

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

IN RE: Rushford Center, Inc. of Meriden, CT d/b/a

- Rushford Center
25 Marlborough Street
Portland, CT 06480
- Rushford Center, Inc
883 Paddock Avenue
Meriden, CT 06450
- Rushford Center, Inc
1250 Silver Street
Middletown, CT 06457
- Rushford Center, Inc
325 Main Street
Portland, CT 06480

CONSENT ORDER

WHEREAS, Rushford Center, Inc. (hereinafter the "Licensee"), has been issued Licenses to operate a Facility for the Care and Treatment of Substance Abusive or Dependent Persons under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the facilities are identified as follows:

- Rushford Center, Marlborough Street, Portland (Facility 1) License No. 0303
- Rushford Center, Inc., Paddock Avenue, Meriden (Facility 2) License No. 0292
- Rushford Center, Inc., Silver Street, Middletown (Facility 3) License No. SA0090
- Rushford Center, Inc., Main Street, Portland (Facility 4) License No. 0304

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on September 13, 2005 and concluding on June 5, 2006; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated December 22, 2005 (Exhibit A – copy attached), March 3, 2006 (Exhibit B – copy attached), April 20, 2006 (Exhibit C – copy attached), July 13, 2006 (Exhibit D – copy attached), and August 23, 2006 (Exhibit E – copy attached); and

WHEREAS, the execution of this Consent Order does not constitute any admission or adjudication of any violation of the Public Health Code by the Licensee, its agents or employees, or any other person or entity.

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 and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Jeffrey Walter, its Executive Director, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.
2. The INC shall function in accordance with FLIS' INC Guidelines (Exhibit F – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of six (6) months at the Facilities unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable state statutes and regulations. The INC shall be at the Facility twelve (12) hours per week for Facilities 1, 3 and 4 and four (4) hours per week for Facility 2 and shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts, as applicable, including holidays and weekends. The Department will evaluate the hours of the INC

at the end of the three (3) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.

4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department initial assessments of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the contract is approved by the Department.
6. The INC shall confer with the Licensee's Administrator, Director of Nursing Services (Facility 3), and other staff determined by the INC to be necessary to the assessment of nursing and clinical services and the Licensee's compliance with state statutes and regulations.
7. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services (Facility 3), Director of Clinical Services and Medical Director for improvement in the delivery of direct client care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
8. The INC shall submit weekly written reports to the Department documenting:
 - i. the INC's assessment of the care and services provided to clients;
 - ii. the Licensee's substantial compliance with applicable state statutes and regulations; and
 - iii. any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the Director of Nurses (Facility #3), Administrator and Medical Director.
10. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct client care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, clinical staff, and mental health workers and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;

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- b. Assessing, monitoring, and evaluating the coordination of client care and services delivered by the various health care professionals providing services;
 - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
 - d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letters dated December 22, 2005, March 3, 2006, April 20, 2006, July 13, 2006 and August 23, 2006 (copies attached).
11. The INC, the Licensee's Administrator, Director of Clinical Services and the Director of Nursing Services (Facility 3) shall meet with the Department every four (4) weeks 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 state statutes and regulations.
 12. Any records maintained in accordance with any state law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
 13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with state laws and regulations. Determination of substantial compliance with state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
 14. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator, Director of Nursing Services (Facility 3) and Director of Clinical Services shall ensure substantial compliance with the following:
 - a. Sufficient qualified staff to include nursing personnel, are available to meet the needs of the clients;
 - b. Client treatments, therapies and medications are administered/delivered as prescribed by the physician and in accordance with each client's comprehensive treatment plan;
 - c. Client assessments are performed in a timely manner and accurately reflect the condition of the client;

- d. Each client care plan is reviewed and revised to reflect the individual client's problems, needs and goals, based upon the client assessment and in accordance with applicable federal and state laws and regulations;
 - e. Staff assignments accurately reflect client needs;
 - f. Programming including group sessions are directed by qualified personnel;
 - g. The personal physician or covering physician is notified in a timely manner of any significant changes in client condition including, but not limited to, deterioration of mental and/or physical status, a change in behavior, a decline and/or request for a change in frequency of services and non-compliance with the treatment plan. In the event that the personal physician does not adequately respond to the client's needs or if the client requires immediate care, the Medical Director is notified;
 - h. Provide necessary supervision and services;
 - i. Policies and procedures related to treatment plan development, clinical services, request for services, discharge, benefit investigation and physician notification will be reviewed and revised as necessary;
 - j. Critical incidents are thoroughly investigated, tracked, and monitored; and
 - k. Fire safety policies and procedures are reviewed and revised as necessary. Staff shall be inserviced on these policies and implementation monitored.
15. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said time frame.
16. The Licensee shall maintain a Quality Assurance Program (QAP) to review resident care issues including those identified in the December 22, 2005, March 3, 2006, April 20, 2006, July 13, 2006 and August 23, 2006 violation letters. The members of the QAP shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Clinical Services, Director of Nurses (Facility 3), Clinical Supervisors, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

17. In accordance with Connecticut General Statute Sections 19a-494 (4) and 19a-494 (7) the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee and orders the Licensee to comply with all statutory and regulatory requirements pertaining to the operation of a Private Freestanding Facility for the Care and Treatment of Substance Abusive or Dependent Persons.
18. The Licensee shall pay a monetary penalty to the Department in the amount of Seven Hundred and Fifty dollars (\$750.00) for Facilities 1, 3 and 4 and Two Hundred and Fifty dollars (\$250.00) for Facility 2, by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:
- Cher Michaud
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12FLIS
Hartford, CT 06134-0308
19. 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.
20. The execution of this document 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.
21. 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 document.

22. 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 Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

23. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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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.

RUSHFORD CENTER, INC OF MERIDEN, CT - LICENSEE

11-8-06
Date

By: Jeffrey Walter
Jeffrey Walter, Executive Director

STATE OF Connecticut

County of New Haven) ss NOV. 8 2006

Personally appeared the above named Jeffrey WALTER and made oath to the truth of the statements contained herein.

My Commission Expires: 04/30/09
(If Notary Public)

Sandra M. Rasch
Notary Public [x]
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

11/9/06
Date

By: Joan D. Leavitt
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 3

December 22, 2005

Jeffrey Walter
Rushford Center Inc
384 Pratt Street
Meriden, CT 06450

Dear Mr. Walter:

An unannounced visit was made to Rushford Center Inc, 43 St. Casimir Drive, Meriden, CT on December 14, 2005 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

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 January 5, 2006 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address the 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

Cher Michaud (BSC)

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

CM

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
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DATE(S) OF VISIT: December 14, 2005

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

The following are violations of the Connecticut Public Health Code Section 19a-495-570 (j)
Environment (1)(A)(ii).

1. Documentation was lacking that any of the required eight quarterly sprinkler inspections were done over the past two years.
2. An approximately two inch void was observed in the wall of the kitchenette from the countertop to the ceiling.

Plan of Correction:

Completion Date:

The following are violations of the Connecticut Public Health Code Section 19a-495-570 (j)
Environment (2)(A)(v) and (vii).

3. Documentation was lacking that sixteen of the required twenty-four monthly fire drills had been done over the past two years.
4. Documentation was lacking that the first aid supplies had been checked over the past two years.

Plan of Correction:

Completion Date:

DATE OF VISIT: December 14, 2005

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 Connecticut Public Health Code Section 19a-495-570 (m) Service Operations (6((A)(i).

5. For three of four client records reviewed, the facility failed to develop an Individualized Program Plan. (e.g.the facility was utilizing the program plans from the client's previous treatment facility).

Plan of Correction

Completion Date

Provider/Representative

Title

Date



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B
PAGE 1 OF 3

March 3, 2006

Jeffrey Walter
Rushford Center Inc
384 Pratt Street
Meriden, CT 06450

Dear Mr. Walter:

An unannounced visit was made to Rushford Center Inc, Middletown, CT on January 31, 2006 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an inspection.

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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 17, 2006 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

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

CM

c: Department of Mental Health and Addiction Services
licensure file



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DATE(S) OF VISIT: January 31, 2006

EXHIBIT B

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 Connecticut Public Health Code Section 19a-495-570(l) Accident or Incident Reports(2).

1. For one resident who received medication in error and required treatment in the emergency department, the facility failed to notified the Department of the incident. Resident #1 was admitted to triage on 1/17/06 and was identified to have a drug allergy to Motrin. Physician standing orders dated 1/18/06 failed to identify the allergy and Motrin 600 mg was administered by the nurse on duty on 1/20/06 in error. The resident was medicated with Benadryl 50 mg and was examined in the emergency department after complaints of being short of breath, choking and feeling "itchy".

Plan of Correction:

Completion Date:

The following is a violation of the Connecticut Public Health Code Section 19a-495-570 (m) Service Operations (6)(A)(ii).

