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

IN RE: Connecticut Renaissance, Inc. of Bridgeport, CT
d/b/a Renaissance West
466 West Main Street
Waterbury, CT 06702

CONSENT ORDER

WHEREAS, Connecticut Renaissance, Inc. of Bridgeport, CT, ("Licensee") has been issued License No. SA-0241 to operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons, ("Facility") known as Renaissance West 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 unannounced inspections commencing on January 29, 2015 and concluding 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, and March 4, 2015, (Exhibit A attached); and,

WHEREAS, office conferences regarding the violation letters were held between the Department and the Licensee on February 5, and February 26, 2015, and March 12, 2015; and,

WHEREAS, the Licensee, while denying any guilt or wrongdoing, 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 Chair of the Board of Directors, 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 two thousand dollars ($2,000.00) 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 S 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 25, 2015

Rachael A. Petitti
Renaissance West
466 West Main St.
Waterbury , CT 06702

Dear Ms. Petitti:

An unannounced visit was made to Renaissance West on January 29, and 30, 2015, by representatives 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 5, 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 March 13, 2015 at 9:00 AM 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,

Alice M. Martinez

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

AMM:mb
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

DATES OF VISIT: January 29 and January 30, 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 (m) Service Operations (7) Staffing (A) and/or (C).

1. Based on facility documentation and interview the facility failed to ensure that supervision and/or supervisory oversight was provided. The findings include:
   a. Review of the Board Meeting dated 11/24/14 identified that labor management had been pivotal in the improvement in the Residential Programs by dramatically reducing the use of per diem staff, accomplished through a combination of a change in budgetary process, where the leadership staff of the residential programs met with the executive team to identify the source of the bugetary losses and as a plan to address them, they designated, the Director of Residential Care so there would be centralized control and accountability of the residential programs. Interview with the second Shift Supervisor #1 on 1/29/15 at 3:20 PM identified she had not received direction from administrative staff to provide coverage as a Program Director, when the previous director left employment in June 2014. The second Shift Supervisor #1 identified that she had emailed the Director of Residential Care and Human Resources but had received no further direction. Interview with the Director of Residential Care on 1/29/15 at 2:02 PM identified that although the facility did not have a Program Director from June 2014 through November 2014, it was not his responsibility but a Human Resources responsibility to staff the position. The facility failed to ensure supervisory oversight was provided.

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) (A) Physical Plant (D) General (i)(ii) and/or (F)(iii) and/or (iv)(g)(i) and/or (a)(e).

2. Based on observations and interviews, the facility failed to ensure a safe environment and/or failed to be maintained in good repair to prevent and minimize all health hazards. The findings include:
   a. During the tour of the facility on 1/29/15 the following was identified:
   Resident rooms' numbers 1 through 25 were observed to have facility owned air conditioner units stored inside the rooms. Interview with Clinician #1 identified the facility owned air conditioner units should be stored in a downstairs storage area.

   b. The facility emergency exit hallways were observed being used as a storage area for air conditioning units.

   c. Observation of the clothes dryers in the 2nd floor and 3rd floor laundry room identified the dryer hose was connected to a wooden board, on the inside of the window sill and inside of the window screen. The dryer hoses which produce heat onto the window screen, was covered/packed with dryer lint.

DATES OF VISIT: January 29 and January 30, 2015

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

d. Observation at 1:00 pm identified a bucket of dirty mop water in the facility's main stairwell at the bottom of the steps leading from the 4th floor. Interview with Clinician #1 at the time identified the mop water should be disposed of after each morning use.

e. Observation of the 2nd and 3rd floor hallways identified dirty and marred walls and the floors were dirty. An interview with Clinician #1 at the time identified the residents of the facility were responsible for the cleaning of the hallways.

f. Room #1 was observed with broken and/or missing floor tiles, holes in the walls, missing radiator covers, rusted radiators, a missing cover on the lights, and the entrance door was dented. The circuit breaker located in the room was unlocked.

g. Room #2 was noted with a damaged and/or cracked bathroom door, the window blinds were broken, the radiator cover was rusted, and the walls had chipped paint. The circuit breaker located in room was unlocked.

h. Room #3 was noted with water damage on the shower ceiling and the entrance door was rusted. The circuit breaker located in room was unlocked.

i. Room #4 was observed with peeling paint on the bathroom walls, food on the dresser and the room lacked a room number on the outside of the entrance door. The circuit breaker located in room was unlocked.

