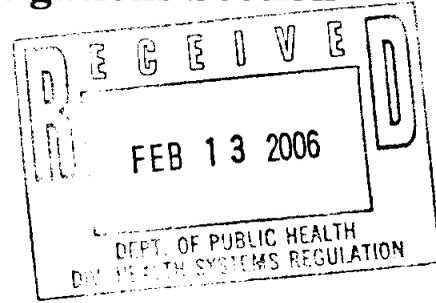


**State of Connecticut  
Department of Public Health  
Facility Licensing and Investigations Section**

In Re: Equinox Home Care, LLC  
305 Boston Avenue  
Stratford, CT 06497



MODIFIED CONSENT ORDER

WHEREAS, Equinox Home Care, LLC of Stratford, CT (hereinafter the "Licensee"), has been issued License No. 0008 to operate a Home Health Care Agency (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490, by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Licensee has a Consent Order with the Department which became effective February 13, 2004, of which is attached hereto (Exhibit A); and

WHEREAS, the Department's Facility Licensing and Investigations Section (hereinafter the "FLIS") conducted unannounced inspections at the Facility for the purposes of conducting an investigation, licensing and survey inspections; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in violation letters dated October 21, 2005 (Exhibit B) and January 12, 2006 (Exhibit C); and

WHEREAS, an office conference regarding the October 21, 2005 violation letter was held between the Department and the Licensee on November 3, 2005 and an office conference regarding the January 12, 2006 violation letter was held on January 24, 2006; and

WHEREAS, the Licensee and the Department have agreed to modify the aforementioned Consent Order.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan D. Leavitt, its Section Chief, and the Licensee, acting herein by Theresa Foreman, its Managing Member, hereby stipulate and agree as follows:

1. The Consent Order executed with the Department on February 13, 2004 shall be incorporated and made part of this Modified Consent Order.
2. In accordance with the provisions set forth in Section 5 of Exhibit A, the assigned individual shall also submit a copy of the monthly reports to the Department regarding the provisions contained within this document to the Licensee's Governing Authority and Professional Advisory Committee at their next scheduled meeting and monthly thereafter.
3. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 6 of Exhibit A, the Licensee through its Governing Body, Administrator and Supervisor of Clinical Services shall also ensure that:
  - a. All initial and re-assessments of patients shall include, but not be limited to, the need for skilled nursing service and/or other ancillary services including therapy, social work and home health aide services; the ability of the caregiver to care for the patient; appropriate assessment of payor source, including homebound status; psychosocial status, and as applicable, pain management and management of diabetes; and re-assessments shall be completed as often as necessary depending on the condition of the patient;
  - b. All plans of care developed and/or revised shall include all appropriate interventions for care of the patient including referral for all additional services as

- appropriate; prompt action shall be taken regarding any change in a patient's in condition and/or deteriorating health and/or safety status;
- c. All services provided to patients shall be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care and integrated with all other entities involved with the patient's care. All coordination activities shall support effective communication and reflect effective case management;
  - d. Patients for whom goals have not been met and for whom a premature discharge is being considered, the agency shall have a case review, as described in Section 19-13-D72 (a)(3)(D) of the Regulations of Connecticut State Agencies with all appropriate parties, prior to any decision and/or action to discharge the patient;
  - e. All care and services furnished to patients shall be provided by appropriately credentialed staff members who have been determined to be competent to provide such services and whose clinical competency is monitored and evaluated on an ongoing basis.
4. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 6 of Exhibit A, the licensee shall also maintain documentation regarding compliance and monitoring of 3a - e for an additional period of two (2) years.
  5. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 7 of Exhibit A, the Licensee shall within fourteen (14) days of the execution of this Modified Consent Order, review and revise, as necessary, each patient's plan of care based upon the patient's current and ongoing assessments.
  6. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 8 of Exhibit A, the Licensee shall within twenty one (21) days of the effective date of this Modified Consent Order review and revise as necessary all policies and procedures which are pertinent to revision of the plan of care; pain assessment and management; management of diabetes; nutritional and

hydration status; coordination of services including services provided in collaboration with other home health agencies and hospice programs; and notification of the physician of the condition of the patient including concerns for the patient's safety.

7. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 9 of Exhibit A, the Licensee shall within thirty (30) days of the effective date of this Modified Consent Order also in-service all direct service staff on topics relevant to provisions of Sections 3, 5 and 6 of this document
8. Effective upon execution of this Modified Consent Order and in accordance with the provisions set forth in Section 10 of Exhibit A, the Licensee shall additionally audit the medical record of each patient currently receiving services and provide additional in-service education as appropriate.
9. The Licensee shall, within thirty (30) days of the effective date of this Modified Consent Order build into the Licensee's current program a mechanism to evaluate the clinical competency of all professional direct service staff that, as a minimum, the Supervisor of Clinical Services shall quarterly conduct joint home visits with each primary care nurse ("PCN"), as well as a clinical record audit of twenty (20) percent of the PCN's current caseload, to assess clinical competence and to initiate a program of remediation, as applicable. At least annually, one joint home visit will include supervision of the home health aide. The administrator shall prepare a report of the program's progress toward goals to be presented to the Professional Advisory Committee at its meetings. Said reports shall be available for review by the Department for a period of two (2) years.
10. The Licensee shall within forty-five (45) days of the execution of this Modified Consent Order, develop and implement a program to assess staff compliance with Licensee's policies, procedures, and standards of practices. The program shall include but not be limited to a mechanism whereby remediation of staff occurs for failure to adhere to facility policy and procedures.

11. The Licensee upon the execution of this Modified Consent Order shall pay a financial penalty of one thousand dollars (\$1,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The check shall be made payable to the Treasurer of the State of Connecticut.
12. The financial penalty and any other reports required by this document shall be sent to:

Victoria V, Carlson, R.N., M.B.A.  
Supervising Nurse Consultant  
Department of Public Health  
Facility Licensing and Investigation Section  
410 Capitol Avenue, MS #12HSR  
P.O. Box 340308  
Hartford, CT 06134-0308
13. Effective upon execution of this Modified Consent Order and in accordance with Connecticut General Statutes Section 19a-494 (5), the Licensee is hereby placed on probationary status for a period of two (2) years.
14. All parties agree that this Modified Consent Order is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Order or of any statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Modified Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
16. The terms of this Modified Consent Order and the Order executed on February 13, 2004, shall remain in effect for a period of two (2) years from the effective date of this document.

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

EQUINOX HOME CARE, LLC OF STRATFORD

2/6/06  
Date

By: [Signature]  
Theresa Foreman, Managing Member

State of Connecticut )  
County of Fairfield

ss Stratford 2/6 2006

Personally appeared the above named Theresa Foreman and made oath to the truth of the statements contained herein.

My Commission Expires: 11-30-10

[Signature]  
Notary Public  
Justice of the Peace  
Town Clerk  
Commissioner of the Superior Court

**ELLEN M. DELNIGRO**  
**NOTARY PUBLIC**  
MY COMMISSION EXPIRES NOV. 30, 2005  
*2010*

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

2/14/06  
Date

By: [Signature]  
Joan D. Leavitt, R.N., M.S., Section Chief  
Facility Licensing and Investigations Section

**State of Connecticut  
Department of Public Health  
Division of Health Systems Regulation**

IN RE: Equinox Home Care, LLC  
d/b/a Equinox Home Care, LLC  
305 Boston Avenue  
Stratford, CT 06497

CONSENT ORDER

WHEREAS, Equinox Home Care, LLC of Stratford, CT ("Licensee"), has been issued License No. 0008 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on July 14, 2003 up to and including November 13, 2003 for the purpose of conducting a licensure inspection; 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 August 27, 2003 (Exhibit A - copy attached) and February 11, 2004 (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-D-66 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 Order, has chosen not to contest the above allegations before a hearing officer and further agrees that this Consent Order shall have the same effect as if ordered after a full hearing pursuant to section 19a-494 of the General Statutes of Connecticut; and,

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Director, and the Licensee, acting herein through Theresa Foreman, its Managing Member, hereby stipulate and agree as follows:

1. The Licensee understands and agrees this Consent Order, and the violations contained therein, shall be deemed proven as true and admissible as evidence in any subsequent proceeding before the Department in which (1) the Licensee's compliance with this same Consent Order 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 Order fully and completely resolves the allegations referenced above without any further proceeding before the Department; and
3. The Licensee waives the right to a hearing on the merits of this matter; and
4. The Licensee understands this Consent Order is a matter of public record; and
5. The Licensee within seven (7) days of the execution of this Consent Order shall designate an individual within the Facility who has responsibility for the implementation of this Consent Order. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document; and
6. Effective upon execution of this Consent Order, the Licensee through its Governing Body, Administrator and Supervisor of Clinical Services shall ensure that:
  - a. All care provided to patients by licensed practical nurses is coordinated by and under the direction and supervision of a registered nurse;
  - b. All patients are initially assessed in a timely and comprehensive manner and all subsequent re-assessments are comprehensive and completed as often as necessary depending on the condition of the patient;
  - c. All patients shall have a comprehensive plan of care developed and/or revised which is based on the individual patient's assessment and is reflective of the needs of the patient;
  - d. All services provided to patients will be provided in accordance with the written plan of care;
  - e. All medications will be administered only as ordered by the patient's physician and all discrepancies in medications shall be clarified with the physician prior to administration and/or pre-pour;
  - f. All plans of care and/or modifications to the plan of care shall be reviewed by the primary care nurse;
  - g. Each patient's personal physician or covering physician is notified in a timely manner of any significant change in condition;
  - h. Each patient's clinical record shall be kept current at all times and all clinical notes shall be incorporated into the clinical record at least weekly.

7. The Licensee shall within fourteen (14) days of the execution of this Consent Order, 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 Order review and revise as necessary all policies and procedures which are pertinent to patient assessment, development and implementation of the plan of care and notification of the physician of the condition of the patient.
9. The Licensee shall within thirty (30) days of the effective date of this Consent Order in-service all direct service staff on topics relevant to provisions of Sections 6, 7 and 8 of this document. The Licensee shall maintain an attendance roster of all in-service presentations, which shall be available to the Department for a period of two (2) years.
10. The Licensee shall audit the medical record of each patient currently receiving services to ensure that each patient's current condition is accurately and consistently documented. Within ten (10) days after the completion of 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 Order documentation of in-services shall be maintained by the Licensee for review by the Department for a period of two (2) years.
11. The Licensee shall employ sufficient and qualified staff. Said individuals shall be qualified in accordance with federal and state laws and regulations which are applicable to the care and services provided by a home health care agency. The full-time Administrator and/or Supervisor of Clinical Services shall, at all times, function in that capacity as described in the respective job descriptions.
12. The Licensee shall immediately notify the Department if the position(s) of Administrator and/or Supervisor of Clinical Services become vacant due to resignations. The Licensee shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
13. In accordance with Connecticut General Statutes Section 19a-494, the Department hereby issues a reprimand to Equinox Home Care, LLC of Stratford, CT for failure to comply with the stated requirements of the Regulations of Connecticut State Agencies.

14. The Licensee upon the execution of this Consent Order shall pay a financial penalty of seven hundred fifty 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 Order. The check shall be made payable to the Treasurer of the State of Connecticut.
15. The financial penalty 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,  
Division of Health Systems Regulation  
410 Capitol Avenue, MS #12 HSR  
P.O. Box 340308  
Hartford, CT 06134-0308

16. The provisions of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document.
17. 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.
18. 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 Division of Health Systems Regulation.
19. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Order in the event the Licensee fails to comply with its terms. .
20. The Licensee may consult with and attorney prior to the execution of this document.
21. The Licensee understands this Consent Order 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 Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

EQUINOX HOME CARE, LLC  
D/B/A EQUINOX HOME CARE, LLC  
OF FARMINGTON, CT.

2/11/04  
Date

By: [Signature]  
Theresa Foreman, Managing Member

State of CT  
County of Fairfield  
2003

ss [Signature]

Personally appeared the above named Theresa Foreman and made oath to the truth of the statements contained herein.

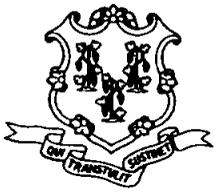
My Commission Expires:  
**NAOMI DORAN**  
**NOTARY PUBLIC**  
My Commission Expires Feb 28, 2004

[Signature]  
Notary Public   
Justice of the Peace   
Town Clerk   
Commissioner of the Superior Court

2/13/04  
Date

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

By: [Signature]  
Marianne Horn, R.N., J.D., Director  
Division of Health Systems Regulation  
Suzanne Blacafflor, M.S.  
Public Health Services Manager  
Division of Health Systems  
Regulations



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

# EXHIBIT B

October 21, 2005

Janet Lamb, RN, Administrator/SCS  
Equinox Home Care, LLC  
305 Boston Avenue, Suite 308  
Stratford, CT 06614

Dear Ms. Lamb:

Unannounced visits were made to Equinox Home Care, LLC on September 13, 14, 15, 16, 19, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and licensing and survey inspections with additional information received through October 20, 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 November 3, 2005 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Victoria V. Carlson, RN, MBA  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

SNC:NC: D. Selby

c. Complaint # CT00004225



Phone: (860) 509-7400  
Telephone Device for the Deaf (860) 509-7191  
410 Capitol Avenue - MS # 12HSR  
P.O. Box 340308 Hartford, CT 06134  
An Equal Opportunity Employer

DATE(S) OF VISIT: September 13, 14, 15, 16, 19, 2005 with additional information received through October 20, 2005

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b)(4)(A)(D) General requirements.

