lacked identifying who they had been prescribed for.

d. Two unopened and one partially used vial of Insulin NPH Human for a client, identified from a different program were located in this refrigerator. Interview with the Program Director on 1/30/15 at 3:00 PM identified that the scond Shift Supervisor was responsible for auditing the medication room and that the Program Director had not been made aware of thes issues.

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

4. Based on facility documentation and interview the facility failed to ensure that fire drills were being conducted on a monthly basis, at various times for the safety of the clients and/or failed to documents the participants. The findings include:
    a. Interview with the Program Director on 1/30/15 at 3:30 PM identified that the facility could not provide curent documentation to the surveyor, to indicate that fire evacuation drills were being conducted throughout the building. The facility lacked the documentation of fire drills during the first shift of the first, second, and fourth quarters of 2014 and for the second shifts of the first, second, third and fourth quarter of 2014. In addition documentation provided for third shift, in the from January 2014 through September 2014 lacked indentifying that fire drills were conducted during the hours of sleep. Further interview with the Program Director on 1/30/15 identified why fire drills had not been conducted since September 2014 and could not identify why the fire drills had not been conducted as required on all shifts. This is a repeated violation.
    b. Review of facility Fire Drill/Emergency Evacuation Record and Inspection records dated 7/28/14, 8/17/14 at 9:02 PM, 9/1/14 at 8:30 AM and 9/28/14 at 11:55 AM failed to identify the staff persons in attendance at the fire drill.

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

5. Based on clinical record review and staff interview for 3 of 3 clinical records, the facility failed to ensure that the treatment plans completed by the staff had the clinical oversight supervision and/or failed to ensure the treatment plan had been reviewed with the client and/or signed timely. The findings include:
    a. Client #1 was admitted to the facility on 12/8/14 with diagnoses that included Alcohol Dependence and Bipolar Disorder. Review of the clinical record identified that the treatment plan dated 12/12/14, although signed and dated as such by Client #1, lacked the date of when the master's prepared clinician had signed it. Additionally, the treatment plan identified that a physician had signed this treatment plan on 1/2/15, 11

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

days after the client had signed it.

b. Client #2 was admitted to the facility on 1/5/15 with diagnoses that included Phencyclidine (PCP) abuse. Review of the clinical record identified that although the master's prepared clinician had signed the admission treatment plan dated 1/12/15, it lacked the signature of the licensed staff person and/or physician as directed. Additionally, this admission treatment plan lacked the client's signature ensuring the staff had reviewed it with the client as directed.

c. Client #3 was admitted to the facility on 12/3/14 with diagnoses that included Alcohol dependence. Review of the clinical record identified that the treatment plan dated 12/11/14 and 1/7/15 identified that staff person had signed them. Both treatment plans lacked it lacked the signatures of the licensed staff person and/or physician as directed. Interview on 1/30/15 at 4:00 PM with the Program Director identified that the person providing clinical oversight for the facility had left the position the week prior. The Program Director could not identify the reasons the treatment plans had not been reviewed. She further identified that the Director of Residential Care would be providing the clinical oversight as soon as he received his license which was currently pending.