

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

IN RE: Home Health Care Services, LLC
574 Heritage Road, Suite 110
Southbury, CT 06488

CONSENT AGREEMENT

WHEREAS, Home Health Care Services, LLC of Southbury, CT ("Licensee"), has been issued License No. C9915701 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Facility Licensing & Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates commencing on January 26, 2005 up to and including April 27, 2005 for the purpose of conducting an investigation and licensing and certification inspections; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated March 14, 2005 (Exhibit A - copy attached) and May 9, 2005 (Exhibit B - copy attached); and

WHEREAS, the foregoing acts constitute grounds for disciplinary action pursuant to section 19a-494 of the General Statutes of Connecticut, taken in conjunction with Sections 19a-13-D66 et seq. of the Regulations; and,

WHEREAS, the parties desire to fully resolve the matter without further proceeding; and,

WHEREAS, the Licensee, in consideration of this Consent Agreement, has chosen not to contest the above allegations before a hearing officer and further agrees that this Consent Agreement shall have the same effect as if ordered after a full hearing pursuant to Section 19a-494 of the General Statutes of Connecticut; and,

WHEREAS, it is expressly understood that the execution of this Consent Agreement, and any statements or discussions leading to the execution of the Consent Agreement, shall not be construed to constitute any admission or adjudication of any violation of the Regulations of Connecticut State Agencies and/or Connecticut General Statute by the Licensee, its officers, directors, agents, employees, or any other person or entity in any subsequent matter, proceeding, hearing or lawsuit.

NOW THEREFORE, the Facility Licensing & Investigations Section of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Section Chief, and the Licensee, acting herein through Stan G. Thurston, its President and CEO, hereby stipulate and agree as follows:

1. The Licensee understands and agrees this Consent Agreement, and the violations contained therein, shall be admissible as evidence in any subsequent proceeding before the Department in which (1) the Licensee's compliance with this same Consent Agreement is at issue, or (2) the Licensee's compliance with any state or federal statute and/or any state, federal, or departmental regulation is at issue; and
2. The Licensee understands that this Consent Agreement fully and completely resolves the allegations referenced above without any further proceeding before the Department.
3. The Licensee waives the right to a hearing on the merits of this matter.
4. The Licensee understands this Consent Agreement is a matter of public record.
5. The Licensee within seven (7) days of the execution of this Consent Agreement shall designate an individual within the Facility who has responsibility for the implementation of this Consent Agreement. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
6. Effective upon execution of this Consent Agreement, the Licensee through its Governing Body, Administrator and Supervisor of Clinical Services shall ensure that:
 - a. All patients are initially assessed in a timely and comprehensive manner and all subsequent re-assessments are accurate, comprehensive and appropriate, including the immediate care and support needs of the patient and completed as often as necessary depending on the condition of the patient.
 - b. All patients shall have a comprehensive plan of care developed and/or revised which is based on the individual patient's assessment/re-assessment and is reflective of the needs of the patient and includes all appropriate interventions for complete care to the total patient; prompt action shall be taken regarding any patient's change in condition and deteriorating health and/or safety status.
 - c. Each patient's personal physician or covering physician is notified in a timely manner of any significant change in condition.
 - d. All services provided to patients, will be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care and is integrated with other entities involved with the patient's care. All coordination activities will support effective communication and interchange to discuss issues pertinent to effective case management.
 - e. All care provided to patients by licensed practical nurses is coordinated by and under the direction and supervision of a registered nurse;

- f. All aspects of the care plan delegated to the home health aide shall be done in an appropriate manner to ensure patient safety and in compliance with all applicable state and federal laws and regulations. All home health aides will be appropriately supervised by the registered nurse to ensure that the written instructions to the home health aide are followed at all times.
 - g. All patients shall be informed, at all times, of all unit charges and billing mechanisms and the extent to which payment may or may not be expected from third party payor sources.
7. The Licensee shall within fourteen (14) days of the effective date of this Consent Agreement, review and revise, as necessary, each patient's plan of care based upon the patient's current and ongoing assessments. Said care plan shall identify each individual patient's problems, needs and goals in accordance with federal and state laws and regulations.
8. The Licensee shall within twenty-one (21) days of the effective date of this Consent Agreement review and revise, as necessary, all policies and procedures which are pertinent to patient assessment; development, implementation and revision of the plan of care; medication administration, management and appropriate delegation to the home health aide; coordination of services including services provided in collaboration with an assisted living services agency; clinical protocols including, but not limited to, cardiovascular and respiratory disease management; and notification of the physician of the condition of the patient including concerns for the patient's safety.
9. The Licensee shall within thirty (30) days of the effective date of this Consent Agreement in-service all direct service staff on topics relevant to the provisions of Sections 6, 7 and 8 of this document. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.
10. The Licensee shall within sixty (60) days of the effective date of this Consent Agreement audit the medical record of each patient currently receiving services to ensure that each patient's current condition is accurately and consistently documented and that care is provided in accordance with the plan of care.
11. Within ten (10) days after the completion date specified above for the medical record audits, all direct care staff shall be provided with in-service education pursuant to deficient practices identified as a result of the medical record audits. Subject to this Consent Agreement documentation of in-services shall be maintained by the Licensee for review by the Department for a period of two (2) years.
12. The Licensee upon the execution of this Consent Agreement shall pay to the Department of Public Health seven hundred fifty hundred dollars (\$750.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Agreement. The check shall be made payable to

the Treasurer of the State of Connecticut.

13. The \$750.00 payment and any other reports required by this Consent Order shall be directed to:
- Victoria V. Carlson, R.N., M.B.A.
Supervising Nurse Consultant, Department of Public Health,
Facility Licensing & Investigations Section
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308
14. The provisions of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document. The Licensee may request that the Department agree to terminate the Consent Agreement at any time after the end of the first twelve (12) month period. The Department may, in its sole discretion, grant such request, taking into consideration the Licensee's compliance with this Consent Agreement over the first twelve (12) month period.
15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
16. The Licensee understands legal notice of any action shall be deemed sufficient if sent to the Licensee's last known address of record reported to the Facility Licensing & Investigations Section.
17. All parties agree that this Consent Agreement 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 this document or of any other statutory or regulatory requirements. This Consent Agreement 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 Department may petition any court with proper jurisdiction for enforcement of this Consent Agreement in the event the Licensee fails to comply with its terms.
18. The Licensee has had the opportunity to consult with an attorney prior to signing this document
19. The Licensee understands this Consent Agreement is effective upon approval and acceptance by the Commissioner's representative, at which time it shall become final and an order of the Commissioner of Public Health.

*

IN WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

HOME HEALTH CARE SERVICES, LLC
OF SOUTHBURY, CT.

Aug 18, 2005
Date

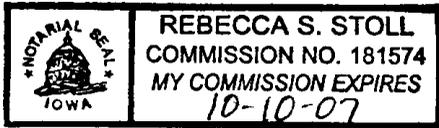
By: Stan G. Thurston
Stan G. Thurston, President and CEO

State of Iowa
County of Folk

ss August 18, 2005 2005

Personally appeared the above named Stan G. Thurston and made oath to the truth of the statements contained herein.

My Commission Expires: 10-10-07

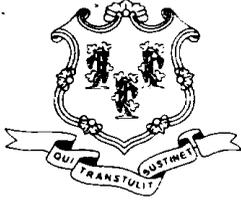


Rebecca S Stoll
Notary Public
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

August 22, 2005
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Section Chief
Facility Licensing & Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 14, 2005

Susan Sokol, RN, Administrator
Home Health Care Services, LLC
574 Heritage Road, Suite 110
Southbury, CT 06488

Dear Ms. Sokol:

Unannounced visits were made to Home Health Care Services, LLC on January 26, 27, 28, 31 and February 1 and 2, 2005 by representatives of the Division of Health Systems Regulation for the purpose of conducting an investigation and certification inspection with additional information received through February 25, 2005.