2. For one resident who received medication in error and required treatment in the emergency department, the facility failed to include the incident on the master treatment plan. Resident #1 was admitted to triage on 1/17/06 and was identified to have a drug allergy to Motrin. Physician standing orders dated 1/18/06 failed to identify the allergy and Motrin 600 mg was administered by the nurse on duty on 1/20/06 in error. The resident received Benadryl 50 mg and was examined in the emergency department after complaints of being short of breath, choking and feeling "itchy. Although the medication administration record identified the resident had an allergy to Motrin, subsequent standing orders and the master treatment plan of 1/24/06 also failed to identify the resident any allergies.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: January 31, 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 Connecticut Public Health Code Section 19a-495-570(m)(5) (C)(i).

- 3. For three of six residents in the intensive, intermediate and long term treatment program the facility failed to ensure that the resident had documentation of a recent physical examination not more than one month prior to admission and/or five days post admission.

Plan of Correction:

Completion Date:

The following is a violation of the Connecticut Public Health Code Section 19a-495-5709(m) Service Operations(9)(E)(i)(a).

- 4. Six of nine residents records reviewed failed to identify that practitioner countersigned physician's verbal orders within 48 hours.

Plan of Correction:

Completion Date:

The following is a violation of the Connecticut Public Health Code Section 19a-495-5709(m) Service Operations(9)(E)(iii)(b).

- 5. For one resident who received medication on an "as needed basis" (Motrin) the facility failed to complete a corresponding entry in the nurse's notes including but not limited to the subjective symptoms, or complaints, the time, dose route of administration and the results of the medications and the nurse's signature.

Plan of Correction:

Completion Date:

Provider/Representative

Title

Date



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT, C
PAGE 1 OF 14

April 20, 2006

Jeffrey Walter
Rushford Center
384 Pratt Street
Meriden, CT 06450

Dear Mr. Walter:

Unannounced visits were made to Rushford Center, 25 Marlborough Street, Portland, CT on January 10, 12, 13, 17, 19, and March 23, 24 and 27, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection and multiple investigations.

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.

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 May 3, 2006 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

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

CM

c: Department of Mental Health and Addiction Services
licensure file
CT5034, CT5288



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DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 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 (c) Licensure Procedure (4)(D):

- 1. Based on observation and staff interview the facility failed to post the license issued by the Department of Public Health in a conspicuous place accessible to the public. The findings include:
 - a. During a tour of the facility on January 10, 2006, the facility's license to provide care or treatment to substance abusive or dependent persons was not posted as required. The staff on duty were unable to locate the license anywhere in the facility.

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 (3) and/or (3)(A).

- 2. Based on staff interviews the facility failed to provide planned activities. The findings include:
 - a. Review of the Residential Group Activity Schedule identified that from 3-4 PM and 4-5PM on Saturdays, a "recreation activity" was to occur. An interview with Clinical Service Attendant (CSA) #3 on 1/12/06 identified that staff attempted to conduct a group activity on Saturday 1/7/06 but could not do so because the gym was locked and the gym keys were not available to staff.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 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).

- 3. Based on record review, review of facility documentation and staff interview the facility failed to notify the local police department of an alleged sexual assault and/or potential illegal activity in a timely manner. The findings include:
 - a. Review of facility documentation identified that on 1/7/06 Client #1 alleged to staff that he was sexually assaulted by (four) 4 other clients. Interview on 1/12/06 with Clinical Service Attendant (CSA) #2 identified that he was instructed by the Associate Director not to call the police at the time the alleged incident was reported to CSA #2.
 - b. Interview on 1/12/06 with the Program Supervisor identified that on 12/1/05, (two) 2 clients (Clients # 10 and 11) reported to him that Client #8 was having an inappropriate relationship with a staff member and that this information was conveyed to the Associate Director. Reviews of the clinical record and facility documentation failed to identify that the police were notified of this alleged incident.
 - c. In an interview on 1/17/06 the Program Supervisor identified that Client #6 alleged to him that Client #1 touched him inappropriately. Reviews of the clinical record and facility documentation failed to identify that the police were notified of the allegation.
 - d. On 3/24/06, during an interview, the Associate Director of Nursing (ADNS) reported that the facility (Facility#1) had received a phone call stating that Client #2 tested positive for heroin upon admission to treatment facility (Facility#2). Subsequent to facility inquiry, clients "let it be known" that that they knew about Client #2 obtaining heroin prior to the notification. Client #2 had allegedly stolen the electronic game which was a gift to the facility and had sold it for 10-12 bags of heroin. The ADNS stated that the other clients must have assisted Client #2 with his exit and entrance back into the locked building. The ADNS stated that Client #2 had left without permission after receipt of the game. There was at least one occasion that the client was found outside smoking and notes that identified "suspicious behavior" on 1/1/06. On 3/24/06 the ADNS also reported that this was not a locked campus and that clients are able to exit on their own. If they do leave without permission, the police and other parties are notified. Clients are allowed to make phone calls and staff only intercede if they hear something suspicious. Additionally the ADNS indicated that it is possible for clients "to arrange to buy drugs, leave and get it and return to the facility." Interview identified that the facility did not notify the police of the incident. Interview with the Associate Director of Adolescent Services identified that when a client leaves the program for an unauthorized leave the police are notified.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 2006

EXHIBIT C

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 (i) Personnel Policies (3)(D).

4. Based on a review of facility information and staff interview the facility failed to obtain past employment reference checks for one of three Clinical Service Attendants (e.g. CSA) reviewed. The findings include:
- a. A review of the personnel file of CSA #1 identified the facility failed to obtain past employment reference checks. An interview with the Director of Human Services on 1/12/06 failed to identify the reason the references were not obtained.

Plan of Correction:

Completion Date:

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

5. Based on a review of facility information and staff interviews the facility failed to report incidents regarding clients and services to the Department of Public Health and/or failed to report the incident in a timely manner. The findings include:
- a. Review of Client # 8's clinical record identified that on 12/1/05 Client's # 10 and 11 alleged that Client #8 was having an inappropriate sexual relationship with a staff member. Review of facility documentation and interview failed to identify that the facility notified the Department of the allegation.
 - b. In an interview on 1/17/06 the Program Supervisor identified that Client #6 alleged to him that Client #1 touched him inappropriately. Review of facility documentation failed to identify that the facility notified the Department of the allegation.
 - c. On 1/10/06 the Department received a facsimile dated 1/9/06 regarding an alleged sexual assault of a client which occurred on 1/7/06. The facility failed to notify the Department immediately by telephone.
 - d. Review of facility documentation identified that on 11/27/05 Client #2 went to a local drug store to "allegedly steal Robitussin and Benadryl." On 11/27/05, Client #2 was observed with slurred and incoherent speech, sweating and dilated pupils. Client #2 was transported to the emergency room where he remained overnight. Staff documentation reflected that the client had a Benadryl overdose. Further review failed to identify that the Department was notified of the

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 2006

EXHIBIT C

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

incident.

e. During a tour of the facility on March 23, 2006, the Director of Facilities identified that on October 14, 2005, a client had pulled a wall mounted thermometer off the wall resulting in the spillage of Mercury. The Department of Environmental Protection was notified and a private company was hired to perform the clean-up. Further interview with the Director of Facilities identified that the Department of Public Health had not been notified nor had the facility initiated an incident report.

Plan of Correction:

Completion Date:

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

6. Based on Clinical record review, review of facility documentation and interview, the facility failed to provide documentation of an assessment of a client after an alleged incident. The findings include:
 - a. Review of facility documentation identified that on 1/7/06 Client #1 alleged that four other Clients (Clients # 2,3,4 and 5) sexually assaulted him. Review of the clinical record failed to identify that facility staff conducted an assessment to determine the client's mental or emotional status after the incident. An interview on 1/17/06 with the Program Supervisor identified that the staff were instructed not to talk to the clients regarding the incident.
 - b. Review of facility documentation identified that on 1/7/06 Clients # 2, 3, 4 and 5 allegedly sexually assaulted Client #1. Review of Clients # 2,3,4 and 5's clinical records failed to identify that the staff conducted an assessment to determine the clients' emotional or mental status after the incident. An interview on 1/17/06 with the Program Supervisor identified that staff were instructed not to talk to the clients regarding the incident.
 - c. In an interview with the Program Supervisor on 1/17/06, the Program Supervisor identified that Client #6 alleged to him that Client #1 touched him inappropriately. Review of Client #6's clinical record failed to identify that staff assessed the client after the report of the incident.
 - d. A review of an Incident Report dated March 20, 2006 identified Client #5 twisted an ankle while playing with peers in the gym at 8:00pm. Clinical Service Attendants accompanying the group

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 2006

EXHIBIT C

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

examined Client #5's right lower extremity and gave him ice to apply. A telephone interview with the Associate Director of Nursing on April 5, 2006 identified that the client's right lower extremity was first assessed by medical personnel on March 21, 2006 by Licensed Practical Nurse (LPN) #1. Subsequently, an appointment was made with the Connecticut Children's Medical Center for March 22, 2006. Review of facility documentation failed to identify that the client was assessed by a qualified individual in a timely manner and/or that the physician was notified of a change in condition in a timely manner.

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)(C) and (6)(A).

