

**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 AGREEMENT

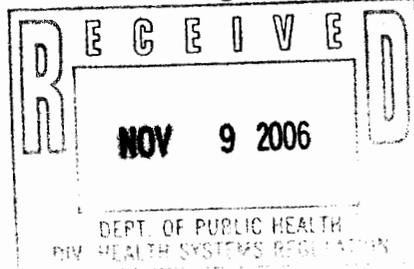
WHEREAS, Crossroads, Inc. (hereinafter the "Licensee") located at 54 East Ramsdell Street, New Haven, CT 06515 has been issued License No.0086 to operate a facility for the care or the treatment of substance abusive or dependent persons (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Department's Facility Licensing and Investigations Section ("FLIS") conducted unannounced inspections commencing on February 10, 2006, March 3, 2006 and March 16, 2006 at the Facility for the purposes of conducting a complaint investigation; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in a violation letter dated April 5, 2006 (Exhibit A – copy attached); and

WHEREAS, an office conference regarding the April 5, 2006 violation letter was held between the Department and the Licensee on April 11, 2006, and

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



NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan D. Leavitt, its Section Chief, and the Licensee, acting herein by Miguel Calder, Executive Director, hereby stipulate and agree as follows:

1. Crossroads agrees not to reinstitute the woman and children's reunification program located at 54 East Ramsdell Street, New Haven, CT without prior notification to the Department of Public Health, Facility Licensing and Investigations Section.
2. Crossroads has consulted with an attorney prior to signing this Consent Agreement.

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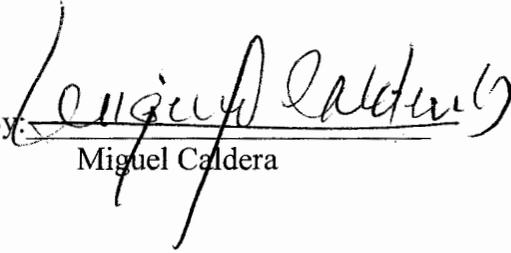
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IN WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed, which Consent Agreement is to be effective immediately upon the signature of a representative of the Department.

By: 
Miguel Caldera

Personally appeared the above named Miguel Caldera on November 7th, 2006, and made oath to the truth of the statements contained herein.

My Commission Expires Feb. 28, 2008 
Notary Public
Commissioner of the Superior Court

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

11/15/06
Date


Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 6

April 5, 2006

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

Dear Mr. Caldera:

Unannounced visits were made to Crossroads Inc on 54 East Ramsdell Street, New Haven, CT on February 10 and March 3, 2006 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 March 16, 2006.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for April 11, 2006 at 2:00 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney 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.

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

Respectfully,

Cher Michaud, RN (BSC)

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

CM

c: Department of Mental Health and Addiction Services
licensure file
CT5063



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: March 16, 2006

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 Connecticut State Agencies Section 19a-495-570(f) Governing Authority and Management(3)(A).

1. Based on interviews, reviews of facility documentation and a client record, the facility staff failed to respond to non-compliance with established program rules concerning children who reside in the treatment program. The finding included:

- a. Review of facility documentation "Program Rules" identified that no child of any age is allowed to sleep in a mother's bed and that non-compliance with program rules regarding child supervision will have program consequences. Client #1 had a diagnosis of substance abuse. On 10/12/05 Client #1 gave birth to a premature infant with diagnoses including respiratory distress, presumed infection and cocaine exposure. On 11/23/05 the infant was "reunited" with his mother at the facility. Facility documentation dated 11/29/05, identified that at 6 am Client #1 was discovered to be sleeping in bed with the baby. The notes further identified "the client sat up not realizing that the infant was next to her and put her hand on top of the baby."

Interviews with Client #1 on 2/10/06 and Client #2 on 3/3/06 identified that on 12/6/05 Client #1 had fallen asleep with the infant in her bed. Client #2 awoke at approximately 2:39 am and noticed the infant was not in his bassinet but lying in the Client #1's bed. Client #2 approached the infant with plans to return him to the crib, but noticed the infant was not breathing. Client #2 ran out of the room to call for help. Cardiopulmonary Resuscitation (CPR) was initiated and the emergency response system was activated. The infant was transported to the hospital where he was pronounced deceased.

An interview with the program director and a review of facility documentation identified that clients were monitored hourly for compliance with facility policies. An interview with Client #1 on 2/10/06 identified that she occasionally fell asleep in her bed with her infant in during a feeding.

Plan of CorrectionCompletion Date

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570 (i) Personnel Practices(6)(B).

2. Based on interview and a review of facility documentation, the facility failed to ensure that staff members received annual Cardiopulmonary Resuscitation (CPR) retraining. The findings include:
 - a. Attendant #1 identified that on 12/06/05 at about 2:37 am Client #1's infant was noted not to be breathing and had no pulse. Attendant #1 began CPR and the emergency response system was

DATE(S) OF VISIT: March 16, 2006

EXHIBIT A

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

activated. The infant was transported to the hospital where he was pronounced deceased. Facility policy identified that staff members must maintain current Red Cross CPR certification. A review of Attendant's #1's employee file failed to identify any documentation related to CPR certification. An interview with the Program Director on 2/10/06 identified that the facility provided CPR retraining annually but lacked a mechanism to ensure that all staff certification was current.