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

An office conference has been scheduled for March 28, 2005 at 10 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified during the inspection. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, 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.

Respectfully,

Victoria V. Carlson, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

SNC:NC:

cc: complaint # CT00003674



Phone:

Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # _____

P.O. Box 340308 Hartford, CT 06134

Affirmative Action / An Equal Opportunity Employer

DATE(S) OF VISIT: January 26, 27, 28, 31, February 1 and 2, 2005 with additional information received through February 25, 2005.

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

2. Based on staff interview and clinical record review, it was determined that the administrator failed to ensure and maintain the quality of care and services rendered to six (6) of twelve (12) patients (Patient #s 3, 5, 6, 8, 11 and 12) as evidenced by the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

Plan of Correction

Completion Date

3. The supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and families by direct service staff under their supervision as evidenced by the care and services rendered to Patient #s 3, 5, 6, 8, 11 and 12 identified in the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2)(3)(A)(B)(C) General requirements.

Plan of Correction

Completion Date

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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4. Based on an onsite visit to the agency's Branford office, staff interviews and review of personnel records, it was determined that the agency administrator/supervisor failed to designate in writing, a qualified registered nurse with at least two years experience in a home health care agency to act during any absence of the supervisor of clinical services (SCS) in the Branford office whenever patient care personnel are serving patients. The findings include:

- a. On 1/26/05 an onsite visit was conducted to the home care agency's Branford office. The office manager informed the surveyor that the administrator/supervisor was out of state, but was available by telephone. When contacted, the administrator/supervisor informed the surveyor that RN #5 was the acting supervisor of clinical services and she was not present in the office because she was out visiting patients.
- b. The surveyor contacted RN #5 on 1/26/05 who stated that she was conducting patient visits and did not plan to come into the Branford office. RN #5 explained that she was not a full time employee at the agency and when her visits were finished she would be available on-call.
- c. Review of RN #5's personnel record determined that her date of hire was 3/10/03 as a per diem nurse and she did not have two years of home health care experience. The personnel record also lacked documentation to designate RN #5 as acting supervisor of clinical services for the Branford office.
- d. When interviewed on 1/31/05 the Vice President of Clinical Operations stated that she neglected to designate in writing that RN #5 was to act as the SCS, but also that she thought RN #5's two years of employment at the agency was sufficient to meet the work experience requirements for acting SCS. The agency administrator/supervisor failed to designate in writing a qualified registered nurse with at least two years experience in a home health care agency to act during any absence of the supervisor of clinical services (SCS) in the Branford office whenever patient care personnel are serving patients.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(5) General requirements and/or D71(b)(4) Personnel polices.

Plan of Correction

Completion Date

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5. Based on clinical record review, staff, physician and family member interviews and nursing policy and procedure review it was determined that for three (3) of twelve (12) patients the primary care nurse failed to accurately and/or consistently and/or appropriately re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner as the patient's health and safety status deteriorated and/or to document the patient's immediate health care needs and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care (Patient #s 8, 11 and 12). The findings include:

a. Patient #8 had a start of care of 12/28/04 with diagnoses including COPD, CHF, CAD, PVD, pulmonary hypertension, atrial fibrillation, spinal stenosis, venous insufficiency with ulceration and diastolic dysfunction. This 96-year-old patient had a history of two myocardial infarcts in 1987 and 2003 and endocarditis in 10/03. Clinical record documentation at the start of care showed the patient used oxygen at 2 liters continuously, had dyspnea with minimal to moderate exertion, ambulated with a rolling walker or wheelchair with supervision of another person at all times, hearing aids bilaterally, cataracts in both eyes and needed someone to do all shopping. The patient had been on the Medicare home health benefit until 12/28/04, when the agency determined that all nursing goals had been met and the patient had stabilized and required a change in payor source. On 12/28/04, the agency continued to provide nursing service 1 time a week to pre-pour medications and home health aide service 14 hours a day, 7 days a week to assist with personal care and instrumental activities of daily living.

i. On 01/05/05, RN #5 documented the patient's "right outer shin had an oblong blister present, no edema and more forgetful in her conversation"; no weight or temperature was documented. On 01/09/05, LPN #1 called RN #3 and reported "huge vesicle formation to the right lower extremity." RN #3 documented on 01/09/05 she found two fluid filled vesicles, 5x3cm and

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4x3cm, which ruptured upon touch and 1+ pedal edema; there was no documentation of weight. On 1/9/05, Physician #3 ordered daily wound care; cleanse legs, swab with bacitracin and cover with bulky, sterile compression dressing. Physician #3 saw the patient on 01/10/05 and made an appointment for the patient with a vascular surgeon for 01/12/05.

On 01/11/05, RN #3 visited the patient, performed the wound care and documented slightly weepy raw areas when washed legs; no signs and symptoms of infection; no cardiovascular and respiratory assessments, blood pressure, pulse and respirations were documented during this visit. Due to a snowstorm on 01/12/05, the patient did not see the vascular surgeon and her appointment with him was rescheduled for 01/14/05. On 01/13/05, RN #3 documented "noteworthy is that on left lower extremity, vesicles are forming behind left leg, blood filled; 2+ bilateral lower extremity edema; asked aide to obtain patient's weight in health center; respirations were diminished in all lobes; poor, slow mobility with walker." There was no clinical record documentation Physician #3 was called concerning lower extremity edema since 01/09/05 and/or that he was made aware of the diminished respirations in all lobes and the new blood filled vesicles; documentation was also lacking that the aide weighed the patient.

On 01/14/05 the patient saw the vascular surgeon who ordered daily dressing for venous insufficiency with ulceration; the dressing consisted of washing the area with mild soap and water, apply bactroban, kerlix gauze wrap then ace wrap.

On 01/15/05, RN #2 documented the patient was dyspneic on exertion, oxygen continuous, breath sounds clear, 1+ bilateral edema, denies pain, new dressing procedure done; no weight or temperature was documented during this visit. On 01/16/05, RN #5 documented that both lower leg dressings were draining large amounts of serous drainage and the lungs were clear; no cardiovascular status including peripheral edema, temperature or weight was documented during this visit.

On 01/17/05, RN #5 documented both sites continue to drain large amounts of serous drainage; there was no documentation of respiratory and cardiovascular assessments nor was a weight, pulse, blood pressure, peripheral edema, respirations or temperature documented during this visit.

On 01/18/05, RN #6 documented at 9:30 am, the patient was still in bed and the patient did not sleep well; short of breath upon position change; complains of right side pain, throbbing; moderate amount sero-sanguinous drainage, right wound approximately half-dollar size with minimal granulation, left posterior side dime size with small granulation; temperature 99 degrees F; respiratory assessment was documented as "short of breath upon position change";

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

cardiovascular assessment was documented as a checkmark; there was no documentation of the patients blood pressure or weight during this visit.

On 01/19/05 RN #5 documented lungs clear throughout; no edema; right leg sores greater than left sores, continue to drain serous drainage; all open sores look improved; weight, blood pressure and temperature were not documented during this visit.

On 01/20/05 RN #2 visited the patient between 8:45 am - 9:15 am and documented the wounds were pink, minimal drainage, denies pain; complains of feeling tired today; aide reports client slow to get up this morning; will monitor; there was no documentation of cardiac and respiratory assessments, temperature, blood pressure, respirations, pulse or weight during this visit.

RN #2 documented on an agency interruption of service form that the patient had been admitted to the hospital on 01/20/05. On interview on 01/31/05, RN #6 stated the patient had been hospitalized with CHF; the patient had not been hospitalized due to deterioration of her leg wounds.

ii. Review of the patient's hospital ER and admission clinical record indicated the patient was admitted on 01/20/05 with acute bronchitis, WOB/SOB and CHF exacerbation. The ER physician documented that according to the patient's aide, the patient had a cough for 3-5 days. The patient complained of a productive cough with green and brown sputum with fatigue and 1 day of SOB. The patient was awake, alert, speaking and oriented to person, place and time.