7. Based on a review of client records and client and staff interviews, the facility failed to develop an individualized treatment plan and/or revise the treatment plan based on the clients needs. The findings include:
 - a. Client #1 was admitted to the facility on 11/22/05 with a diagnosis of Oppositional Defiant Disorder. The Admission/Intake Summary dated 11/22/05 identified problems including poly-substance use, unable to control anger, running away, difficulties in school, and homicidal and suicidal ideation in the past. The initial Treatment Plan dated 11/22/05 identified problems of substance abuse, aggressive behavior, and depression. Further review of the treatment plan failed to identify the additional areas were addressed.
 - b. Client #2 was admitted to the facility on 6/17/05 with a history of of poly-substance abuse, bipolar disorder, defient of school rules, theft and a desire to leave the program. Review of the current (as of 1/17/06) Treatment Plan identified substance abuse, family relational problems, anger

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and limited communication as problems. Further review failed to identify the history of theft and the desire to leave the facility and/or interventions to address such.

- c. A review of the communication log reflected that on 10/9/05 Client #2 was overheard "whispering about trying to bring something in after his pass" that was scheduled for 10/10/05. The unsigned log note advised staff to be vigilant upon his return, however the treatment plan was not revised or interventions developed. On 10/10/05 upon return from the pass, Client #2 tested positive for THC (cannabis). On 3/24/06 Clinician#1 reported that those comments made by the client would have been grounds to revoke the pass.
- d. Client #2 was admitted to the facility on 6/17/05. Diagnoses include polysubstance abuse and bipolar disorder. Client #2 had positive urine tests for THC (cannabis) on 10/10/05, 10/29/05, 11/12/05, 11/25/05 and 12/26/05. All positive results were obtained after passes (leave of absence) with family members. A review of the treatment plan update dated 10/11/05 identified that the client reported that he had used cannabis over the week-end, however the treatment plan was not revised. On 3/24/06 an interview with the Associate Director of Nursing reflected that interventions may be found in various locations i.e. clinician notes, incident reports, rounds sheets and/or the communication log book. Revisions are not necessarily made on the treatment plan. The facility failed to provide a consistent system of revising the Treatment Plan and communicating the changes to the staff.
- e. Client #2 was admitted to the facility on 6/17/05. The 6/17/05 admission/intake summary reflected that the client smoked two packs a day for the past 6 months until and including the day of admission. A review of the medical record identified multiple occasions when the client was found outside smoking and or staff smelling smoke when Client #2 exited a room or area on 10/17, 11/8, 11/26/05, 1/1, and 1/18/06. The master treatment plan initiated 6/17/05 did not address the issue of smoking.
- f. A review of incident reports, clinical notes and /or communication log documentation reflected that Client #2 had left the facility without permission on 11/27/05, 10/17/05, 10/19/05, 8/2/05 and 7/29/05. The facility failed to revise the treatment plan to identify the problem and/or interventions to prevent future episodes.
- g. An incident report reflected that on 8/2/05 Client #2 attempted to steal a compact disc at a store. The master treatment plan was not revised to address the allegations of theft and/or need for increased supervision.
- h. A review of the communication log reflected that on 11/10/05 Clinician #2 documented that Client #2 reported using marijuana and phentanyl (Fentanyl) while in treatment. A review of the clinical record reflected that the treatment plan had not been revised subsequent to this information nor had testing been conducted for fentanyl use during the client's stay at the facility.
- i. Client #3 was admitted to the facility on 12/6/05 with a history of poly-sustance abuse, family relational problems, impulsive behavior and sexual abuse/perpetration. A review of a progress note dated 12/13/05 identified a significant concern regarding sexual abuse and perpetration and that this needed to be followed up on during his stay at the facility. Review of the Treatment Plan identified as problems: polysubstance abuse, Post Traumatic Stress Disorder Symptoms/Anger Management and discharge planning issues. Further review failed to identify the problem of, or interventions addressing the sexual abuse/perpetrator.
- j. Client #4 was admitted with diagnoses inclusive of alcohol abuse, oppositional defiance disorder,

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and cannabis abuse. An assessment dated 12/20/05 identified limited insight and judgment. Recommendations included treatment for oppositional behavior with a focus of individual strategies using a basic behavioral model. The Multidisciplinary Treatment Plan (MTP) dated 1/10/06 identified problems with substance abuse, oppositional behaviors, and family relation problems. Interventions included the client follow directions and learn new coping skills while in the program and learn strategies to prevent relapse. Although review of daily collateral notes dated 12/20/05, 1/5/06, and 1/10/06 identified that Client # 4 was "jabbing self with scissors, was threatening peers, and aggressive behaviors, respectively, the facility failed to revise the MTP to include the self injurious behaviors and/or the threatening behaviors.

k. Client # 5 was admitted to the facility on 11/30/05 with a history of substance abuse, being destructive and weapon involvement. Review of the treatment plan dated 12/23/05 identified substance abuse, Attention Deficit/Hyperactivity Disorder (ADHD) symptoms and family relational problems. Further review failed to identify the history of and/or interventions addressing destructive behavior and/or weapon involvement.

l. Client #6 was admitted to the facility on 8/2/05 with a history of substance abuse, seizures, running away, self injurious behavior, stealing, anxiety and obesity. A review of the Treatment Plan identified substance abuse, conduct disorder and family relational problems. Further review failed to identify the problems of and/or the interventions addressing the history of seizures, running away, self-injurious, stealing, anxiety and/or obesity.

m. Client #7 was admitted to the facility on 1/04/06. Review of the clinical record identified that on 1/16/06 the client wanted to smoke and walked off grounds to do so. Review of the treatment plan failed to identify the risk of leaving the facility without permission, the history of tobacco use and/or the intervention addressing such.

n. Client #9 was admitted to the facility on 6/27/05, with a history of daily tobacco use, substance abuse, and fire starting. The Sakhum Fire Setting Risk Assessment Protocol identified Client #9 as a definite or severe fire setting risk. A review of the treatment plan identified substance abuse, family relational problems and anger. Further review failed to identify the problem of, or interventions addressing the tobacco use or the risk of fire setting.

o. Resident#12 was admitted to the facility on 12/23/05. Diagnoses included substance abuse and major depressive disorder. A review of Resident#12's clinical record and facility documentation reflected that the resident had left without permission on 2/15/06, 3/4/06 and 3/7/06. The 2/10/06 treatment plan was not revised to identify the episodes and/or interventions to prevent further occurrences.

p. Client #12 was admitted to the facility on 12/23/05. Diagnoses included substance abuse. A review of Client #12's clinical record reflected multiple pages documenting "special precautions" On 3/24/06 during an interview the Associate Director of Nursing reported that special precautions mean every 10-minute checks related to unsafe behavior. Recommendations for these precautions come from the team, clinician or physician. The treatment plans did not include any information regarding "special precautions."

q. A review of Client #12's clinical record, related incident reports and interviews with Teaching Staff #1 and #2 identified that Client #12 had attempted to staple himself on 1/26 and 1/30, with the stapler while in classroom #501. During 2/3/04 incident, the client stapled 7 staples into his neck. The area was noted to be red and bleeding and the client was subsequently transferred and

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admitted to an acute care facility (2/3 to 2/0/06). On 3/7/06 Client #12 removed the stapler remover from the teacher's desk in room 503 and tried to staple his ear. On 3/21/06 the client took two staples from the bulletin board in room #502, folded and swallowed them as the staff attempted to "talk him down". The treatment plan was not revised subsequent to any of the incidents. Tours of the three classrooms on 3/24/06 revealed the stapler remover still in the teacher's desk drawer in room 503 and staples still on the bulletin board in the computer room. A review of facility documentation reflected that after the 1/26/06 incident the teacher was advised to keep such items out of the reach of the client. A review of the treatment plan failed to identify and/or provide interventions addressing these incidents.

r. A review of Client #12's clinical record and incident report documentation reflected that on 1/16/06, during a pass with a family member, Client #12 purchased three boxes of Coricidan. Client #12 consumed 16, 30 mg tablets. Client #12 reported that he also provided Client #13 with 16 tablets. The facility contacted poison control and was advised to send the client to the emergency room. On 3/24/06, during an interview the Associate Director of Nursing reported that subsequent to the 1/16/06 incident there were new restrictions placed on Client #12's passes, he would be allowed only to go to the family members house. The treatment plan was not revised to reflect this.

s. A review of the clinical records of Client #'s 3, 4, 5, and 13 identified all treatment modalities and the frequency those modalities were offered were listed on a separate page of the individualized program plan. An interview with the Clinical Director of Child and Adolescent Services on March 27, 2006 identified she was unaware that treatment types and frequencies needed to be specific to stated program plan problems/goals.

t. A review of an incident report dated 1/16/06 identified Client #13 was confronted by staff when another client alleged that he was "under the influence." The client was evaluated by emergency medical staff and after consulting with Poison Control he was sent to the emergency room for evaluation. Middlesex Hospital emergency department record showed the client intentionally overdosed on Coricidin. An interview with the Clinical Director of Child and Adolescent Services on 4/5/06 identified the incident was handled clinically but the treatment plan was not updated to reflect the behavior. A review of the individualized program plan lacked interventions to prevent further incidents.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 2006

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WERE IDENTIFIED**

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operations (7) and the Connecticut General Statutes Section 20-74s-3 (a) and (b).

