

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

IN RE: Greystone Rest Home, Inc  
d/b/a Greystone Rest Home  
44 High Street  
Portland, CT 06480

CONSENT ORDER

WHEREAS, Greystone Rest Home, Inc. ("Licensee"), has been issued License No. 1275 to operate a Residential Care Home known as Greystone Rest Home ("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 an unannounced inspection on January 28, 2012; 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 a violation letter dated February 1, 2012 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order 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 Luel Swanson, its President ("Person in Charge") hereby stipulate and agree as follows:

1. Within thirty (30) days of the execution of this Consent Order the Person In Charge shall develop and/or review and revise, as necessary to assure compliance with regulatory requirements and the safety and welfare of its residents, policies and procedures related to resident supervision and leave of absences. The Person in Charge shall The Person in Charge shall keep a written record of its review and any policy and procedure changes made. Such written records shall be made available to the Department upon request.
2. Within ten (10) business days of completion of the review and revision to the policies and procedures identified in paragraph 1, all Facility staff shall be in-serviced regarding such policies and procedures. The Facility shall maintain a record indicating the date each staff member was in-serviced regarding the revised policies and procedures. Such record shall be made available to the Department upon request.
3. 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 are supervised in accordance with their needs;
  - c. The facility policy and procedure related to a missing resident is enforced;
  - d. Reporting of unusual occurrences to the Department in accordance with applicable state regulations; and
  - e. Job descriptions are reviewed and revised as appropriate and reviewed with each staff member to ensure that staff are providing the necessary care and services to the residents and in accordance with facility policies and procedures.
4. Within two (2) weeks of the effective date of this Consent Order, the Facility shall contract with an Independent Consultant ("IC") to review with the staff and management, the regulations and the facility's compliance with the regulations and other responsibilities set forth herein. The terms of the contract executed with the IC shall include all pertinent provisions contained in this Consent Order. This IC must have experience in Residential Care Homes and must be pre-approved in writing by the Department. The IC's duties shall be performed by a single individual unless otherwise

approved by the Department. The Licensee shall incur the cost of the IC. The IC shall function in accordance with the FLIS' IC Guidelines (Exhibit B – copy attached).

5. The IC shall be at the facility eight (8) hours every other week for three (3) months. The Department will evaluate the hours of the IC at the end of the three (3) months and may, in its discretion, reduce, eliminate or increase the hours of the IC and/or the IC's responsibilities, if the Department determines any such changes are warranted. The IC 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.
6. The IC 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 federal, state and local 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 IC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within three (3) weeks after the effective date of this Consent Order.
8. The IC shall confer with the Licensee's Owner, the Person in Charge and other staff determined by the IC to be necessary to the assessment of the Licensee's compliance with federal and state statutes and regulations.
9. The IC shall make recommendations to the Licensee's Person in Charge for achieving or maintaining regulatory compliance and improvement in the delivery of services provided to the residents. If the IC and the Licensee are unable to reach an agreement regarding the IC's recommendation(s), the Department in its absolute and sole discretion, after meeting with the Licensee and the IC shall make a final determination as to implementation of the IC's recommendation(s), which shall be binding on the Licensee.
10. The IC shall submit written reports to the Department every other week for the first four weeks of this Consent Order and monthly thereafter documenting:
  - i. The IC's assessment of the care and services provided to residents;

- ii. The Licensee's compliance with applicable federal and state statutes and regulations; and
  - iii. Any recommendations made by the IC and the Licensee's response to implementation of the recommendations.
- 11. Copies of all IC reports shall be simultaneously provided to the Person in Charge and the Department.
- 12. The IC shall have the responsibility for:
  - a. Monitoring and evaluating the delivery of services with particular emphasis and focus on residents rights, building and fire safety, medication administration and staffing;
  - b. Recommending to the Department an increase in the IC's contract hours if the IC is unable to fulfill the responsibilities within the stipulated hours per week; and
  - c. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated February 1, 2012 (Exhibit A).
- 13. The IC and the Licensee's Person in Charge shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at twelve (12) week intervals for one year 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 federal and state statutes and regulations.
- 14. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the IC and the Department, upon request.
- 15. The Licensee shall, within two (2) business days, notify the Department if the Person In Charge changes.
- 16. The Licensee, within seven (7) days of the effective date of this Consent Order, 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.

17. Any reports required by this document shall be directed to:

Maureen Klett, R.N., M.S.N., 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

18. 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.
19. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
20. The terms of this Consent Order shall remain in effect for a period of eighteen months from the effective date of this Consent Order.
21. 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 and the Regulations that exists at the time this Consent Order 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.
22. The Licensee consulted with its attorney prior to the execution of this Consent Order.

23. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges to encompass the findings identified in the February 1, 2012 violation letter referenced in this Consent Order.