The patient was started on Ceftriaxone 1g IV, Doxycycline 100mg po, Lasix 80mg IV, Combivent inhalation, Lopressor 100mg po, ASA 325mg po and Nitropaste 1.5 inches topically. The hospital admission physical examination report documented the patient stated her feet had been swollen for 1-2 weeks and she had several days of a productive cough with brown sputum.

iii. On 02/09/05, RN #2 stated on interview she had assessed the patient on 01/15/05 and found her ineligible for Medicare as the wound care dressing was not intermittent (defined by RN #2 as less than 3-4 times a week); she felt the wound would not progress to intermittent dressings; the patient refused to do the dressing change; the patient did not want someone else doing the dressings, therefore she would pay privately for the nursing services; the wounds were superficial; the patient was out in the managed residential community in her wheelchair with her aide because she did not want to stay in her bedroom all day. RN #2 stated her assessment was that the patient maintained this non-Medicare eligible status through her 01/20/05 visit. RN #2 stated her "thorough assessment on 01/20/05 found the patient not to be in CHF or respiratory distress and nothing unusual". RN #2 stated she did not call the vascular surgeon to discuss the patient's status as she was in receipt of the wound care instructions from the physician and it was therefore not necessary to contact him.

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Interview with RN #6 on 02/08/05 she stated during her 01/18/05 visit, she did not assess the patient's cardiovascular status, including blood pressure, respiratory status, homebound status and she did not notify the physician of the patient's pain and shortness of breath upon position change.

iv. On 02/16/05, H-HHA #5 stated on interview the patient became lethargic, not herself and had a decreased appetite 2-3 days before her hospitalization on 01/20/05. She did not tell the nurse about this because the patient was very moody and this was not abnormal for her. On 02/23/05 H-HHA #5 stated on interview when the patient woke up at around 8:00am on 01/20/05, she found the patient very lethargic, didn't look good, skin color didn't look right, tired, didn't want to eat, very out of it, had a cough, very slow to get up, very weak and not herself. H-HHA #5 stated she called the office and reported this to the scheduler. The scheduler informed H-HHA #5 that RN #2 was on her way to the patient's home for her regular nursing visit. H-HHA #5 stated when RN #2 arrived to do the patient's leg care she reported to RN #2 all of this but she cannot remember if she told RN #2 about the cough. H-HHA #5 stated that about an hour later the patient began coughing again; the patient's son called during this time and he told her (H-HHA #5) to call resident services; H-HHA #5 called resident services because the patient wasn't getting any better and LPN #2 came and assessed the patient; LPN #2 called the patient's son. The patient's son called Physician #3; the son wanted to send his mother to the hospital but she refused. H-HHA #5 stated the patient remained in bed and took only fluids; she did not call the home health care nurse, RN #2 to report the decline in the patient's health status. On 02/16/05, H-HHA #5 stated on interview she met the patient at the hospital ER when the ambulance arrived; the patient's son came about an hour later; she was there to be a companion to the patient; she doesn't remember saying to anyone at the hospital that the patient had a cough for 3-5 days; the patient was alert and oriented in the ER.

v. On 02/04/05, Physician #3 stated on interview the patient was seen in her office on 01/10/05 with ulcerations on the right shin with black spots on her distal right toes. Physician #3 stated she immediately made an appointment for the patient with Physician #5, a vascular surgeon, as she was concerned about healing given the degree of vascular compromise. Physician #3 ordered daily sterile compression dressings by the home care nurse and instructed the patient to keep her legs elevated as much as possible. She further stated the patient was always short of breath, needed oxygen continuously, unable to ambulate more than five feet and needed a wheelchair with aide in attendance and to her knowledge, Patient #8 never left the managed residential community except to see the doctor.

On 02/03/05, Physician #5's (vascular surgeon) RN stated on interview that Physician #5

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documented that on 01/14/05 he found evidence of chronic venous insufficiency in her lower extremities bilaterally with open ulcers and erythema with possible infection. On 01/14/05, Physician #5 ordered an ace wrap to aid in supporting the venous flow and Cipro for the possible wound infection. The patient was status post aortobifemoral bypass graft and a right femoral popliteal bypass graft in 03/04. Physician #5's RN stated there was no documentation in the patient's office record that anyone from the agency had called to discuss the patient's status; Physician #5's RN inquiry of Physician #5 was that he did not recollect any calls from the agency concerning the patient.

vi. On 02/04/05, the patient's son stated on interview his mom was alert and oriented, was basically confined to a wheelchair or scooter, used a walker for short distances in her apartment, got short of breath easily, needed oxygen at all times, needed an aide to assist her in ADLs and IADLs, had ulcers on her legs and had recently been hospitalized with heart failure and bronchitis.

vii. Review of the agency's skilled nursing policies and procedures outlined the need to obtain the patient's weight, especially for CHF patients; proper respiratory and cardiac assessments; how to measure pedal edema; proper wound assessment including weekly measurements in centimeters, exact location, wound color, amount of drainage and assessment of surrounding skin.

viii. RN #s 2, 5, 6, and 7 failed to accurately and/or appropriately and/or consistently perform cardiovascular and respiratory assessments, including blood pressure, pulse, respirations including both objective and subjective data, peripheral edema and weight, and failed to properly document the status of the patient's wounds from 01/05/05 through 01/20/05. Primary care nurse, RN #2 failed to develop a plan of care that addressed the changes in the patient's conditions.

b. Patient #11: Clinical record documentation on the nurse's initial assessment dated 12/17/04 stated that the patient had arthritis and used a walker. There was no documentation to indicate that the nurse observed the patient's mobility and/or physical findings regarding her functional status. During the period from 12/17/04 to 2/2/05 consistent documentation was lacking to indicate that agency nurses assessed the patient's mobility and/or that they communicated with the physical therapist that was treating the patient. During that time there was no determination of homebound status, however, documentation on the nurse visit note dated 2/2/05 by RN #1 stated that the patient's mobility was limited.

ii. Clinical record documentation between 12/17/05 and 1/18/05 determined that the patient received daily skilled nursing wound care, but that the wound was not improving. RN #1

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documented on 1/18/05 that she contacted the physician to report that the wound was not healing, that it had worsened in appearance and she questioned if antibiotics should be repeated. Physician #2 on 1/21/05 examined the wound and ordered debridement to be done twice weekly and as needed by the physical therapist.

iii. When interviewed on 1/31/05 RN #1 stated that the patient had not been changed to the Medicare payer source because she was not homebound. During a home visit by the surveyor and RN #1 on 1/31/05 the patient told the surveyor that her daughter was in charge of all of her affairs including Medicare issues. However, the patient stated that she does not regularly leave home any longer because the activity caused her physical fatigue and right leg discomfort. Patient #11 stated that she leaves home to go to physical therapy twice a week, to her physician's office when necessary and to obtain meals that she could not otherwise prepare. Patient #11 stated that she ambulated with her walker to the dining hall for her meals and that she ambulated "up the hall" with her walker to physical therapy. When interviewed on 1/31/05 after visiting the patient, RN #1 stated that she was previously unaware that the patient had restricted her activities.

iv. When interviewed on 2/2/05 the agency administrator gave the surveyor documentation of a case conference dated 2/1/05 with the physical therapist treating the patient. The therapist reported that the patient ambulated at physical therapy 300-500 feet without fatigue and that on one occasion the patient reported to her that she had attended a social occasion.

v. When interviewed on 2/3/05 the patient's daughter stated that the patient only leaves home when it's necessary because she has complained that she does not feel strong enough and fears falling. In the past month the patient complained of dizziness, not feeling well and sleeping all afternoon.

The agency failed to evaluate the patient's functional status at the initiation of care and/or as care progressed in order to accurately determine her homebound status and possible eligibility to receive her Medicare benefits for home health care services.