j. Room #5 was observed with chipped paint on the bathroom walls, a rusted bathroom vent, holes in the walls and the window lacked a screen. The circuit breaker located in room was unlocked.

k. Room #6 was observed with a rusted radiator cover, 2 mattresses piled on one bed, a dresser drawer was heavily damaged, a radio on the bathroom sink was plugged into an electric outlet. The circuit breaker located in room was observed unlocked.

l. Room #7 was observed with water damage on the bathroom walls, the shower head was rusted and the window was missing blinds. The circuit breaker located in room was observed unlocked.

m. Room #8 was observed to have the upper portion of the window completely missing and covered with cardboard. Interview with Clinician # identified the window had been broken for over 1 week. The temperature reading in the room taken on 1/29/15 between 2:00pm – 3:00 PM identified the temperature was 67 degrees Fahrenheit. Interview with the Residents # 10 and # 11, who reside in the room identified the temperature in the room was "freezing" at night. Observation of Resident #11 identified being +layered with pajamas, outside clothing and a jacket. The facility was unable to provide documentation that a window had been ordered. Subsequent to an inquiry from the Building Fire and Safety Inspector for the

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

facility's immediate action plan, the facility applied a material to cover the window to ensure acceptable temperatures were maintained until the new window was installed. On 1/30/15, surveyor temperature reading for Room #8 was 74 degree F. On 1/31/15 documentation was forwarded to the Department that identified a requisition dated 1/21/15, for a 33 and 3/4 x 65 window, that would take two weeks to be delivered. As of 2/10/15 this window had not been replaced. Additionally, Room #8 had missing and/or broken floor tiles, holes in the bathroom walls, broken window blinds and missing window screen. The circuit breaker located in room was observed unlocked.

n. Room #9 was noted with a broken radiator cover, rusted radiator, bathroom floor tiles were broken and/or missing, the shower head was leaking, a hole in the bathroom door and the window lacked a screen. Interview with the resident identified the leaking shower head had been leaking for over a week and the resident had taped a plastic bag over the shower head to eliminate the sound of the dripping. The circuit breaker located in room was observed unlocked.

o. Room #10 was observed with peeling paint on the bathroom walls. The circuit breaker located in room was observed unlocked.

p. Room #11 was observed with missing window screens, missing window blinds and a bed sheet being utilized as a blind. The circuit breaker located in room was observed unlocked.

q. Room #12 was observed with heavily damaged, broken and/or missing floor tiles, the door had a cracked door frame and 2 mattresses were observed on a residence's bed. The circuit breaker located in room was observed unlocked.

r. Room #13 was observed with a dresser that lacked drawers and was exposed, the bathroom and shower walls were damaged with holes and water damage, the bathroom floor was dirty, the window lacked a screen and smelled of cigarette smoke. The circuit breaker located in room was observed unlocked.

s. Room #14 was observed with a broken shower curtain, a hole in the wall and there were empty bags of potato chips on floor. The circuit breaker located in room was observed unlocked.

t. Room # 15 was observed with a large hole the in window screen. The circuit breaker located in room was observed unlocked.

u. Room #16's bathroom floor was noted with broken and/or missing floor tiles, the bathroom pipes were rusted, the walls were observed with holes, and the room contained potato chip bags throughout the floor. The circuit breaker located in room was observed unlocked.

DATES OF VISIT: January 29 and January 30, 2015

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

v. Room #17 was observed with a rusted entrance door, graffiti on the entrance door, the dresser had a broken drawer, the radiator was rusted, and soda bottles were on the floor. The circuit breaker located in room was observed unlocked.

w. Room #18 was observed with broken and/or missing bathroom floor tiles and the bathroom door was falling off the hinges. The circuit breaker located in room was observed unlocked.

x. Room #19 was observed with the window blind broken, broken and/or missing bathroom tiles, peeling paint on the walls in the bathroom and the bathroom door was heavily damaged. The circuit breaker located in room was observed unlocked.

y. Room #20 was observed with broken and/or missing bathroom floor tiles, the toilet seat was broken, the shower curtain was broken, the mirror in the bathroom appeared to be damaged from water, the light fixture was missing a cover, the walls were marred and the bathroom radiator was rusted. The windows lacked screens; the floor had soda and snack food debris throughout the room. The circuit breaker located in room was observed unlocked.

z. Room #21 was noted with a rusted bathroom radiator, the walls were marred and the floor was dirty. The circuit breaker located in room was observed unlocked.