8. Based on a review of facility information and staff interviews the facility failed to provide qualified and/or adequate staff to met the needs of the clients and/or implement measures to prevent future incidents from occurring. The findings include:
- a. In an interview on 1/17/06 the Program Supervisor identified that Client #6 alleged to him that Client #1 touched him inappropriately. Record review and review of facility documentation identified that Client #6 was placed on 1:1 supervision. Further review failed to identify measures to prevent Client #1 from potentially inappropriately touching other clients.
 - b. Review of facility documentation identified that on 1/7/06 Client #1 alleged that Clients # 2, 3, 4 and 5 sexually assaulted him. Record review identified that Client #1 was placed on 1:1 supervision. Further review failed to identify measures to prevent Client's #2, 3, 4 and 5 from potentially assaulting another client.
 - c. A review of Master Treatment Plans for all clients reviewed failed to identify indication of review by a Licensed Alcohol and Drug Counselor (e.g. LADC). An interview with the Associate Director of Adolescent Services on January 10, 2006 identified the facility did not employ or have a contract with an LADC.
 - d. Interviews with Clinical Service Attendant's #1, 2, and 3 identified that two of the three were in a staff office during an alleged incident involving five clients on January 7, 2006 leaving one staff member "supervising" all ten clients in house. Review of the facility policy identified that staff is expected to supervise clients at all times without exception and each staff must have eyes on their assigned clients at all times.
 - e. Review of the schedule of group sessions identified that the Clinical Service Attendants (CSA) provided the following group sessions: Substance abuse, challenge group, relapse prevention and anger management. Interview with facility staff identified that the staff uses a designated binder of information to run the group, no training was provided and there were no specific objectives noted for each group. In addition the CSA's were noted to not be clinical staff and were not qualified to facilitate the sessions.
 - f. On 1/17/06 Client #4 was observed telling staff that he would be walking from the main building back to school. The client proceeded outside unescorted. Review of facility policy identified that staff is expected to supervise clients at all times without exception.
 - g. Client #2 was admitted to the facility on 6/17/05. Client #2 was then discharged to Facility#2 on 1/27/06. Diagnoses included polysubstance abuse and bipolar disorder. On 3/24/06, during an interview, the Associate Director of Nursing (ADNS) reported that Facility#1 had received a phone call stating the Client #2 tested positive for heroin upon admission to the new treatment facility, Facility#2.
- The ADNS reported that all clients were tested for the use of drugs subsequent to this notification and the results were negative. Subsequent to this, clients "let it be known" that that they knew about Client #2 obtaining heroin prior to the notification. Client #2 had allegedly stolen an electronic game that was given to the facility and had sold it for 10-12 bags of heroin. The ADNS stated that the other clients must have assisted Client #2 with his exit and entrance back into the locked building. The ADNS stated that Client #2 had left without permission after the facility received the game. A review of the clinical record and incident reports failed to identify any

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episodes of Client #2 leaving without permission after 12/25/05. There was at least one occasion that the client was found outside smoking and notes that identified "suspicious behavior" on 1/1/06. On 3/24/06 the ADNS also reported that this was not a locked campus and that clients are able to exit. If they do go leave without permission, the police and other parties are notified. Client's are allowed to make telephone phone calls and staff only intercede if they hear something suspicious. A review of information from the Facility#2 identified that on 1/27/06 Client #2 had four tract marks on his left arm. Client #2 presented with gastrointestinal upset, sweating, bone/joint aches and yawning identified by the facility as an alteration in comfort related to opioid withdrawal. Client #2 reported using heroin at Facility#1 prior to admission to Facility #2.

h. A review of Client #12's clinical record, related incident reports and interviews with Teaching Staff #1 and #2 identified that Client #12 had attempted to staple himself on 1/26 and 1/30, with the stapler while in classroom #501. During a 2/3/04 incident, the client stapled 7 staples into his neck. The area was noted to be red and bleeding. On 3/7/06 Client #12 removed the staple remover from the teacher's desk in room 503 and tried to staple his ear. On 3/21/06 the client took two staples from the bulletin board in room #502, folded and swallowed them as the staff attempted to "talk him down". The client was transferred to an acute facility from 2/3 through 2/8/06. The treatment plan was not revised subsequent to any of the incidents. A review of facility documentation reflected that after the 1/26/06 incident the teacher was advised to keep such items out of the resident's way. Tours of the three classrooms on 3/24/06 revealed the stapler remover still in the teacher's desk drawer in room 503 and staples still on the bulletin board in the computer room. The facility failed to notify the medical physician subsequent to the incident on 3/21/06 when Resident#12 was observed swallowing 2 folded staples. On 3/23/06, during an interview, the Quality Manager reported that the client was examined by the nurse. On 3/24/06, the Associate Director of Nursing reported that she examined the client subsequent to the incident and there were no abrasions in his mouth and the medical doctor was not notified. The psychiatrist was notified on 3/23/06 during the team meeting.

i. Review of facility documentation identified that on 11/27/05 Client #2 went to a local drug store to "allegedly steal Robitussin and Benadryl." On 11/27/05, Client #2 was observed with slurred and incoherent speech, sweating and dilated pupils. Client #2 was transported to the emergency room where he remained overnight. Staff documentation reflected that the client had a Benadryl overdose. The facility failed to supervise the client at all times. Review of the facility policy identified that staff is expected to supervise clients at all times without exception.

Plan of Correction:

Completion Date:

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EXHIBIT C

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WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570(m) Service Operations (9)(G)(ii).

9. Based on observation and interview the facility failed to ensure that medications were administered by qualified staff and/or administered according to physician's orders. The findings include:
 - a. During an interview on 1/17/06 the Associate Director of Nursing identified that when a nurse is not available to administer medications a Clinical Service Attendant (CSA) will administer medications. This occurs on the evening and night shifts and on weekends.
 - b. Client #12 had a 2/14/06 physician order for Wellbutrin SR 150mg at 8AM and 8PM. A review of the 2/06 medication record reflected that the client did not receive the 8PM. dose of Wellbutrin on 2/14, 2/15, 2/16 and 2/17/06. On 3/24/06 the Associate Director of Nurse identified that Client #12 did not receive the medication as ordered because the staff member was not aware there was a second page to the medication administration record which identified the Wellbutrin. Review of facility documentation identified that Recreation Therapist#1 was assigned the medication pass on all 4 evenings.
 - c. An interview with the Associate Director of Nursing on March 23, 2006 at 4:10PM identified that CSA's administered medications to clients 99% of the time. She described that the Clinical Service Attendants (CSA's) became medication certified after completing a course provided by the Connecticut Department of Children and Families.

Plan of Correction:

Completion Date:

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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(m) Service Operations (3)(A).

- 10. Based on record review and interview, the facility failed to provide an intervention as outlined in a client treatment plan. The findings include:
 - a. A review of Client #12's treatment plan dated 2/10/06 and a minimum treatment schedule undated but signed 3/20/06 identified that Client #12 would be involved with a smoking cessation group conducted by the registered nurse. On 3/24/06, during an interview the Associate Director of Nursing identified that although it was part of the treatment plan the smoking cessation group had not yet been started.

Plan of Correction:

Completion Date:

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

- 11. Based on interview and review of facility documentation the facility failed to ensure that all staff and/or agency staff were oriented and knowledgeable of facility policies and procedures. The findings include:
 - a. Interview and review of facility documentation identified that the facility employs and/or utilizes agency staff. A logbook entry dated 10/08/05 identified that the lights were out in the facility for a period of time and that staff were unaware of emergency procedures. An interview with the Quality Assurance person identified that staff verbally inform agency staff when they arrive at the facility of protocols, however no formal orientation is provided. The facility failed to provide documentation that each of these individuals received training on and/or were knowledgeable of facility policies and procedures.

Plan of Correction:

Completion Date:

DATE(S) OF VISIT: January 10, 12, 13, 17 and 19 and March 23, 24 and 27, 2006

EXHIBIT C

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 (j) Environment (1)(F)(viii)(b).

- 12. Based on observation and review of facility documentation, the facility failed to maintain hot water at proper temperatures. The findings include:
 - a. During a tour of the facility on 3/23/06 a test of the water temperatures at plumbing fixtures intended for client use identified temperatures which exceeded 120 degrees Fahrenheit as follows: a recording of 133.0 degrees in the bathroom located near room 515 and a reading of 132.6 degrees in the bathroom located near room 507. The facility failed to provide documentation of the monitoring of hot water temperatures.

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)(vi).

- 13. Based on observation and staff interview the facility failed to audit first aid supplies. The findings include:
 - a. During a tour of the facility on March 23, 2006 the first aid kit was noted to be in the main office. An interview with the Associate Director of Nursing at that time identified that the facility lacked a mechanism (e.g. policy and procedure) for the monthly auditing of first aid supplies.