1. The governing authority failed to assume responsibility for the quality of services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 & 12 as evidenced by the violations listed in this document. When interviewed on 9/19/05 the governing body consisting of the agency owners stated that they were not aware of any patient problems and that they thought that administrator/supervisors and nursing staff were qualified to perform their jobs.

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

2. The administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 & 12 as evidenced by the violations listed in this document.

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

3. The supervisor of clinical services failed to assume responsibility for coordinating, managing and/or maintaining the quality of clinical services rendered to patients and families by direct service staff under her supervision and/or failed to effectively supervise the clinical competence of assigned nursing personnel and/or failed to directly evaluate the clinical competence of assigned nursing personnel as evidenced by the care and services rendered to Patient #s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 & 12 identified by the violations listed in this document. When interviewed on 9/16/05 the administrator/supervisor stated that since her date of hire 8/22/05 she was preoccupied with billing and patient related problems that emerged each day and that she was unaware of nurses patient visit schedules, that she had neither, reviewed clinical records, communicated with staff regarding current patients, and/or visited current patients in their home settings.

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

4. Based on clinical record review, staff interviews, home visits and interviews with other entities involved in the patient's care it was determined that for four (4) of twelve (12) patients the nurse failed to coordinate services with all persons/entities involved in the patient's care (Patient #s 1, 8, 9 & 12). The findings include:

DATE(S) OF VISIT: September 13, 14, 15, 16, 19, 2005 with additional information received through October 20, 2005

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

a. Patient #1: The clinical record documentation by RN #2 dated 7/27/05 indicated that the patient's blood pressure was 140/64, lungs were clear and there was no lower extremity edema. RN #2 documented that FBS was 217 and that the insulin dependent diabetes was poorly controlled, requiring frequent treatment adjustment and dose monitoring. LPN #3 revisited the patient on 7/30/05 and documentation included blood pressure 100/60, trace bilateral pedal edema and there was no documentation of blood sugar assessment and/or respiratory assessment. There was no documentation to support that RN #2 and LPN #3 communicated to discuss Patient #1's status, however, documentation by RN #2 on a telephone call note dated 8/1/05 stated that the family called to inform the home care nurse that the patient was taken to the emergency room and documentation on a transfer OASIS by RN #2 dated 8/1/05 stated that the patient was admitted to hospital. When interviewed on 9/15/05 RN #2 he stated that he did not communicate about the patient with LPN #3. RN #2 also stated that he was unsure why the patient was readmitted to hospital. When interviewed on 9/27/05 LPN #3 stated that when she started working with RN #2, the plan was to coordinate visits so that he revisited monthly. She stated, however that it was a very confusing time for her because RN #2 was did not communicate with her and he was very difficult to contact because when she left messages, he did not respond. LPN #3 stated that she was told by the supervisor to visit Patient #1, but no report was given and she had no idea that her assessment indicated status changes. After the visit LPN #3 was unable to contact RN #2.

Agency nurses failed to communicate about the patient's status and failed to share information necessary to assure that safe, coordinated care was accessible to all persons involved in the patient's care.

b. Patient #8 had a start of care date of 3/10/05 with diagnoses of liver failure, hypovolemia, esophageal varices, diabetes and depression. The plan of care included skilled nursing 1-3x a week and the aide was on hold pending Area Agency on Aging authorization. The plan of care and admission assessment identified the patient as terminal, having 3 months to live, not Medicare eligible due to the fact that she was not homebound and was chronic. The patient was to be transferred to a hospice home care agency the next week.

Review of the clinical record from 3/10/05 to 3/22/05 indicated that the patient did not receive nursing visits after 3/10/05 and never received aide services. The OASIS discharge assessment dated 3/22/05 was completed without a visit and stated that the patient was transferred to a new agency on 3/22/05. The clinical record lacked documentation to support that the nurse coordinated the patient's care with the new agency and/or had any contact with the new agency. The clinical record lacked information regarding the name of the new agency. The record lacked documentation regarding communication with the Area Agency on Aging after the admission of 3/10/05 until the patient's discharge of 3/22/05. The case manager at the Area Agency on Aging stated that according to her notes in the patient's record she had informed RN #3 that the patient was Medicare eligible for services. She stated the name of the hospice home care agency the patient was discharged to and identified the date transfer to the new agency as 3/18/05 and not 3/22/05.

RN #3 who was the agency administrator was not available for interview since she was no longer employed by the agency.

- DATE(S) OF VISIT: September 13, 14, 15, 16, 19, 2005 with additional information received through October 20, 2005

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

The nurse failed to coordinate care with all entities involved with the patient and/or failed to provide discharge information to the new agency caring for the patient.

c. Patient #9 told RN #3 that he was dying. RN #3 instructed the family to contact the physician to inquire about hospice care and the patient was admitted to inpatient hospice when the physician's office made the referral. There was no clinical record documentation to determine that the nurse communicated with the physician about the patient's status that necessitated hospice services and/or that there was communication between the home health care and the hospice so that all information necessary to assure safe, coordinated care to the patient was accessible and available to all participating agencies.

d. Patient #12 had a start of care date of 6/2/04. Diagnoses included diabetes and hypertension. The plan of care for certification period 3/29/05 through 5/27/05 identified skilled nurse (SN) visits 1-3 times weekly and a home health aide (HHA) 20 hours per week. A review of the skilled nurse visits identified that there were no visits during the weeks of 4/24/05 and 5/22/05. There were two documented missed HHA visits on 5/23/05 and 5/25/05. There was no documentation of any HHA visits during the month of 5/05.

A ten-day notice to discharge was dated 5/17/05 with a discharge date of 5/27/05.

The Manager and the Administrator stated Patient #12 was discharged due to a lack of staffing. Although the Manager, Administrator and the former Administrator stated that Patient #12 frequently was not at home and/or refused SN and HHA visits and was non-compliant with the plan of care, documentation in the medical record failed to indicate the patient's refusal of SN and HHA visits. The medical record lacked documentation to indicate that family/patient counseling had been conducted regarding a change of the patient's plan of care.

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

5. Based on clinical record review, staff interviews, physician interviews, interviews with other entities involved with the patients' care and home visits it was determined that for eleven (11) of twelve (12) patients the nurse failed to consistently and/or accurately assess and evaluate the patient's health status and nursing needs that may have suggested a need to alter the plan of care (Patient #s 1, 2, 3, 4, 6, 7, 8, 9, 10, 11 & 12). The findings include:

a. Patient #1's start of care date was 7/27/05. Diagnoses included seizure disorder, insulin dependent diabetes mellitus, hypertension, Alzheimer's disease and dementia. Documentation on the certification plan of care dated 7/27/05 to 9/24/05 ordered skilled nursing services 1-2 times per week for status changes, to assess vital signs, neurological status, endocrine status, medication compliance and to instruct patient regarding reportable symptoms, medication dose, effects and side effects. Medications included Glyburide, Aricept, Avandia, Seroquel, Lisinopril, Iron, Coreg, Colace, Coumadin, Celexa, Lasix, Multivitamin, Protonix, Provachol, Colchicine and Regular

DATE(S) OF VISIT: September 13, 14, 15, 16, 19, 2005 with additional information received through October 20, 2005

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

Insulin. Documentation on the inter-agency referral report dated 7/25/05 ordered nursing, physical therapy and occupational therapy.

Documentation on the start of care OASIS/comprehensive assessment dated 7/27/05 stated that this 94-year-old patient was alert, oriented, but forgetful. He had lower extremity weakness, used a walker, but gait was unsteady and he was a high fall risk. The patient's diabetes had been difficult to control. The primary care giver (PCG) reported that the blood sugar ranged from 70-150. Appetite was fair, but there was no documentation of a nutritional assessment. Patient #1 lived with his daughter who was the PCG and he was dependent for all ADLs/IADLs, blood sugar testing and medication administration. Documentation by RN # 2 dated 7/27/05 on the nurse visit note stated that blood pressure was 140/64, there was no peripheral edema, and fasting blood sugar was 217. There was no documentation to indicate that the nurse assessed for factors that could have caused the blood sugar elevation. On 8/30/05 LPN #3 visited and documented that blood pressure was 100/60, but failed to document assessment of postural changes. She stated however, that the patient had trace pedal edema bilaterally, gait was unsteady and the patient was not remembering to use his walker. LPN #3 failed to document a respiratory assessment. She stated that blood sugar was uncontrolled, failed to document current and past blood sugar levels but documented that the PCG was monitoring blood sugar and administering Regular Insulin. There was no documentation to indicate how much Insulin the patient was taking. Documentation was also lacking that LPN #3 communicated with the physician and/or with the PCN (RN #2) about the patient's changed status. Documentation by RN #2 dated 8/1/05 stated that the family informed the home health agency that the patient was sent to the emergency room.

Documentation on a hospital interagency referral report dated 8/16/05 stated that the patient was admitted after an episode of dizziness that caused him to fall. Upon admission the patient's blood sugar was "40" and it was determined that the glucometer the PCG had been using in the home was dysfunctional. The patient was also diagnosed with a deep vein thrombosis, pulmonary embolism and left pulmonary effusions. LPN #3 was unavailable for comment. On 9/15/05 RN #2 stated during interview that he was unaware of the patient's changed status because he and LPN #2 were just starting to work together and had not been communicating about patients she was visiting.

Patient #1 was discharged from hospital on 8/16/05 with orders for home health care nurse to assess blood sugar, cardio-pulmonary status and physical therapy for reconditioning. All blood pressure medications were placed on hold, Regular Insulin was discontinued and the dose of Glyburide was doubled.

New medication orders included to discontinue Provachol and Protonix and to add Zocor, Prilosec and Cardura.

Documentation by RN #2 on the resumption of care OASIS/comprehensive assessment dated 8/17/05 stated that the patient's diagnosis was left pleural effusion and there was no documentation about the deep vein thrombosis and/or the pulmonary embolism and the comprehensive assessment failed to include assessments of the patient's history, his current blood sugar, cardio-pulmonary status and/or nutritional assessment. A physician's verbal order documented by RN #2 dated 8/1/05 ordered resumption of skilled nursing 1-2 times per week and H-HHA not to exceed 20 hours per week, but failed to include ordered medication changes. Clinical record documentation was also lacking to indicate that the medication profile was updated at the resumption of care. When interviewed on

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9/27/05 RN #2 stated that he did not know about the medication changes ordered on 8/16/05 because the patient's daughter did not tell him. RN #2 stated that he did not obtain a copy of the interagency referral report dated 8/16/05 until 9/27/05. RN #2 stated that he did not know the patient's current medications that were ordered on 8/16/05. He stated that since the resumption of care on 8/16/05 he had continued to assess the patient for effects and side effects of medications and doses that were ordered on the initial plan of care dated 7/27/05.

b. Patient #2 had a start of care date of 8/19/05. Diagnoses included diabetes, hypertension, arthritis, and hypercholesterolemia. The patient was a self-referral. The plan of care dated 8/19/05 to 10/17/05 included skilled nursing 1-2x a week x 60 days for status changes, assess cardiopulmonary, endocrine, peripheral vascular statuses/circulation, diabetic management, VS, A/I pulse taking; A/I diet, blood glucose monitoring, medication dose, administration, compliance, response, side effects/interactions, assessment of pain management and pain medication effectiveness and what is acceptable level of pain for the patient; home health aide 2-3x a week to assist with personal care, ADLs and IADLs (aide was scheduled to assist the patient late afternoon 5x a week).

Review of the admission comprehensive assessment of 8/19/05 indicated that the patient was Spanish speaking, lived alone, was alert and oriented, needed assist to get dressed and bathed and experienced intractable pain in her lower back daily but not constantly and current pain medication was adequate. The patient was independent in toileting, transferring, ambulation, cooking, housekeeping and laundry and was independent in taking her medications but needed someone to draw up her insulin.

Review of the clinical record from 8/19/95 to 9/9/05 indicated that the patient went to a senior center every AM to play bingo. RN #1 stated on 9/14/05 that the center picked the patient up in the AM Mon. through Fri. and brought her home after noontime.

Review of the nursing notes from 8/19/05 to 9/9/05 indicated that the patient had pain ranging from 0 to 6 and the physician changed the patient's pain medication on 8/3/05 after a routine office visit. The nurse did not call the physician to confirm the reason for the medication change and did not add the medication to the patient's medication list. The nursing notes lacked documentation to support that the nurse assessed the patients pain medication schedule and/or instructed the patient how/when to take her pain medication in order to provide pain management with possible adjustment of the pain medication especially if the pain was intractable. The nurse documented the pain to be sometimes in the lower back and sometimes her in her lower abdomen. The nursing notes indicated that the patient was non-compliant with her meds and diet and the nurse instructed the patient on the importance of compliance. The clinical record lacked documentation that the nurse had pre-poured the patients medications in order to assess accurately the patient's compliance with meds and/or she failed to document any communication with the senior center regarding the patient's diet since the patient had breakfast and/or lunch/snacks at the center. On her visit of 9/6/05 the nurse noted the patient's pain level to be a 5 but the nurse failed to assess and document if the patient was taking her new pain medication correctly.