Agency professional staff failed to accurately and appropriately assess the patient's functional status in that the patient was complaining of limited functional mobility secondary to fatigue and right leg discomfort and the nurse was not aware of this change in condition that suggested a need to alter the plan of care to meet her nursing needs and/or that the patient's status may have changed to homebound enabling her eligibility for Medicare home health benefits.

c. Patient #12's start of care date was 5/1/97 with diagnoses including Korsikoff's syndrome with dementia, functional decline, intertrigo, and history of gastro-intestinal bleed, hip replacement, arthritis, multiple actinic keratosis and flexion contractures. Documentation on the recertification

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plan of care dated 12/14/04 to 2/14/05 ordered skilled nurse once weekly and as needed for instructions regarding safety, instruct and evaluate medication regime, desired effects and side effects of medications, to pre-pour medications weekly and to instruct/evaluate safe use of Serita lift; home health aide (H-HHA) 24 hours a day, seven days a week for assist with all activities of daily living (ADL) and instrumental activities of daily living (IADL). Documentation on the certification plan of care dated 12/14/04 stated that Patient #12 was alert, but forgetful, that she lived alone, was contractured with limited endurance, required transfers from the bed to the chair and that her skin was paper thin and fragile. Interview with Physician #1 on 2/3/05 determined that the patient had a history of mild intertrigo with recurrent rashes. Documentation on the H-HHA's care plan ordered position change every 2 hours; peri care; skin care for incontinence, as needed; to provide all personal care needs including bathing, shampooing, denture care, foot soaks, fingernail care, skin care and massage with lotion; to empty commode every two hours and use of Sarita lift to transfer. Interviews dated 2/5/05 with H-HHA #s 2, 3 and 4 and interview dated 2/8/05 with H-HHA #1 determined that the patient was bathed in bed because she could not sit up straight and foot soaks were not done. There was no documentation of a toileting plan for every two hours; H-HHA #s 1 and 4 stated that they did put the patient on the commode every two hours and she responded appropriately; however, H-HHA #3 stated that the plan to place the patient on the commode every two hours was old and was no longer implemented. When interviewed on 2/5/05 RN #1 stated that she does not review the H-HHA visit sheets because they are given directly to the Branford office when completed by the aides. She stated that she presumed the aides knew the care plan and completed the assigned tasks as ordered. RN #1 stated that there was no plan for placing the patient on the commode frequently in order to prevent incontinence. When interviewed on 2/8/05 RN #1 stated that the H-HHA's plan of care instructed the aide to empty the commode every two hours. RN #1 thought that the H-HHAs should have known that this meant to put the patient on the commode every two hours, but she did not supervise this procedure and did not know if it was consistently done. RN #1 stated that when she supervised the H-HHAs she referred to the plan of care, but she did not observe all of the tasks that were delineated.

i. Clinical record documentation dated 12/30/04 by RN #2 (Administrator/SCS) documented that there were pink areas on the buttocks, but no open areas. She instructed the H-HHA on re-positioning and skin care for the buttocks to include applications of zinc oxide after washing well three times daily and as needed. There was no documentation to support that agency nurses revisited to examine the patient for four days until 1/3/05 when RN #1 documented that the patient's buttocks and coccyx were "much irritated" with reddened patchy areas; RN #1

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contacted the physician who agreed to see the patient the following day. On 1/7/05 RN #1 wrote a physician's verbal order for: Econozole Nitrate cream to irritated peri and buttock areas (to be done twice daily), Diflucan 100 mg daily for two days and Keflex 500 mg three times a day for seven days. RN #1 wrote in the nurse's visit note of 1/7/05 that the patient's skin at the peri area, coccyx and buttocks were very irritated, but there was no documentation to state that the Diflucan and/or Keflex were pre-poured and/or to state who would apply the Econozole cream. When interviewed on 2/8/05 RN #1 stated that she pre-poured the medications when they were delivered to the patient's home and that she had instructed the daytime H-HHA to apply the Econozole Nitrate twice daily and left written instructions for the evening and night home health aides; RN #1 stated that no other creams were supposed to be used between the Econozole Nitrate applications and she presumed that the H-HHAs would have known that. When interviewed on 2/5/05 H-HHA #s 2, 3, and 4 all stated that RN #1 instructed H-HHA #1 (weekday day time aide) to apply the Econozole twice daily and she (H-HHA #1) passed the instructions onto the others. H-HHA #s 2, 3, and 4 all stated different protocols for applications of creams and/or ointments in that H-HHA #1 applied Econozole Nitrate twice daily on the 7AM to 3PM shift, H-HHA # 2 applied A & D ointment and/or Zinc Oxide on the 11PM to 7 AM shift, H-HHA # 3 applied Econozole Nitrate one time with alternate applications of A & D ointment with baby powder on the 3PM to 11PM shift and H-HHA # 4 applied A & D ointment, Zinc Oxide cream and Econozole Nitrate each at different diaper changes when she worked the 3PM to 11PM week end shift and/or the 11PM to 7PM night shift during the week. RN #1 did not revisit until 1/10/05 (three days later) and documented in the nurse visit notes that the patient's buttock, coccyx and peri area were very reddened. RN #1 informed the patient's physician of the worsening skin inflammation, but she failed to discuss implementation of possible nursing interventions such as a physical therapy evaluation to enhance the patient's functional mobility and/or to prevent further deterioration of functional status in order to provide ease in transferring that would enable the aides to shower and/or to adequately bathe the patient to enhance cleaning the affected areas, and/or more frequent nursing assessment with application of Econozole Nitrate as ordered, appropriate supervision of the H-HHAs and/or a consistent toileting plan. RN #1 revisited on 1/11/05 and documented that the skin was very reddened and irritated on the patient's buttocks, peri area and bilateral groin folds and right hip; the physician was contacted and she ordered Levaquin 250 mg daily for seven days, and requested to see the patient the following day. On 1/12/05 the patient was examined by the physician and admitted to a skilled nursing facility for intravenous antibiotic therapy.

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ii. When interviewed on 2/3/05 Physician #1 (primary physician) stated that the patient had a history of intertrigo and that this episode was a horrible rash that could be attributed to hygiene. Physician #1 stated that a culture of the affected skin determined that most of the bacteria present were secondary to stool.

When interviewed on 2/7/05 Physician #2 (skilled nursing facility medical director) stated that she examined the patient upon admission on 1/12/05. The diagnosis was severe intertrigo with staphylococcus and this responded to treatment within 24 hours with Oxystat cream twice daily and antibiotic therapy. She stated that the rapid response time could be interpreted as resulting from differences in physical care provided from the home environment to the skilled nursing facility.

Upon arrival at the facility on 1/12/05, Patient #12 was examined by Physician #2 and diagnosed with severe intertrigo. The director of nursing (DON) at the facility documented that the patient's groin, peri area including the entire area covered by the patient's diaper and measuring 6 x 6 inches across the pelvis, as well as a 9 x 9 inch area across the buttocks was covered with "profound redness", with excoriation, weeping and scaling. The DON also stated that the patient was bathed immediately after admission and required two aides to perform peri care in order to be cleaned adequately and for the medicated cream to be applied appropriately. She stated that these factors helped the situation so well that that the inflammation was dramatically decreased within 24 hours.

iii. When interviewed on 2/2/05 RN #1 stated that she only supervised the day and evening shift and had seen them washing the patient, but never observed a complete body wash and that she had not monitored the aide's ability to provide adequate incontinent care during this period while the skin was inflamed. RN #1 stated that she had not considered physical therapy because her supervisors told her the patient had previously received those services. She stated that she when she took over the patient's care in October 2004 there was no order to shower the patient and it did not occur to her to consider that intervention.

