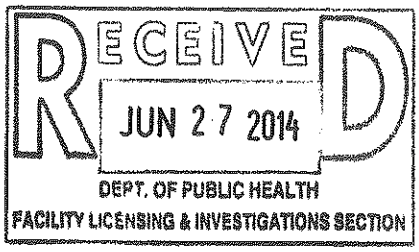
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

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,

Chermichaud RN

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

CM

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

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

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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).

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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

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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

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

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.

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

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.

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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.