During a joint home visit to the patient on 9/14/05 the surveyor noted that the nurse spoke only a little Spanish and had difficulty communicating with the patient. The patient had medication bottles on the dining room table and stated that she was taking all her medications; the nurse did not count the

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medications so she could not accurately assess if the patient was compliant. The nurse did not ask the patient how often she was taking her pain medications but when asked by the surveyor she stated twice a day and not 3x a day as needed and ordered. The home health aide stated as she arrived on 9/14/05 that she never showered the patient because the patient showered and dressed herself in the AM prior to going to the center. She stated that she only did housework and occasionally rubbed the patient's back. RN #1 stated on 9/14/05 that she visited the patient 2x a week due to her medication/diet noncompliance and pain. She stated that the patient did not need a pre-pour for her PO meds and that the patient administered her insulin with dose specific pens.

RN #1 stated on 9/14/05 that the patient's daughter wanted 20hrs/ a week of home health aide services but she told the daughter that she could not justify 4hrs/day of aide services but would give her 2hrs. per day.

The nurse failed to accurately and consistently evaluate the patient's pain status, medication/diet compliance, the patient's level of function and/or the appropriate need of an aide for personal care since the OASIS/comprehensive assessment did not support the need for 5x a week aides and the fact that the aides were not performing personal care.

c. Patient #3 had a start of care date of 7/26/05 with diagnoses of diabetes, arthritis, hypertension and asthma. The patient was self-referred. The plan of care dated 7/26/05 to 9/23/05 included skilled nursing 1-2 x a week to assess CP, and endocrine statuses, VS and pain management; home health aide 4hrs 5x a week x 60 days to assist with personal care, meal preparation and light housekeeping. The 10-day summary to the physician indicated that the patient's pain was relieved with rest and prn medication. The physician's plan of care and the patient's medication profile did not include a prn pain medication and only included aspirin 81mg, po qd. The patient's BP was 154/96 and the nurse indicated that her BS range was 71-151 and controlled.

The admission comprehensive assessment dated 7/26/05 indicated that the patient was alert and oriented, lived alone, had intractable pain daily but not constantly in her knees and hands at a level 6 which was relieved by current pain control medications and was independent in all ADLs and IADLs, used an assistive device for ambulating and could drive a car or use public transportation. The comprehensive assessment indicated the patient was obese but failed to include a completed nutritional assessment including the patient's ordered diet.

The clinical record lacked documentation that the patient was taking any regular pain medication for the intractable pain. The patient performed blood glucose monitoring independently daily and prn. Review of the nursing noted from 7/26/05 to 8/31/05 indicated that the patient did not have any pain except for the visit on 8/31/05 when the nurse noted that the patient's pain level was an eight in R/L hands and she took Advil prn for relief. The patient was independent in all aspects of her care and was not visited the week of 8/22/05 because she was not at home. The patient was borderline hypertensive with BP's ranging from 130/79 to 154/96 but the record lacked documentation to support that the physician was notified and/or the nurse assessed the contributing factors for the hypertension and/or assessed her dietary habits.

Review of the aide's activity sheets indicated that from 8/3/05 (the start date of the aide) to 9/16/05 the patient received an aide 4hrs. a day (12:30 to 4:30) Monday through Friday, 5 days a week. The aide

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showered the patient, prepared meals (only diabetic diet was listed on the aide's care plan), reminded the patient to take her medications and performed housekeeping chores, however, the patient had been assessed as being totally independent in ADLs and IADLs and taking her medications.

Upon surveyor's inquiry on 9/15/05 RN #2 stated that he didn't know why he needed to visit the patient every week. He stated that he was told by his supervisor to refer for an aide not to exceed 20hrs. /week and he was to visit once a week to do a general assessment. He stated that the aide combed the patient's hair and prepared meals. The nurse's previous supervisor was not available for interview since she was no longer employed by the agency.

The nurse failed to consistently and accurately assess the patient's health status, nursing needs, functional status, and the need for 20hr. a week home health aide when the OASIS/comprehensive assessment did not support the need for a home health aide.

d. Patient #4's start of care date was 5/9/05. Diagnoses included chronic obstructive pulmonary disease (COPD), asthma, hypertension and agoraphobia. Medications included Albuterol nebulizer, Vasotec, Procardia, Effexor, Percocet and Valium. The patient used oxygen at 3 liters as needed. The certification plans of care dated 5/9/05 to 7/7/05 and 7/8/05 to 9/5/05 ordered skilled nurse visits 2 times per week to assess cardio-pulmonary status, vital signs and coping mechanisms and to assess/instruct pulse taking, signs and symptoms to report to the physician/emergency response, oxygen use, environmental triggers and compliance with the care plan; H-HHA not to exceed 20 hours weekly for personal care, ADLs and IADLs. Documentation by RN #2 on the admission note dated 5/9/05 stated that this 47-year-old patient had severe asthma and shortness of breath that limited her functional abilities. Lungs had wheezes posteriorly with auscultation and shortness of breath was observed with ambulation. Past history of hypertension that was managed with medications. RN #2 documented on the OASIS/comprehensive assessment dated 5/9/05 that the patient's blood pressure was 148/75 and pulse was 94. On 5/19/05 RN #2 reported to the physician that the patient's blood pressure was 168/101 pulse of 110. After physician's exam on 5/28/05 new medication orders included Hydroxysine HCL and Prednisone in tapering doses from 40 mg to 10 mg over the next ten days and skilled nursing was increased to 3 times per week to monitor exacerbation of severe asthma. On 5/28/05 after a physician's exam Procardia was increased to 120 mg daily, but no blood pressure parameters were identified. During the next three revisits RN #2 documented as follows: 5/31: BP 147/95, pulse 103 and expiratory wheezes bilaterally, 6/1/05: BP 145/95, pulse 110 and audible expiratory wheezes, 6/3: BP 151/95, pulse 107 and wheezes with nonproductive cough. RN #2 documented on the 6/3/05 nurse note that the patient's blood pressure and respiratory status were improving and skilled nurse visits were decreased to twice weekly despite the continued blood pressure and pulse elevations. Clinical record documentation by RN #2 indicated that the next physician's appointment was 6/14/05, however, RN #2 revisited on 6/14/05 and documented that the blood pressure was 170/100, pulse was 108 and lung sounds included rhonchi, wheezes, cough and shortness of breath. He stated that the physician "was aware" and wanted continued monitoring and to see the patient again in 2 weeks, but there was no documentation to determine how the physician was aware and/or that RN #2 contacted the physician. When interviewed on 9/19/05 RN #2 stated that he had not called the physician about the patient's status because the patient reported the information to the physician during the scheduled

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physician appointment. Documentation from the physician's office received by the surveyor on 9/27/05 reflected that the patient did not keep an appointment on 6/10/05 and was not seen by the physician again until 6/28/05.

The re-certification dated 7/8/05 to 9/5/05 ordered skilled nurse twice a week. The sixty-day summary documented by RN #2 identified the patient's status that was assessed on 7/8/05. RN #2 failed to inform the physician that the patient had been compliant with ordered medications, and that abnormal blood pressures, pulses and respiratory status had persisted.

During the period from 7/8/05 to 9/2/05 RN #2 visited twice weekly totaling 17 revisits and documented medication and/or low salt diet compliance, however blood pressures ranged from 134/92 to 179/107 with 16 diastolic elevations greater than 90 and 9 greater than 100. Pulse ranged from 90 to 120 and respiratory status consistently included wheezing with intermittent reports of accompanying shortness of breath, cough and/or rhonchi. During that period the patient also reported headache pain with increased frequency; occurring in eight out of eleven nursing visits from 7/18 to 8/24/05. There was no clinical record documentation that RN #2 intervened to report the patient's status to the physician and/or to alter the plan of care to implement measures focused at more intensive and specific assessment of factors conducive to elevated blood pressure and asthma exacerbations.

When interviewed on 9/14/05 RN #2 stated that he frequently spoke with the physician, but did not obtain blood pressure parameters, but after the Procardia was increased the blood pressures improved and the physician wanted home health nurses to just monitor for changes.

Upon arrival for a joint home visit on 9/15/05 the surveyor observed that the patient was finishing a fast food breakfast. RN #2 assessed that the blood pressure was 146/92, but could not compare the value to the last visit because he only brought a stethoscope and blood pressure monitor into the home. He stated that the physician's goal for the patient's blood pressure was 130/70, but that the physician knew the blood pressure was still high, but that RN #2 planned to contact the physician to inform him that the blood pressure was not decreasing.

When interviewed on 9/26/05 the physician's office staff stated that their record indicated that the patient was not seen since 6/28/05 and her blood pressure was elevated at 160/95 on that day. The physician's office record indicated that RN #2 last called the physician on 5/28/05.

Documentation on the medication profile updated by RN #2 on 7/5/05 and 9/2/05 stated Procardia 90 mg daily. Documentation on the re-certification plan of care dated 7/8/05 to 9/5/05 ordered Procardia 150 mg daily. During the home visit on 9/15/05 the surveyor noted that the patient's prescription bottle was labeled "Procardia XL 60 mg (Nifedipine ER), take 2 daily and the patient stated that she was taking the medication in divided doses twice daily. RN #2 stated that he was not sure what the dose should be and documentation that he had in the home showed the recertification dose of Procardia 150 mg. Later that day RN #2 explained to the surveyor that the dose of Procardia should be 120 mg daily as he had written on a verbal order dated 5/27/05. There was no documentation in the clinical record to indicate that the ordered Procardia was "extended release." RN #2 failed to accurately assess the medications the patient was taking and/or failed to consult with the physician when the ordered dose failed to reduce the patient's blood pressure to the desirable goal of 130/70.

RN # 2 failed to accurately assess and/or failed to document assessment of the patient's response to medication changes for elevated blood pressures and asthma and/or failed to consult with the physician

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when the blood pressure was consistently elevated and/or when the patient complained of increased frequency of headaches and/or when the patient's respiratory status remained compromised with tachycardic pulse rates and/or failed to intervene to change the care plan to implement nursing interventions to increase nursing visits to closely monitor and teach low salt dietary intake and/or measures to improve coping effectiveness, etc.

e. Patient # 6's start of care date was 5/23/05. Diagnoses included chronic obstructive pulmonary disease/emphysema, deep vein thrombosis, edema, hypertension and anxiety. The home health certification plans of care dated 5/23/05 to 7/21/05 and 7/22/05 to 9/19/05 ordered skilled nurse weekly to assess status changes, cardio-pulmonary status, vital signs, peripheral vascular status/circulation including circulation, mobility and sensation to extremities, mobility, fall risks, safety, medication compliance/effects and pain management. Clinical record documentation indicated that skilled nursing visits were made weekly during the period from 5/23/05 to 8/24/05 and review of the nursing notes revealed that the patient's cardio-vascular status was stable and joint pain was well controlled with Tylenol. There was no nursing documentation that indicated a continued need for skilled nursing service.

When interviewed on 9/18/05 RN #2 stated that the patient referred himself for nursing services about four months after he experienced a deep vein thrombosis. RN #2 stated that the physician informed him at the start of care that the patient has not had any exacerbations of the chronic obstructive pulmonary disease and/or the hypertension.

When interviewed on 10/20/05 the physician stated that the patient underwent vascular surgery in February 2005. Since that time there have been no exacerbations of his COPD and/or hypertension and there have been no medication changes. The physician concluded that since the patient was stable and because he routinely accesses outpatient medical care independently that there was no justification for home health care services.

The registered nurse failed to accurately assess the needs of the patient, as there was no documented evidence for the continuing need for skilled nursing services. There had been no documented exacerbations of the patient's diagnoses. The patient's goal in the plan of care did not show any instability. There was no change in the nursing plan of care, goals and/or additional medical and/or nursing intervention, which would demonstrate that a reasonable probability of change in the patient's condition would occur.

f. Patient #7 had a start of care date of 6/7/05 with diagnoses of GI bleed, dementia, cerebral vascular accident and atrial fibrillation.

Review of all the patient's clinical records indicated that the patient was originally admitted on 6/1/05 under Managed Care Medicare following discharge from a skilled nursing facility on 5/30/05.

Review of the nursing home's discharge summary of 5/30/05 indicated that the patient was on medication for her GI bleed with no further episodes, experienced digoxin toxicity as an inpatient and was now on a lower dosage, was alert and confused and ambulated with a rolling walker or assist of 1 or 2 and needed encouragement. Patient's appetite was fair; she experienced difficulty with chewing and weighed 112 lbs. The patient lived with 2 sons, one of which was handicapped. The family had

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requested discharge from the nursing home due to a financial issue.

