

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

IN RE: Garden View Manor, Inc. of Hamden, CT
 d/b/a Garden View Manor
 1840 State Street
 Hamden, CT 06514

CONSENT ORDER

WHEREAS, Garden View Manor, Inc. of Hamden, CT d/b/a Garden View Manor ("Licensee"), has been issued License No. 1793 -RCH to operate a residential care home known as Garden View Manor ("Facility") under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates which concluded on December 31, 2012,

WHEREAS, based upon the inspections, the Department issued a Violation Letter dated January 14, 2013 (Attached as Exhibit A).:

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 Barbara Cass, its Section Chief, and the Licensee, acting herein and through Angela Boyle, its President and hereby stipulate and agree as follows:

1. Effective immediately upon execution of this Consent Order, Susan Taylor shall be prohibited from entering the premises of Garden View Manor for any reason and is prohibited from any and all future contacts with the residents at Garden View Manor. Ms. Taylor shall be prohibited from having access to any and all resident funds, any funds of the Facility, any and all resident medication and any

and all Facility documents. The Department consents to Ms. Taylor continuing to receive health care insurance provided by the Licensee if the Licensee chooses to provide such a benefit.

2. The Licensee's license shall be placed on probation for a period of two years under the following terms and conditions.
3. The Licensee shall enter into a contract with an independent certified public accountant within ten (10) days of the effective date of this Consent Order. The independent accountant shall have the responsibility of conducting an audit of resident funds for the time period of January 1, 2012 through December 31, 2012. The accountant shall provide the Department and the Licensee with a copy of the completed audit report within four weeks of the effective date of this Consent Order and shall make recommendations to the Licensee regarding maintenance of accurate records, record keeping, accounting and any other recommendations he or she deems necessary. The Licensee shall implement the recommendations of the accountant. Should there be any dispute regarding the implementation of the recommendations, the Department shall have sole and absolute discretion to resolve the dispute, and the decision of the Department regarding this issue is final and not subject to further review in any forum. In addition, the certified public accountant shall conduct a second audit during the month of July, 2013 for the period of January 1, 2013 through June 30, 2013. The accountant shall provide the Department and the Licensee with a copy of the completed audit report on or before July 31, 2013.
4. The Licensee shall enter into a contract with a consultant, pre-approved by the Department, within ten (10) business days of the effective date of this Consent Order. The terms of the contract executed with the consultant shall include all pertinent provisions contained in this Consent Order. The consultant's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur all costs associated with the hiring of the consultant. The Licensee shall provide the Department with a signed copy of the contract with the consultant within forty-eight (48) hours of its execution.
5. The consultant shall be physically present at the Facility at least eight (8) hours per week unless the Department approves otherwise based upon a request from

the consultant. The consultant shall serve in this capacity for at least a period of two (2) months.

6. The consultant shall act and perform the duties assigned herein at all times in helping to assure the safety, welfare and well-being of the residents and to secure compliance with applicable state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
7. The consultant shall assist in corrections of non-compliance with state laws to assure the health and safety of the residents served.
8. The consultant shall have access to all areas of the Facility at all times, seven days a week and twenty-four hours per day. The Licensee agrees to cooperate with the consultant in all respects and to provide the consultant with any documents or information the consultant deems necessary in order to complete his responsibilities. The consultant shall be compensated by the Licensee at a rate agreed upon by the consultant and the Licensee.
9. The consultant shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the residents and to secure compliance with applicable state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
10. The consultant shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order.
11. The consultant shall confer with all staff determined by the consultant to be necessary to the assessment of resident services and the Licensee's compliance with state statutes and regulations.
12. The consultant shall make recommendations to the Licensee for improvement in the delivery of resident care in the facility. If the consultant and the Licensee are unable to reach an agreement regarding the consultant's recommendation(s), the Department, after meeting with the Licensee and the consultant shall make a final determination, which shall be binding on the Licensee.
13. The consultant shall submit written reports monthly to the Department documenting:

