

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

IN RE: Danbury Visiting Nurse Association, Inc.
4 Liberty Street
Danbury, CT 06810

CONSENT AGREEMENT

WHEREAS, Danbury Visiting Nurse Association, Inc. of Danbury, CT ("Licensee"), has been issued License No. C805510 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates commencing on May 4, 2005 up to and including August 29, 2005 for the purpose of conducting licensing and certification inspections; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated July 12, 2005 (Exhibit A - copy attached) and October 24, 2005 (Exhibit B - copy attached); and

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

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

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

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

NOW THEREFORE, the Facility Licensing & Investigations Section of the Department of Public Health of the State of Connecticut acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein through Eric Bergstraesser, its President of Board of Directors, hereby stipulate and agree as follows:

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

- f. All care provided to patients by licensed practical nurses is coordinated by and under the direction and supervision of a registered nurse;
7. The Licensee shall within fourteen (14) days of the effective date 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 Agreement review and revise, as necessary, all policies and procedures which are pertinent to patient assessment; development, implementation and revision of the plan of care; medication administration; coordination of services including services provided in collaboration with all agency staff and other entities involved in care to the patient; clinical protocols including, but not limited to, wound care and management, diabetic management, pain assessment and management, nutritional assessment and management, including risk for weight loss and cardiovascular disease management; and notification of the physician of the condition of the patient including concerns for the patient's safety.
 9. The Licensee shall within thirty (30) days of the effective date of this Consent Agreement in-service all direct service staff on topics relevant to the provisions of Sections 6, 7 and 8 of this document. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.
 10. The Licensee shall within sixty (60) days of the effective date of this Consent Agreement audit the medical record of each patient currently receiving services to ensure that each patient's current condition is accurately and consistently documented and that care is provided in accordance with the plan of care.
 11. Within ten (10) days after the completion date specified above for the medical record audits, all direct care staff shall be provided with in-service education pursuant to deficient practices identified as a result of the medical record audits. Subject to this Consent Agreement documentation of in-services shall be maintained by the Licensee for review by the Department for a period of two (2) years.
 12. The Licensee upon the execution of this Consent Agreement shall pay to the Department of Public Health seven hundred fifty hundred dollars (\$750.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The check shall be made payable to the Treasurer of the State of Connecticut.

13. The \$750.00 payment and any other reports required by this Consent Agreement shall be directed to:

Victoria V. Carlson, R.N., M.B.A.
Supervising Nurse Consultant, Department of Public Health,
Facility Licensing & Investigations Section
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

14. The provisions of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document.
15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
16. The Licensee understands legal notice of any action shall be deemed sufficient if sent to the Licensee's last known address of record reported to the Facility Licensing & Investigations Section.
17. All parties agree that this Consent Agreement is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Agreement in the event the Licensee fails to comply with its terms.
18. The Licensee has had the opportunity to consult with an attorney prior to signing this document.
19. The Licensee understands this Consent Agreement is effective upon approval and acceptance by the Commissioner's representative, at which time it shall become final and an order of the Commissioner of Public Health.

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

DANBURY VISITING NURSE ASSOCIATION,
INC. OF DANBURY, CT.

2/6/06
Date

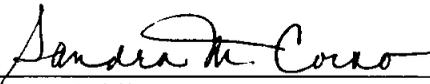
By: 
Eric Bergtraesser, President
Board of Directors

State of Connecticut
County of Fairfield

ss February 6, 2006

Personally appeared the above named Eric Bergtraesser and made oath to the truth of the statements contained herein.

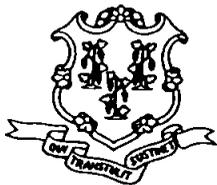
My Commission Expires: 2/28/08


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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/15/04
Date

By: 
Joan Leavitt, R.N., M.S., Section Chief
Facility Licensing & Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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July 12, 2005

Mary Ann Faraguna, MPH, RN, Administrator
Danbury VNA, Inc.
4 Liberty Street
Danbury, CT 06810

Dear Ms. Faraguna:

Unannounced visits were made to Danbury VNA, Inc. on May 4, 5, 9, 10, 11, 12, 13, 17, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting licensing and survey inspections with additional information received through July 5, 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 August 1, 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.