During the period from 1/3/05 to 1/12/05 the nurse failed to furnish services requiring specialized nursing skill in that she failed to accurately and appropriately re-evaluate the patient's inflamed skin and/or to make arrangements to change the patient's plan of care to include implementation of interventions such as increasing skilled nursing visits for application of the medicated cream as ordered by the physician; and/or inappropriately delegated to the home health aide application of the medicated cream and assessment of response to the treatment. The registered nurse failed to implement changes to the H-HHAs plans of care including appropriate supervision and instruction regarding the skin care regime, which should have excluded their application of previous skin care treatments while including showers, if appropriate, and a consistent toileting plan. The registered nurse failed to adequately supervise the H-HHAs on

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each shift to determine their ability to manage the patient's care in order to assure that the plan of care was consistently followed as ordered and/or to determine if a physical therapy evaluation would have been beneficial.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(1)(3)(D) Services.

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6. Based on clinical record review and staff and physician interviews it was determined that for four (4) of twelve (12) patients, the registered nurse failed to make necessary revisions to the plan of care that accurately reflected the patient's health status and determined the immediate care and support needs of the patient (Patient #s 3, 6, 8 and 12). The findings include:

a. Patient #3 had a start of care date of 09/24/04 with diagnoses including COPD, pacemaker, cardiomyopathy, CHF, atrial fibrillation and a gait disorder. The patient had limited endurance with dyspnea on exertion, oxygen at 2 liters when dyspneic/PRN, oriented, forgetful, anxious at times and used a walker for short distances with rest periods. Interview on 01/26/05 with RN #4 she stated the patient was homebound, left the community only for doctor's appointments and since 09/24/04 her condition was chronic and stable. For the certification period 12/23/04-02/23/05, nursing was ordered every other week (QOW) to pre-pour the patient's medications

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and case manage; home health aide service was ordered 5-7 times a week in the AM for personal care.

- i. On 01/08/05 the ALSA nurse notified RN #4 that the patient had a URI. RN #4 telephoned Physician #4 to report the ALSA nurse's findings. The covering physician ordered Doxycycline 100mg, BID, po for 10 days. The ALSA RN adjusted the patient's medication box on 01/08/05 to include the Doxycycline. RN #4 last visited the patient on 12/30/04. RN #4 did not return to visit until 01/13/05 to pre-pour the medications; at that time RN #4 documented there were a few crackles right lower lobe, had puffy feet, forgetful and anxious. RN #4 stated on interview on 01/26/05 that she did not discuss with the physician the need to adjust the plan of care; she did not revisit the patient to assess her respiratory status and the effectiveness of the Doxycycline because the home health aide would assess that and let her know of any problems.
- ii. Interview with Physician #4 on 02/02/05 he stated the covering physician received a call from the home care nurse reporting cough with yellow secretions, temperature 98, diminished breath sounds bilaterally, crackles right base, nebulizer given without much improvement and Advair with some relief; Doxycycline was ordered. Interview with Physician #4 on 02/10/05, he stated it was his expectation the home care nurse would increase her visits to assess the patient's respiratory status and monitor the medication's effectiveness. He was not aware that nursing visits had not been increased nor had anyone from the agency contacted him to discuss changing the plan of care.

The registered nurse failed to make the necessary revisions to the plan of care based on a change in the patient's respiratory status and the need for antibiotic treatment and follow-up skilled nursing assessment.

b. Patient #6 had a start of care of 05/12/04 with diagnoses including Parkinson's disease, Alzheimer's disease, gait abnormality, osteoporosis and depression. The patient was forgetful, disoriented, anxious, irritable at times, paranoid, used a three-wheeled walker for ambulation a few feet in her apartment and used a wheelchair for most of her mobility. For the certification periods of 11/12/04-01/12/05 and 01/12/05-03/12/05, nursing was ordered QOW to pre-pour the patient's medications and assess the patient's general health and safety; home health aide service was ordered 24 hours a day for personal care and safety. Interview with RN #4 on 01/27/05 she stated the patient was homebound, left her apartment only to go to the sunroom for short periods and to physician appointments, her condition was chronic and stable.

- i. On 11/08/04, Physician #4 decreased the Lasix 20mg and KCl 20meg. to 1 time per week on Monday, cancel Wednesday dose; increase Sinemet 25/100 to 2 pills at noon daily; increase Lexapro to 10mg at bedtime; Risperdal 0.5mg at 6pm daily. On 12/17/04 the physician decreased the noon Sinemet 25/100 to 1 from 2; stopped the bedtime dose of Risperdal; decreased Lexapro to one-half of 10mg pill at bedtime; started Cipro 250mg 1 pill before

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breakfast and supper for 7 days for a UTI. On 12/22/04 the physician increased the Lexapro to 10mg from 5mg at HS. On 12/28/04 the physician added an 8pm dose of Risperdal 0.5mg. Interview with RN #4 on 01/27/05 she stated she doesn't know why the physician frequently changed the patient's medications; he usually did this following a visit to him; she stated the home health aide assessed and observed for any medication signs and symptoms. RN #4 stated she does not increase her nursing visits to assess the effectiveness of the medications, instead she relies on the aide's assessment nor did she know what diagnosis the patient had necessitating the need for Risperdal. RN #4 stated she probably adjusted the patient's medications since she is in the facility frequently.

ii. Interview with Physician #4 on 02/10/05, he stated it was his expectation the home care nurse would increase her visits when he made changes to the patient's medication regimen as it was necessary to monitor it's effectiveness. He was not aware the nurse had not routinely done this. Physician #4 stated no one from the agency had contacted him to change the plan of care. The registered nurse failed to initiate, with the physician, the potential revisions to the plan of care suggested by the frequent and numerous medication changes the physician had made due to changes in the patient's physical and/or mental status.

c. Patient #8 had a start of care of 12/28/04. Based on clinical record documentation from 01/05/05 through 01/20/05, Patient #8 exhibited a gradual deterioration in her cardiovascular and respiratory status. On 01/09/05, Patient #8 exhibited an acute change in her venous insufficiency status, necessitating daily nursing visits for wound care. On 01/20/05, the patient was admitted to the hospital with bronchitis and CHF.

Interview with RN #2 on 02/18/05, she stated that on 01/20/05, H-HHA # 5 informed her the patient was slow in getting up that morning and the patient stated she felt tired. RN #2 stated based on the patient's appearance and conversation with her and no apparent shortness of breath (SOB), she determined the patient was not in respiratory distress. RN #2 stated H-HHA #5 must be confused and mistaken when H-HHA #5 told the surveyors she had reported the cough, lethargy, weakness, not eating and very slow to get up to her (RN #2). RN #2 stated she knew the patient well and that any changes the patient exhibited since 01/05/05 were normal for her. The registered nurses failed to change the patient's plan of care to reflect the patients deteriorating condition and health care needs. See Violation #5.

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d. Patient #12: The registered nurse failed to initiate necessary revisions to the plan of care to address the deterioration of the patient's skin at the perineum, buttocks and pelvic area from areas of pink blotches on the buttocks on 12/30/04 to reddened, excoriated, scaling and weeping skin on the perineum, buttocks, coccyx and pelvic areas on 1/12/05. See Violation #5.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(A) Services.

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7. Based on clinical record review, policy review and staff interviews, it was determined that for two (2) of twelve (12) patients the registered nurse failed to furnish those services requiring substantial and specialized nursing skill to apply prescription strength medicated creams to the patient's compromised skin and/or to assess the response to that treatment and/or to appropriately delegate these tasks to the H-HHAs and/or that she failed to instruct and/or appropriately supervise the H-HHAs and/or to provide complete and clear instructions regarding any pertinent aspects of the patient's condition to be observed and reported to the RN (Patient #s 8 and 12). The findings include:

a. Patient #8: Following RN #2's home visit the morning of 01/20/05, Patient #8's physical status continued to deteriorate. When this occurred, H-HHA #5 called resident services of the managed residential community (MRC) requesting a nurse to visit and LPN #2 visited the patient. H-HHA #5 did not report the patient's deteriorating condition to the home health care nurse, RN #2.

The patient's start of care was 12/28/04. Review of the most current H-HHA plan of care dated 11/10/05, prepared by RN #3, failed to indicate what changes in the patient's condition or any concerns the H-HHA should report to the primary care nurse (PCN). The H-HHA's plan of care required the name of the PCN and the PCN's cell phone and/or beeper number; no PCN was identified and there were no cell and/or beeper numbers documented. Interview with RN #2 on 01/31/05 she stated she was the current PCN for Patient #8.