Review of the patient's initial plan of care dated 6/1/05 included skilled nursing 2x a week x 60 days to assess CP, neurological, GI statuses, VS, assess for GI bleed, pain and medication effectiveness. The 10-day summary to the physician of 6/1/05 indicated that the patient's BP was 132/71, the patient was forgetful, experienced weakness in her upper and lower extremities, had an unsteady gait and difficulty with bed mobility, stairs, IADLs, coordination, balance and endurance, needed assistance with ADLs and was totally dependent. Review of the admission record from 6/1/05 to discharge on 6/6/05 lacked documentation that the patient was referred for physical therapy, home health aide service and/or a social worker to assist the patient's family with long term planning. The clinical record lacked documentation that an OASIS/admission comprehensive assessment or any comprehensive assessment was completed. The nurse visited the patient on 6/3/05 and discharged the patient from Managed Care Medicare on 6/6/05 with all goals met and a BP of 92/50, totally dependent in transfers, dyspneic on exertion and confused. The HABB, which was issued on 6/6/05 and not signed by the patient's POA and stated that Medicare does not pay for custodial care as the reason for discharge.

The administrator stated on 9/19/05 that an OASIS/comprehensive assessment was not completed because the agency believed that Managed Care Medicare was considered insurance and an OASIS assessment was not needed.

RN #2 stated that he was new to home care and this was one of his first patients therefore he was not aware that he should refer for other disciplines such as PT, aide and MSW. He was told to discharge the patient from Medicare since they would no longer pay for services and transfer the patient to Medicaid. The physician's plan of care of 6/7/05 under Medicaid included skilled nursing 2x a week for 60 days to assess CP, neuron, GI statuses, VS, pain management and medication effectiveness, A/I in s/s of GI bleeding; home health aide not to exceed 20 hrs. week x 60 days to assist with personal care, ADLs/IADLs, patient transfers.

Review of the OASIS/comprehensive assessment of 6/7/05 indicated that the patient lived with a son who cared for the patient day/night but failed to identify if he could safely care for the patient. The patient's BP was 95/50, she was dyspneic on exertion, a moderate nutritional risk, constantly confused, experienced weakness in all extremities and was now totally dependent for all her ADLs and IADLs, was not ambulatory, unable to transfer and was bedfast. The clinical record lacked documentation to support that a physical therapist was referred to evaluate the patient's rapid decline in functional status and the ability of the family to assist the patient and to maintain safety in the home.

Review of the nursing notes from 6/7/05 to 6/17/05 indicated that the patient would eat if meals were prepared, was non-ambulatory, totally dependent and had no s/s of GI bleed. The clinical record lacked documentation to support that the nurse assessed the quantity of the patient's diet, assessed for devices to prevent skin breakdown in the home, assessed the patient's skin integrity, assessed the patient's regime regarding the transfer to a chair and/or the procedure the family utilized regarding the transfer of the patient and/or the regime for turning a non ambulatory patient.

The nursing visit note of 6/20/05 noted see wound care flow sheet and the nurse instructed the family to turn the patient to decrease the risk of skin break down and to transfer bed to chair with total assist only. A telephone log dated 6/20/05 noted that the nurse notified the physician that Patient #7 had a stage 2 ulcer on the coccyx and the physician instructed the nurse to use his judgment to apply a topical

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ointment. The wound care flow sheet indicated that the wound was assessed from 6/20/05 until it healed on 7/15/05. The clinical record lacked documentation regarding the frequency that wound care was performed by the nurse and/or the wound care procedure. The record lacked a physician's order for wound care treatment. Review of the nursing notes from 7/15/05 to 8/26/05 indicated that the patient remained hypotensive, non-ambulatory, had a poor appetite and demonstrated no s/s of GI bleeding, however a stool for quiac was never obtained. The nurse documented that he encouraged the family to increase fluids and food. The nursing notes lacked documentation that the nurse assessed the family/aide's ability and routine to transfer the patient, the amount of time the patient spent in bed and out of bed, where the patient sat, any preventative devices in place to prevent skin breakdown, quantifiable data regarding the patient's nutritional status and/or the need for a protein supplement/Vitamin C and/or zinc supplement, the patient's ability to turn and/or family's ability to turn the patient every 2 hours and provide incontinent care and/or the family's coping status. A note on 8/11/05 noted that the patient needed assist of 2 to transfer to a wheelchair and bedside toilet. Review of the clinical record from 6/7/05 to 8/26/05 noted multiple discrepancies. The comprehensive assessment of 6/7/05 identified that the patient was constantly disoriented and non ambulatory but the physician's plan of care of 6/7/05 identified the patient as oriented but forgetful and using a walker. The patient's BP was 95/50 on the comprehensive assessment of 6/7/05 but was listed as 132/71 on the 6/7/05 summary to the physician. The nursing admission note of 6/7/05 noted that the patient understood medications and was compliant however the comprehensive assessment of 6/7/05 noted that the patient was totally dependent for medication administration and was disoriented.

RN #2 stated on 9/19/05 that he was new to home care when he admitted Patient #7. He stated that the patient's functional status declined but he had not thought of referring for physical therapy, MSW or SCAAA. He stated that the patient had a wheelchair with a cushion and an old hospital bed with some type of cushion. RN #2 did not know exactly how many times a day the patient would get up to the wheelchair and he never observed the son transferring the patient. He stated that he had discovered the stage 2 coccyx decubitus and he changed the Duoderm every 5 days to the coccyx decubitus but failed to obtain a physician's order for the wound care. He did not document that the patient was taking Ensure 1-2x a day. He stated that the patient's stools were black due to Feosol (iron supplement) but he had not tested her stools for quiac.

During a joint visit with RN #2 on 9/15/05 the surveyor observed that the patient was somnolent and essentially nonverbal. Her son (PCG) stated that the patient was totally dependent for all of her needs. The surveyor observed that the PCG had difficulty ambulating and standing with a walker due to lower extremity deformities and expressed discomfort at his bilateral knees. The PCG informed the surveyor that he managed the patient's care alone most of the time and that the patient is routinely in bed on an egg crate mattress from 5-6 PM to 1-2 PM the following day. The H-HHA assisted in the morning and early afternoon to wash and feed the patient, then to get the patient out of bed. The PCG stated that he cannot transfer the patient alone and that she is up in the chair sitting on a donut cushion for at least three hours until his brother returns from work and assists to put the patient back to bed. At least 3 out of 5 evenings, however, the brother works late and on those nights the PCG stated that he struggles to get his mother back to bed alone since she is minimally weight bearing for only a few seconds. "At times I get her at least ½ onto the bed, but sometimes I just can't lift her and I have to put her down on

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the floor until my brother comes home." He stated, "I dread the evenings when I'm alone with her." The PCG stated that once he gets the patient back to bed, he is unable to turn her, but does the best he is able to pull her diaper off, clean her and reapply dry clothing then to change her position and her diaper as best as he can about 11 PM. On Saturday the PCG is alone most of the day and the patient remains in bed. The PCG informed the surveyor that two weeks earlier, he requested additional H-HHA assistance from the home health agency nurse, but there had been no response. He also stated that he cooks all of the patient's meals, but he was concerned that doing his best to cook was not adequate. In response to surveyor inquiry, the PCG stated that he never heard of the meals on wheels program. During the visit, RN # 2 stated that he requested increased home health aide hours for the patient about two weeks earlier, but the HHA supervisor had not responded and he did not follow up on the request. The surveyor inquired about the PCG's ability to transfer Patient #7 and RN #2 stated that he had never observed the transfer and that he was not aware that the patient could benefit from home physical therapy and/or that P.T. would assist the PCG to learn how to move the patient. He also stated that he did not know about meals on wheels since he was new to home health care, but that he had instructed the PCG to give the patient supplements.

During the joint visit RN #2 discovered a wound dressing on the patient's coccyx. The PCG informed him that a few days earlier, the H-HHA noticed that the skin was broken and that she applied Desitin and the dressing. RN #2 removed the dressing and the surveyor observed at least five small stage 2 decubiti that were heavily coated with Desitin. RN #2 placed the patient on her back, onto the wound site stating that he would return later in the evening to dress the wounds. He stated that he planned to use Duoderm and needed the H-HHA to wash off the Desitin when she returned that afternoon. RN #2 stated that he did not want to do this himself for risk of hurting the patient by turning her on her side. RN #2 did not contact the physician about the patient's new wounds during the visit; however, H-HHA #3 returned during the joint visit and assisted the nurse to apply Duoderm to the coccyx decubiti after she cleaned them.

In response to surveyor inquiry, H-HHA #3 told the surveyor that she discovered the wounds a few days ago, but she did not call the agency because she did not have the telephone number.

The PCG told the surveyor that he was trying to keep his mother from going to a nursing home. He stated that he was not aware that medical social services could be available to the patient to assist to access resources for community and/or state entitlement programs for elders. RN #2 stated that he was planning to contact the patient's state worker to obtain this assistance.

When interviewed on 9/15/05 the agency office manager stated that H-HHA services were not increased because the patient was already receiving 20 hours a week and it would take special permission to add more hours.

When interviewed on 9/16/05 the Administrator/SCS told the surveyor that Medicaid had approved an additional 20 hours of H-HHA for the patient, but the surveyor suggested to the Administrator/SCS that this patient exhibited needs for skilled nursing care and Medicare should probably be the primary benefit provider.

The nurse failed to consistently and accurately assess the patient's functional status, psychosocial status, safety, caregiver's ability to care for the patient, caregiver's coping strategies, nutritional status and need for preventative devices and/or failed to refer to appropriate services for the patient in order to prevent

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deterioration in her level of function, mental status and skin integrity. The patient's functional status deteriorated in two months from ambulating with a rolling walker and transferring from bed to chair to bedfast and total care for all ADLs and IADLs.

g. Patient #8 had a start of care date of 3/10/05 after being sent to the hospital and discharged from the home care agency with dehydration on 3/7/05. The patient's diagnoses included liver failure, hypovolemia, esophageal varices, diabetes and depression. The plan of care dated 3/10/05 to 5/8/05 included skilled nursing 1-3x a week x 3 wks for general assessment, C/P, endocrine, GI assessment and medication pre-pour every week; home health aide was on hold pending authorization from Area Agency on Aging and the patient's daughter agreed to accept responsibility until authorization was received. The plan of care stated that interventions would include advocating for the patient's end of life decisions until transfer next week to a hospice home care agency, support patient and family with anticipatory grieving and anger issues and allow the daughter to verbalize anger. The discharge plan was to discharge the patient next week to a new home care agency and psychiatric services.

The summary to the physician of 3/10/05 indicated that the patient had end stage liver disease with 3 months to live. Poor family dynamics were observed and were deteriorating rapidly. The patient agreed to hospice home care but the hospice agency could not accept the patient for a week. The patient had an increase in forgetfulness therefore needed her medications prepared by the nurse.

The start of care comprehensive assessment of 3/10/05 completed by RN #3 indicated that the patient lived alone, had a good appetite, skin was WNL, she was alert and oriented, depressed, needed assist with ADLs and IADLs. The patient utilized a walker and a wheelchair. The RN indicated that the patient was not homebound but was not specific as to the frequency, duration and taxing effort regarding leaving home. The admission visit note of 3/10/05 was completed by LPN #3 and she noted that the patient had a tracheotomy for which she was independent in its care, had no appetite and skin turgor was poor. The administrator stated on 9/18/05 that both the RN and LPN visited the patient for the admission visit of 3/10/05 and was not sure as to the reason the both nurses admitted the patient.

A case conference note on 3/10/05 between the RN, LPN, clinical supervisor and Area Agency on Aging noted that the patient needed to be transferred to hospice home care, aides were on hold pending approval from Area Agency on Aging, and that the family was not coping well.

Review of the clinical record from 3/10/05 to 3/22/05 identified that LPN #3 pre-poured the patient's medications on 3/12/05 to 3/19/05, which was recorded on a pre-pour medication record. No further documentation of the visit was noted in the clinical record. The clinical record lacked documentation to support that a nursing visit was conducted and/or that the patient /family/ home situation was assessed on 3/12/05 and that the plan of care of 1-3x a week was followed. The clinical record indicated that the patient was transferred to a hospice homecare agency on 3/22/05 and the transfer OASIS assessment of 3/22/05 noted that the last nursing visit was conducted on 3/12/05.

The nurse failed to re-evaluate a patient who was identified as hospice appropriate, no longer had an aide for assistance, exhibited poor skin turgor, poor appetite, was depressed, had a dysfunctional family situation, was increasingly forgetful and needed a pre-pour of medications following the admission visit of 3/10/05 and prior to discharge on 3/22/05.

RN #3, who was also the administrator/supervisor of clinical services at the time, was unavailable for

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interview since she is no longer employed by the agency. LPN #1 stated to the current administrator on 9/19/05 that she did not write a nursing note for the visit to the patient on 3/12/05 for the pre-pouring of medications.

The nurse failed to accurately evaluate the patient's homebound status and denied the patient needed home health aide services that would have been covered under Medicare until the patient was transferred to a hospice home care agency.

The nurse failed to accurately assess the patient's psychosocial status and refer the patient for social worker services after identifying family discord, depression and the need for long term planning.