Plan of Correction:

Completion Date:

Provider/Representative

Title

Date



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT D
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July 13, 2006

Jeffrey Walter
Rushford Center Inc
384 Pratt Street
Meriden, CT 06450

Dear Mr. Walter:

Unannounced visits were made to Rushford Center Inc, 1250 Silver Street, Middletown, CT on April 25, May 2, 3 and 5, 2006 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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 August 9, 2006 at 1:30 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

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

CM

c: Department of Mental Health and Addiction Services
licensure file
CT 5404,5442



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: April 25, May 2, 4 and 5, 2006

EXHIBIT D

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(f) Governing Authority (3)(A)

- 1. Based on a review of facility documentation and interviews with facility staff, the facility lacked documentation of orientation to the facility for temporary nursing agency staff, and /or lacked policies and procedures regarding action to be taken when the facility and payor source disagree on discharge plans. The findings include:
 - a. Documentation was lacking to identify that nursing agency staff person, Registered Nurse (RN)#1, had received orientation to the facility policies and procedures necessary to perform her duties. On 5/1/06 during a telephone interview, the Detoxification Unit Manager reported that there is no written documentation that RN#1 received orientation to the facility. The facility policy and procedure for temporary and contract personnel stated that temporary personnel are not employees of the facility. The procedure stated that temporary staff were held accountable to the facility standards regarding ethics, professional conduct and attire. The policy did not address orientation to the facility policies and procedures.
 - b. Review of facility documentation identified that the facility lacked a policy and procedure directing action to be taken when the outcome of the evaluation conducted by facility staff in regards to appropriate level of care upon discharge differs from the approved level of care by the payor source. On 5/4/06, during an interview, Utilization Manager#1 reported that there was no written policy for action to be taken and/or direction when the insurance company representative disagrees with the facility staff regarding discharge plans. On 5/4/06 the Supervisor of Utilization Management reported that there was no written policy to direct staff for when the team and insurance company disagree on discharge plans, and that the actions taken are a process or facility practice.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service operations (2)

- 2. Based on a review of clinical records and interviews with facility staff, the facility failed to document orientation and receipt of the rules for the day treatment program (PHP). The findings

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EXHIBIT D

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include:

- a. Client # 5 was admitted to the Intensive Treatment Program (ITP) on 4/1/06 from the detoxification and evaluation unit. On 4/21/06 the Client was discharged to the PHP at the facility. Client #5's clinical record lacked documentation that the client had received orientation to the PHP.
- b. Client # 6 was admitted to ITP on 4/21/06 from the detox (residential detoxification and evaluation unit). On 5/3/06 the client was discharged to the PHP program. Client #6's clinical record lacked documentation that the client had received orientation to the PHP.
- c. Client #7 was referred to the PHP on 4/24/06. Client #7's clinical record lacked documentation that the client had received orientation to the PHP. Clinician #4 was unable to locate an orientation for Client #7. On 5/3/06 the client was discharged to the PHP at the facility. On 5/4/06 Clinician #6 reported that there are usually 23-25 people in a group. Clients usually sign in at 9:30am when they transfer from ITP then they are assigned a group. Usually they are assigned a clinician after the first day. The first day they attend the groups. The next day during team meeting they are assigned to a clinician. Clients are expected to go to orientation but it might be after they attend the group. Staff don't always conduct an orientation group everyday.

Plan of CorrectionCompletion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operation (3)(A)

3. Based on a review of clinical records and interviews with facility staff, the facility failed to ensure that clinical record documentation was accurate and complete. The findings include:
 - a. Reviews of Client #1, #2, #3 and #4's clinical records reflected that the computerized preprinted master treatment plan form had areas to check off and/or initial and in multiple instances the top line would be initialed and a line drawn down to include the remainder of the entries which resulted in inaccurate responses to many of the preprinted areas. On 4/25/06, during an interview, the Detoxification Unit Manager reported that each appropriate line should be initialed.
 - b. Client #1's clinical record failed to clearly identify the resident's response to detoxification

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program i.e. signs and symptoms. A review of the master treatment plan identified that nursing documentation failed to identify the actual symptoms that would be consistent with the COWS (clinical opiate withdrawal scale) scores. A review of the clinical record reflected that documentation on the medication records would identify the administration of prn (as needed) medication however on multiple occasions it did not identify the specific behaviors experienced which required medication just the COWS score. Additionally, the COWS tool would be utilized to obtain the score but the document itself was not retained.

Although medication record reflected the cows scale is used to assess sign and symptom severity there was no completed COWS forms available for review. Additionally, a review of the nursing documentation did not reflect documentation of the signs and symptoms that would generate the assigned COWS score. On 4/25/06, during an interview, the Detoxification Unit Manager reported that the staff utilizes the COWS form to determine the score but does not necessarily document it on the form.

c. Review of Client #1's master treatment plan included the diagnoses of diverticulosis, however, the resident did not have the diagnoses. The information remained on the master treatment plan all days of his stay at the facility. On 4/25/06 during an interview, the Detoxification Unit Manager reported that the inclusion of the diverticulosis diagnoses was an error.

d. Review of Client#1's clinical record reflected that documentation was lacking to identify when Client#1 was advised that he had not been approved for inpatient treatment after discharge and that alternatives had been discussed with the client. A review of the utilization review documentation reflected that services had been approved through 4/7/06. The 4/6/06 discharge summary reflected that the client was appropriate for intensive treatment (inpatient). On 4/25/06, Clinician #1 reported that Client #1 was aware he could stay until 4/7/06 but he decided he was "OK to go" on 4/6/06. He wanted to be discharged to an inpatient program, however he was not authorized for inpatient by his insurance and was discharged to outpatient. The facility policy and procedure on daily documentation reflected that all therapeutic interactions with clients be documented daily and filed in the client charts.

e. Review of Client #1's clinical record reflected a discharge summary dated 4/6/06 written by Clinician #1. Clinician #1 was not Client#1's primary clinician. On 4/25/06, during an interview, Clinician #2 who was Client #1's primary clinician reported that she had started a discharge summary for Client #1 on 4/6/06 but that the discharge summary she wrote was no longer in the clinical record. On 4/25/06, during an interview, Clinician #1 reported that she was off on 4/7/06. Clinician #1 reported that on 4/9/06 she had been contacted by administrative staff to make sure that Client #1's chart "was perfect". The discharge summary written by Clinician #2 had no information regarding the client's request to go inpatient after discharge. Clinician #2 initiated a new discharge summary and discarded the document done by Clinician #2.

f. Client #7 was discharged from the ITP (intensive treatment) on 4/24/06 and referred to PHP (Day treatment). A review of Client #7's clinical record reflected multiple occasions when there was no documentation about Client #7's absence at the PHP groups. Documentation was lacking to reflect that Client #7 attended all required and scheduled groups. (i.e. 4/25 all three groups, 4/26 group 2 and 3, 5/1 group 2 and 3, 5/2 all three groups and 5/4). Documentation was lacking to identify when Client #7 was absent from the PHP groups.

The facility policy and procedure regarding daily documentation reflected that all therapeutic

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interactions with clients in groups, individually and/or family is to be documented daily and filed in the client charts. Documentation shall note excused and unexcused absences. All notes shall be filed in the chart no later than the next treatment day. On 5/4/06 during an interview Clinician#4 reported that they had noticed Client #7 wasn't coming and that she usually makes her calls about problems at the end of the week. She wouldn't necessarily call them right away for absences.

g. Client #5 was discharged from the ITP to the PHP on 4/21/06. A review of documentation from the PHP reflected that Client #5 attended only one group on 4/21/06 at 11:15 a.m. Although all discharge documentation from the ITP level reflected that the Client was to attend the PHP, the daily progress sheet from the outpatient program reflected that the Client was in the IOP which would only require attendance three days a week instead of 5 days a week. There was no documentation of the client's absence from the PHP 1st and 3rd groups on 4/21 or all three groups 4/24/06. On 4/25/06 Client #5 committed suicide.

h. Review of Client #6's clinical record reflected that Client #6 was discharged from the ITP to the PHP on 5/3/06. Documentation reflected that Client #6 attended groups 1,2 and 3 on 5/3/06. Documentation was lacking that Client #6 attended any groups on 5/4/06. Staff reported that when the driver went to pick him up on 5/4/06 he was not there. On 5/5/06 Client #6 returned to the facility but did not attend the groups. On 5/5/06, during an interview, Counselor Assistant#1 reported that Client#6 came to the cafeteria and advised her that if he went into the river that things wouldn't be a problem and that he had no reason to live. He was observed walking to the river. Facility staff found the client in the river and were able to rescue him. The Client was transported to the hospital.

Plan of CorrectionCompletion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570(m) Service Operations (4).

4. Based on a review of clinical records, a review of facility policies and procedures and interviews with facility staff the facility failed to ensure that a referral had been made for after care for Client #1. The findings include:
 - a. The discharge summary dated 4/6/06 identified that Client #1 was discharged without a formal referral. The assessment at the time of discharge identified that the resident was appropriate for the intensive treatment unit but that the insurance denied ITP (intensive treatment program). The client

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was then advised to contact a specific out-patient facility as the clinician was unable to make contact to make a formal referral.