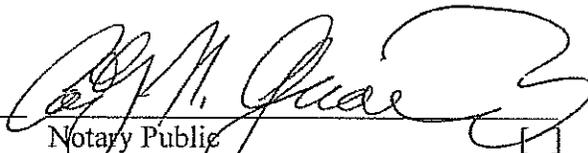
WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below. I, Luel Swanson, hereby represent and warrant that I am the President of the Licensee Greystone Rest Home, Inc. of Portland, Connecticut, and that I am authorized to sign this Consent Order on behalf of the Licensee.

Greystone Rest Home, Inc. of Portland d/b/a  
Greystone Rest Home

By:   
Luel Swanson, Person in Charge

On this 6<sup>th</sup> day of March, 2013, personally appeared the above named Luel Swanson, and made oath to the truth of the statements contained herein.

My Commission Expires: \_\_\_\_\_  
(If Notary Public)

  
Notary Public   
Commissioner of the Superior Court

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH

March 7, 2013

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



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

February 1, 2012

Luel Swanson, Administrator  
Greystone Rest Home, Inc.  
44 High Street  
Portland, CT 06480

Dear Mr. Swanson:

An unannounced visit was made to Greystone Rest Home Inc on January 28, 2012 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was 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 February 15, 2012 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

**An office conference has been scheduled for Wednesday, February 15, 2012 at 9:00 am in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish retain legal representation, your attorney may accompany you to this meeting.**

Please address 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.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

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

Respectfully,

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

MHK:lsl



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 OF VISIT: January 28, 2012

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 19-13-D6 (c) Administration (1) and/or (c) Administrator (5).

1. Based on a review record of one resident who did not return from a leave of absence as identified in a sign out log (R #1), the facility failed to reasonably ensure the resident's safety was maintained. The findings include:
  - a. Resident # 1, a 59-year-old resident, had diagnoses that included schizophrenia, paranoid type with schizotypal personality disorder. A 6/20/11 nurse's note identified that the resident had an appointment with Physician # 1, the psychiatrist. A psychiatrist progress note dated 6/20/11 identified that the resident's mental state is basically unchanged and that the resident is requesting a decrease in the Zyprexa to 10 milligrams (mg) and that Physician # 1 has agreed to decrease the Zyprexa. A physician's order dated 6/20/11 directed a decrease in the Zyprexa from 15 mg to 10 mg PO at hours of sleep. A 7/5/11 physician order identified to stop Flaxseed oil and a nurse's note of the same date that identified that the resident had seen Physician # 1. A nurse's note dated 7/10/11 identified the resident was selling some of his/her belongings to raise money for a new spiritual treatment, appeared to be stable and was going out on a leave of absence (LOA) with a boy/girlfriend and for a walk to the library. An 8/14/11 nurse's note identified that the resident enjoyed walks/trips outside to the library and periodic LOAs with his/her boyfriend and family. An 8/22/11 nurse's note identified an appointment with Physician # 1. The psychiatrist progress note dated 8/22/11 identified that there were no significant change in the resident's condition, including presentation and mental status. The note further indicated that the resident was quite concerned with the long-term side effects of his/her antipsychotic medication, particularly the Orap and wants to stop taking this medication. He/she is not willing to try a decrease in the medication and Physician # 1 identified his/her intent to discontinue the medication. A follow up appointment was scheduled for 9/19/11. A physician order dated 8/22/11 directed to discontinue (d/c) Orap, a neuropsychiatric medication. A nurse's note dated 9/11/11 identified that the resident seems to be doing well without Orap and continues to complain about not sleeping well and frequently found resting on his/her bed. A nurse's note date 9/22/11 identified that the resident had an appointment with Physician # 1. A physician order dated 9/23/11 identified to decrease the Trazodone to 100 mg at HS (hours of sleep) PRN (as necessary) times one week and then discontinue and to add Sinequan 25 mg PO at HS PRN. A 10/4/11 nurse's note identified the resident was found standing naked in her room with a piece of glass in her right hand trying to put it down her throat. It further indicated the resident had broken a picture in her room, she was nonverbal and wouldn't let staff dress her and was sent to the emergency room (ER) by ambulance for an evaluation of his/her mental status. A 10/5/11 physician order from the ER visit from the ER physician identified Ativan 0.5 mg BID (twice a day). A nurse's note dated 10/6/11 identified that on 10/4/11 when the staff was waiting for the ambulance to arrive, the resident was trying to gouge his/her eye out with his/her