aa. Room #22 was observed with soda bottles and other drinks on the floor, the light fixture was missing a light cover and the floor had broken and/or missing floor tiles. The circuit breaker located in room was observed unlocked.

bb. Room #23 was observed with a rusty room radiator, floor tiles were broken and/or missing, the floor was dirty, bathroom tiles were broken and/or missing and the bathroom door was heavily damage. The circuit breaker located in room was observed unlocked.

cc. Room #24 was observed with holes and marred walls and paint peeling off the wall. There were holes in window screen, the window pane was damaged and the floor tiles were missing, and the room's dresser drawers were broken. The circuit breaker located in room was observed unlocked.

dd. Room #25 was observed with a rusty radiator was, the bathroom walls were marred and had water damage, the bathroom sink's fixture was broken exposing sharp edges, and the window blinds were broken. The circuit breaker located in room was observed unlocked.

ee. The 2nd and 3rd Floor laundry rooms had broken and/or rusted radiator covers, the floor tiles were broken and/or missing, the floor was covered with lint, the light fixtures were missing covers, and the ceiling had water damage. The window pane had chipped paint and the windows were covered with dryer lint.

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ff. The client's dining room was observed to have a partial wall partition near the steam table. The partition had wall repair coating without benefit of paint covering the coating and had a missing tile on the floor where the partitioned met the floor.

gg. Observation of the group room on 1/29/15 with Clinician #1, which was located in the basement, identified 6 chairs and four sofas that had the plastic and/or vinyl covering on them split and torn.

hh. The group room had missing floor tiles, loose baseboard molding and large holes in the wall under the television stand.

ii. The television stand was a large cardboard box with videos placed on the floor.

jj. Observation of the exercise room, adjacent to the group room identified a treadmill that was broken.

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 (k) Food Services (4) and/or (5) and/or (m) Service Operations (7) Staffing (A).

3. Based on observation and interview the facility failed to ensure written menus for the minimum of a one week period and/or failed to ensure infection control practices were implemented. The findings include:
   a. Observation of the dining room and other public bulletin boards in the facility failed to identify that a dietary menu was posted. Interview on 1/30/15 with the Dietary Supervisor identified the menu was not posted because the facility was in a fifth week of a four week cycle. Further interview identified that in the fifth week, the leftover freezer food items were used for the meals.

   b. Observation of the food service at the noon meal on 1/29/15 identified four males in the kitchen taking food from the oven, placing pizzas and salad in the dining room and passing out cookies and pears for dessert. Interview with the Kitchen Supervisor on 1/29/15 identified that the four males providing food services were not staff, but clients. The Kitchen Supervisor further identified the lack of food service training documentation for the clients.

   c. Observations on 1/29/15 at 4:15 PM identified the Kitchen Supervisor and four males in the kitchen draining spaghetti in a colander, all persons lacked the benefit of the wearing hairnets and/or hair coverage.

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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) and/or (iii).

4. 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 refrigerators. The findings include:
   a. Observation of the medication room identified the room was cluttered with boxes of copy paper, a biohazard box that contained used syringe containers and buckets of laundry detergent stacked on the floor in front of the medication counter.

   b. The shelves in the medication room contained four boxes of printer items, three buckets of a biohazard material, a box of powdered drink mix, a box of coffee and creamers, and a box full of garbage bags and a box of toilet paper. Crutches and a broom were leaning against the wall.

   c. The medication floor had a heavy accumulation of dirt, laundry powder and debris.

   d. The unlocked refrigerator had a heavy accumulation of ice build-up surrounding the freezer compartment.

   e. An injectable EpiPen 0.3 mg with an unreadable expiration date was located in the refrigerator and appeared frozen. Temperatures of this medication refrigerator were identified not monitored.

   f. The second refrigerator containing urine specimens was unlocked and soiled. Interview with the Case Manager and the Program Director identified the cleanliness of the medication room and the temperatures of the medication and the urine specimen refrigerator had not been monitored. The Program Director could not identify who was responsible to clean the refrigerator's.

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 (i) Personnel Records (3)(F) and/or (m) Service Operations (7) (A) and/or (C).

5. Based on a review of facility documentation and interview for 3 of 6 sampled personnel records reviewed, the facility failed to ensure that annual job performance evaluations were conducted and/or failed to provide supervision and oversight to ensure the evaluations were conducted. The findings include:
   a. Night Watchman #2 was hired on 4/3/09. Review of the personnel file identified the last the job performance evaluation was conducted on 6/19/11. Interview with the Director of Residential Care services on 1/29/15 identified "I just found out he works here."