- a. The consultant's assessment of the care and services provided to residents;
 - b. The Licensee's compliance with applicable state statutes and regulations; and
 - c. Any recommendations made by the consultant and the Licensee's response to implementation of the recommendations.
14. Copies of all consultant reports shall be simultaneously provided to the Licensee and the Department.
15. The consultant shall have the responsibility for assisting in the:
 - a. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on resident rights and medication administration;
 - b. Assessing, monitoring, and evaluating the coordination of resident care and services provided and delivered; and
 - c. Recommending to the Department an increase or decrease in the consultant's contract hours if the consultant is unable to fulfill the responsibilities within the stipulated hours per week or if the hours are in excess of what the consultant deems necessary.
16. The Licensee and the consultant shall meet with the Department every four (4) weeks for the first four (4) months after the effective date of this Consent Order.. 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.
17. Any records maintained in accordance with any state law or regulation related to licensure as a residential care home or as required by this Consent Order shall be made available to the consultant and the Department, upon request.
18. Angela Boyle shall assume the position of person in charge effective upon the effective date of this Consent Order. During the period of probation, if Ms. Boyle cannot continue in this position for any reason, the Department must pre-approve the person in charge prior to that person taking over that position. Ms. Boyle may hire such additional staff as she deems necessary to fulfill her responsibilities. Ms. Boyle may consult with Susan Taylor regarding matters,

including, but not limited to, scheduling staff provided that Ms. Taylor complies with all of the terms of this Consent Order.

19. The Department shall retain the authority to extend the period the consultant 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. The Licensee reserves all of its rights to contest any such findings.

20. Within thirty (30) days of the execution of this Consent Order the Licensee shall develop and/or review and revise, as necessary, policies and procedures related to continuing resident rights and medication administration.

21. Within thirty (30) days of the revision of the policies as set forth above, all Facility shall be in-serviced, to the policies and procedures identified in above..

22. Effective upon the execution of this Consent Order, the Licensee, shall ensure substantial compliance with the following:

- a. Sufficient personnel are available to meet the needs of the residents;
- b. Residents shall be free from abuse, neglect, intimidation, retaliation and misappropriation of property;
- c. Resident rights;
- d. Medication administration;
- e. Maintain documentation for narcotic reconciliation in accordance with state laws and regulations; and
- f. Management of resident personal funds.

23. 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 timeframe.

24. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the

methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

25. The allegations and/or violations contained in the Violation Letter (attached as Exhibit A) shall be deemed true in any subsequent proceeding before the Department in which the Licensee's compliance with this Consent Order or the Connecticut General Statutes or Regulations of Connecticut State Agencies is at issue.
26. 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.
27. 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.
28. The Licensee shall pay a monetary penalty to the Department in the amount of one thousand dollars (\$1000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and delivered to the Department with the signed, original Consent Order. The civil penalty and any reports required by this document shall be directed to:

Maureen Klett, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

29. If the Licensee is not be able to maintain substantial compliance with the requirements of the Consent Order, the Department retains the right to issue charges including those related to the allegations contained above.
30. The Licensee has consulted with its attorney prior to the execution of this Consent Order.
31. Susan Taylor may apply to the Department for relief from the terms of this Consent Order provided that the Department has sole and absolute discretion regarding whether to agree to any modification of the Consent Order's terms.
32. The investigation regarding the misappropriation of resident funds has not been completed, and the Department reserves the right to seek restitution or other discipline against the Licensee and/or any person the Department determine that there is sufficient evidence that funds were misappropriated. Likewise, the Licensee shall retain the right to defend itself or any of its staff should the Department seek restitution or other discipline based upon the alleged misappropriation of resident funds.

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.

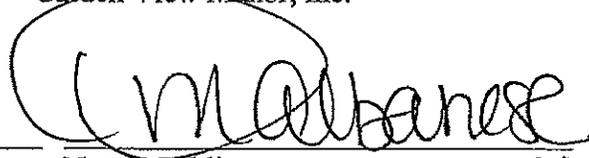
On this the 18th day of January, 2013, before me, personally appeared Angela Boyle, who acknowledged herself to be the President of Garden View Manor, Inc., and that she, as such, is authorized to enter into this Consent Order on behalf of the Licensee and the Corporation, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by herself as their President.



Angela Boyle, President
Garden View Manor, Inc.