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finger nail and upon her return last evening (10/5/11), the resident spent the entire evening on the floor "doing her penance." The note further indicated the Mobile Crisis Unit was called and the resident was sent to the ER and the nurse's note dated 10/19/11 identified that the resident returned to the facility yesterday afternoon (10/18/11) after a stay in the hospital. October 18, 2011 physician orders directed Zyprexa 15 mg PO at HS, Lorazepam 0.5 mg, one tablet PO BID PRN and Ambien 10 mg, one tablet PO HS PRN. 10/24/11 nurse's note identified that the Resident had an appointment with Physician # 1. A physician's order dated 10/24/11 identified to add Orap 2 mg PO (by mouth) in the AM. A 11/13/11 nurse's note identified that the resident's mood was somber, sleep pattern disturbed and that the A-- A---- continues "verbalizing punishment" and that he/she is going to talk to spiritual advisors because he/she believes the punishment is not fair. He/she discussed incident of 10/4 and 10/6 on own and said he/she was feeling safe but was not sleeping. The nurse's note dated 1/14/11 and 12/19/11 identified an appointment with Physician # 1. The physician orders dated 1/14/11 identified to discontinue the Sinequan and to add Trazodone 200 mg PO at HS PRN for insomnia. A physician progress note dated 1/19/12 identified that the resident continued to report both visual and auditory hallucinations and that there was no new changes in her behavior and that over the last few years she had been able to resist the telling of her to blind herself and others. The progress note further identified that the physician was ordering a Zyprexa level. A nurse's note dated 1/19/12 identified that the resident continued to complain about not being able to sleep, was taking Ambien at bedtime, Trazodone when she wakes up, then Valium, if Trazodone does not work. It further identified that the resident claimed that the Ativan doesn't work at all and that the resident spends most of the day resting on bed and talks about A-- A---- punishing him/her. The last recorded nurse's note and physician order documented in the resident's chart reflect an appointment with Physician # 1 where the Ativan was discontinued. Review of a laboratory bloodwork Zyprexa level dated 1/27/12 identified that the resident's Zyprexa level was 35.9 ng/ml (normal range 5.0 – 75.0 ng/ml). There were no other changes identified to the resident's medication regime. A review of the facility sign out sheet identified that on 1/26/12 at 3:00 PM the resident signed out to go to a neighboring library and for dinner with an expected return as what appears to be 6:30 PM. The 6:30 PM has been written over to reflect either 8:30 PM or 9:30 PM, unclear by whom. Review of the resident Medication Administration Record for the month of January identified that on 1/26/12 the resident's medications HS medications, including Zyprexa 10 mg, Zyprexa 5 mg, for a total of 15 mg and Calcium Citrate 200 mg, had not been signed off as having been administered. An interview on 1/28/12 at 5:00 pm with Staff Member # 1 identified he/she realized at 8:00 PM on 1/26/12 that Resident # 1 had not come to take his/her medications and at that time Staff Member # 1 went to the leave of absence book at the front desk and realized Resident # 1 had signed out. At that time she asked Staff Member # 3 if he/she had seen Resident # 1 and was told he/she had not. She further stated he/she did not tell the oncoming 11:00 PM – 7:00 AM staff members that Resident # 1 had not returned because "it totally slipped my mind." Interview on 1/28/12 at 2:40 PM with Staff Member # 4 identified that she was the staff person

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positioned in the front area, she made checks every 15 minutes to every ½ hour on the 11:00 PM to 7:00 AM shift and had not been told that Resident # 1 did not return. Staff Member # 4 further identified that she went to Resident # 1's room to check on her roommate, Person # 2 approximately 4-5 times between 11:30 AM – 5:00 AM and realized between 2:00 AM and 3:00 AM that Resident # 1 was not there. Staff Member # 4 also stated that she did not check the sign out log to see where Resident # 1 was because she thought she just assumed she was out on an overnight and she did not tell anyone on the 7:00 AM to 3:00 PM shift that she had not seen Resident # 1 during the night. She further indicated she did not speak to the Administrator or Staff Member # 5, both of whom were in other parts of the building sleeping during the 11:00 PM to 7:00 AM shift on 1/26/12. An interview on 1/30/12 at 9:09 AM with Staff Member # 6 identified that she was the person who supervised the residents taking their medication on 1/27/12 during the 7:00 AM – 3:00 PM shift and that at 9:30 AM, after Resident # 1 had not taken her medications, he/she asked Staff Member # 7 to look for the resident. Staff Member # 6 further indicated that around 10:00 AM he/she contacted the staff member who worked the 11:00 PM – 7:00 AM prior shift, Staff Member # 4, to see if he/she knew where Resident # 1 was and then let Staff Member # 1, the Admissions Coordinator know he/she wasn't in the building. An interview on 1/30/12 at 11:59 AM with Staff Member # 1 identified that he/she believed she was notified that staff could not locate Resident # 1 around 10:30 AM on 1/27/12 and that is when she told the Administrator. According to Police Officer # 1 in an interview on 1/30/12, the call came into the police department at 2:14 PM on 1/27/10 (18 hours and 45 minutes after the resident indicated he/she would return). Police Officer #1 further identified that while at the building sitting in a conference room, a call came from a staff member identifying that a suicide note had been found in the resident's drawer. An interview with the Administrator on 1/28/12 at 12:00 PM identified that although there is no written policy, the practice is that if person doesn't return within one hour of the time identified than the expectation is that the facility staff will look for the resident. A subsequent interview on 1/30/12 at 12:35 PM with the Administrator identified that they didn't report the resident was missing sooner because they were going into their own protocol of looking for the resident and had sent staff out in a car looking for him/her. The Administrator further indicated on 1/3/12 at 12:35 PM that the resident had not been located or had not returned to the facility. On 1/31/12 at 3:34 PM, a phone call was received by the Department of Public Health from Police Officer # 1 which identified that Resident # 1's body had been found in the water and had been sent to the Medical Examiner's office.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (4)(C) and/or (5).