The case coordinator at the Area Agency on Aging stated on 9/21/05 that the administrator/supervisor of clinical services of the home care agency was told by the Area Agency on Aging that the patient was clearly Medicare appropriate and they should have provided all needed services under Medicare. She stated that the patient's daughter was upset and displeased that the home care agency did not provide needed services to the patient the weekend of 3/12-13/05. The case worker stated that the patient was admitted by another home care agency on 3/18/05 with a plan of care that included nursing, twice a day home health aides, MSW and chaplain services.

h. Patient #9's start of care date was 12/13/04 with diagnoses including leukemia and degenerative joint disease. Documentation on the certification plan of care dated 12/13/04 to 2/10/05 ordered skilled nurse once weekly for cardio-pulmonary assessment, general assessment, side effects of chemotherapy and to monitor fatigue; H-HHA 2 times per week for ADL and IADL assist. The admission note by RN #3 stated that Patient #9 was 93 years old, lived alone, complained of fatigue and that he was homebound. Patient #9's treatment for leukemia included chemotherapy, weekly labs and multiple transfusions. RN #3 stated on the OASIS/comprehensive assessment dated 12/13/04 that the primary care giver was the patient's niece who provided assistance with IADLs and psychosocial support 1-2 times a week. RN #3 also documented that the patient required assistance in all ADLs and IADLs. When interviewed on 9/22/05 the case worker at the Area Agency on Aging stated that she referred Patient #9 to home health care for nursing to monitor the leukemia and to provide H-HHAs to assist him in the home. The caseworker stated that when she visited the patient at home in early December she observed that he ambulated with a cane or walker, but he was weak with unsteady gait and had lower extremity aching due to degenerative joint disease. The caseworker expressed concern that the only bathroom was upstairs which the patient was unable to get to, limiting his ability to wash and he refused to use a commode. She stated that the primary care giver was a niece who lived several miles away.

Clinical record documentation by RN #3 dated 12/21/04 stated that the patient refused the H-HHA on 12/16 and 12/17/04, but there was no documentation that she revisited to assess how the patient's immediate needs were being met. RN #3 documented on 12/21/05 that she contacted the patient's niece who stated that she would provide the needed care. Documentation was lacking that RN #3 evaluated how this plan was working and/or how the patient's needs for assistance in ADLs and IADLs were being met each day and/or that she increased visits to monitor the effectiveness of the plan of care. Documentation on the OASIS/comprehensive assessment on 12/13/04 stated that leukemia symptoms were controlled with difficulty and that the patient had less than 6 months to live. However, upon

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admission on 12/13/04 the patient signed a HHABN (completed by the nurse) that stated that his condition was chronic. There was no documentation to determine that RN #3 had contacted the physician to inquire about the patient's actual medical status. When interviewed on 9/21/05 the patient's physician stated that as early as November 2004, the patient was profoundly anemic and transfusion dependent; responding poorly to treatment with progressive weakness and lethargy. She stated that this progression continued through the month of December when hemoglobin and white blood cell counts fell to very poor levels. The physician stated that she had no records or recall of calls from the home care agency nurses during the period that she cared for the patient.

Clinical record documentation determined that RN #3 visited the patient on 12/21/05 and documented that the patient was tired, but otherwise asymptomatic. RN #3 stated that she discussed hospice with the patient and family and the family planned to speak with the oncologist, however there was no documentation to determine why RN #3 thought the patient was hospice appropriate and/or that she contacted the physician to report the patient's status. On 12/29/04 RN #3 documented that she spoke with the patient's niece who reported that the patient was declining, that he was speaking of death more, but there was no change in his medical condition. RN #3 did not revisit on 12/29/04, but assigned the patient to be revisited on 12/30/04 by LPN #2. Documentation by LPN #2 on a nurse visit note dated 12/30/04 stated that the patient had limited mobility with a cane and limited endurance. There was no documentation of respiratory status, but the patient was otherwise asymptomatic. RN #3 documented on 12/30/04 that LPN #2 reported that the patient was doing well. When interviewed on 9/22/05 the administrator stated that LPN #2 told her that the patient was well, but that he spoke a lot about his life and he was preparing to die. On 1/4/05 RN #3 documented on a transfer OASIS that the last nursing visit was 12/30/04. She stated that the patient was admitted to home health care with end-stage leukemia and that he spoke about end of life issues that she felt he was processing well. RN #3 stated that a call was made to hospice for a bed because the patient wanted to go, that the family and the physician were notified and the patient was transferred by ambulance on 1/4/05. RN #3 stated that large amount of emotional support "was given via telephone." RN #3 was not available for interview.

When interviewed on 9/21/05 the physician stated that she received a call from the patient's niece who reported that he had become acutely ill over the previous few days. The physician stated that in talking with the niece she determined that the patient had endured an "acute episode," that he was experiencing gastro-intestinal (GI) bleeding and there were no treatment options that would help. The physician's office referred the patient to inpatient hospice where he was admitted and died on 1/4/05.

When interviewed on 9/20/05 the medical records nurse at the inpatient hospice stated that the patient was referred by the physician's office and admitted to inpatient hospice on 1/4/05 with vomiting, diarrhea with evidence of GI bleeding, severe anemia, multiple body bruises and cellulites and edema of the bilateral lower extremities; knees to feet.

RN #3 failed to accurately and appropriately assess and/or to document assessment of the patient's status when he was admitted with end-stage leukemia and/or failed to accurately re-evaluate his medical status when he consistently complained of fatigue and limited endurance and refused H-HHA services and/or when he began to speak with the nurse about his belief that he was dying and/or failed to communicate with the physician about this change in status that suggested a need to alter the plan of care.

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i. Patient #10 had a start of care date of 6/17/05. Diagnoses included degenerative joint disease, hypertension, anxiety, depression and hypercholesterolemia. The patient was a self-referral. The plan of care dated 6/17/05 to 8/16/05 included skilled nursing 1-2x a week to assess CP status, coping mechanisms, pain management and pain medication effectiveness of current treatment, gait/mobility, transfers, safety and falls, s/s of depression/anxiety; home health aide 4hrs/day 5x a wk to assist with personal care, ADLs/IADLs, maintain home safety, meal prep and housekeeping. The patient's medications listed on the plans of care remained the same and did not include any pain medications although the plans of care state that the nurse was to assess the effectiveness of the current medications for pain.

The 10- and 60-day summaries to the physician dated 6/17/05 and 8/16/05 stated that the patient c/o bilateral knee pain with minor relief from prn medications (none listed in the medication profile) and rest.

The admission comprehensive assessment of 6/17/05 indicated that the patient had a pain level of 6-8, which occurred all the time in both knees, was intractable and was relieved by rest and medication. The clinical record lacked documentation to support that the patient was on any medications for pain. The comprehensive assessment noted that the patient was obese but lacked a completed nutritional assessment including diet. The plans of care noted the patient was on a low sodium and low cholesterol diet.

Review of the nursing notes from 6/17/05 to 8/12/05 indicated that the patient experienced pain in bilateral knees on a range of 6-10 and was taking APAP prn with acceptable relief. The nursing notes lacked documentation that the nurse communicated with the patient's physician to order daily pain medication to control the patient's pain and/or a possible referral for physical therapy since the nurse identified that the patient experienced unsteady gait due to the pain. The record lacked documentation to support that the nurse consistently and or accurately assessed the name, frequency and dose of the prn medication. Pain medications were not listed on the medication profile and/or the physician plans of care.

RN #2 stated on 9/26/05 to his supervisor that the patient did not want to take anything for the pain and that the pain was subsiding.

On the admission comprehensive assessment of 6/17/05 the patient was identified as experiencing depression/anxiety and in the admission note of 6/17/05 the nurse stated that the patient was depressed due to a move to a new home and the loss of the family pet. Review of the nursing notes from 6/12/05 to 8/16/05 consistently indicated that the patient was depressed and/or anxious due to her living conditions. The clinical record lacked documentation to support that the nurse referred for MSW and/or a psychiatric nurse and /or consulted with the patient's physician regarding her current anti-anxiety/depression medication in order to alleviate her depression/anxiety.

RN #2 stated on 9/26/05 to his supervisor that the patient is no longer depressed and during the time she was depressed he did not think about referring her for other services.

On the admission note of 6/17/05 and the next visit of 6/22/05 the patient's BPs were 90/60 and 91/74. On the subsequent visit of 6/29/05 at 11 AM the patient's BP was 161/94 and the visit note stated no change in the patient's status from the last visit. On subsequent visits from 7/6/05 to 9/6/05 the patient's

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BP was elevated on 7/6, 7/12, 8/16, 8/24, 8/31 and 9/6/05. On all nursing visits the nurse indicated that the patient was compliant with her medications. The clinical record lacked documentation to support that the nurse assessed the effectiveness of the patient's antihypertensive medications and/or reported these findings to physician in order to possibly alter the plan of care. The nursing notes from 6/17/05 to 9/6/05 lacked documentation to support that the nurse assessed the patient's diet regime but occasionally noted that he instructed the patient in a low sodium/cholesterol diet and the patient ate three meals a day.

RN #2 stated to his supervisor on 9/23/05 that when the patient's BP was elevated she had not taken her BP medications as yet, however the nursing visits were often conducted in the late AM or in the afternoon when all medications should have been taken.

The nursing note of 8/2/05 indicated that the patient had left calf pain and with ambulation the veins in the leg were raised, hard and painful to touch. The nurse did not indicate if the leg was edematous, red and/or if a Homan's sign was assessed. The nurse sent the patient to the ER. The nurse failed to revisit and/or to call the patient until a week later on 8/12/05 in order to assess any changes to the plan of care and/or medications and the nurse did not document any information pertaining to the ER visit on the subsequent visit of 8/12/05.

RN #2 stated to his supervisor on 9/23/05 that he did not think of assessing the patient's ER visit a week later and did not think of calling the patient to assess if there were changes to the plan of care.

The plans of care of 6/17/05 and 8/16/05 included home health aide 20 hrs. week 5x a week to assist with personal care, meals, ADLs and IADLs. The initial comprehensive assessment of 6/17/05 and the follow up comprehensive assessment of 8/11/05 indicated that the patient was alert/oriented, obese, needed assistance with dressing, bathing, utilized an assistive device for transferring and ambulating, was independent in preparing meals, performing light laundry and housekeeping and was not homebound. The home health aide plan of care 6/17/05 and 8/11/05 did not include any bath/shower but included back and foot care, dressing assist, meal preparation and homemaking tasks.

From 6/30/05 to 7/14/05 the patient received an aide 4hrs/day 5 days per week and she circled that she gave the patient a shower. On 7/15, 7/20, 7/21, 7/22, 7/25, 7/26, 8/2 the patient canceled the aide. Other than the previous dates mentioned, the patient received an aide 4hrs/day 5days/week and often did not receive personal care.

The clinical record lacked documentation that the nurse accurately assessed the patient's functional status and the need for aide services 20hrs/week for a patient that frequently refused the aide and did not need assistance for personal care.

RN #2 stated on 9/14/05 that he was told to put in up to 20 hrs. / week of home health aide hours by his supervisor and since he was new to home care he did what she suggested. RN #2's initial supervisor was unavailable for interview since she is no longer employed by the agency. The current administrator/supervisor stated on 9/19/05 that the primary care nurse decides the amount of aide hours the patient should receive.

The nurse failed to consistently and/or accurately assess the patient's pain management, blood pressure, medication regime, ER episode, psychosocial needs, functional status and the appropriate need for home health aides/ the appropriate hours of home health aide and the need for referrals to other appropriate services.

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j. Patient #11's start of care date was 8/10/05. Diagnoses included diabetes, dementia and Alzheimer's disease. Documentation on the certification plan of care ordered skilled nurse 1 time weekly to assess coping mechanisms, symptoms of depression/anxiety, neurological status weekly, diabetic management, cardio-pulmonary status, vital signs and signs and symptoms of infection, nutrition, hydration, to assess ability to perform activities of daily living (ADLs) and to teach diabetic diet and lifestyle changes to promote wellness; H-HHA 4-6 hours per day, 5 times per week for personal care, ADLs, IADLs, meal preparation and to maintain home safety. Documentation by RN #1 on the OASIS/comprehensive assessment dated 8/10/05 stated that the patient was 76 years old, disoriented, forgetful and depressed with impaired judgment and she required 24-hour supervision. She was Spanish speaking, but with expressive aphasia (cause not documented) and she was ambulatory, but totally dependent for all ADLs, IADLs on her daughter who lived in the home, but worked 8 hours a day. Documentation by RN #1 on a State of Connecticut Authorization of Home Health Services form dated 8/10/05 from the Department of Social Services identified that the patient had been going to day care, but could no longer attend because she had become "wild, hitting, and biting others." There was no documentation to support that the nurse contacted the physician to determine if this behavior was new, but on 8/26/05 RN #1 documented on a physician's telephone order for additional 20 hours of H-HHA services because the patient was unable to stay home without assistance. There was no clinical record documentation to support that the nurse assessed the patient's specific needs that indicated the necessity to increase H-HHA hours and there were no changes to the H-HHA's plan of care dated 8/10/05. When interviewed on 9/19/05 RN #1 stated that upon admission she underestimated the patient's needs and that the H-HHA was necessary because the patient was confused, she was incontinent a lot of the time and she was unable to care for herself. In response to surveyor inquiry, RN #1 stated that she did not consider that there might be other community and/or elder care programs to assist the patient's needs and that she did not communicate with the patient's state case worker and/or refer the patient for medical social services.

