2016

POC Accepted
M. Sara Sousa RN
5-11-16

FACILITY: Covenant Village of Cromwell Assisted Living Services

DATES OF VISIT: August 27, 28, 31, 2015

PLAN OF CORRECTION

1. **Section 19-13-D105 (e) General requirements for assisted living services agency (11).**
   - Policy 34.00 Emergency Response to 911 Call was developed on 08/27/2015 to direct emergency personnel to proper entrance location in Assisted Living to ensure ease of access for emergency personnel.
   - All appropriate staff have been educated on 4/15/2016 regarding emergency response to 911 call.
   - New signage has been posted on campus to ensure ease of access for emergency personnel.
   - SALSA/Designee will monitor for 100% compliance through a report log completed after each 911 call. This will be reviewed at the weekly Core Service Meeting for ALSA.

2. **Section 19-13-D105(k0 Client Service Record (2) (H) (ii).**
   - Reviewed Policy/procedure 31.30 AL resident assessment program.
   - All ALSA staff have been educated on 4/15/2016 regarding requirement to update service plan upon each change in condition episode, per policy.
   - SALSA/Designee will ensure, via random audits (5 charts) of the client service plan X 60 days.
   - SALSA/Designee will monitor for 100% compliance and report at the next QA meeting scheduled every 120 days. If goal not met will continue to monitor until 100 % compliance is achieved.

3. **Section 19-13-D105 (k) Client service record (2) (L)**
   - Reviewed and revised policy/procedure 31.30 AL resident assessment program, to ensure individualized and comprehensive services to residents.
   - All licensed nurses will be educated per policy 31.30 to ensure accuracy of assisted living aide flow sheets.
   - Assisted Living aide Flow sheets will be monitored for accuracy via random audits x 60 days (5 charts) by the SALSA/Designee.

POC Accepted
M. San Souci RN
5/11/16

- SALSA/Designee will monitor for 100 % compliance and report at the next QA meeting scheduled every 120 days. If goal not met will continue to monitor until 100% compliance is achieved.

4. **Section 19-13-D105 (h) Nursing services provided by an assisted living services agency (4) € and/or (k) client service record (2)(K).**

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- Reviewed Policy/procedure 31.18 Self administration of medication VII. A licensed nurse shall ensure that the resident or representative is aware of resident's medication regimen and is able to make decisions regarding medication administration. All drugs in the facility will be handled in a manner that protects the safety and well being of each resident.
- All licensed nurses have been educated on 4/15/16 per policy 31.18.
- SALSA or designee will perform random audits (5 charts) x 60 days to ensure that the resident or representative is aware of medication regimen and is able to make decisions regarding medication administration per policy.
- SALSA/Designee will monitor for 100% compliance and report at the next QA meeting, scheduled every 120 days. If goal not met will continue to monitor until 100% compliance is achieved.

ii. _____

- Reviewed policy/procedure 31.5 Contracted services. A contract or written MOU (memo of understanding) between the contracting agency and ALSA will be developed by the contracting agency and will be found in the client record.
- All licensed nurses have been educated On 4/15/16 per policy 31.5.
- SALSA or designee will perform random audits (5 charts) x 60 days to ensure that a MOU has been developed for each resident receiving services from another agency.
- SALSA or designee will monitor for 100% compliance and report at the next QA meeting scheduled every 120 days. If goal not met will continue to monitor until 100% compliance is achieved.

5. **Regulations of Connecticut State Agencies 19-13-D105 (h) Nursing Services provided by an assisted living services agency (3) (C).**

- Reviewed/Revised policy/procedure 31.25 Falls Evaluation Program. A falls assessment will be completed on each client who sustains a fall witnessed or unwintnessed.
- All licensed nurses where educated on 4/15/2016 per policy 31.25.
- SALSA or designee will perform random audits (5 charts) x 60 days to ensure that a falls assessments are being completed per policy.
- SALSA or designee will monitor for 100% compliance and report at the next QA meeting scheduled every 120 days. If goal not met will continue to monitor until 100% compliance is achieved.