No referrals of health care professionals were initiated as a result of this inspection.

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

c. Nurse Consultant



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 VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

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

1. The governing body failed to assume responsibility for the services provided by the agency to ensure the safety and quality of care rendered to all patients and their families based on the violations listed in this document.

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

2. Based on staff interview and clinical record reviews, it was determined that the administrator failed to ensure and maintain the quality of care and services rendered to thirteen (13) of nineteen (19) patients (Patient #s 3, 5, 6, 7, 10, 11, 13, 14, 15, 16, 17, 18, and 19) 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) General requirements.

3. The supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and families by direct service staff under their supervision and/or failed to effectively supervise and/or evaluate the clinical competence of assigned nursing personnel in providing care and services to Patient #s 3, 5, 6, 7, 10, 11, 13, 14, 15, 16, 17, 18, and 19 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)(3)(B)(C) General requirements.

4. Based on personnel file review, agency policy review, clinical record review and staff interview it was determined that for RN #2 the agency failed to maintain personnel records that were kept current and included qualifications. The findings include:

a. Personnel file documentation for RN #2 was lacking to indicate that she was knowledgeable of basic diabetes competencies.

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- b. Patient clinical record reviews determined that during the period from 2/3/04 to 3/15/04, RN #2 was the case manager for Patient #19 whose diagnosis included type 2 diabetes.
- c. Review of RN #2's personnel file determined that a "Basic Diabetes Competencies" questionnaire, distributed on 2/4/04 and to be completed by 2/27/04, was incomplete on 5/13/05. Documentation on the questionnaire identified that of 11 questions, RN #2 only completed two answers.
- d. Documentation in RN #2's personnel record by SCS #2, dated 3/26/04, stated that the agency received a call on 3/22/04 from a hospital case manager (date is after Patient #19 was readmitted to hospital on 3/17/04) stating that the patient believed the nurse had not cared for her (Patient #19) appropriately. Documentation by SCS #2 dated 3/26/04 stated that review of Patient #19's clinical record determined that the nurse's assessments had not identified symptoms of wound infection and/or consistently elevated blood sugars.
- e. When interviewed on 5/19/05 SCS #2 stated that RN #2 was new to home care and that she had difficulties adapting. RN #2's date of hire was 9/2/03 and she received the routine 90 day orientation period, but the orientation was necessarily extended twice for thirty days each time because she had difficulty adapting. At the end of the last orientation period (January 2, 2004) she continued to "require improvement to seek clarification with supervisors when needed". SCS #2 stated that he didn't know about the incomplete "Diabetic Competencies" test in RN #2's personnel file. When interviewed on 5/25/05 SCS #1 stated that RN #2 completed this same competency test when she was hired in September 2003, but that it could not be found and the outcome of that test was not known. See Violation #s 3 and 7.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(1)(2)(3) Services.

- 5. Based on clinical record review, staff interviews and home visit observations it was determined that for Patient #5 the nurse failed to accurately and/or consistently furnish wound care services requiring specialized nursing skill in accordance with standards of practice. The findings include:
 - a. Patient #5 had a start of care date of 2/12/05 with diagnoses including post-op infection, open wound of the abdomen and hernia. The plan of care dated 2/12/05 included skilled nursing 7x a week to perform wound care to an abdominal incision using clean technique. The patient was readmitted to the hospital for an uncontrolled MRSA infection on 3/4/05 with the home health agency nurse resuming care on 3/9/05. During a home visit to the patient on 5/4/05 the nurse informed the surveyor that the patient had MRSA and that she (surveyor) needed to gown as well as glove for the wound care procedure. The nurse gloved and removed the abdominal dressing, which was saturated with a large amount of tan, serosanguineous drainage. The nurse then cleansed the wound and placed clean 4x4 gauzes on the wound without washing her hands and changing her gloves after removing the "dirty" dressing. The nurse tied the soiled Montgomery straps and abdominal binder with the same "dirty" gloves.