On 4/25/06, during an interview, Clinician #1 reported that she was not able to contact staff directly at the outpatient facility where Client #1 was being referred and so a message was left. Contact was not made before discharge. The client was instructed to contact the agency for outpatient services. A review of the facility policy and procedure regarding discharge identified that the primary counselor would assure that contact had been made with outside referral sources after a written consent from the client was obtained.

b. A review of the available documentation regarding Client #1 reflected that contact was made with the insurance company on 4/3/06 at 2am (to advise of admission) and on 4/3 at 2p.m, approval was given for four days 4/3-4/6 with the next review to be done on 4/7. Progress notes identified the Clients desire for continued inpatient treatment. A 4/7/06 entry said message left that Client#1 had been discharged. On 4/25/06, during an interview, Utilization Review Care Manager#1 reported that she had an additional contact with the insurance company on a date she did not document and could not recall however at that time that insurance Contact#1 denied the requested intensive treatment program (inpatient) and only would approve out-patient. On 4/25/06 during an interview the Utilization Review Care Manager #1 reported that she did not discuss any alternative type of discharge arrangements with Client #1. She indicated that the insurance will not approve inpatient treatment after detoxification unless there have been prior failures in an outpatient setting. On 4/25/06, during an interview, the Utilization Review Supervisor reported that she was not aware that Client#1 was requesting to go inpatient and had been denied until after the "unfortunate incident." If a client wants inpatient the facility may try alternatives like partial hospitalization program with boarding or some other option. Recommendations for this may be made to the clinician who is responsible for discharge planning. During an interview on 4/25/06 the Detoxification Manager identified that the Utilization Manager would call to request a doctor to doctor (Facility and Insurance Company) review of a client's record for course of treatment. Additionally she identified that the Physician was not made aware of the client's desire to remain in an inpatient treatment program. On 4/27/06, during an interview, the insurance company representative reported that the insurance company had not been contacted to request any additional treatment. That the only contacts made were three contacts, 4/3/06 on two occasions and on 4/7/06 to advise that the client had been discharged.

On 5/4/06 during an interview MD#1 reported that he was not asked to contact the insurance company. He would only get involved if there was a medical reason "for not going along with the insurance approval".

c. A review of the medication records reflected that on 4/6/06 Client #1 received Librium 50mg at 7am for a COWS score of 8 and shakes and at 11am for shakes and sweats. There was no documentation that the physician was notified on 4/6/06 that the client continued with withdrawal symptoms and/or that the client wanted to be discharged to an inpatient setting and that he would not be. On 4/25/06, during an interview the nurse manager reported that nursing had not notified the physician. On 4/25/06 during an interview Utilization Review Nurse#1 reported that the physician was not notified that the client wanted to be discharged to an inpatient and that he would normally not be. A "doc-to-doc"(physician-to-physician) review with the insurance company had not been requested.

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On 5/1/06, during a telephone interview, RN#2, who was on duty 4/6/06, reported that she did not discuss the client's specific symptoms or his request to go in-patient with the physician.

Plan of CorrectionCompletion Date

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

5. Based on a review of clinical records and interviews with facility staff the facility failed to develop comprehensive treatment plans. The findings include:
 - a. Client#1 was admitted to the residential detoxification unit on 4/3/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) must be addressed in treatment were not incorporated into the master treatment plan i.e. depression, relapse prevention, no supports and medication issues. The 4/3/06 master treatment plan included, in part, the following problem list: admission to detox, orientation, status observation, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, opiate and cocaine detox protocol and diverticulosis. It also included an entry to initiate appropriate units of care. On 4/25/06, interviews with the Detoxification Unit Manager and Clinician #1 stated that the treatment plan for the detoxification unit was for issues specific to the actual detoxification process. Subsequent to transfer to a lower level of care i.e. intensive treatment or outpatient, the identified psychosocial problems would be incorporated into the treatment plan. A new treatment plan is printed out for each day and the nursing documentation is done directly on this form. The facility policy and procedure regarding assessment leading to care plan reflected that the if a client is admitted to detox (residential detoxification and evaluation) then an individualized treatment plan is developed on admission. The plan is recorded on the computer. All the biopsychosocial problems are addressed through applying the relevant "units of care" (aspects of care i.e. goals, observation and interventions) to the care plan for every identified problem that can be attended to during the episode of care.

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- b. Client #2 was admitted to the detoxification unit on 4/14/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan i.e. depression, lacks relapse prevention skills, lacks coping skills. The master treatment plan included, in part the following problem list, admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and alcohol detox protocol. It also included an entry to initiate appropriate units of care.
- c. Client #3 was admitted to the facility 4/16/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan although they were identified as "must be addressed in treatment" i.e. rule out depression, grief/loss, limited support and uninsured. The master treatment plan included, in part the following problem list admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and opiate and cocaine detox protocol, leave against medical advice prevention and homeless. It also included an entry to initiate appropriate units of care.
- d. Client #4 was admitted to the detox unit 4/5/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan although they were identified as "must be addressed in treatment" i.e. anxiety and depression, no medication, housing. The master treatment plan included, in part the following problem list admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and alcohol detox protocol, leave against medical advice prevention. It also included an entry to initiate appropriate units of care.
- The facility policy and procedures regarding in- house transfers directed that the client chart will accompany the client to the receiving level of care. This ensures a reliable data-base to construct a treatment plan that maintains a continuity of care. The facility policy and procedure on initial treatment plans directed a initial treatment plan to be written within 24 hours utilizing the client data base unless a master treatment plan was developed within 24 hours. The initial treatment plan will focus on emergency needs and orientation to the program and setting.
- e. Client #7 was discharged from the ITP to the PHP on 4/24/06. A review of the clinical record on 5/4/06 reflected that Client #7s record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/16/06 with a discharge summary dated 4/20/06.
- f. Client #5 was discharged from the ITP to the PHP on 4/21/06. A review of the clinical record on 5/4/06 reflected that Client#5's record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/11/06 completed in the ITP with a discharge summary from the ITP dated 4/21/06.
- g. Client#6 was discharged from the ITP to the PHP on 5/3/06. A review of the clinical record on 5/4/06 reflected that Client #6's record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/28/06 with a discharge summary dated 5/5/06 from the ITP level of care.
- On 5/4/06 during an interview Clinician#4 reported that clients are usually assigned a clinician after

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the first day. The first day they attend the groups the next day during team meeting they are assigned to a clinician. Staff in the PHP don't develop a new treatment plan for PHP they utilize the plan from ITP. They review it from a PHP perspective. They don't necessarily document on it. The initial treatment plan would be reviewed/completed by the orientation person or the assigned clinician.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operations (7)(A).

- 6. Based on a review of the clinical record, A review of facility job descriptions, personnel files and interviews with facility staff the facility failed to employ a manager of the evaluation and treatment unit that had the academic qualification identified by the facility and /or lacked documentation that an appropriately credentialed supervisor provided direct supervision to staff on a minimum of a weekly basis and/or reflected biopsychosocial assessments were conducted by appropriately credentialed clinicians. The findings include:
 - a. Reviews of Client #1, #2, #3, #4, #5 and #6's clinical records lacked documentation that a staff person who was a Licensed Alcohol and Drug Counselor (LADC) provided direct supervision on a minimum of a weekly basis. During an interview the Detoxification Unit Manager reported that at group "C.A.D.C.", supervision of the clinicians was conducted by the clinical coordinator of another unit on a weekly basis. On 5/1/06 during an interview the Intensive Treatment Program coordinator, who is an LADC, reported that she provided once-a-week supervision called C.A.D.C. supervision to the three clinicians from the detoxification unit and the two clinicians from the intensive treatment unit. The supervision includes discussion of issues, presentation of particular subject matter or chart reviews. It may also be information on how to obtain the C.A.D.C. license. Chart reviews are not conducted every week. The charts reviewed are usually of a "difficult case" or preparation of the intensive treatment unit staff for a difficult case being transferred to that unit. Charts are not signed by the LADC after the reviews. The record for Client#1 as with other short term clients was not reviewed prior to discharge.
 - b. Review of Client#1, #2, #3 and #4's clinical records reflected that the biopsychosocial assessments were conducted by Clinician#1, #2, #3 who were staff that had associate degrees but lacked licensure and/or certification. The assessment document had an area for a sign off by the

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physician but had not been signed off. On 5/5/06, during an interview, MD#1 reported that he did not sign off on this document. Often he sees the client prior to these forms being completed. His notes on the MD physical assessment form " see intake" refers to the triage form.

c. The job description for the manager of the detoxification unit identified the educational requirement for the manager as a master's degree. The current manager was a licensed registered nurse who also had an associate's degree in general studies. On 5/5/06, during an interview the Detox Manager identified that she did not possess a master's degree and was not aware that the job description required one.

Plan of Correction

Completion Date

Provider/Representative

Title

Date



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT E
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Amended

August 23, 2006

Jeffrey Walter
Rushford Center Inc
384 Pratt Street
Meriden, CT 06450

Dear Mr. Walter:

This is an amended version of the violation letter dated July 13, 2006.