Review of the agency's policy concerning preparation of the H-HHA plan of care by the RN stated all instructions must be in writing. The RN #2 failed to properly supervise and give clear instructions to H-HHA #5 to ensure the H-HHA reported any changes in the patient's condition to her. RN #2 failed to document on the H-HHA's plan of care what changes in the patient's condition the H-HHA should report to her. See Violation #5.

b. Patient #12: Documentation on a physician's verbal order dated 1/7/05 ordered Econazole Nitrate cream to be applied to affected skin twice daily. When interviewed on 2/8/05 RN #1 stated that she directed the H-HHAs to apply Econazole Nitrate cream twice daily and expected that they would know not to apply previous treatments in between.

When interviewed on 2/5/04 and 2/8/04 H-HHA #s 1, 2, 3 and 4 verbalized that RN #1 told H-HHA #1 to apply Econazole Nitrate Cream twice daily and that H-HHA #1 passed on the information to the others. The aides stated that they applied Econazole Nitrate cream from 1-3 times a day and that previous skin treatments were being applied between those applications. The nurse failed to administer all medications (application of prescription strength medicated creams to the patient's compromised skin) and/or to assess the response to that treatment and/or she inappropriately delegated these tasks to the H-HHAs and/or she failed to instruct and/or

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appropriately supervise the H-HHAs in the performance of these tasks that had been inappropriately delegated to the H-HHAs. See Violation #5.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(G)(H) Services.

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8. Based on personnel record review and staff interviews it was determined that from March 2004 to January 31, 2005 the agency failed to maintain a personnel record for the administrator/supervisor that contained a signed contract or letter of appointment specifying the conditions of employment. The findings include:

- a. When interviewed on 1/26/05 the administrator/supervisor stated that she was appointed to that position in March 2004.
- b. Review of the administrator/supervisor's personnel file determined that there was no documentation of a signed contract or letter of appointment specifying the conditions of employment in the capacity of administrator/supervisor.

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c. The Vice President of Clinical Operations stated on 1/31/05 that it would have been her responsibility to include the letter of appointment in the administrator's personnel file and she had failed to issue a letter of appointment. The agency failed to maintain a personnel record for the administrator/supervisor that contained a signed contract or letter of appointment specifying the conditions of employment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-19-13-D71(b)(4) Personnel policies.

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9. Based on observation in a managed residential community (MRC) and staff interviews it was determined that when patient care services were provided through other offices of the agency the agency failed to appoint a supervisor of clinical services to that patient service office. The findings include:

- a. When interviewed on 1/26/05 RN # 5 told the surveyor that agency nurses maintained their offices for agency business in some of the managed residential communities (MRC) where the agency serviced patients.
- b. On 1/26/05 the surveyor visited MRC #1, identified by RN #5 as having an office maintained for agency home health care services and the following was observed: current clinical records

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were stored in RN #5's desk drawer. RN #5 stated that the records in her drawer were her patient's current clinical records.

c. When interviewed during the on site visit on 1/26/05 RN #1 stated that she was employed 20 hours a week by the home health agency to visit patient's in MRC #1. She stated that she kept her home care patient's charts in a locked desk drawer in her office in MRC #1, that she sent and received patient related information via telephone and fax in that office from the agency and patient's physicians.

d. The administrator stated on 1/31/05 that the nurse should not have been storing home care records in MRC #1 and should not have been conducting patient care services from MRC #1's office. The administrator stated that the home care agency did not consider the office in MRC #1 a patient service office and therefore a supervisor of clinical services was not appointed. The agency failed to assign a supervisor of clinical services to an operational office in MRC #1 that functioned as a patient service office.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-19-13-D77 Administrative organization and records.

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10. Based on clinical record review, staff and caregiver interviews and agency policy it was determined that for two (2) of six (6) patients the agency failed to inform the patient, orally and in writing, of the extent to which payment may be expected or not expected from Medicare, prior to initiating care (Patient #s 5 and 11). The findings include:

a. Patient #5 had a start of care date of 6/21/04 with diagnoses including frequent falls, dementia, alcohol abuse, hypertension and cancer of the bladder. The patient was referred to the home care agency by the assisted living facility where the patient resided. Review of the assisted living notes of 6/21/04 indicated that the patient had been referred to the home health agency for nursing and 24 hour home health aide coverage due to the fact the patient had been sent to the ER on 6/20/04 for question of a fall, severe head, neck and right shoulder pain attributed to a flare up of degenerative joint disease and was unable to care for herself in her apartment. The physician's plan of care dated 6/21/04 included skilled nursing every other week to pre-pour medications, assess general health, safety and supervise the home health aide; home health aide 24 hours a day to assist with ADLs, IADLs and safety.

Review of the clinical record lacked documentation to support that the agency informed the patient, a Medicare beneficiary, and/or power of attorney (POA) verbally and in writing of the extent to which payment would not be expected from Medicare and the reason for Medicare ineligibility.

The patient's POA stated on 2/4/05 that the SALSA or the home care nurse prior to providing services for home care did not discuss Medicare eligibility with him.

The acting supervisor of clinical services stated on 1/31/05 that the policy of the agency has been to issue, in writing, a Medicare denial when the agency discharged a patient from Medicare to another payment source. Agency policy did not include notifying all the patients who are Medicare beneficiaries, orally and in writing, of the extent to which payment may be expected from Medicare, before care is initiated and another payment source is utilized. The agency failed to notify Patient #5, a Medicare beneficiary, before care is initiated of the extent and reason why payment may or may not be expected from Medicare.

b. Patient #11's start of care date was 12/17/04 with primary diagnosis of infected left shin and secondary diagnoses of osteoporosis, hypertension, atrial fibrillation and s/p fracture of the right femur in the spring of 2004. Skilled nursing was ordered daily to provide wound care. Documentation in the initial nurse visit notes dated 12/17/04 indicated that the patient lived alone and managed her activities of daily living independently. When interviewed on 2/3/05 the patient's daughter stated that agency professional staff had not discussed the availability or lack of availability of Medicare benefits for her mother and that she did not know that the patient's changed status might determine that she was homebound and eligible for her Medicare benefits.

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When interviewed on 2/8/05 Physician #2 stated that she was unaware that the patient was experiencing problems with her mobility. The physician stated that she had not been contacted by the home care agency to discuss the patient's mobility and/or her eligibility to receive benefits for home health services from Medicare. The agency failed to advise the patient orally and in writing of the extent to which payment for agency services may be expected from Medicare or other sources. See Violation #5.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(a) Patient's bill of rights and responsibilities.

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11. Based on clinical record review, policy review and staff and family member interviews it was determined that for four (4) of six (6) patients the agency failed to advise the patient, orally and in writing, as soon as possible, but no later than thirty (30) days after the agency becomes aware of changes in the extent to which payment may be expected and/or not expected from Medicare when a change in the patient's health status occurs (Patient #s 3, 6, 8 and 12). The findings include:

a. Patient #3's respiratory status changed on 01/08/05 when she was diagnosed with an upper respiratory infection (URI). The physician ordered Doxycycline 100mg BID for 10 days. The patient's respiratory status had deteriorated, suggesting a need for a change in the plan of care. Documentation was lacking in the clinical record that the agency notified the patient orally and in writing of the extent and reason why payment may or may not be expected from Medicare. The agency failed to inform Patient #3 orally and in writing how payments might change during the course of care when a change in the patient's condition suggested a need to increase nursing visits. See Violation #6.

b. Patient #6's medications were changed several times by the Physician #4 during the period of 11/8/04 to 12/28/04 due to changes in the patient's physical and mental status, which suggested a need for a change in the plan of care. Documentation was lacking in the clinical record that the agency notified the patient orally and in writing of the extent and reason why payment may or may not be expected from Medicare; they failed to inform the patient orally and in writing how payments might change during the course of care when a change in the patient's condition suggested a need to increase nursing visits. See Violation #6.

c. Patient #8 had a start of care of 12/28/04. On 02/09/05, RN #2 stated on interview that her assessment of the patient on 01/15/05 found her ineligible for the Medicare home health care benefit even though she now required daily visits for wound care. On 02/04/05, the patient's son stated on interview his mother was homebound and it was very difficult for his mother to get out; Physician #5 told him during his mother's medical appointment on 01/14/05 that her daily wound care would be paid for by Medicare. The son stated he paid for his mother's care and the agency had not explained the Medicare home health care benefit to him. On 01/09/05 the patient developed a change in her medical condition requiring daily wound care suggesting a need for a change in her plan of care. Documentation was lacking in the clinical record that the agency notified the patient orally and in writing of the extent and reason why payment may or may not be expected from Medicare. They failed to inform the patient orally and in writing how payments might change during the course of care when a change in the patient's condition suggested a need to increase nursing visits. See Violation #5.