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Upon surveyor inquiry on 5/4/05 RN #1 stated that she usually did change her gloves between "dirty" and clean dressings and did teach the patient to wash her hand and change her gloves between "dirty" and clean when performing the dressing changes.

The nurse failed to use appropriate clean technique when performing wound care on a surgical wound infected with MRSA.

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

6. Based on clinical record reviews and staff interview, it was determined that for four (4) of nineteen (19) patients agency nurses failed to coordinate services and/or to document coordination of services to inform all personnel involved in the patient's care of changes in the patient's condition and needs (Patient #s 3, 5, 6 and 18). The findings include:

a. Patient #3 had a start of care date of 4/2/05 with diagnoses including traumatic hip fracture, muscle weakness, diarrhea, hypovolemia and breast cancer. The initial interagency referral form from the skilled nursing facility listed Lopressor 12.5 mg. bid but indicated to hold the medication for a BP below 100 and a for a heart rate below 55. The memo of understanding between the home care agency and the assisted living facility (ALF) dated 4/2/05 indicated that the assisted living was responsible for pre-pouring the patient's medications and did not include the medication instruction related to holding the Lopressor stated in the interagency referral form from the hospital to the home health agency. Review of the patient's start of care assessment of 4/2/05 indicated that the patient had been to the ER in the AM for dehydration and diarrhea. The patient's BP was 98/50 during the home care agency assessment visit. The clinical record lacked documentation to support that the home care nurse communicated to the supervisor of the assisted living the criteria for holding the Lopressor and/or if the Lopressor was held. The home care nurse did not visit the patient again over the weekend and the patient was readmitted to the hospital early on 4/5/05 for weakness and reoccurrence of the diarrhea. The supervisor of clinical services of the ALF stated on 5/11/05 that although the home care nurse had not communicated with the ALF nurse regarding the criteria for holding the Lopressor, the documentation in the patient's ALF clinical record indicated that the medication was held due to the ALF nurse's clinical judgement. She stated that both ALF nurses previously worked for the home care agency and had a good understanding of home care services. The ALF nurse indicated that the home care nurse did not visit the patient over the weekend because the ALF nurse communicated to her that the patient had improved. She deteriorated again during the night on 4/4/05 and needed to be re-hospitalized for reoccurrence of the diarrhea and increased weakness. The home care clinical record lacked documentation regarding any communication with the ALF nurse.

The nurse failed to communicate and/or document communication with the ALF regarding medication orders and/or assessment of the patient's health status.

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b. Patient #5 had a start of care date of 2/12/05 with diagnoses including post-op infection, open wound of the abdomen and hernia.

From 3/4/05 to 3/9/05 the patient was hospitalized for an uncontrolled MRSA infection. The interagency referral form from the hospital (W-10), dated 3/9/05, indicated that the patient would need PICC line care and twice a day wound care. The patient was to receive an IV medication every 12 hrs. The home care agency's resumption of care orders dated 3/9/05 stated that that the patient was instructed to do the wound care in the PM. The nurse stated that the patient had a PICC line in the right arm and the patient was complaining of pain and a burning sensation up from the IV site. The nurse indicated that an IV company was coming in the PM to administer the antibiotic and advised the patient to tell the IV Company about the pain and advised her to apply warm compresses to the site. The patient reported that the hospital was aware of the pain. On subsequent visits of 3/10/05 (physician was notified of PICC site pain) to 3/24/05 the nurses inconsistently documented the IV administration of Vancomycin and the status of the PICC line site. The 3/16/05 visit note indicated that the patient was independent in administering the IV medication and that the IV department would visit on 3/17/05 to change the PICC site dressing. On 3/22/05 the patient reported to the nurse that she did not have any more Vancomycin. The visit note did not indicate when her last dose occurred. The PICC line was discontinued on 3/23/05. The clinical record lacked documentation to support that the nurse communicated with the IV Company and/or had a written memo of understanding identifying the responsibilities of each entity and/or the name of the IV Company and/or the dressing protocol of the PICC site and line.