POC Accepted
M Sara Sonci RN

The above Plan of Correction will be put in effect immediately.

Respectfully Submitted,

Maryann Trocchio RN

Maryann Trocchio, RN, Director of Assisted Living/SALSA

Covenant Village of Cromwell
52 Missionary Road
Cromwell, CT 06416

(860)635-5511

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 1, 2016

Brandy Rahhi, Supervisor of Assisted Living Services Agency
Covenant Village Of Cromwell Assisted Living Services Agency
52 Missionary Road
Cromwell, CT 06416

Dear Ms. Rahhi:

Unannounced visits were made to Covenant Village Of Cromwell Assisted Living Services Agency on August 27, 28 and 31, 2015 by representatives 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 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 April 15, 2016 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 within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS 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-D105 (e) General requirements for an assisted living services agency (11).

1. Based on clinical record review, agency documentation and staff interview, for one of four clients (Client #1) in the survey sample, the agency failed to ensure the development of emergency policies. The findings include:
   a. Client #1 was admitted to the assisted living facility on 11/1/14 with diagnoses that included hyperlipidemia, osteoporosis, altered mental status, hypertension, difficulty in walking, adjustment disorder with depression, history of breast malignancy and intestinal perforation. The client service program dated 6/30/15 and updated on 8/2/15 identified the need for assistance with activities of daily living and safety checks.
   Interview and review of the facility documentation with the Service Coordinator on 8/28/15 indicated that on 8/13/15, Client #1 exhibited an increase in delirium (went in the shower under hot water three times between 3 AM and 10:30 AM), the physician was notified and directed to transfer the client to the Emergency Department for evaluation, but the ambulance personnel were delayed in reaching the client as the ALSA failed to establish signage of the building (the ambulance staff reported to the skilled nursing facility next door instead), the ALSA staff failed to wait for the ambulance personnel by the entrance door, and the elevator was not on hold for the emergency priority.

   Interview and review of the agency documentation with the Service Coordinator on 8/28/15 failed to identify policies and procedures with appropriate steps to follow in emergencies, and/or appropriate orientation of all staff to the emergency procedures.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (k) Client service record (2) (H) (ii).

2. Based on clinical record review and staff interview, for one of four clients (Client # 1) in the survey sample, the Supervisor of Assisted Living Services Agency (SALSA) failed to update the goals of management in the client service record. The findings include:
   a. Client #1 was admitted to the assisted living facility on 11/1/14 with diagnoses that included hyperlipidemia, osteoporosis, altered mental status, hypertension, difficulty in walking, adjustment disorder with depression, history of breast malignancy and intestinal perforation. The client service program dated 6/30/15 and updated on 8/2/15 identified the need for assistance with activities of daily living and safety checks.

   On 8/8/15 the ALSA nurse documented that Client # 1 was taking clothes off, stating the client was told to do so.
   On 8/9/15 the ALSA nurse documented that Client #1 activated the call bell (pendant) at 12:15 AM, was found sitting in chair wearing underpants only, stating there were no clothes to wear and/or no food in the refrigerator to cook breaksfast. The client was dressed and

assisted back to bed. In the morning the client complained of shortness of breath, with a respiratory rate of 36, and agreed to a transfer to the Emergency Department for evaluation of respiratory status and confusion. The client was diagnosed with slight delirium and returned to the ALSA on 8/10/15 at 3 PM with new orders for Seroquel 12.5mg at 5 PM.

On 8/11/5 the ALSA nurse documented that Client #1 exhibited bizarre behavior, walked around the apartment without clothes on, laughing, stating that none of the clothes fit, and the aide assisted the client in getting dressed again. One hour later the aide found Client #1 sitting in the shower with the shower hose outside the shower stall, flooding the floor. Client #1 did not know where the client was.