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WERE IDENTIFIED

d. Patient #12: Clinical record documentation on the nurse's visit notes during the period from 1/4/05 to 1/12/05 determined that the patient's skin status deteriorated and indicated the need for skilled nursing interventions; she was homebound. However, clinical record documentation was lacking that the nurse discussed with the patient's power of attorney and/or informed him in writing about possible changes in Medicare coverage due to her change in status.

Review of agency policy determined that patient's are informed orally and in writing when the agency determines that Medicare will not cover services and the physician does not agree with the agency's determination. However, the policy lacked documentation to show that patient's who are Medicare beneficiaries and using an alternate payer source are informed orally and in writing about changes in their Medicare coverage when their condition changes.

When interviewed on 2/2/05 RN #1 stated that she thought about changing the patient's payer source to Medicare, but she did not have a new diagnosis and had not discussed it with the physician.

When interviewed on 2/3/05 the patient's daughter, who was in charge of the patient's care, stated that she had no idea that the patient's increased nursing needs might make her eligible for Medicare home health care benefits and that agency personnel had not discussed this with her.

When interviewed on 2/9/05 Physician #1 stated that agency nurses did not contact her to discuss the patient's increased needs for skilled nursing care and/or her possible eligibility for Medicare home health benefits.

Documentation was lacking in the clinical record that the agency notified the patient orally and in writing of the extent and reason why payment may or may not be expected from Medicare; they failed to inform the patient orally and in writing how payments might change during the course of care when a change in the patient's condition suggested a need to increase nursing visits. See Violation #5.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(a) Patient's bill of rights and responsibilities.

Plan of Correction

Completion Date



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 9, 2005

Susan Sokol, RN, Administrator
Home Health Care Services, LLC
574 Heritage Road, Suite 110
Southbury, CT 06488

Dear Ms. Sokol:

Unannounced visits were made to Home Health Care Services, LLC on April 11 & 12, 2005 by representatives of the Division of Health Systems Regulation for the purpose of conducting a follow-up visit with additional information received through April 27, 2005.

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 23, 2005 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:

- a. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, repairs, etc.).
- b. Date corrective measure will be effected.
- c. 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.

Respectfully,

Victoria V Carlson, RN, MBA
Supervising Nurse Consultant
Division of Health Systems Regulation

VVC

c: Nurse consultant



Phone:

Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # _____

P.O. Box 340308 Hartford, CT 06134

Affirmative Action / An Equal Opportunity Employer

DATE(S) OF VISIT: April 11& 12, 2005 with additional information received through April 27, 2005

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

1. Based on staff interview and clinical record review, it was determined that the administrator failed to ensure and maintain the quality of care and services rendered to six (6) of eleven (11) patients in that the agency failed to implement their stated plan of correction for the letter dated March 14, 2005 (Patient #s 14, 17, 19, 20, 21, 22). See Violation #s 2 & 3.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (d)(2) General requirements.

Plan of Correction

Completion Date

Provider/Representative

Title

Date

DATE(S) OF VISIT: April 11 & 12, 2005 with additional information received through April 27, 2005

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

2. Based on staff interview and clinical record review, it was determined that the supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and families by direct service staff under their supervision as evidenced by the care and services rendered to six (6) of eleven (11) patients in that the agency failed to implement their stated plan of correction for violation letter dated March 14, 2005 (Patient #s 14, 17, 19, 20, 21, 22). See Violation #3.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (d)(2),(3)(A)(B)(C) General requirements.

Plan of Correction

Completion Date

DATE(S) OF VISIT: April 11 & 12, 2005 with additional information received through April 27, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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3. Based on clinical record review and staff interviews it was determined that for six (6) of eleven (11) patients agency professional staff failed to establish and/or to document that effective interchange, reporting and coordination took place during case conferences and/or that case conferences were conducted at specific time points as determined in the agency's plan of correction for letter dated 3/14/05 in order to support the objectives outlined in the plan of care and/or to accurately and/or consistently re-assess the patient and/or to document reassessment of the patient and/or to take prompt action (Patient #s 14, 17, 19, 20, 21, 22). The findings include:

- a. Documentation on the agency's plan of correction for the letter dated 3/11/05 stated that effective 3/31/05 agency direct care professional staff and/or the supervisor of clinical services (SCS), administrator and corporate compliance director and/or designee would conduct weekly case conferences on all pending admissions and/or new admissions, discharges, pending discharges, re-certifications and/or physician renewals, changes in status or any emergency calls and on-call logs.
- b. Patient #14's start of care date was 10/31/01 with diagnoses including coronary artery disease, breast cancer and history of coronary artery bypass surgery. Documentation on the re-certification plan of care dated 3/1/05 to 5/1/05 ordered skilled nurse to assess general health, safety and to supervise the homemaker home health aide (H-HHA) and H-HHA 2-3 times per week to assist personal care, activities of daily living and safety. Clinical record documentation during the period from 12/8/04 to 3/7/05 determined that the patient's blood pressure range was 120/80 to 160/80 and reflected her baseline status. Clinical record documentation by RN #1 dated 3/7/05 stated that the blood pressure was 106/70 and on 4/4/05 her blood pressure was 102/54 sitting and 102/50 standing. On both dates RN #1 requested that the resident service staff check the patient's blood pressure and/or that the patient should call the nurse if she became symptomatic. Clinical record documentation on 3/31/05 by RN #2 was identified by the agency administrator as the case conference summary and stated that there were no changes to the plan of care. There was no clinical record documentation in the case conference summary to support that participants discussed that the patient's blood pressure was significantly lowered during the past two nursing visits.

When interviewed on 4/12/05 the agency administrator stated that the agency was not caring for this patient medically, but she acknowledged that as part of the agency's plan of correction nurses received in-service training focused on patient assessment and reporting to supervisors of changes in health care status.

- c. Patient #17's start of care date was 2/24/00 with diagnoses including hypertension, peripheral vascular disease, diverticulosis, macular degeneration and history of hip fracture. Documentation on the recertification plan of care dated 2/14/05 to 4/14/05 ordered skilled nurse every other

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week to pre-pour medications, assess general health, safety and to supervise the H-HHA and H-HHA 2 times a week to assist personal care, activities of daily living, instrumental activities of daily living and to maintain maximum level of safety. Clinical record documentation by agency nurses during the period from 11/17/04 to 3/17/05 determined that the patient's blood pressure had ranged from 128/70 to 130/80. Documentation on a nurse visit noted dated 3/31/05 by RN # 8 stated that the patient's blood pressure was 106/68, that the nurse pre-poured medications including Lasix and Lopressor and that the next visit was not planned until 4/14/05.

Documentation on a case conference note by RN # 4 dated 4/1/05 stated that the client had no change in medical condition.