My Commission Expires: _____
(If Notary Public)

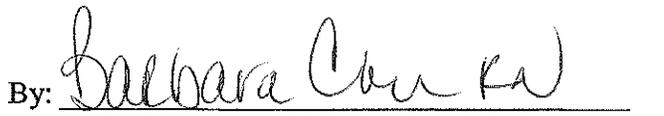
OLIVIA M. ALBANESE
NOTARY PUBLIC
MY COMMISSION EXPIRES 3/31/2013



Notary Public
Commissioner of the Superior Court

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

January 18, 2013

By: 

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 14, 2013

Garden View Manor
1840 State Street
Hamden, CT 06514

Dear Ms. Boyle:

Unannounced visits were made to Garden View Manor on December 31, 2012 by representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, with additional information received through January 3, 2013.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the 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 **January 28, 2013** or if a request for a meeting is not made by the stipulated date, the violation 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.

An office conference has been scheduled for January 28, 2013 at 2:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut, to address the findings identified in the January 14, 2013 violation letter.

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

Respectfully,

Maureen H. Klett, R.N., C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CT 13913, CT 14006 and CT 14561



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: December 18, 19 and 31, 2012

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 19-13-D6
(c) Administration (1) and/or (c) Administration (5) and/or (b) Physical Plant (2).

1. Based on observations of fire extinguishers during a tour of the building identified that fire extinguishers had not been checked monthly for function. The findings include:
 - a. On 12/19/12 at 8:15 AM a tour of the building identified that a fire extinguisher outside Room # 1 was last checked for function on 5/20/12, while one situated outside Room # 6 had no monthly signatures, indicating that it had been checked. Both fire extinguishers were last checked by tyhe professional vendor on 3/2012.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6
(c) Administration (5) .

2. Based on observation and interview of the kitchen identified that resident's medication was not stored in a safe manner. The findings include:
 - a. On 12/19/12 at 8:25 AM, during a tour of the kitchen identified that a prefilled syringe containing Risperadol 50 milligrams (mg) was in the facility refrigerator. The observation further identified that there were three (3) bottles of Lantus insulin, 2 unused syringes and one (1) unlabeled prefilled syringe, containing a liquid substance.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6
(c) Administration (1) and/or (c) Administration (5).

3. Based on an observation of the general environment, the facility failed to ensure the Residential Care Home (RCH) was maintained in a manner that promoted health, comfort and safety. The findings include:
 - a. In the front parking lot, in front of one of two dumpsters, there was an approximately a five (5) foot by (5) foot wide depression in the asphalt and another depression that measured approximately four (4) foot by one (1) foot adjacent to one that was one (1) foot by one and one-half foot that possed a saftey issue to residents who were observed walking about in the parking lot, or to anyone else. An interview on 12/19/12 at 11:30 AM with the President of the corporation identified that they were waiting to spring, however, she would call them to see what could be done.
 - b. An observation on 12/19/12 identified that inside the shower that is located adjacent to the nurses' station, there was a moldy, grey substance around the bottom grout, the shower handle had a build up of soap scum, the paper towel container contained rest and the cabinet door of the sink in the bathroom was observed with deteriorated particle board visible at the top and bottom.

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The following are a violation of the Regulations of Connecticut State Agencies 19-13-D6(c) Administration (1) and/or (c) Administration (5) and/or (m) Administration of Medications and/or (F) Storage and Labeling and/or the Connecticut General Statutes, Section 21a-262-10 Storage of controlled substances.

4. Based on observation of medication self administration, review of storage and management of controlled substances, review of the Resident House Agreement, and interviews of staff, residents, Home Health Care Providers, Physicians, and Pharmacy Providers and resident record reviews, for five of five residents who self administered medications and/or a controlled substance, Resident (R) #1, R #5, R #9, R #11, and R #13, the facility failed to ensure that medications and/or controlled substances were self administered, stored, and/or inventoried satisfactorily. The findings include:

- a. R #1 was admitted to the facility on 08/28/07 with diagnoses that included schizophrenia, and mental retardation and did not have a legally appointed responsible party. Observation of medication self-administration on 12/19/12 at 8:12 AM, identified that Attendant #1 handed Resident #1 several blister packs of medications and the resident removed tablets from each blister pack, placed the medication in his/her mouth. 1 tablet dropped on the floor and R #1 was cued by another resident to take the pill. R #1 picked up the tablet, put it in his/her mouth and drank the water, in the presence of Attendant #1 who did not intervene.
- b. R #5 was admitted to the facility on 03/30/12 with diagnoses that included depression, dependent personality disorder and history of alcohol, opiate, and sedative dependence and did not have a legally appointed responsible party. Observation of medication self-administration on 12/19/12 at 8:10 AM, identified that R #5 self-administered multiple medications. Attendant #1 handed the resident several blister packs of medications and the resident removed tablets from each blister pack, placed the medication in his/her mouth. In the presence of Attendant # 1, Resident # 5 dropped one tablet on the floor, picked it up and placed it in her mouth. Attendant # 1 did not attempt to intervene.