Documentation by RN #1 on the OASIS/comprehensive assessment dated 8/10/05 identified that the patient was depressed, however there was no documentation to support that the nurse assessed the patient's coping and/or anxiety level. During the period from 8/17/05 to 9/2/05 RN #1 consistently documented that the patient was anxious and/or pacing during nursing visits. There was no clinical record documentation to determine that the nurse reported this status to the physician to collaborate on possible interventions and there was no clinical record documentation that the nurse intervened to implement measures to alleviate the patient's anxiety. Documentation by the agency administrator on a progress note dated 9/14/05 stated that the H-HHA called to report that the patient had become aggressive and was hitting the home health aide. There was no documentation to indicate that a nursing visit was made; however, the administrator contacted the daughter at work and asked that she bring the patient to the physician in order to determine if underlying factors were causing the changed behavior. After the patient's visit to the physician, the administrator called the physician's office and was informed that an order for Ativan 0.5 mg every six hours as needed had been ordered. On 9/15/05 RN #1 revisited and documented that the patient was calm, pacing less and she was more receptive to care. There was no documentation to determine that the nurse taught the daughter about Ativan and/or that

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the nurse assessed how much Ativan the patient was using. When interviewed on 9/19/05 RN #1 stated that she did not know if the patient's combative behavior at day care was new and that she had not discussed the patient's depression, anxiety and/or combativeness with the physician.

The nurse failed to perform a baseline assessment of the patient's psychological status and/or failed to accurately re-assess the patient's depression and consistent anxiety and/or failed to intervene to report these symptoms to the physician and/or failed to revise the plan of care to implement appropriate measures focused on alleviation and/or management of the patient's anxiety.

Documentation by RN #1 on the OASIS/comprehensive assessment dated 8/10/05 identified that the patient's appetite was good and that she ate three times a day with snacks, but there was no documentation to determine the patient's diet, and the nutritional assessment was incorrectly completed in that no consideration was given to diet changes due to diabetes, and tooth problems that RN #1 documented as 3-4 bottom teeth only. These omissions determined that the patient was a moderate nutrition risk when she was actually a high nutrition risk that required coordination with the physician, dietician and/or social worker to improve nutritional health and to address nutritional status in the plan of care. Documentation on the endocrine comprehensive assessment stated that the patient was taking Humalog Insulin twice daily and that the PCG reported that blood sugar ranged from 69 to 150s. There was no indication of what time of day and/or meal proximities that related to this blood sugar range. And there was no documentation that appropriate blood sugar parameters were obtained from the physician. Documentation by RN #1 on the nurse visit notes dated 8/17/05 to 9/15/05 stated that fasting blood sugars were consistently above normal ranges, but documentation was lacking to indicate that RN #1 assessed the specific foods and amounts that the patient was eating. On 9/2/05 RN #1 documented on a telephone call log that she called the PCG to report the elevated blood sugar and suggested that the PCG consult the physician and on 9/6/05 the PCG obtained a physician's appointment for late September. On 9/9/05 the PCG reported to RN #1 that the patient was confused and was eating anything she found. There was no clinical record documentation to indicate that RN #1 intervened to contact the physician to report the patient's status and/or to clarify the patient's ordered diet and/or that RN #1 made necessary revisions to the care plan to include increased nursing visits to provide accurate assessments of the patient's actual food intake and/or to instruct the H-HHA and/or PCG to log food consumption.

Documentation by RN #1 on the OASIS/comprehensive assessment for Patient #11 dated 8/10/05 identified that there were no genitourinary problems, and that the patient was continent of urine. On 9/2/05 RN #1 documented that the patient had urinary frequency/urgency and that she continually paced to and from the bathroom. There was no clinical record documentation to indicate that the nurse contacted the physician. On 9/14/05 the agency administrator documented that she contacted the physician after the patient's appointment and a urinalyses was done, but that the patient had no symptoms of a urinary tract infection. When interviewed on 9/19/05 RN #1 stated that the patient was incontinent of urine at least every 15 minutes and that she even urinated on the floor at times, but no interventions had been implemented to initiate the use of diapers and/or a toileting regime.

RN #1 failed to accurately assess and/or to document assessment of the patient's baseline psychological status and/or failed to report the patient's mental status to the physician as care progressed and/or failed to implement appropriate interventions to address the patient's anxiety and/or combativeness and/or

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failed to assess and/or to document assessment of the patient's baseline nutritional status and/or failed to appropriately implement interventions to address possible nutritional components contributing to the elevated blood sugars and/or failed to implement revisions to the plan of care to address the apparent changes in the patient's urinary status during the period from 9/2/05 to 9/15/05.

k. Patient #12 had a start of care date of 6/2/04. Diagnoses included depression.

A review of the follow up OASIS indicated Patient #12 was independent with all ADLs. The nurse's care plan identified the patient had 20 hours of home health aide services per week. A review of the home health aide (HHA) activity sheets indicated that the HHA worked from 9:00 am until 4:00 pm and no personal care was completed. HHA #1 stated that Patient #12 was able to wash herself and no personal care was provided for Patient #12. Although the nurse assessed that Patient #12 was depressed and non-compliant with medication and personal care, there was no documentation to support that a MSW or a psychiatric nurse was referred to address the patient's problems.

6. G141 Based on personnel record review, clinical record review and staff interviews, it was determined that for RN #2 the agency failed to maintain a personnel record that was comprehensive and kept current and accurate. The findings include:

a. RN #2 had a date of hire of 5/10/05 as a per diem nurse and 6/19/05 as a full time nurse. His resume stated that the only nursing position he held prior to employment at the home care agency was in a coronary unit from 2005 to his hire date and as a per diem nurse for a per diem employment agency from 2005 to present. RN #2 had no previous home care experience.

b. RN #2's personnel record documented that he was oriented to all health service programs, patient care policies, clinical record/documentation/ nursing visit, quality assurance, state/federal regulations governing home health services, Medicare and Medicaid Guidelines, personnel policies, mandatory in-services, orientation in the field with Supervisor Clinical Services on 4/18/05. RN #2 and the Supervisor of Clinical Services signed that he had successfully completed the mandatory orientation program prior to delivery of health care services and that he received orientation/ Medicare/Medicaid manuals on 4/18/05.

c. The competency skills checklist for home care nurses was checked off in all areas as completed by the Supervisor of Clinical Services and RN #2 on 4/18/05 and 4/28/05. The supervisor included a note at the end of the competency check list which stated that RN #2 was new to home care and would be supervised with all paperwork and case management activities x 90 days; RN #2 would be re-assessed on 7/28/05.

d. Review of RN #2's personnel record lacked any documentation to support the supervision of RN #2's paperwork/case management activities and/or any care conferences that occurred between the Supervisor and RN #2. The personnel record lacked documentation that RN #2 had been re-assessed on 7/28/05 as stated in the record by the supervisor.

RN #2 stated on 9/15/05 that although he signed/dated the orientation check list he did not remember being oriented to all the areas identified. He stated that he had conferenced with the previous supervisor but he failed to document any conferences.

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The Supervisor who oriented RN #2 was no longer employed by the agency.

The present Administrator/Supervisor of Clinical Services whose hire date was 8/22/05 stated on 9/14/05 that she had not as yet met with the agency's nurses individually and did not have a current calendar of their patient and/or visit schedule.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72(a)(3)(D) Patient care policies.

7. Based on clinical record review and staff interviews, for one patient, Patient #12, the agency failed to conduct any case conferences prior to discharge. The findings include:

a. Patient #12 had a start of care date of 6/2/04. Diagnoses included diabetes and hypertension. The plan of care for certification period 3/29/05 through 5/27/05 identified skilled nurse (SN) visits 1-3 times weekly and a home health aide (HHA) 20 hours per week. SN services included diabetic management and medication pre-pour; HHA services included assistance with ADLs, personal care and light housekeeping.

A review of the skilled nurse visits identified that there were no visits during the weeks of 4/24/05 and 5/22/05. There were two documented missed HHA visits on 5/23/05 and 5/25/05. There was no documentation of any HHA visits during the month of 5/05.

A ten-day notice to discharge was dated 5/17/05 with a discharge date of 5/27/05.

The Manager and the Administrator stated Patient #12 was discharged due to a lack of staffing.

Although the Manager and the Administrator stated that Patient #12 frequently was not at home and/or refused SN and HHA visits and was non-compliant with the plan of care, the clinical record failed to identify that any case conferences were held prior to discharge. The record lacked documentation that addressed the issues of non-compliance with the patient's plan of care

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan.

8. Based on clinical record review and staff interviews it was determined that for seven (7) of twelve (12) patients the nurse failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of alterations to the plans of care (Patients #s 1, 2, 4, 7, 8, 10 & 12). The findings include:

a. Patient #1's start of care date was 7/27/05. Documentation on an interagency referral form dated 7/25/05 ordered physical therapy (P.T.) and occupational therapy (O.T.). Documentation by RN #2 on the OASIS/comprehensive assessment dated 7/27/05 stated that the patient had bilateral lower extremity weakness, ambulated with unsteady gait and that he was a high fall risk. On 8/30/05 LPN #3 stated that the patient was forgetful about using his walker. There was no documentation to indicate that a referral for P.T. and/or O.T. services was initiated. The patient fell on 8/1/05 and documentation

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on an interagency referral form dated 8/16/05 stated that the patient needed physical therapy and reconditioning. Documentation by RN #2 on the OASIS/comprehensive assessment dated 8/17/05 stated that the patient had lower extremity weakness, ambulated with the walker, but that gait was unsteady and he was at high risk for falls. During the period from 8/17/05 to 8/29/05 agency nurses visited the patient twice weekly and consistently documented that gait was unsteady, however, there was no documentation to indicate that the patient was referred for P.T. services.

Review of agency policy determined that ordered services are initiated within 48 hours.

Documentation by the Administrator/SCS on a physician's verbal order dated 9/29/05 ordered a P.T. evaluation. When interviewed on 9/19/05 RN #2 stated that he did not realize a P.T. was necessary until the Administrator/SCS ordered the service. The agency failed to implement the physician ordered plan of care including P.T., O.T. in a timely manner and/or failed to inform the physician that these services were not provided.

Clinical record documentation determined that the agency resumed skilled nursing services after the patient was discharged from hospital, however, RN #2 failed to obtain physician's orders for medication changes. The agency failed to monitor the patient's responses to medications ordered by the physician and/or failed to communicate with the physician to clarify medication orders.

b. Patient #2 had a start of care date of 8/19/05 and services which included home health aide 2-3 x a week for personal care and meal preparation. The aide's care plan of 8/19/05 listed shower as needed and listed a no added salt (NAS) diet and omitted no concentrated sweets (NCS) diet as noted in the comprehensive assessment of 8/19/05.

Review of the aide activity sheets indicated that the aide did not start until 8/25/05. The week of 8/29/05 the patient received a home health 5x a week and not 2-3x a week per physician orders and the aide did not provide any personal care to the patient as indicated in the aide's care plan. The aide did indicate that she prepared dinner for the patient. No further activity sheets were available at the time of survey. RN #1 stated on 9/14/05 that she was not aware that the patient did not receive personal care. She was not aware that the patient was receiving more aide hours than ordered by the physician.

c. Patient #4's start of care date was 5/9/05. Clinical record documentation by RN #2 dated 5/19/05 indicated that skilled nursing visits were 3 times per week. Documentation by RN #2 dated 6/3/05 stated that the patient's blood pressure and respiratory status were improving and skilled nurse visits were decreased to twice weekly, however clinical record documentation by RN #2 indicated that the patient's status was compromised at that time as follows: 5/31: BP 147/95, pulse 103 and expiratory wheezes bilaterally, 6/1/05: BP145/95, pulse 110 and audible expiratory wheezes, 6/3: BP 151/95, pulse 107 and wheezes with nonproductive cough. RN #2 documented that during the period from 6/3/05 to 7/23/05 the patient's status continued with consistently elevated blood pressures and pulses with compromised respiratory status. RN #2 visited twice weekly. There was no documentation to indicate that RN #2 communicated with the physician about the patient's status and/or the plan to reduce skilled nursing visits. The nurse failed to revisit the patient as ordered by the physician and/or failed to inform the physician about this alteration in the plan of care.