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

b. The kitchen Supervisor was hired on 7/7/08. Review of the personnel file identified the last job performance evaluation was conducted on 6/24/13.

c. The second Shift Supervisor #1 was hired on 1/5/12. Review of the personnel file identified the last job performance evaluation was conducted on 10/22/12.
Interview with the Second Shift Supervisor on 1/29/15 at 3:20 PM identified she had not received direction from administrative staff to provide coverage as a Program Director, when the previous director left employment in June 2014. Further interview identified she emailed the Director of Residential Care and the Director of Human Resources but received no further direction. Second Shift Supervisor identified she did what could be done to keep the building running and staff evaluations were not conducted. The Program Director identified that two staff persons had been hired during the summer 2014 and although orientation was provided, she was unable to provide documentation the orientation was completed. Interview with the Director of Residential Care on 1/29/15 identified it was not his responsibility to have a plan for covering the Program Director, but Human Resources responsibility to staff the position.

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 (i) Personnel Records (3)(A) and/or (G) and/or (m)Service Operations (7) (A) and/or (C).

6. Based on a review of facility documentation and interview for 3 of 6 sampled personnel records reviewed, the facility failed to ensure orientation of job description and facility policies and procedures was provided. The findings include:
   a. The Program Manager was hired on 10/6/14. Review of the personnel file failed to include a review of the job description and documentation for orientation to the responsibilities of Program Manager.

   b. Case Manager Aide #1 was hired on 7/14/14. The personnel file lacked documentation that an orientation to the job description and facility policy and procedures was provided.

   c. Case Manager #1 was hired on 9/16/14. The personnel file lacked a job description and/or documentation that an orientation to the job description or facility policy and procedures was provided.

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 (D) and/or (g) Executive Director (1)and/or (2) and/or (m) Service Operations (3) Client Records (B) (xiii) and/or (7) Staffing (A) and/or (C).

7. Based on review of the clinical record and staff interview for 1 of 2 clients reviewed for leaving the facility grounds, the facility failed to ensure the safety of the client. The findings include:
   a. Client #1 was admitted to the facility on 10/27/14 with diagnoses that included Opioid

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dependence. An incident report dated 1/19/15 identified Client #1 was outside the facility unsupervised and without staff permission. Review of the clinical record failed to identify why the client was outside unsupervised and failed to identify how the facility addressed the incident with Client #1 and/or facility staff. Review of the treatment plan failed to identify a revision was implemented following the incident. Interview with the Program Director on 1/30/15 identified Client #1 was on tier 1 which indicated he/she could not go outside unsupervised for 30 days. Review of the sign out log which is utilized for clients to sign out when leaving the facility with the Program Director dated 1/19/15 from the hours of 8:30 AM through 3:30 PM (the only documented sign out times) failed to identify Client #1's signed out of the facility. The Program Director identified the case manager on duty was responsible to supervise the client.

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 (m) Service Operations (10)(A) and/or (ii)(iv)(vi).

8. Based on observation of the self-administration of medication and staff interview, the facility failed to accurately record administration of medication and/or ensures medications were self-administered safely. The findings include:
   a. Client #5 was admitted to the facility on 12/17/14 with diagnoses that included Cannabis dependence. Observation of the medication label identified Suboxone sublingual (SL) films 8/2 for administration one and one half films under the tongue every morning and one film in the evening. Review of the Client Medication Form dated 1/22/15 identified 1 strip signed out at 7:30 AM and 1 strip signed out at 4:30 PM. Review of the Client Medication Form dated 1/26/15 identified 1 strip signed out at 7:30 AM and 1 strip at 4:30 PM. The documentation failed to reflect that one and a half strips were taken on 1/22/15 and 1/26/15 as identified on the medication label. Review of Client #5's Medication Form dated 1/29/15 identified eight and one half films were counted at 7:30 AM. The record failed to identify a prescription was obtained to ensure the correct dosage was taken by Client #5. Interview with Night Watchman #2 on 2/2/15 identified the client had taken the correct dose of one and a half strip in the morning on 1/22/15 and 1/26/15, but it had not been documented correctly on the medication form. Review of the Medication policy directed, in part, that following administration, the medication is logged on the client medication distribution form with a date, time, name of medication, dosing dispensed, how administered and signature of the staff member distributing the medication.

   b. Client #6 was admitted to the facility on 12/19/14 with diagnoses that include substance dependence. Observation on 1/30/15 at 1:00 PM identified Client #6 self-administered three (3) Excedrin Extra Strength caplets. Review of the manufacturer's instructions identified to administer two (2) caplets every six hours. Interview with the Case Manger #1 on 1/30/15 identified that he did not know why the client was taking three (3) extra strength Excedrin caplets. Case Manger #1 further identified that over the counter medications are logged, but not recorded on the client individual record when self-administered by the client.