The registered nurse failed to report that the patient's blood pressure was significantly lowered during the last visit and/or that the nurse pre-poured diuretic and anti-hypertensive medications which suggested a need to alter the plan of care to revisit the patient within a shorter time period for blood pressure assessment.

d. Patient #19's start of care date was 5/12/03 with diagnoses including hip fracture and rectal polyp removal. Documentation on the recertification plans of care dated 1/11/05 to 3/11/05 and 3/12/05 to 5/12/05 ordered nursing 1 time a month and as needed for changes and H-HHA twice weekly as companion. Clinical record documentation on a case conference note dated 4/5/05 and signed by the agency administrator, SCS #1 and RN # 9 stated that the last H-HHA supervision was on 2/8/05 (eight weeks previously), however, there was no documentation in the case conference note to support that agency nurses acknowledged that the H-HHA supervision was four (4) weeks overdue and/or that they planned to revisit to supervise the H-HHA. When interviewed on 4/12/05 the agency administrator stated that she thought a H-HHA supervision was done in March 2005, but there was no documentation of the visit. Agency nurses including the administrator failed to acknowledge during a case conference that the H-HHA had not been supervised and thus they failed to discuss issues that were pertinent to effective case management.

e. Patient #20 had a start of care date of 03/2/05 with a primary diagnosis of an open wound to the left lower extremity and secondary diagnoses including hypertension, macular degeneration and osteoarthritis. The recertification period of 03/22/05 - 05/20/05 ordered skilled nursing two (2) times a week for wound care and skilled case management; home health aide service was ordered twenty-four (24) hours a day as the patient was chair and bed bound.

On 04/07/05, RN #9 documented there was purulent drainage, some erythema, afebrile; RN #9 contacted the physician who ordered Tequin 400 mg for 10 days and changed the Alginate to Aquacell AG; RN #9 instructed the aide in symptoms to report to agency; RN #9 would check on the patient tomorrow. There was no clinical record documentation to support that RN #9 held a case conference with the agency administrator and/or supervisor of clinical services (SCS)

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concerning the change in wound status. RN #9 next visited the patient four (4) days later on 04/11/05. The wound continued to deteriorate and there now was a question of tunneling; RN #9 contacted the physician; an appointment was made for the patient to see the physician on 04/14/05. There was no clinical record documentation to support that RN #9 held a case conference with the agency administrator and/or SCS concerning the lack of wound improvement. RN #9 failed to re-assess the patient's wound in a timely manner; RN #9 waited four (4) days before re-assessing the wound on 04/11/05; by that time the wound had deteriorated, showing signs of possible tunneling; RN #9 inappropriately instructed the home health aide to assess the patient wound status.

Interview with the agency administrator on 04/12/05, she stated that the case conference was not scheduled until 04/14/05; both she and the SCS were aware of this case; case conferences are held only once a week, not necessarily when a change in the patient's status took place.

The agency failed to follow their plan of correction for a violation letter dated 03/14/05, which stated a case conference would be held with agency direct care professional staff when there is a change in a patient's status.

f. Patient #21 had a resumption of care date of 04/07/05 with a principle diagnosis of ischemic colitis and secondary diagnoses including hypertension, PVD, peripheral neuropathy, hypothyroidism, spinal stenosis and chronic lower extremity edema. The interim orders dated 04/07/05 - 05/08/05 ordered nursing one (1) time a week to assess cardio-pulmonary status, vital signs, diet, safety, medications and assess gastrointestinal status; home health aide service was ordered three (3) times a week to assist with personal care; physical therapy was ordered one (1) time a week times one (1) week, then two (2) times a week times two (2) weeks for gait training. As of 04/12/05, there was no clinical documentation that a case conference was conducted on admission. When interviewed on 04/12/05, RN #6, who is not the patient's primary care nurse, stated the case conference was held 04/12/05.

The agency failed to follow their plan of correction for violation letter dated 03/14/05 that agency direct care professional staff, SCS and/or administrator would conference about new patient admissions.

g. Patient #22's start of care date was 3/31/05 with diagnoses including malignant neoplasm of the brain, convulsions, abnormality of gait, unspecified essential hypertension and hyperlipidemia. Documentation on the certification plan of care dated 3/31/05 to 5/29/05 ordered skilled nurse two times per week for one week, three times per week for two weeks, two times a week for two weeks then one time a week for one week to assess neurological status, pain, response to interventions and treatments, vital signs, home safety, nutrition and hydration and knowledge deficit; H-HHA 1-3 times per week to assist personal care and physical therapy three

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times per week for lower body muscle strengthening, gait training, adaptive device, bed mobility and wheel chair management.

Documentation on the certification dated 3/31/05 stated that this 83 year old patient had decreased endurance and lower extremity weakness due to altered neurological status and that she required assistance to ambulate and that she had blurred vision at times. The patient was status post chemotherapy and radiation for a brain tumor and was planning for additional chemotherapy and she required monitoring of vital signs and physical functioning.

Documentation on the OASIS/comprehensive assessment dated 3/31/05 stated that the patient's blood pressure had been running high, that her vision was normal and that there was no blurred vision. Documentation on the OASIS also determined that the patient had a surgical incision (at the left frontal lobe), however there was no clinical record documentation to determine what surgery had been performed and/or when it was performed. Documentation on the skilled nurse visits by RN #10 during the period from 3/31/05 to 4/5/05 determined that the patient's visual status was within normal limits. On 4/7/05 RN #10 documented in the nurse's note that the patient complained of blurred vision, however there was no clinical record documentation to support that RN #10 assessed to what the degree the blurred vision interfered with the patient's functional status and/or her safety at home in the managed residential community where she lived alone. There was no clinical record documentation to support that agency nurses case conference at specific time points including weekly at pending admission and/or admission and at changes in status as outlined in the plan of correction for completion date of 3/31/05.

When interviewed on 4/13/05 RN #10 stated that she did not know what surgery the patient had and/or which part of the patient's brain was affected by her disease, surgery and/or radiation treatments. RN #10 stated that she did not know who the patient's physician was until a week ago, but then sent a fax to the surgeon in Massachusetts about the blurred vision. RN #10 stated that the APRN in the surgeon's office acknowledged the fax, but RN #10 had not spoken with that physician to inquire about what chemotherapy the patient had or what chemotherapy is being planned and/or to find out about the patient's surgery, radiation and location of the brain tumor/tumors. RN #10 stated that she has not contacted the primary physician about these issues, nor did she discuss the difficulties she was experiencing in identifying and contacting the physicians with her supervisor. RN #10 then stated, however, that she case conferences with her supervisors when the patient was admitted and after the blurred vision occurred, but she did not document the discussion.

The registered nurse failed to conduct case conferences with supervisors at designated specific time points in order to discuss the patient's status at admission, as her health status changed and/or to collaborate about case management problems she was experiencing that interfered with the patient's health care management.

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h. Agency registered nurses failed to document that effective interchange, reporting and coordination took place during case conferences and/or failed to conduct case conferences at specific time points as outlined in the agency's plan of correction for completion date of 3/31/05 in order to support the objectives outlined in the plan of care.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(C)(D) Services.

Plan of Correction

Completion Date

4. Based on personnel record review and staff interviews it was determined that from February 21, 2005 to April 11, 2005 the agency failed to maintain a personnel record for the supervisor of clinical services of the Southbury office that contained a signed contract or letter of appointment specifying the conditions of employment. The findings include:

a. Review of the supervisor of clinical services personnel file determined that there was no documentation of a signed contract or letter of appointment specifying the conditions of employment in the capacity of supervisor of clinical services.

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b. When interviewed on 4/11/05 the agency administrator stated that she was unaware that the appropriate contract was not in the supervisor's personnel record. On 4/11/05 the administrator gave the surveyor a copy of the supervisor of clinical service's job description that she stated was to be used in place of the letter of appointment and that was signed by the administrator and the supervisor of clinical services that day.

The agency failed to maintain a personnel record for the supervisor of clinical services of the Southbury office that contained a signed contract or letter of appointment specifying the conditions of employment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71(b)(4) Personnel policies.

Plan of Correction

Completion Date