The manager of clinical services stated on 5/11/05 that the agency should have a memo of understanding with other entities providing care to the patient in the home. She stated that the nurse did not communicate with the IV Company and did not document consistently regarding the PICC line due to the fact that the IV Company was responsible for the patient's IV treatment.

c. Patient #6: During the period from 2/24/04 to 4/22/04 clinical record documentation identified that the patient received five visits by five different agency nurses; the clinical record lacked documentation to support that the nurses communicated effectively to address the patient's fasting blood sugar which was fluctuating with increased frequency of below normal values and/or to communicate with the patient's son (PCG) to determine the patient's compliance with ordered medications and/or medication changes and/or to communicate with the physician to discuss acceptable fasting blood sugar levels, current medication lists and/or interventions for coordinating the patient's care among nurses and caregivers more effectively.

When interviewed on 5/9/05 RN #5 stated that when the patient was visited by another nurse communication was maintained through voice mail messages, but that she had not considered that the patient's status had changed so that she did not change the plan of care. See Violation #s 7 and 8.

d. Patient #18 had a start of care date of 3/16/04 with diagnoses including leukemia, gastric bypass operation, bilateral mastectomy, decubitus ulcer, herpes zoster and pneumonia. The physician's plan of care dated 3/16/04 to 5/14/04 included skilled nursing 3x a wk. x 1 wk. and 7x a wk x 8 wk. to perform wound care, notify the physician regarding s/s of infection, assess very closely pain management,

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nutritional status, home safety; refer for home health aide, MSW, OT and PT and wound care specialist.

i. The summary to the physician of 3/16/04 stated that the patient verbalized that she had chronic pain to her back and stage 4 decubitus ulcer regions with poor relief from the Dilaudid that she was taking. She had taken excessive doses of Dilaudid due to frustration over poor pain management. The nurse called a pain management specialist and was waiting for a return call. The patient had a stage 4 decubitus ulcer of the coccyx and orders were obtained for hydrocolloid dressing daily. The patient had a Hickman catheter to the chest wall and the PICC dressing had last been changed on 3/11/04. The nurse would follow up regarding which agency would care for the dressing; the patient previously had the oncologist change the dressing weekly and the husband would administered the heparin flush daily. Patient #18 was described as alert and oriented, appeared very fatigued and pale, weighed 92 lbs. and stated that she was no longer receiving chemotherapy. The nurse was to conference with the insurance company's case manager for a MSW and nutrition consult because the patient appeared emaciated, had four (4) small children in a cluttered house and needed more support with home and child care needs. The patient did not appear motivated to function at a level that would facilitate increased endurance.

ii. Goals identified on the plan of care included: adequate nutrition, adequate oxygenation, effective level of symptom/pain control, optimal GI function, will verbalize social/emotional needs were met, demonstrate weight was consistent with goals, will demonstrate effective pain management principles.

iii. Review of the clinical record from 3/16/04 until 4/23/04 lacked documentation to support that the patient had an effective nurse case manager who was coordinating the patient's care with other disciplines and the patient in order to achieve the patient's goals. The patient refused any further home care services on 4/23/04 due the fact that the agency referred to DCF and the patient/husband did not feel that the agency met the patient's goals.

The patient was 35-year-old woman who resided with her husband/caregiver and four (4) small school age children. She was dependent on her husband for wound care, medication administration, flush of the Hickman catheter and ADLs and IADLs.