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Furthermore, Case Manger #1 indicated the over the counter medication was not on the individual medication record , therefore, Case Manger #1 had no way of identifying the dose prescribed for the over the counter medication. Review of the Medication policy, in part, directed both prescribed and over the counter medication administration shall be supervised by staff.

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 (D) and/or (g) Executive Director (1) and/or (2) and/or (m) Service Operations (10) (A)(vi) and/or (B)(ii).

9. Based on interview and review of facility documentation, the facility failed to provide staff training of medication administration on a semi-annual basis. The findings include:
   a. Interview with Night Watchman #2 on 2/2/15 identified he did not receive medication administration training in the last six months. Night Watchman #2 could not recall the last time he attended medication administration training. Interview with the Program Director on 1/31/15 identified that she was not aware if medication training was provided to Night Watchman #2 and was unable to provide documentation of any training or a training record for Night Watchman #2.

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 (m) Service Operations (m)(5)(C)(i) and/or (7)Staffing (A) and/or (C).

10. Based on review of the clinical records for 2 of 4 current clients (Client #1 and Client #2), the facility failed to provide a physical examination one month prior or within five days after admission. The findings include:
    a. Client #1 was admitted to the facility on 11/17/14 with diagnoses that included alcohol dependence. Review of the clinical record failed to identify that a physical examination had been conducted of the client.

    b. Client #2 was admitted to the facility on 10/27/14 with diagnoses that included Opioid dependence. Review of the clinical record failed to identify that a physical examination had been conducted for the client.

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 (m) Service Operations (7) Staffing (A) and/or (C).

11. Based on clinical record review and staff interview for 6 of 9 clinical records, the facility failed to ensure clinical oversight supervision for complete assessments and/or discharge plans and/or treatment plans and/or failed to developed a comprehensive treatment plan. The findings include:

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a. Client #1 was admitted to the facility on 11/17/14 with diagnoses that included Alcohol and Opioid Dependence. The Intake Instrument and the Narrative Assessment dated 11/19/14 identified the Intake Coordinator signed the assessment; however, the assessment lacked the signature of licensed clinical staff ensuring that oversight was provided. Review of the Treatment Plan dated 12/24/14 identified that although the treatment plan had been signed by a Master Prepared Clinician, the treatment plan lacked the signatures of a licensed staff and physician as directed.

b. Client #2 was admitted to the facility on 10/27/14 with diagnoses that included Opioid Dependence. The Discharge and Continuing Care Plan dated 1/26/15 was signed by a Counselor, however, lacked the signature of a licensed staff person ensuring clinical oversight.

c. Client #4 was admitted to the facility on 12/9/14 with diagnoses that included Opioid Dependence and Cannabis Dependence. The Intake Instrument and Narrative Assessment dated 12/11/14 identified the Intake Coordinator signed the assessment. This assessment lacked the signature of a licensed clinical staff, ensuring that oversight had been provided. The Treatment Plan dated 1/6/15 was signed by the Client #4 and a staff person, however, the treatment plan lacked the signatures of a licensed staff and the physician signature as directed.

d. Client #7 was admitted to the facility on 6/23/14 with diagnoses that included Opioid dependence. Review of the clinical record identified the Narrative Assessment dated 6/25/14 identified the Intake Coordinator signed the assessment; however, the assessment was not reviewed by the licensed personnel. Review of the Discharge and Continuing Care Plan dated 7/26/14 identified the client had not completed treatment as he/she had abounded from the facility. This discharge plan although signed by the Masters prepared clinician, failed to identify the signature of a licensed clinician.

e. Client #8 was admitted to the facility on 4/16/14 with a history of Heroin and Marijuana dependence. Review of the clinical record identified the Narrative Assessment dated 4/6/14 was signed by the Intake Coordinator, however, lacked the signature of a licensed clinical staff person, to ensure oversight. Review of the treatment plan dated 4/17/14, identified a review on 5/14/14 with the added concern of asthma. The treatment plan failed to reflect interventions were implemented to address the diagnosis of asthma. Additionally, the treatment plan dated 4/17/14 failed to reflect the client signed the care plan, and lacked signatures of a licensed staff and the physician. Review of the treatment plan dated 7/9/14 although signed by the licensed clinician, lacked the signature of the physician. Review of the Discharge and Continuing Care Plan although signed by a Masters prepared Counselor, lacked the signature of a licensed staff person ensuring clinical oversight.