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- d. Patient #7 had an initial start of care date of 6/1/05 with diagnoses of GI bleed and dementia. The plan of care includes skilled nursing 2x a week. On 6/20/05 the patient developed a stage 2 decubitus ulcer on her coccyx. RN #2 called the physician who told RN #2 to use his (RN#2's) judgment for wound care. The clinical record lacked documentation to support the wound care procedure/frequency. RN #2 stated on 9/19/05 that he failed to obtain an order for the wound care but stated he used Duoderm q 5 days.
- e. Patient #8 had a start of care date of 3/10/05 after being sent to the hospital and discharged from the home care agency with dehydration on 3/7/05. The patient's diagnoses included liver failure, hypovolemia, esophageal varices, diabetes and depression. The plan of care included skilled nursing 1-3x a week x 3 wks for general assessment, C/P, endocrine, GI assessment and medication pre-pour every week; home health aide was on hold pending Area Agency on Aging approval. Patient #8's daughter agreed to accept responsibility until the plan of care was approved. The plan of care stated that interventions would include advocating for the patient's end of life decisions until transfer next week, support patient and family with anticipatory grieving and anger issues and allow daughter to verbalize anger. The discharge plan was to discharge the patient next week to a hospice home care agency and psychiatric services.  
Review of the clinical record from 3/10/05 to 3/22/05 indicated that the nurse visited the patient on 3/10/05 and 3/12/05 and did not visit the patient again. The patient was transferred to another agency on 3/22/05 without a visit.  
The administrator stated on 9/19/05 that she spoke to the LPN who visited the patient on 3/10 and 3/12/05 and she stated that the patient was listed on her calendar to be visited the next week but someone crossed her name off and she did not know why therefore she did not visit the patient after 3/12/05.
- f. Patient #10's start of care date was 6/17/05 with diagnoses including degenerative joint disease, hypertension, anxiety, depression and hypercholesterolemia. The plans of care dated 6/17/05 and 8/16/05 included skilled nursing 1-2x a week to assess CP status, coping mechanisms, pain management and pain medication effectiveness, gait/mobility, transfers, safety and falls, s/s of depression/anxiety.  
Review of the clinical record from 6/17/05 to 8/16/05 indicated that the patient consistently had a pain level of 6-10 in her lower extremities, was not taking a routine pain medication but occasionally took a pain medication which was not identified on the patient's medication profile. The record lacked documentation to support that the nurse accurately assessed the patient's pain medication effectiveness or provided pain management as indicated in the physician's plan of care.
- g. Patient #12 had a start of care date of 6/2/04. Diagnoses included diabetes and hypertension. The plan of care for certification period 3/29/05 through 5/27/05 identified skilled nurse (SN) visits 1-3 times weekly and a home health aide (HHA) 20 hours per week. SN services included diabetic management and medication pre-pour. HHA services included assistance with ADLs, personal care and light housekeeping. Although the patient was certified for services through 5/27/05 and was issued

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a notice of discharge effective 5/27/05, a review of the skilled nurse visits identified that there were no visits during the weeks of 4/24/05 and 5/22/05. There was no documentation of any HHA visits during the month of 5/05, except for two documented missed HHA visits on 5/23/05 and 5/25/05. The clinical record was reviewed with the Manager and lacked documentation that indicated the physician was notified of missed visits and/or interruption of services.

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

9. Based on clinical record review, home visits, agency policies, staff interviews, physician interviews and interviews with other entities providing care to the patient it was determined that for eight (8) of twelve (12) patients the agency failed to accurately inform the patient orally and in writing of the extent to which payment may be expected from Medicare, Medicaid or any other federally funded or aided programs known to the home health agency. (Patient #s 1, 2, 3, 7, 8, 9, 10 & 11). The findings include:

a. Patient #1's start of care date was 7/27/05. Clinical record documentation on a home health advance beneficiary notice (HHABN) signed by the patient's spouse on 7/27/05 identified that Medicare would probably not pay, but failed to state what services would not be paid for and/or the reason. Clinical record documentation between the periods of 7/27/05 to 8/25/05 determined that the patient was receiving skilled nursing care and H-HHA services that were being billed by the agency to Medicare. When interviewed on 9/15/05 RN #2 stated that he thought all patients must sign the HHABN form.

b. Patient #2 had a start of care date of 8/19/05. Review of the clinical record indicated that the patient was not homebound and went to a senior center every morning with assistance. The patient on 8/19/05 signed a home health advance beneficiary notice without being appropriately completed by the nurse in order for the patient to understand the content of what she was signing. The nurse failed to identify the services, which the agency expected Medicare probably would not pay for, and the reason Medicare would probably not pay. RN #1 stated on 9/18/05 that she was not aware of the policy regarding explanation and completion of the HHABN.

c. Patient #10 had a start of care date of 6/17/05 with diagnoses of degenerative joint disease (DJD). The plan of care dated 6/17/05 included skilled nursing 1-2 x a week and home health aide 20 hrs. week, which were billed to Medicaid. The admission comprehensive assessment dated 6/17/05 stated that the patient was not homebound however the nurse failed to document in the clinical record the frequency, duration or level of assistance the patient needed to leave home. The clinical record lacked a HHABN signed by the patient, which informed the patient why services were not billed to Medicare. RN #2 stated on 9/15/05 that he was new to the agency and home care when the patient was admitted, and was unaware that the HHABN needed to be issued on admission.

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d. Patient #3 had a start of care date of 7/26/05. The patient's birth date was 6/4/39 (66 years old). Review of the clinical record lacked a Medicare number for the patient, the Medicare secondary payor form stated that the patient did not have Medicare and the patient was identified as not homebound. The record lacked documentation to support that a HABBAN was issued to the patient. Upon surveyor's inquiry regarding the patient's Medicare status, the supervisor stated on 9/15/05 that the patient did not have Medicare but she was unsure as to the reason she did not have Medicare and the reason and/or communication regarding the reason was not documented in the record.

e. Patient #7 had an initial start of care date of 6/1/05 with diagnoses including GI bleed, dementia, CVA and atrial fibrillation. The patient was in a nursing home from 5/11/05 to 5/30/05. The discharge note from the nursing home stated that the patient needed much encouragement with ambulation but she could do it with encouragement. The patient was homebound and needed assistance with all ADLs and IADLs. The nurse completed an admission visit on 6/1/05 and a subsequent visit on 6/3/05; the patient's BP readings were 132/71 and 137/87, respectively. The nurse discharged the patient from Medicare on his visit of 6/6/05 with the patient's BP identified as 92/50 and stated all goals met under Medicare. The nurse failed to refer for a home health aide, PT and MSW under Medicare for a patient who needed a PT evaluation of her unstable functional status and/or safety issues and a MSW evaluation for her caregiver's coping strategies and long term planning. The nurse's admission note supported the need for a home health aide. The nurse discharged the patient from Medicare. The patient was transferred to Medicaid on 6/7/05 and received 4hrs. /day of home health aides. The patient's POA issued a HABBAN on 6/6/05, which stated that Medicare does not pay for custodial care and the POA did not sign the HABBAN. The patient developed a stage 2 decubitus on 6/20/05, was homebound and could no longer ambulate and the nurse did not transfer the patient to Medicare. RN #2 stated on 9/19/05 that he did not know how to properly fill out the HABBAN and was told to transfer the patient to Medicaid after 3 visits under Medicare. He was not aware that he should have transferred the patient to Medicare on 6/20/05 following the skin breakdown.

f. Patient #8 had a start of care date of 3/10/05 after being sent to the hospital and discharged from the home care agency with dehydration on 3/7/05. The patient's diagnoses included liver failure, hypovolemia, esophageal varices, diabetes and depression. The plan of care included skilled nursing 1-3x a week x 3 wks for general assessment, C/P, endocrine, GI assessment and medication prepour every week. Home health aide services were on hold pending Area Agency on Aging approval. The discharge plan was to discharge the patient next week to a new hospice home care agency. The summary to the physician indicated that the patient had end stage liver disease with 3 months to live. Poor family dynamics were observed and were deteriorating rapidly. The patient agreed to hospice home care but the hospice agency could not accept the patient for a week. The start of care comprehensive assessment of 3/10/05 completed by the RN indicated that the patient lived alone, was alert and oriented, depressed, needed assist with ADLs and IADLs. The patient utilized a walker and a wheelchair. RN #3 indicated that the patient was not homebound but was not specific as

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to the frequency, duration and taxing effort regarding leaving home. LPN #3 note of 3/10/05 indicated that the patient had a tracheotomy, which she was capable of maintaining, had no appetite and skin turgor was poor.

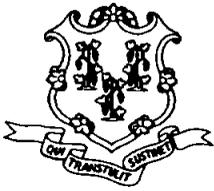
A case conference note on 3/10/05 between the RN, LPN, clinical supervisor and Area on Aging noted that the patient needed to be transferred to hospice home care, aides were on hold pending approval from the Area on Aging, and the family was not coping well.

The administrator/supervisor of clinical services who was the admitting RN issued the patient the Medicare Home Health Advance Beneficiary Notice that stated Medicare would not cover the services provided to the patient because the patient was chronic. The patient's payor for services was listed as Area Agency on Aging.

The case coordinator of the Central Area on Aging stated on 9/21/05 that the administrator was told on 3/10/05 that they would not approve services because the patient was clearly eligible for Medicare since she was terminal and met all Medicare's criteria. The home care nurse denied the patient needed services i.e.: nursing, HHA, MSW due to an inaccurate assessment of the patient's correct payer source.

g. Patient #9's start of care date was 12/13/04. Clinical record documentation on a Home Health Advance Beneficiary Notice (HHABN) signed by the patient's conservator on 12/13/04 stated that Medicare would probably not pay for services because his condition was chronic. Clinical record documentation between 12/13/04 to 1/4/05 indicated that the patient had experienced changes in his clinical status that indicated the need for increased skilled nursing interventions, including his consistent and progressive fatigue and weakness and his persistent talk of dying. The patient was homebound. When interviewed on 9/19/05 the administrator stated that the nurse no longer worked with the agency and no current staff was familiar with this patient's case.

h. Patient #11's start of care date was 8/10/05. Clinical record documentation on a Home Health Advance Beneficiary Notice (HHABN) signed by the patient's conservator on 8/10/05 stated that Medicare would probably not pay for services, but no reason was stated. Clinical record documentation between 8/10/05 to 9/15/05 indicated that the patient had experienced changes in her clinical status, which indicated the need for increased skilled nursing interventions. The changes included the addition of Ativan to her medication regimen due to anxiety, elevated blood sugars and urinary frequency and urgency. The patient was homebound. When interviewed on 9/19/05 RN #1 stated that the patient was chronic and she was not aware that she should have changed the payer source to reflect the patient's need for increased skilled nursing services. The agency failed to advise the patient of the extent to which payment for agency services may be expected from Medicare or other sources when the patient experienced a change in clinical status and to change the payer source for ongoing home health services.



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

# EXHIBIT *C*

January 12, 2006

Janet Lamb, RN, Administrator  
Equinox Home Care, LLC  
305 Boston Avenue, Suite 308  
Stratford, CT 06614

Dear Ms. Lamb:

Unannounced visits were made to Equinox Home Care, LLC on December 6, 7, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a follow-up survey inspection with additional information received through December 22, 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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by January 26, 2006 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Victoria V. Carlson, RN, MBA  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

SNC:NC:



Phone: (860) 509-7400  
Telephone Device for the Deaf (860) 509-7191  
410 Capitol Avenue - MS # 12HSR  
P.O. Box 340308 Hartford, CT 06134  
*An Equal Opportunity Employer*

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

1. Based on clinical record review and staff interviews it was determined that for four (4) of ten (10) patients the nurse failed to consistently and/or accurately assess and re-evaluate and/or to document assessment of the patient's health status and nursing needs that may have suggested a need to alter the plan of care (Patient #s 16, 17, 20, 22). The findings include:

a. Patient #16's start of care date was 11/1/05 with diagnoses including non-insulin dependent diabetes mellitus, hypertension, chronic lung disease, arthritis and morbid obesity. Documentation on the certification plans of care dated 11/1/05 to 12/30/05 and 11/25/05 to 1/23/06 ordered skilled nursing 1-2 times per month with two as needed visits for status changes to assess neurological status, pain management, body systems and to assess wound management; H-HHA 5 times per week. Documentation on the certification plan of care dated 11/25/05 to 1/23/06 ordered physical therapy. Documentation by agency nurses on the OASIS/comprehensive assessments dated 11/1/05 and 11/25/05 stated that this 74 year old patient was non-ambulatory, dependent for all activities of daily living and required a Hoyer lift for transfer. A H-HHA plan of care documented by RN #2 dated 11/1/05, ordered the H-HHA to use a Hoyer lift for transfers.

Documentation by RN #4 on a nurse visit note dated 11/17/05 identified that the patient complained of right shoulder pain (new) that was at level "10" out of a scale of 1-10. RN #4 identified that by using propoxyphene, the patient obtained relief to "5," but there was no documentation to support that RN #4 assessed how much medication the patient was using and/or the duration of relief; an x-ray was planned for that day. RN #4 documented that she spoke with the H-HHA about the wound care, however there was no documentation to indicate that she intervened to re-evaluate the patient's ability to tolerate Hoyer lift transfers and/or that she addressed this with the aide.

Documentation by RN #4 on a physician's verbal order dated 11/18/05 ordered physical therapy evaluation and treatments three times per week.