Observation of R#5's blister pack dispensed by Pharmacy #1 on 11/28/12 identified a printed label that directed Klonopin 1 milligram (mg), take 1 tablet twice daily with 60 tablets dispensed a 30 day supply (60 tablets). On 12/19/12, 3 tablets remained and a hand written note on the edge of the blister pack identified that, on 12/15/12 tablets # 1

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through #10 were returned for R #9.

Observation of R#5's blister pack dispensed by Pharmacy #1 on 12/25/12 identified a printed label that directed Klonopin1 milligram (mg) take 1 tablet twice daily with 60 tablets dispensed. On 12/31/12, 35 tablets remained and a hand written note on the edge of the blister pack identified return to R #9. All visible tablets were light blue in color except for the tablet in blister #11 which was dark blue and the foil backing appeared to have been breached and was covered with a piece of clear tape.

- c. R #9 was admitted to the facility on 08/14/03 with diagnoses that included schizoaffective disorder and did not have a legally appointed responsible party and self-administered his/her medications. Observation of a blister pack on 12/19/12, dispensed by Pharmacy #1 on 12/12/12 identified the prescription for Klonopin1 milligram (mg) take 1 tablet twice a day as needed with 60 tablets dispensed. 26 tablets remained in the blister pack and blisters #1 through #10 were missing with a handwritten note on the edge of the packet that identified that the tablets were returned to R #5.

Observation of the same blister pack on 12/31/12, dispensed by Pharmacy #1 on 12/12/12 identified the prescription for Klonopin1 milligram (mg) take 1 tablet, twice a day with 60 tablets dispensed. 3 tablets remained in the blister pack and blisters #1 through #10 were missing with a handwritten note on the edge of the packet that identified that the tablets were returned to R #5.

Observation of R#5's blister pack on 12/19/12, dispensed by Pharmacy #1 on 12/03/12 identified the prescription for Zolpidem 10 mg tablets, take one at bedtime with 30 tablets dispensed. 14 tablets remained in the blister pack and blister #1 was empty with the foil backing breached and a handwritten note next to blister #1 that identified that the tablet was missing on 12/09/12.

- d. R #12 was admitted to the facility on 03/26/97 with diagnoses that included dependent personality, and chronic schizophrenia and did not have a legally appointed responsible party. Observation of medication self-administration on 12/19/12 at 8:14 AM identified that Attendant #1 handed the resident several blister packs of medications and the resident removed tablets from each blister pack, placed the medication in his/her mouth. 1 tablet dropped on the floor and R #12 picked up the tablet put it in his/her mouth, in the presence of Attendant # 1 who did not intervene.
- e. R #13 was admitted to the facility on 04/19/12 with diagnoses that included bipolar disorder, depression, and dependent personality, did not have a legally appointed responsible party and self-administered his/her medications. Observation of a blister

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pack on 12/19/12, dispensed by Pharmacy #2 on 12/04/12 identified a prescription for Lorazepam 0.5 mg tablets, take four times a day by mouth with 120 tablets dispensed. The word "four" was crossed out and the number 3 was written in. Additionally, handwritten instructions directed 8:00 AM and 8:00 PM. The observed blister pack had 60 usable blisters with 30 tablets remaining. A handwritten notation identified 1 of 2. Blister pack # 2 could not be located and was missing. Additionally, another 120 tablets of Lorazepam 0.5 mg were dispensed on 12/30/12 containing 60 tablets in two blister packs. An interview on 1/2/13 with Attendant #5 reported that he/she located a blister pack dispensed on 12/30/12 and labeled 1 of 2 that had tablets missing from blisters #51 through #60. This was located in a single locked cabinet, but not in the controlled medication lock box. She further identified that the blister pack labeled 2 of 2 was not available.