f. Client #9 was admitted to the facility on 4/15/14 with diagnoses that included Opioid dependence, Alcohol dependence and Cannabis dependence. Review of the clinical record

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identified the Narrative Assessment dated 4/15/14 was signed by the Intake Coordinator, however, lacked the signature of a licensed clinical staff person to ensure oversight. The treatment plans dated 4/14/14, 5/12/14 and 7/14/14, identified client and master prepared clinician signature, however, the treatment plans lacked the signatures of a licensed staff and physician to ensure clinical oversight. Review of the Discharge and Continuing Plan dated 7/18/14 identified a signature by the Masters prepared Counselor, however, lacked the signature of a licensed staff person ensuring clinical oversight.

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (j) Environment (1) Physical Plant.

1. On 1/29/15 at 2:30 PM., during document review and a tour of the facility, while accompanied by the Maintenance Tech and West Director, the following observations were identified:

a. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the battery powered, emergency light fixtures located throughout the building were being tested annually (90-minute), as required by the CFSC, Part IV, 33.3.2.9; i.e. no documentation of number of devices, location of devices and results of testing for 2014; Note this is a repeat violation, from violation letter dated June 22, 2011.

b. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the battery powered, emergency light fixtures located throughout the building were being tested monthly (30-seconds), as required by the CFSC, Part IV, 33.3.2.9; Note this is a repeat violation, from violation letter dated June 22, 2011.

c. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the fire alarm has been tested/inspected within the last year, as required by NFPA 72 & the CFSC, Part IV, 33.3.3.4.1; i.e. reports lacks the required location and serial number of Initiating and Supervisory Device Tests and Inspection; Note this is a repeat violation, from violation letter dated June 22, 2011.

d. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the smoke detectors that are connected to the fire alarm throughout the building have been sensitivity tested within the last 2 years, as required by NFPA 72 & the CFSC, Part IV, 33.3.3.4.1; documentation provided indicated that there are nineteen (19) Photo Detectors, lacking locations, and sixteen (16) smoke detectors were tested for sensitivity during four inspection and testing conducted throughout 2013. Note this is a repeat violation, from violation letter dated June 22, 2011.

e. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that fire evacuation drills were being conducted throughout the building as required by the CFSC, Part V, 20.5.2.3; i.e. no documentation of fire drills during the first shift of the third quarter of 2014 and for the first, second and third shifts of the fourth quarter of

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2014. In addition documentation provided for third shift drills indicated that at least two (2) drills were not conducted when the residents were asleep; Note this is a repeat violation, from violation letter dated June 22, 2011.

f. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the emergency generator was being inspected weekly and tested under load monthly, as required by the CFSC, Part V & NFPA 110; Note this is a repeat violation, from violation letter dated June 22, 2011.
The surveyor while accompanied by the West Director observed that the sectional, floor valves/drains on each story had not been connected or piped to allow for drainage of individual floors or flow alarm testing, as required by the CFSC, Part V, NFPA 13 & 25; i.e. no physical way to drain water from piping unless entire sprinkler system is shut off & no physical way to test water flow alarms throughout building; Note this is a repeat Citation from survey conducted on 06/16/11.

g. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the 5th year, preventative maintenance items had been conducted on the sprinkler system, as required by the CFSC, Part V, NFPA 25;i.e. no reports of internal obstruction investigation, check valve & strainer inspections, etc.; Note this is a repeat violation, from violation letter dated June 22, 2011.

h. The West Director and/or the Maintenance Technician did not provide documentation to the surveyor to indicate that the automatic sprinkler system had been inspected on a quarterly basis during the past twelve (12) months by an authorized service company as required by CFSC, Part V and NFPA 25; i.e., first quarter, third quarter and fourth quarter inspection reports were not available.

i. The surveyor while accompanied by the Dietary Director observed that the ceiling in the Dietary cooking area did not promote the maintenance of a sanitary condition; i.e., the ceiling tiles and metal grid were laden with an accumulation of grease.

j. The facility did not ensure that Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits as required by the CFSC; i.e., the rear exit stairway landings were being used for the storage of portable air conditioning units and construction materials.