On 8/13/15 the ALSA nurse documented that Client #1 was found in the shower with the hot water on at 3 AM. The aide dressed the client and assisted the client back to bed. The aide subsequently checked on the client and found the client in the shower under the hot water again. At 10:30 AM Client #1 was found in the shower under hot water for the third time. The physician was called and directed to transfer the client to the Emergency Department for evaluation.

On 8/14/15 the ALSA nurse documented that the client was evaluated at the Emergency Department and discharged to a skilled nursing facility where the client would be treated by a psychiatrist.

Review of the client service plan failed to identify updates in the goals of management to reflect the client's change in condition, after each behavioral episode.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D105 (k) Client service record (2) (L).

3. Based on review of the clinical record and staff interview, for one of four clients (Client # 1) in the survey sample, the assisted living aides failed to accurately document the care and services provided. The findings include:
   a. Interview and review of Client #1's clinical record with LPN #1 on 8/28/15 at 12:30pm identified documentation by the ALSA Aides that Client #1 received medication reminders by the aides from 8/1/15 through 8/10/15, when in fact LPN #1 confirmed that Client #1 was not receiving medication reminders from the ALSA aides during the period of 8/1/15 through 8/10/15, and failed to identify accurate documentation of aide services provided to the client.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D105 (h) Nursing services provided by an assisted living services agency (4) (E) and/or (k) Client service record

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

(2)(K).

4. Based on clinical record review, staff interview and surveyor observation, the ALSA nurse failed to reconcile the client's medication. The findings include:
   a. Client #4 was admitted to the Assisted Living program on 07/28/14 with diagnoses that included Alzheimer's dementia, chronic kidney disease, osteoarthritis, osteopenia, overactive bladder, cataracts, venous insufficiency, hypertension and hyperlipidemia.
      i. The client service program for the period of 07/22/15 to 11/18/15 included weekly skilled nursing services to pre-pour medications and medication reminders by the aide. The client's medications included Exelon 13.3 milligram (mg) patch topically once a day and Xanax 0.5 mg by mouth twice a day as needed for anxiety.

         The client service record (CSR) dated 08/01/15 identified the need for assistance with medication set-up, re-order and medication reminders by nursing assistant. The next-of-kin applied the Exelon patch.
         On 04/14/15, a physician identified by licensed practical nurse (LPN #1) as the psychiatrist directed to decrease the Exelon patch to 9.5 mg daily as a trial for a week (though 4/21/15).
         On 6/2/15, the psychiatrist also directed to discontinue the as-needed Xanax 0.5 mg.

         Interview and review of Client # 4's medication record dated 08/17/15 with LPN #1 on 08/31/15 at 11:30 a.m. identified Exelon patch as 9.5 mg./24 hour started on 04/14/15, based on a fax from the physician's office dated 08/25/15 to continue Exelon 9.5 mg.

         During a joint visit to Client # 4 on 08/31/15 at 11:35a.m., the client's next-of-kin indicated that the Exelon patch in use came from a cabinet holding patches of Exelon 13.3 mg.

         Interview and review of the ALSA documentation with LPN #1 on 08/31/15 failed to identify clarification of the physician's orders and accurate teaching to the patient's next-of-kin of the required strength of the Exelon patch;
      ii. On 8/14/15, the physician ordered home care services from a Home Health agency, with the home health agency nurse now pre-pouring the medications, instead of the ALSA nurse, and with additional aide services from the home health agency.

         Interview and review of the clinical record and agency documentation with LPN # 1 on 8/31/15 failed to identify documentation of coordination of services between the ALSA and the Home Health agency staff.

The following is a violation of the Regulations of Connecticut State Agencies 19-13-D105 (h) Nursing Services provided by an assisted living services agency (3) (C).

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5. Based on clinical record review and interview with agency staff, for one of four clients (Client #2) in the survey sample, the agency registered nurse failed to promptly re-assess the client after a change in condition. The findings include:
   a. Client #2 was admitted to the Assisted Living Services Agency (ALSA) on 08/07/14 with diagnoses that included macular degeneration, hearing loss, muscle weakness, difficulty walking a history of falls.