Interview with Attendant #4 on 01/03/13 at 7:30 AM identified that R #13's blister pack dispensed 12/30/12 labeled 2 of 2 was located in the single locked cabinet and contained 60 tablets. The interview identified this was found in a different cabinet, not the cabinet where narcotics are stored.

Interviews with Attendants #1, #2, #3, #4, #5, and #6 interviewed on 12/18/12, 12/19/12, 12/31/12 01/02/13, and 01/03/13 identified that they were not required to be medication certified, but provided supervision of residents who self-administered their own medications. This supervision was not documented, however, when a controlled substance was self-administered by a resident, Person-In-Charge #1 directed that the attendant who supervised and the resident who administered were to initial and date the blister from which the medication was taken. Attendant #1, #4, #5, and #6 identified that they did not always follow the procedure as there were too many irregularities with the controlled medications. The Attendants identified that they were not directed to count and/or track the use of the controlled substances stored in the medication room.

Interview with the Person-In-Charge on 12/18/12 at 10:00 AM identified that he/she ordered and received all medications for residents who self-administered. He/she was unaware that borrowing from one resident for another resident was not acceptable practice and frequently would return the borrowed medications, including controlled substances by taping the tablet back into the breached blister pack. The Person-In-Charge identified that she was unaware why R #5 and R #9 did not receive and adequate supply of medications timely, requiring borrowing. R #13's physician, Physician #1, had directed that the resident required the Lorazepam only 2 times per day, but did not notify Pharmacy #1 that the prescribing instructions had changed and could not identify why a card of 60 tablets of Lorazepam dispensed on 12/04/12 were missing. The facility lacked policies to inventory controlled substances satisfactorily.

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Resident House Agreement identified that as a condition of residency, the residents agree to follow Doctor's prescribed plan of treatment and understand that all medications will be kept locked and that no medication is allowed in resident's rooms.

The following are a violation of the Regulations of Connecticut State Agencies 19-13-D6(c) Administration (1) and/or (c) Administration (5) and/or Connecticut General Statutes, Section 19a-550 Patient's Bill of Rights.

2. Based on interviews from staff, resident, pharmacy, and Police Detective # 1 and resident record reviews for 6 of seven residents without legally appointed responsible parties, R #1, R #5, R #6, R #9, R #11, and R #13 the facility failed to ensure that the residents were free of financial misappropriation and/or treated with respect and dignity. The findings include:
 - a. R #1 was admitted to the facility on 08/28/07 with diagnoses that included history schizophrenia, and mental retardation. The resident did not have a legally appointed responsible party. Interview with Police Detective #1 on 12/18/12 at 1:30 PM identified that, on 12/03/12, Person-In-Charge/Owner #1 was charged with Forgery, 2 counts of issuing a bad check, and Larceny regarding management of R #1's personal funds.

Interview with R #1 on 12/19/12 at 1:30 PM identified that he/she received an allowance of \$48.00 per month distributed by Owner #2 monthly; however, Person-In-Charge/Owner #1 borrowed money from him/her and failed to reimburse him/her.
 - b. Resident #6 was admitted to the facility on 10/20/2000 with a diagnosis of paranoid schizophrenia and did not have a legally appointed responsible party. Interview with the resident on 12/31/12 at 10:00 AM identified that Person-In-Charge/Owner #1 managed his/her money, kept it in an account and bought things for him as needed. R #6 further identified that 3-4 years ago Person-In-Charge #1 stopped maintaining documentation of his/her financial transactions and he/she does not receive a financial statement. Interview with Attendant #4 on 01/02/13 at 2:30 PM identified that he/she had never known R #6 to have any money and frequently observed him/her requesting money from visitors and people in the street. Attendant #4 further identified that the Person-In-Charge/Owner #1 had requested to borrow money from him/her and Attendant #4 refused.
 - c. R #9 was admitted to the facility on 08/14/03 with diagnoses that included schizoaffective disorder. R #9 did not have a legally appointed responsible party. Interview with Police Detective #1 on 12/18/12 at 1:30 PM identified that on 12/03/12, Person-In-Charge #1 was charged with Larceny 4, ATM theft, and Identity (ID) theft related to use of R #9's funds. Interview with R #9 on 12/19/12 at 10:30 AM identified