Plan of Correction:

Completion Date:

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570 (j)Environment(2)(A).

- 3. Based on interview and a review of the facility policies, the facility failed to develop a comprehensive evacuation policy. The findings include:
 - a. Review of the facility fire and disaster plan failed to identify the procedure for the evacuation of all occupants including clients, visitors and children residing with clients in the building.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: March 16, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570(m) Service Operations(3)(E).

4. Based on interview and a review of the clinical record, for one client the facility failed to ensure that medications were listed in the clients record. The findings include:
 - a. Client #1 had a diagnosis of substance abuse. Although Client #1 received daily Methadone daily, which was administered at an ambulatory clinic, the client's record failed to identify the Methadone dosage Client #1 received daily. An interview with the Program Director identified that although frequent dialogue between the facility's staff and other providers occurred, the facility did not have a formal mechanism for communication with other agencies.

Plan of Correction:

Completion Date:

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operations(3)(A).

5. Based on record review and interview, the facility failed to provide evidence of an assessment of the clients ability to care for another individual in her care while receiving active substance abuse treatment. The findings include:
 - a. Review of facility documentation "Program Rules" identified that no child of any age is allowed to sleep in a mother's bed and that non-compliance with program rules on child supervision will have program consequences. Client #1 had a diagnosis of substance abuse. On 10/12/05 Client #1 gave birth to a premature infant with diagnoses including respiratory distress, presumed infection and cocaine exposure. On 11/23/05 the infant was "reunited" with his mother at the facility. Facility documentation dated 11/29/05, identified that at 6 am Client #1 was discovered to be sleeping in bed with the baby adjacent to her. The notes further identified "the client sat up not realizing that the infant was next to her and put her hand on top of the baby." Although the notes of 11/29/05 identified the possibility that her nighttime medications required adjusting, no changes were addressed. Subsequent notes dated 12/2/05 for the 11 pm to 7 am shift identified that at 2:30 am Client #2, who shared a room with Client #1, was awake and caring for Client #1's infant.

DATE(S) OF VISIT: March 16, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

Client #2 stated that Client #1 was "knocked out from her medication and couldn't hear the baby crying." Client #2 fed and changed the infant.

Client #1 went out on regular basis for substance abuse treatment. According to facility staff the clients would either take the child with them, leave them in the "therapeutic nursery" or leave them with another client at the facility. Review of Client #1's record failed to provide evidence that the facility assessed the client to determine that the current treatment plan was appropriate for the client actively caring for an infant in this setting and /or that the client was able to make appropriate decisions for the care of this infant at the time.

Plan of Correction:

Completion Date:

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570(m)Service Operations (6)(A)(ii).

6. Based on interview and a review of the clinical record, for one client the facility failed to ensure that the plan of care was revised to include interventions to meet the demands of the care of a new born who was medically compromised and was receiving home health services until transfer to the facility. The findings include:
 - a. Client #1 had a diagnosis of substance abuse. On 10/12/05 Client #1 gave birth to a premature infant with diagnoses including respiratory distress, presumed infection and cocaine exposure. On 11/23/05 the infant was "reunited" with his mother at the facility. On 11/29/05 facility documentation identified that at 6 am the client was noted to be sleeping in bed with the baby adjacent to her. The notes further identified the client sat up not realizing that the infant was next to her and put her hand on top of the baby. Facility documentation dated 12/2/05 for the 11 pm to 7 am shift identified that at 2:30 am Client #2, who shared a room with Client #1, was awake and

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caring for Client #1's infant. Client #2 stated that Client #1 "was knocked out from her medication and could not hear the baby crying" Client #2 fed and changed to infant.

Although Client #1's responsibilities included active participation in daily therapies as well as night time feedings and care of her infant, no changes were identified in Client #1's plan of care to address the demands related to the care of a newborn on a client participating in active treatment for substance abuse.

Plan of Correction:

Completion Date:

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-495-570 (f) Governing Authority and Management (1).

- 7. Based on observation, record review and interviews the facility failed to be licensed by the Department of Public Health for all the services provided. The findings include:
 - a. The facility has a license issued by the Department for a 109 bed private freestanding facility for the care or the treatment of substance abusive or dependant persons. A tour of the building identified a census of 92 adults. Futher review identified that infants/children have and currently occupy non-licensed beds. According to facility staff, the infants/children are the responsibility of the clients of the facility. The clients can utilize the "therapeutic nursery" during the day when they need to go out to an appointment or attend a group meeting. The facility provides items to the clients to care for the infants/children. On 12/5/2005 it was noted that the staff administered cardiopulmonary resusitation to an infant, who resided with a client, who was noted to be not breathing.

Plan of Correction:

Completion Date:

Provider/Representative

Title

Date