The nurse revisited on 11/25/05 (8 days later) and assessed that the patient continued to have high-level pain at eight out of a scale of 1-10. The patient identified that by using the propoxyphene the pain decreased to 3-5 and she described this as "fair" relief. There was no documentation to support that RN #4 assessed how much pain medication the patient was using and/or the duration of relief provided and/or that RN #4 contacted the physician to consult about the patient's pain and/or the results of the x-ray performed on 11/17/05. RN #4 documented that the Hoyer lift continued to be used for transfers, but there was no documentation that she re-evaluated the patient's tolerance to the transfer procedure. RN #4 failed to revisit until 12/2/05 (7 days later). She documented that pain intensity was six out of a scale of 1-10 and that relief was "fair" using propoxyphene and rest, but that right shoulder movement caused increased pain. The patient informed RN #4 that the x-ray determined that there was arthritis in the right shoulder, but no broken bones.

On the survey date of 12/7/05 there was no clinical record documentation to support that a physical therapy evaluation was completed.

Clinical record documentation determined that from 11/17/05 through 12/7/05 there was no

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documentation to indicate that the nurse collaborated with the physician about the patient's changed status and/or the x-rays done on 11/17/05 and/or there were no revisions to the nursing plan of care to intervene to implement increased assessments of pain management and functional mobility and/or to address possible modifications to the Hoyer lift transfer process.

When interviewed on 12/7/05 the agency administrator stated that RN #4 was new to home care, but that the administrator and RN #4 conferred about this patient and they determined that physical therapy was needed; a message was left for the physician, but not documented. The administrator stated that the patient understood about the delay in the start of physical therapy and was willing to wait as there was a problem getting a physical therapist for Patient #16; a physical therapist was planning to visit on Thursday 12/8/05.

Agency nurses failed to consistently and accurately assess the patient's pain and decreased functional mobility, failed to collaborate with the physician regarding the patient's changed status and delay in the start of physical therapy services an/or failed to intervene to implement changes to the care plan for Hoyer lift transfers, appropriate pain management and measures to maintain optimal functional mobility.

b. Patient #17 had a start of care date of 11/21/05 with diagnoses including arthritis and acute depression. The plan of care dated 11/21/05 to 1/19/06 ordered skilled nursing 1x a week to assess/instruct medication response, side effects, precautions and interactions, assess pain management status, assess pain and pain effectiveness. The pain medication listed on the plan of care was Oxycodone 5/325 po, prn, q 6 hr.

The OASIS start of care comprehensive assessment of 11/21/05 indicated that the patient's pain level was an 8 out of 10 and the patient experienced intractable pain all the time. The pain was relieved by medication and he took his breakthrough medication 2-3x a day; the plan of care did not include any ordered breakthrough medication.

Review of the clinical record indicated that the only visit conducted was on 11/21/05 and during that visit, the nurse identified that the patient's pain was relieved by the Oxycodone and Alleve for breakthrough pain. The nurse did not indicate how often the patient was taking the Oxycodone in order to assess the effectiveness of the medication and the need for the Alleve for breakthrough pain. She was not able to assess the patient's response/side effects to his medications since the patient refused to let her take his vital signs.

The patient had contractures of his hands but he was independent in his ADLs. The nurse indicated on the OASIS dated 11/21/05 that she was referring to PT due to the contractures and his inability to grasp objects; as of 12/5/05, a physical therapist had not evaluated the patient, as planned, as a result of the initial comprehensive assessment.

RN #4 stated on 12/7/05 that she had made another visit after the initial visit but she and/or the agency staff could not locate the visit note. She stated that the patient was not taking his Oxycodone but only taking the Alleve. The patient was not very accepting of nursing so she was waiting to establish rapport with the patient before pressing the issue of taking his vital signs. She had not called the physician to discuss the patient's pain medication/pain management. RN #4 did not know the reason that PT had not commenced; the supervisor of clinical services stated on 12/7/05 that they were trying to have the patient go to outpatient PT but it had not yet occurred.

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The nurse failed to accurately and appropriately assess the patient's pain status and provide pain management. She failed to follow through with the physical therapy referral in response to the patient's need for PT. The record lacked documentation that the patient was visited after the admission visit of 11/21/05 in accordance with physician orders.

c. Patient #20 had a start of care date 5/17/05 with diagnoses including diabetes and hypertension. The recertification plan of care dated 11/13/05 included skilled nursing 1-2 x a week to assess CP, endocrine statuses, diabetic management and diet, instruct patient in lifestyle changes to promote wellness and assess compliance; home health aide 2 hrs. per day x 6 days a week to assist with ADLs and IADLs and assist the patient to maintain home safety. The summary to the physician dated 11/13/05 stated that the patient was alert and oriented, remained safe and active in the community, CP status was stable, patient was compliant and managed her own medications and blood sugars, which were WNL (within normal limits).

The OASIS follow-up assessment of 11/10/05 indicated that the patient did not have any problems with any systems, was independent in all her ADLs but could use some assistance with dressing but not bathing and was not homebound.

The weekly nurses notes from 11/10/05 to 11/30/05 indicated that the patient's vital signs were stable as was her blood sugars, she was without pain and all systems were WNL. The patient was compliant with diet and medications. The plan of care remained stable without any changes.

Subsequent to surveyor's inquiry as to why the patient needed skilled nursing services and home health aide services 2 hrs per day 5-6x a week, RN #2 stated on 12/7/05 that he had decreased her aide hours from 4 hrs. /day and would continue to decrease the aide hours. He stated that the patient really needed a homemaker to prepare meals but due to her age, she did not qualify. RN #2 stated the he visited her 1x a week because she told him that his visits kept her compliant.

The nurse failed to accurately and appropriately reassess the patient's health status and nursing needs since the patient did not require weekly skilled nursing visits and/or an aide 6 x a week when she her health status continued to remain stable and she was independent in her ADLs.

d. Patient #22 had a start of care date of 10/28/05 with diagnoses of diabetes, BKA right and left leg, hypertension, gastric reflux and hypothyroidism. The plan of care dated 10/28/05 to 12/26/05 included skilled nursing 1x a week for status changes, assess CP status, endocrine status and diabetic management; home health aide bid x 5-7 days to assist with personal care. The summary to the physician dated 10/28/05 stated that the patient was wheelchair bound due to bilateral BKA and was presently going to outpatient physical therapy so the patient was reopened under Title 19.

Review of the OASIS start of care comprehensive assessment dated 10/28/05 identified the patient as alert and oriented, non-ambulatory, wheelchair bound and needing assist for all her ADLs and IADLs including transfers and toileting. The patient was identified as not homebound although the record lacked specific data as to why the patient was not homebound when she was totally dependent for her ADLs and IADLs and needed aide services bid x 7 days a week.

The supervisor of clinical services stated on 12/7/05 that the physician referred the patient for outpatient PT and she was not aware of the reason. She stated that she did not know if the physician was aware that the patient could receive PT in the home. The supervisor stated that the agency did have

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a problem with their contracted physical therapist and were in the process of hiring a new PT. The nurse failed to accurately and appropriately assess the patient's need for home physical therapy based on the patient's health status and level of functioning.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan and/or D72 (a)(1)(F) Patient care policies.

2. Based on clinical record review and staff interviews it was determined that for five (5) of ten (10) patients the nurse failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of alterations to the plans of care (Patient #s 13, 14, 16, 17, 21). The findings include:

a. Patient #13 had a start of care date of 11/18/05 with diagnoses including right leg wound, PEG tube, HTN, Alzheimer's disease, diabetes, CVA and CHF. The plan of care dated 11/18/05 included nursing 1-3x a week and home health aide 7x a week.

Review of the home health aide care plan dated 11/18/05 indicated that the patient was a DNR and no CPR was to be initiated.

Review of the clinical record including the physician's plan of care of 11/18/05 lacked documentation of a physician's order for the DNR and/or a living will identifying the patient as a DNR.

The supervisor of clinical services confirmed on 12/23/05 that although the agency had been told that Patient #13 was a DNR, they did not have a confirming order and/or living will to identify the patient as a DNR; the agency would no longer indicate that the patient was a DNR on the aide's care plan without confirmation of a physician's order.

b. Patient #14's start of care date was 11/22/05 with diagnoses including Alzheimer's disease, dementia, hypertension, non-insulin dependent diabetes, congestive heart failure, gastro/esophageal reflux, depression and diverticulitis. Documentation on the certification plan of care dated 11/22/05 ordered skilled nurse one time weekly for status changes, body systems assessment, safety including gait, mobility, transfers and falls; H-HHA 3 times per week and physical therapy. Ordered medications included Buspar, Metoprolol, Zolof, Lasix, Synthroid, Reglan, Lisinopril, Glipizide, Cyproheptadine and Digoxin. Documentation by RN #4 dated 11/22/05 identified that the patient was 92 years old, lived with her daughter (who worked full time), ambulated with a walker and required 24-hour supervision because she had intermittent disorientation, forgetfulness and would wander.

Documentation by RN #4 on the OASIS comprehensive assessment dated 11/22/05 stated that the patient ambulated with an unsteady gait. The fall risk assessment identified that the patient was "35" (threshold for high risk was "15") and required implementation of education regarding prevention strategies, referral to physical therapy and/or occupational therapy, monitoring of areas of risk to reduce falls and patient re-assessment. Documentation on revisit notes by RN #4 dated 11/25/05 and 12/2/05 identified that the patient continued to have intermittent confusion and to ambulate with unsteady gait, but there was no documentation to support that physical therapy was initiated.

Documentation by the administrator dated 11/23/05 identified that the patient was referred for physical

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therapy services. On 11/28/05 (5 days later) the administrator documented that she called the contracting agency again and was told that they were unable to meet the need. The administrator on 11/28/05 contacted a second agency and a message was left; on 12/1/05, the administrator contacted the second agency again and was informed they were not able to meet the request. The administrator contacted a third contractor physical therapist and scheduled a physical therapist evaluation for 12/7/05. There was no clinical record documentation to support that the physician was informed of this alteration in the plan of care that suggested revision of the nursing plan of care in order to re-evaluate and maintain optimal patient safety and/or to refer the patient to a home health care agency that could provide immediate physical therapy services.

When interviewed on 12/7/05 the administrator stated that the agency did not have a policy for timeliness of referrals, but the expectation is within 48 hours. The administrator stated that she contacted the patient's daughter who expressed willingness to wait, but did not document the call. The administrator stated that the physician was not informed because efforts to get a physical therapist were ongoing.

Agency professional staff failed to provide physical therapy services in a timely manner and/or failed to inform the physician about this alteration in the plan of care.

c. Patient #16: The agency failed to provide ordered physical therapy services in a timely manner after the patient complained of consistent unrelieved right shoulder pain that was exacerbated with motion and diagnosed on x-ray as arthritis. See Tag G172.

d. Patient #17 had a start of care date of 11/21/05 with diagnoses of arthritis and acute depression. The plan of care dated 11/21/05 to 1/19/06 ordered skilled nursing 1x a week to assess/instruct medication response, side effects, precautions and interactions, assess pain management status, assess pain effectiveness.

The 11/21/05 summary to the physician indicated that the patient had poor hand grasps related to contractures of his hands. The nurse indicated on the OASIS that she was referring to PT due to the contractures and his inability to grasp objects. The supervisor of clinical services stated on 12/7/05 that they were trying to have the patient go to a special outpatient PT but it had not yet occurred. As of 12/5/05 the physical therapist had not evaluated the patient as planned as a result of the comprehensive assessment and documentation was lacking that subsequent nursing visits were made after the initial visit in accordance with physician orders and/or that documentation was lacking that the physician was notified of the alterations in the plan of care.

e. Patient #21's start of care date was 10/23/05 with diagnoses including mental retardation, asthma and pervasive development disorder. Documentation on the certification plan of care dated 10/23/05 ordered skilled nursing one time per week to instruct the patient/family in the use of inhalers, signs and symptoms reportable to the physician and emergency services, to assess the patient's coping, orientation, behavior, sleeping patterns, skin integrity, bowel pattern/incontinence management, medication compliance and response to medications. The nursing goals included ambulation without falls, patient participation in activities of daily living, toilet training, activities of daily living met through H-HHA assistance and adequate coping skills.

DATE(S) OF VISIT: December 22, 2005

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

Clinical record documentation by RN #1 on 11/1/05 stated that the H-HHA was oriented to the plan of care and that the patient had no need for skilled nursing. During the period from 11/9/05 to 12/3/05 there was no clinical record documentation to support that the physician was informed of the nurse's assessment of no need for skilled nursing and/or that the nurse did not re-visit as ordered.

When interviewed on 12/7/05 RN #1 stated that the patient had no skilled needs, but upon admission, she had a sore throat so the plan was to visit in one week to follow up. When RN #1 contacted the grandmother (PCG) to arrange the visit the following Monday (11/8/05) and/or on Friday 11/12/05, the visits were refused. RN #1 stated that during the period from 11/12/05 to 12/3/05 the PCG continued to refuse visits each Monday and/or Friday, sometimes because she had to take the patient to school and/or therapy. RN #1 stated that she did not try to arrange visits for other days of the week because other patients had to be visited on those days.

There was no clinical record documentation to determine that the physician was informed that the nurse did not revisit as ordered.