   On 03/30/15 the client was transferred to the Memory Care Unit with diagnoses of dementia and confusion.
   The nursing note dated 4/03/15 indicated that the client was found on the floor in front of a recliner chair at approximately 9:00 PM by an ALSA aide. The client was able to move legs, was assisted to stand up by two aides, and the supervisor of assisted living services (SALSA) was notified.

   Interview and review of the nursing documentation with Licensed Practical Nurse (LPN) #1 on 08/29/15 at 10:05 AM failed to identify a post-fall assessment by a registered nurse (RN) until the following day, 04/04/15 at 12:04 PM.

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Covenant Acres
The Grove + Pine View
Missionary Rd, Cromwell CT 06416

Signature of FLIS Staff
Michael D. Smith RN Nurse Consultant
Mary Jo Sanford RN Nurse Consultant

Licensure Category: Assisted Living Services

Licensed Capacity: 41 AL
Licensed Capacity: 9 Dementia

Census: 34
Census: 6

Date(s) of onsite inspection: 8/27/15, 8/28/15, and 8/31/15

Date(s) additional information obtained: 4-1-16 Brandy Rahhal SAUSA

Personnel contacted: Becky Cubeta Servic Coordinator; Pam Klapproth Ex. Director

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other:* _____

[ ] Desk Audit _____ [ ] Amended Letter: _____

[ ] Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[ ] See Reportable Event Investigation # _____

[ ] See Certification File.

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: _____ **DATE OF REPORT:** 9/3/15

[X] Approval for issuance of license granted by: Loan Nguyen **DATE:** 4-1-16
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 1, 2016

mary Ann Tvocchio

Brandy Rahhi, Supervisor of Assisted Living Services Agency
Covenant Village Of Cromwell Assisted Living Services Agency
52 Missionary Road
Cromwell, CT 06416

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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 April 15, 2016 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 within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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   a. Client #1 was admitted to the assisted living facility on 11/1/14 with diagnoses that included hyperlipidemia, osteoporosis, altered mental status, hypertension, difficulty in walking, adjustment disorder with depression, history of breast malignancy and intestinal perforation. The client service program dated 6/30/15 and updated on 8/2/15 identified the need for assistance with activities of daily living and safety checks.
   Interview and review of the facility documentation with the Service Coordinator on 8/28/15 indicated that on 8/13/15, Client #1 exhibited an increase in delirium (went in the shower under hot water three times between 3 AM and 10:30 AM), the physician was notified and directed to transfer the client to the Emergency Department for evaluation, but the ambulance personnel were delayed in reaching the client as the ALSA failed to establish signage of the building (the ambulance staff reported to the skilled nursing facility next door instead), the ALSA staff failed to wait for the ambulance personnel by the entrance door, and the elevator was not on hold for the emergency priority.

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On 8/11/5 the ALSA nurse documented that Client #1 exhibited bizarre behavior, walked around the apartment without clothes on, laughing, stating that none of the clothes fit, and the aide assisted the client in getting dressed again. One hour later the aide found Client #1 sitting in the shower with the shower hose outside the shower stall, flooding the floor. Client #1 did not know where the client was.

On 8/13/15 the ALSA nurse documented that Client #1 was found in the shower with the hot water on at 3 AM. The aide dressed the client and assisted the client back to bed. The aide subsequently checked on the client and found the client in the shower under the hot water again. At 10:30 AM Client #1 was found in the shower under hot water for the third time. The physician was called and directed to transfer the client to the Emergency Department for evaluation.

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The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D105 (h) Nursing services provided by an assisted living services agency (4) (E) and/or (k) Client service record

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

(2)(K).