Unannounced visits were made to Rushford Center Inc, 1250 Silver Street, Middletown, CT on April 25, May 2, 3 and 5, 2006 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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 August 9, 2006 at 1:30 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

Respectfully,

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

CM

c: Department of Mental Health and Addiction Services
licensure file
CT 5404,5442



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

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EXHIBIT E

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(f) Governing Authority (3)(A)

- 1. Based on a review of facility documentation and interviews with facility staff, the facility lacked documentation of orientation to the facility for temporary nursing agency staff, and /or lacked policies and procedures regarding action to be taken when the facility and payor source disagree on discharge plans. The findings include:
 - a. Documentation was lacking to identify that nursing agency staff person, Registered Nurse (RN)#1, had received orientation to the facility policies and procedures necessary to perform her duties. On 5/1/06 during a telephone interview, the Detoxification Unit Manager reported that there is no written documentation that RN#1 received orientation to the facility. The facility policy and procedure for temporary and contract personnel stated that temporary personnel are not employees of the facility. The procedure stated that temporary staff were held accountable to the facility standards regarding ethics, professional conduct and attire. The policy did not address orientation to the facility policies and procedures.
 - b. Review of facility documentation identified that the facility lacked a policy and procedure directing action to be taken when the outcome of the evaluation conducted by facility staff in regards to appropriate level of care upon discharge differs from the approved level of care by the payor source. On 5/4/06, during an interview, Utilization Manager#1 reported that there was no written policy for action to be taken and/or direction when the insurance company representative disagrees with the facility staff regarding discharge plans. On 5/4/06 the Supervisor of Utilization Management reported that there was no written policy to direct staff for when the team and insurance company disagree on discharge plans, and that the actions taken are a process or facility practice.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service operations (2)

- 2. Based on a review of clinical records and interviews with facility staff, the facility failed to document orientation and receipt of the rules for the day treatment program (PHP). The findings

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include:

- a. Client # 5 was admitted to the Intensive Treatment Program (ITP) on 4/1/06 from the detoxification and evaluation unit. On 4/21/06 the Client was discharged to the PHP at the facility. Client #5's clinical record lacked documentation that the client had received orientation to the PHP.
- b. Client # 6 was admitted to ITP on 4/21/06 from the detox (residential detoxification and evaluation unit). On 5/3/06 the client was discharged to the PHP program. Client #6's clinical record lacked documentation that the client had received orientation to the PHP.
- c. Client #7 was referred to the PHP on 4/24/06. Client #7's clinical record lacked documentation that the client had received orientation to the PHP. Clinician #4 was unable to locate an orientation for Client #7. On 5/3/06 the client was discharged to the PHP at the facility. On 5/4/06 Clinician #6 reported that there are usually 23-25 people in a group. Clients usually sign in at 9:30am when they transfer from ITP then they are assigned a group. Usually they are assigned a clinician after the first day. The first day they attend the groups. The next day during team meeting they are assigned to a clinician. Clients are expected to go to orientation but it might be after they attend the group. Staff don't always conduct an orientation group everyday.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operation (3)(A)

- 3. Based on a review of clinical records and interviews with facility staff, the facility failed to ensure that clinical record documentation was accurate and complete. The findings include:
 - a. Reviews of Client #1, #2, #3 and #4's clinical records reflected that the computerized preprinted master treatment plan form had areas to check off and/or initial and in multiple instances the top line would be initialed and a line drawn down to include the remainder of the entries which resulted in inaccurate responses to many of the preprinted areas. On 4/25/06, during an interview, the Detoxification Unit Manager reported that each appropriate line should be initialed.
 - b. Client #1's clinical record failed to clearly identify the resident's response to detoxification

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program i.e. signs and symptoms. A review of the master treatment plan identified that nursing documentation failed to identify the actual symptoms that would be consistent with the COWS (clinical opiate withdrawal scale) scores. A review of the clinical record reflected that documentation on the medication records would identify the administration of prn (as needed) medication however on multiple occasions it did not identify the specific behaviors experienced which required medication just the COWS score. Additionally, the COWS tool would be utilized to obtain the score but the document itself was not retained.

Although medication record reflected the cows scale is used to assess sign and symptom severity there was no completed COWS forms available for review. Additionally, a review of the nursing documentation did not reflect documentation of the signs and symptoms that would generate the assigned COWS score. On 4/25/06, during an interview, the Detoxification Unit Manager reported that the staff utilizes the COWS form to determine the score but does not necessarily document it on the form.

c. Review of Client #1's master treatment plan included the diagnoses of diverticulosis, however, the resident did not have the diagnoses. The information remained on the master treatment plan all days of his stay at the facility. On 4/25/06 during an interview, the Detoxification Unit Manager reported that the inclusion of the diverticulosis diagnoses was an error.

d. Review of Client #1's clinical record reflected that documentation was lacking to identify when Client #1 was advised that he had not been approved for inpatient treatment after discharge and that alternatives had been discussed with the client. A review of the utilization review documentation reflected that services had been approved through 4/7/06. The 4/6/06 discharge summary reflected that the client was appropriate for intensive treatment (inpatient). On 4/25/06, Clinician #1 reported that Client #1 was aware he could stay until 4/7/06 but he decided he was "OK to go" on 4/6/06. He wanted to be discharged to an inpatient program, however he was not authorized for inpatient by his insurance and was discharged to outpatient. The facility policy and procedure on daily documentation reflected that all therapeutic interactions with clients be documented daily and filed in the client charts.

e. Review of Client #1's clinical record reflected a discharge summary dated 4/6/06 written by Clinician #1. Clinician #1 was not Client #1's primary clinician. On 4/25/06, during an interview, Clinician #2 who was Client #1's primary clinician reported that she had started a discharge summary for Client #1 on 4/6/06 but that the discharge summary she wrote was no longer in the clinical record. On 4/25/06, during an interview, Clinician #1 reported that she was off on 4/7/06. Clinician #1 reported that on 4/9/06 she had been contacted by administrative staff to make sure that Client #1's chart "was perfect". The discharge summary written by Clinician #2 had no information regarding the client's request to go inpatient after discharge. Clinician #2 initiated a new discharge summary and discarded the document done by Clinician #2.

f. Client #7 was discharged from the ITP (intensive treatment) on 4/24/06 and referred to PHP (Day treatment). A review of Client #7's clinical record reflected multiple occasions when there was no documentation about Client #7's absence at the PHP groups. Documentation was lacking to reflect that Client #7 attended all required and scheduled groups. (i.e. 4/25 all three groups, 4/26 group 2 and 3, 5/1 group 2 and 3, 5/2 all three groups and 5/4). Documentation was lacking to identify when Client #7 was absent from the PHP groups.

The facility policy and procedure regarding daily documentation reflected that all therapeutic

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interactions with clients in groups, individually and/or family is to be documented daily and filed in the client charts. Documentation shall note excused and unexcused absences. All notes shall be filed in the chart no later than the next treatment day. On 5/4/06 during an interview Clinician#4 reported that they had noticed Client #7 wasn't coming and that she usually makes her calls about problems at the end of the week. She wouldn't necessarily call them right away for absences.

g. Client #5 was discharged from the ITP to the PHP on 4/21/06. A review of documentation from the PHP reflected that Client #5 attended only one group on 4/21/06 at 11:15 a.m. Although all discharge documentation from the ITP level reflected that the Client was to attend the PHP, the daily progress sheet from the outpatient program reflected that the Client was in the IOP which would only require attendance three days a week instead of 5 days a week. There was no documentation of the client's absence from the PHP 1st and 3rd groups on 4/21 or all three groups 4/24/06. On 4/25/06 Client #5 expired as a result of an accident.

h. Review of Client #6's clinical record reflected that Client #6 was discharged from the ITP to the PHP on 5/3/06. Documentation reflected that Client #6 attended groups 1,2 and 3 on 5/3/06. Documentation was lacking that Client #6 attended any groups on 5/4/06. Staff reported that when the driver went to pick him up on 5/4/06 he was not there. On 5/5/06 Client #6 returned to the facility but did not attend the groups. On 5/5/06, during an interview, Counselor Assistant#1 reported that Client#6 came to the cafeteria and advised her that if he went into the river that things wouldn't be a problem and that he had no reason to live. He was observed walking to the river. Facility staff found the client in the river and were able to rescue him. The Client was transported to the hospital.

Plan of Correction

Completion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570(m) Service Operations (4).

- 4. Based on a review of clinical records, a review of facility policies and procedures and interviews with facility staff the facility failed to ensure that a referral had been made for after care for Client #1. The findings include:
 - a. The discharge summary dated 4/6/06 identified that Client #1 was discharged without a formal referral. The assessment at the time of discharge identified that the resident was appropriate for the intensive treatment unit but that the insurance denied ITP (intensive treatment program). The client

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was then advised to contact a specific out-patient facility as the clinician was unable to make contact to make a formal referral.