2. Based on review of the residents log sheets for all residents who signed out and interviews the facility failed to have a system in place to ensure the resident's safety, if the resident did not return when identified and/or for one resident (R #1) failed to reasonably ensure the resident's safety when he/she did no return as anticipated. The findings include:

DATE OF VISIT: January 28, 2012

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
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- a. A review of the resident sign out sheets between 12/25/11 and 1/28/12 identified that 173 of 265 occasions where residents were signed out for LOAs, there was no indication of whether they had returned to the facility. The sign out log further identified that on 101 of those occasions, the residents had not identified their expected time of return as required. An interview with the Administrator on 1/28/12 at 12:00 PM identified that there is no written documentation of communication regarding residents returning from LOAs, just word of mouth and upon request, was unable to provide a missing persons policy. On 1/28/12 at 3:45 PM the Administrator was notified of the need to provide the Department of Public Health with an Immediate Action Plan to address a system of reporting from shift to shift, on residents who are on LOA and a policy and procedure to address missing residents. On 1/28/12 at 6:30 PM the Administrator provided a policy for when a Resident Does Not Return by written sign in time that included after one (1) hour of a resident not returning to the facility as identified on the logout sheet, the staff member calls over the PA system, checks rooms and the facility grounds for the resident. If the resident cannot be found either the Administrator, Admission Director or Charge Nurse is to be notified. The administrative person in charge would call the family and notify the police department. It further identified that staff members would verbally notify each other at the change of shift of anyone who has signed out and has not returned and would sign a log verifying that they have each received the shift change information.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (j) Attendants Required.

3. Based on observation and/or staff interview, the facility failed to ensure staff accessibility to the residents during the 11:00 pm – 7:00 am shift. The findings include:
  - a. An interview and observation on 1/28/12 at 2:30 PM with the Administrator identified that there are three (3) people in the building on the 11:00 PM -7:00 AM shift, an awake person who makes rounds every 15 minutes. This person also has other responsibilities such as sweeping the recreation room and doing laundry, a second and third person who were identified as the 2<sup>nd</sup> sleep person and 3<sup>rd</sup> sleep person. An observation of second floor where Staff Member # 8 and the Administrator sleep, alternately, identified that it was behind a closed door, up a stairway, through a hallway and behind another door. The Administrator identified that there was a phone in the room, but was unable to show such and/or the awake person would call his/her or Staff Person # 8's cell phone. The room also included a mattress on the floor with linen present and rolled up at the top of the bed. At that time the Administrator identified that a 3<sup>rd</sup> floor stairwell led to storage area upon being asked. The Administrator further identified that the person sleeping on the second floor could not hear residents' call bells ringing from this location. At this time the Administrator also identified that the other staff member who worked the 11:00 PM – 7:00 AM shift, Staff Member # 5, slept in the conference room situated behind the dining room and kitchen, with both doors closed and if needed would be called on her cell phone by the awake person. Subsequent to this observation, the Administrator

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identified that Staff Member # 8, in fact did sleep on the 3<sup>rd</sup> floor and would be called through her cell phone if needed, could not hear the residents' call bells, if help was needed. An interview on 1/28/12 at 2:40 PM identified that she is the awake person for this 58 bed facility and that the sleep person # 2 and # 3 could not hear the residents' call bells, if they were to ring. On 1/28/12 at 3:45 PM the Administrator was notified of the need to provide the Department of Public Health with an Immediate Action Plan to address the availability of staff to address the residents' needs on the 11:00 PM – 7:00 AM shift. The Action Plan included that an outside vendor would be notified to determine if a buzzer system can be installed on the 2<sup>nd</sup> and 3<sup>rd</sup> floors. Until such time, staff members working the 11:00 PM – 7:00 AM shift will stay in the library with the doors open and/or will situate themselves in the New Wing lounge so they will be accessible to the residents.