4. Based on clinical record review, staff interview and surveyor observation, the ALSA nurse failed to reconcile the client's medication. The findings include:
   a. Client #4 was admitted to the Assisted Living program on 07/28/14 with diagnoses that included Alzheimer's dementia, chronic kidney disease, osteoarthritis, osteopenia, overactive bladder, cataracts, venous insufficiency, hypertension and hyperlipidemia.
      i. The client service program for the period of 07/22/15 to 11/18/15 included weekly skilled nursing services to pre-pour medications and medication reminders by the aide. The client's medications included Exelon 13.3 milligram (mg) patch topically once a day and Xanax 0.5 mg by mouth twice a day as needed for anxiety.

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         On 04/14/15, a physician identified by licensed practical nurse (LPN #1) as the psychiatrist directed to decrease the Exelon patch to 9.5 mg daily as a trial for a week (though 4/21/15).
         On 6/2/15, the psychiatrist also directed to discontinue the as-needed Xanax 0.5 mg.

         Interview and review of Client # 4's medication record dated 08/17/15 with LPN #1 on 08/31/15 at 11:30 a.m. identified Exelon patch as 9.5 mg./24 hour started on 04/14/15, based on a fax from the physician's office dated 08/25/15 to continue Exelon 9.5 mg.

         During a joint visit to Client # 4 on 08/31/15 at 11:35a.m., the client's next-of-kin indicated that the Exelon patch in use came from a cabinet holding patches of Exelon 13.3 mg.

         Interview and review of the ALSA documentation with LPN #1 on 08/31/15 failed to identify clarification of the physician's orders and accurate teaching to the patient's next-of-kin of the required strength of the Exelon patch;
      ii. On 8/14/15, the physician ordered home care services from a Home Health agency, with the home health agency nurse now pre-pouring the medications, instead of the ALSA nurse, and with additional aide services from the home health agency.

         Interview and review of the clinical record and agency documentation with LPN # 1 on 8/31/15 failed to identify documentation of coordination of services between the ALSA and the Home Health agency staff.

The following is a violation of the Regulations of Connecticut State Agencies 19-13-D105 (h) Nursing Services provided by an assisted living services agency (3) (C).

DATES OF VISIT: August 27, 28 and 31, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5. Based on clinical record review and interview with agency staff, for one of four clients (Client #2) in the survey sample, the agency registered nurse failed to promptly re-assess the client after a change in condition. The findings include:
   a. Client #2 was admitted to the Assisted Living Services Agency (ALSA) on 08/07/14 with diagnoses that included macular degeneration, hearing loss, muscle weakness, difficulty walking a history of falls.

      On 03/30/15 the client was transferred to the Memory Care Unit with diagnoses of dementia and confusion.
      The nursing note dated 4/03/15 indicated that the client was found on the floor in front of a recliner chair at approximately 9:00 PM by an ALSA aide. The client was able to move legs, was assisted to stand up by two aides, and the supervisor of assisted living services (SALSA) was notified.

      Interview and review of the nursing documentation with Licensed Practical Nurse (LPN) #1 on 08/29/15 at 10:05 AM failed to identify a post-fall assessment by a registered nurse (RN) until the following day, 04/04/15 at 12:04 PM.

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Covenant ACLF
The Grove + Pine View
Missionary Rd, Cromwell CT 06416 860 294 4147

Signature of FLIS Staff
Michael D. Smith RN Nurse Consultant
Melissa J. Sansouci RN Nurse Consultant

Licensure Category: Assisted Living Services

Licensed Capacity: 41 AL
Licensed Capacity: 9 Dementia

Census: 34
Census: 6

Date(s) of onsite inspection: 8/27/15, 8/24/15, 8/31/15

Date(s) additional information obtained: ___

Personnel contacted: Becky Cubeta Service Coordinator; Pam Klapproth Ex. Director

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other*: ___

[ ] Desk Audit ___ [ ] Amended Letter: ___

[ ] Revisit for the purpose of ___

[ ] See Complaint Investigation # ___

[ ] See Reportable Event Investigation # ___

[ ] See Certification File.

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: [signature] DATE OF REPORT: ___

[X] Approval for issuance of license granted by: Joan Dragen DATE: 9-30-15
Supervisor/Title