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that Owner #2 distributes his/her monthly allowance of \$238.00 in cash and the resident deposits the money into a personal bank account. R #9 documents the account balance. Person-In-Charge #1 frequently asked to borrow money and, in March of 2012, he/she requested to borrow \$200.00. R #9 accompanied the Person-In-charge to the bank and he/she assisted the resident in withdrawing the money via the ATM machine as he/she did not know how to use the ATM. Sometime later when R #9 failed to receive his/her usual monthly bank statement, R #9 checked with the bank and was informed that his balance was \$1.00. R #9 believed that \$ 1300.00 was taken. R #9 identified that he/she attempted to discuss the matter with Person-In-Charge #1 and he/she would not discuss it, however, he/she did refund the initial \$200.00. R #9 identified that the Person-In-Charge also borrowed money from R #11, but usually paid it back.

- d. R #11's was admitted to the facility on 01/20/09 with diagnoses that included schizophrenic disorder, mood disorder, borderline personality, and epilepsy and did not have a legally appointed responsible party. Interview with the resident on 12/19/12 at 10:45 AM identified that Person-In-Charge/Owner #1 had not requested to borrow money. Interview with R #5 on 12/31/12 at 8:25 AM identified that Person-In-Charge/Owner #1 borrowed \$300.00 from a resident who wished to remain anonymous (R #11) as he/she was afraid of the Person-In-Charge. According to R #5, when R #11, asked for the money to be refunded, the Person-In-Charge refunded \$40.00, and, later, asked to borrow money again.
- e. R #13 was admitted to the facility on 04/19/12 with diagnoses that included bipolar disorder, depression, and dependent personality and did not have a legally appointed responsible party. Interview with the resident on 12/19/12 at 12:35 PM identified that Owner #2 distributes his/her monthly allowance of \$238.00 in cash. Person-In-Charge/Owner #1 collects \$40.00 in cash monthly from the allowance to pay for a pharmacy co-payment. Interview with Pharmacy Owner #2 on 01/02/13 identified that R #13's co-payment requirement ended in September 2012. The last payment made by the facility was in May 2012 and R #13 has a pharmacy balance due of \$463.00. Pharmacy #2 sends an individual bill for each resident to the facility monthly and the Person-In-Charge pays the bills with a personal check. In October of 2012, the personal check used to pay Pharmacy #2 was returned by the bank due to insufficient funds.

Interview with Employee #1 on 12/31/12 at 10:45 AM identified that Person-In-Charge #1 had borrowed money from him/her multiple times totaling \$1600.00 that has not been repaid. Employee #1 stopped loaning money to Person-In-Charge/Owner #1 one year ago and identified that Person-In-Charge/Owner #1 gets angry if anyone refuses to give him/her the requested money. Employee #1 identified the he/she was aware that Person-In-Charge/Owner #1 had requested money from Residents #1, #5, #9, and #11.

Interview with Attendant #1 on 12/31/12 at 9:45 AM identified that he/she had been

DATE(S) OF VISIT: December 18, 19 and 31, 2012

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

informed by multiple residents and staff members that Person-In-Charge/Owner #1 had requested to borrow money and/or that they had money missing. When Attendant #1 brought these concerns to Person-In-Charge/Owner #1, he she was directed to stay out of Person-In-Charge/Owner #1's business.

Interview with Person-In-Charge/Owner #1 on 12/31/12 identified that all residents for whom the facility is Representative Payee and/or who do not have a legally appointed Conservator, receive a monthly allotment of \$238.00 distributed in cash by Owner #2. Owner #2 has each resident sign a signature sheet when they receive their money. Additionally, no statements are given and/or personal funds accounts maintained as all the residents monthly allotment of money is distributed directly to the residents. Person-In-Charge #1 collects a monthly Pharmacy co-payment from Resident's #6 and #12 but does not keep the pharmacy invoices and/or document receipt of cash payment from each resident.

Interview with Owner #2 on 12/31/12 identified that for Resident's #6 and #12, for whom the facility is Representative Payee, he/she distributes the Residents' monthly cash allotment directly to the residents, in the presence of Person-In-Charge/Owner #1. Residents # 6 and # 12 then gives Person-In-Charge/Owner # 1 cash for those items that they need to pay for or are given spending money from the allotment.

Review of a Resident House Agreement identified that the management advised all residents that it was best not to borrow or lend to other residents.