On 4/25/06, during an interview, Clinician #1 reported that she was not able to contact staff directly at the outpatient facility where Client #1 was being referred and so a message was left. Contact was not made before discharge. The client was instructed to contact the agency for outpatient services. A review of the facility policy and procedure regarding discharge identified that the primary counselor would assure that contact had been made with outside referral sources after a written consent from the client was obtained.

b. A review of the available documentation regarding Client #1 reflected that contact was made with the insurance company on 4/3/06 at 2am (to advise of admission) and on 4/3 at 2p.m, approval was given for four days 4/3-4/6 with the next review to be done on 4/7. Progress notes identified the Clients desire for continued inpatient treatment. A 4/7/06 entry said message left that Client#1 had been discharged. On 4/25/06, during an interview, Utilization Review Care Manager#1 reported that she had an additional contact with the insurance company on a date she did not document and could not recall however at that time that insurance Contact#1 denied the requested intensive treatment program (inpatient) and only would approve out-patient. On 4/25/06 during an interview the Utilization Review Care Manager #1 reported that she did not discuss any alternative type of discharge arrangements with Client #1. She indicated that the insurance will not approve inpatient treatment after detoxification unless there have been prior failures in an outpatient setting. On 4/25/06, during an interview, the Utilization Review Supervisor reported that she was not aware that Client#1 was requesting to go inpatient and had been denied until after the "unfortunate incident." If a client wants inpatient the facility may try alternatives like partial hospitalization program with boarding or some other option. Recommendations for this may be made to the clinician who is responsible for discharge planning. During an interview on 4/25/06 the Detoxification Manager identified that the Utilization Manager would call to request a doctor to doctor (Facility and Insurance Company) review of a client's record for course of treatment. Additionally she identified that the Physician was not made aware of the client's desire to remain in an inpatient treatment program. On 4/27/06, during an interview, the insurance company representative reported that the insurance company had not been contacted to request any additional treatment. That the only contacts made were three contacts, 4/3/06 on two occasions and on 4/7/06 to advise that the client had been discharged.

On 5/4/06 during an interview MD#1 reported that he was not asked to contact the insurance company. He would only get involved if there was a medical reason "for not going along with the insurance approval".

c. A review of the medication records reflected that on 4/6/06 Client #1 received Librium 50mg at 7am for a COWS score of 8 and shakes and at 11am for shakes and sweats. There was no documentation that the physician was notified on 4/6/06 that the client continued with withdrawal symptoms and/or that the client wanted to be discharged to an inpatient setting and that he would not be. On 4/25/06, during an interview the nurse manager reported that nursing had not notified the physician. On 4/25/06 during an interview Utilization Review Nurse#1 reported that the physician was not notified that the client wanted to be discharged to an inpatient and that he would normally not be. A "doc-to-doc"(physician-to-physician) review with the insurance company had not been requested.

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EXHIBIT E

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

On 5/1/06, during a telephone interview, RN#2, who was on duty 4/6/06, reported that she did not discuss the client's specific symptoms or his request to go in-patient with the physician.

Plan of Correction

Completion Date

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

- 5. Based on a review of clinical records and interviews with facility staff the facility failed to develop comprehensive treatment plans. The findings include:
 - a. Client#1 was admitted to the residential detoxification unit on 4/3/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) must be addressed in treatment were not incorporated into the master treatment plan i.e. depression, relapse prevention, no supports and medication issues. The 4/3/06 master treatment plan included, in part, the following problem list: admission to detox, orientation, status observation, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, opiate and cocaine detox protocol and diverticulosis. It also included an entry to initiate appropriate units of care. On 4/25/06, interviews with the Detoxification Unit Manager and Clinician #1 stated that the treatment plan for the detoxification unit was for issues specific to the actual detoxification process. Subsequent to transfer to a lower level of care i.e. intensive treatment or outpatient, the identified psychosocial problems would be incorporated into the treatment plan. A new treatment plan is printed out for each day and the nursing documentation is done directly on this form. The facility policy and procedure regarding assessment leading to care plan reflected that the if a client is admitted to detox (residential detoxification and evaluation) then an individualized treatment plan is developed on admission. The plan is recorded on the computer. All the biopsychosocial problems are addressed through applying the relevant "units of care" (aspects of care i.e. goals, observation and interventions) to the care plan for every identified problem that can be attended to during the episode of care.

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b. Client #2 was admitted to the detoxification unit on 4/14/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan i.e. depression, lacks relapse prevention skills, lacks coping skills. The master treatment plan included, in part the following problem list, admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and alcohol detox protocol. It also included an entry to initiate appropriate units of care.

c. Client #3 was admitted to the facility 4/16/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan although they were identified as "must be addressed in treatment" i.e. rule out depression, grief/loss, limited support and uninsured. The master treatment plan included, in part the following problem list admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and opiate and cocaine detox protocol, leave against medical advice prevention and homeless. It also included an entry to initiate appropriate units of care.

d. Client #4 was admitted to the detox unit 4/5/06. A review of the treatment plan revealed that the problems identified on the master problem list (psychosocial) were not incorporated into the master treatment plan although they were identified as "must be addressed in treatment" i.e. anxiety and depression, no medication, housing. The master treatment plan included, in part the following problem list admission to detox, orientation to detox, status observation, nutritional screen, vital signs every four hours, vital signs every shift, vital signs as needed, medicate as needed, medicate as ordered, universal precautions and alcohol detox protocol, leave against medical advice prevention. It also included an entry to initiate appropriate units of care.

The facility policy and procedures regarding in-house transfers directed that the client chart will accompany the client to the receiving level of care. This ensures a reliable data-base to construct a treatment plan that maintains a continuity of care. The facility policy and procedure on initial treatment plans directed a initial treatment plan to be written within 24 hours utilizing the client data base unless a master treatment plan was developed within 24 hours. The initial treatment plan will focus on emergency needs and orientation to the program and setting.

e. Client #7 was discharged from the ITP to the PHP on 4/24/06. A review of the clinical record on 5/4/06 reflected that Client #7s record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/16/06 with a discharge summary dated 4/20/06.

f. Client #5 was discharged from the ITP to the PHP on 4/21/06. A review of the clinical record on 5/4/06 reflected that Client#5's record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/11/06 completed in the ITP with a discharge summary from the ITP dated 4/21/06.

g. Client#6 was discharged from the ITP to the PHP on 5/3/06. A review of the clinical record on 5/4/06 reflected that Client #6's record lacked a treatment plan specific to care and services provided at the PHP level of care. The most current treatment plan update was dated 4/28/06 with a discharge summary dated 5/5/06 from the ITP level of care.

On 5/4/06 during an interview Clinician#4 reported that clients are usually assigned a clinician after

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the first day. The first day they attend the groups the next day during team meeting they are assigned to a clinician. Staff in the PHP don't develop a new treatment plan for PHP they utilize the plan from ITP. They review it from a PHP perspective. They don't necessarily document on it. The initial treatment plan would be reviewed/completed by the orientation person or the assigned clinician.

Plan of CorrectionCompletion Date

The following are violations of the Regulations of Connecticut State Agencies Section 19a-495-570 (m) Service Operations (7)(A).

6. Based on a review of the clinical record, A review of facility job descriptions, personnel files and interviews with facility staff the facility failed to employ a manager of the evaluation and treatment unit that had the academic qualification identified by the facility and /or lacked documentation that an appropriately credentialed supervisor provided direct supervision to staff on a minimum of a weekly basis and/or reflected biopsychosocial assessments were conducted by appropriately credentialed clinicians. The findings include:
 - a. Reviews of Client #1, #2, #3, #4, #5 and #6's clinical records lacked documentation that a staff person who was a Licensed Alcohol and Drug Counselor (LADC) provided direct supervision on a minimum of a weekly basis. During an interview the Detoxification Unit Manager reported that at group "C.A.D.C.", supervision of the clinicians was conducted by the clinical coordinator of another unit on a weekly basis. On 5/1/06 during an interview the Intensive Treatment Program coordinator, who is an LADC, reported that she provided once-a-week supervision called C.A.D.C. supervision to the three clinicians from the detoxification unit and the two clinicians from the intensive treatment unit. The supervision includes discussion of issues, presentation of particular subject matter or chart reviews. It may also be information on how to obtain the C.A.D.C. license. Chart reviews are not conducted every week. The charts reviewed are usually of a "difficult case" or preparation of the intensive treatment unit staff for a difficult case being transferred to that unit. Charts are not signed by the LADC after the reviews. The record for Client#1 as with other short term clients was not reviewed prior to discharge.
 - b. Review of Client#1, #2, #3 and #4's clinical records reflected that the biopsychosocial assessments were conducted by Clinician#1, #2, #3 who were staff that had associate degrees but lacked licensure and/or certification. The assessment document had an area for a sign off by the

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physician but had not been signed off. On 5/5/06, during an interview, MD#1 reported that he did not sign off on this document. Often he sees the client prior to these forms being completed. His notes on the MD physical assessment form "see intake" refers to the triage form.

c. The job description for the manager of the detoxification unit identified the educational requirement for the manager as a master's degree. The current manager was a licensed registered nurse who also had an associate's degree in general studies. On 5/5/06, during an interview the Detox Manager identified that she did not possess a master's degree and was not aware that the job description required one.

Plan of Correction

Completion Date

Provider/Representative

Title

Date

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
 - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
 - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
 - Assessing administration's ability to manage and the care/services being provided by staff.
 - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.