During the first week of nursing visits to the patient six (6) different nurses visited the patient. The patient was not compliant with her diet/nutrition, physician appointments, pain medications and/or other medications and childcare. The patient continued to eat "junk food" instead of foods high in protein/Vitamin C for wound healing. She continued to lose weight and her weight was 82 lbs (weight was 92 lbs on 3/16/04); the physician was aware but no weight parameters were identified; the patient became very upset at gaining a pound due to a poor body image. The patient did not take her pain medication properly and her pain was most often between 8-10. She was often identified as fatigued, sleepy and disoriented. The nurse sent the patient to the ER on 3/31/04, which angered the husband, and he refused to have the RN case manager visit the patient so a new RN case manager was assigned. The patient's wound care was changed from hydrocolloid to Silvasorb but the record lacked documentation as to the date the Silvasorb was initiated.

On 4/12/04 the MSW documented that the children were often left alone when the patient had physician appointments and medications were left all over the living room with the young school age children present.

Multiple physicians were called by the different disciplines for the patient's many different problems.

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Review of nursing notes indicated that all nurses visiting the patient did not know who was responsible for changing the patient's Hickman catheter dressing.

The clinical record lacked documentation to support that case conferences with all the patient's disciplines and/or the patient/husband were held to discuss the patient's goals and agency's goal's for the patient and mutual interventions to achieve these goals such as parameters for weight gain with appropriate interventions i.e. nutritional consult in the home, nutritional logs etc; medication pre-pours by the nurse and/or a locked box to protect the children; a contract to ensure compliance etc. The nurse did weigh the patient, noted the weight loss and reported her findings to multiple physicians but did not alter her plan of care and/or interventions with all the services involved in the patient's care.

The supervisor of clinical services stated on 5/27/05 that all the services involved in the patient's care attempted to assist the patient in improving her health and social statuses but the patient's family situation was difficult and her physicians did not view her weight loss as a problem. The home care agency felt the patient should have been hospitalized but the physicians did not agree. She stated that the patient would not agree to many suggested interventions. The supervisor noted that although the disciplines may not have communicated as a group, they did confer with one another but this was not documented.

The nurse failed to implement interventions agreed upon by all the disciplines involved with the patient to support the goals outlined in the plan of care and/or to effectively manage, with all persons involved, the patient's complicated care in a comprehensive manner.

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

7. Based on clinical record reviews, agency policy review, skilled nursing home record review; patient, caregiver, physician and staff interviews and surveyor observations, it was determined that for seven (7) of nineteen (19) patients the nurse failed to accurately and/or appropriately re-evaluate and/or to accurately document the re-evaluations of the patient's status (Patient #s 3, 4, 5, 6, 7, 16 and 19). The findings include:

a. Patient #3 had a start of care date of 4/2/05 with diagnoses including traumatic hip fracture, muscle weakness, diarrhea, hypovolemia and cancer of the breast. The interagency referral forms dated 4/1/05 and 4/6/05 referred for nursing, home health aide and physical therapy. The plan of care dated 4/2/05 to 5/31/05 included skilled nursing and referral for physical therapy. The start of care assessment and the resumption of care assessment indicated that the patient needed assistance with her ADLs and IADLs. She required assistance with her bath. A verbal order to the physician of 4/7/05 indicated that the patient denied a need for a home health aide at this time. The memo of understanding with the assisted living facility dated 4/2/05 indicated that the patient refused a home health aide. Review of the nursing notes from 4/2/05 to 4/26/05 indicated that the patient weighed between 88-90 lbs. and ambulated with a rolling walker, was forgetful at times and often refused to be weighed.

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The PT noted on her admission assessment of 4/11/05 that the patient has been sponge bathing. On her visit note of 4/29/05 the PT indicated that the patient required frequent cues for proper use of her rolling walker.

On a joint home visit to the patient on 5/4/05 the surveyor asked if she (Patient #3) had assistance with her shower and/or bath. The patient replied that she had been sponge bathing since she came home from the hospital but she would like a shower at least once a week.

The clinical record lacked documentation to support that the nurse reassessed the patient's need for and/or willingness to accept a home health aide after the initial assessment.

RN #4 stated on 5/4/05 that she had not admitted the patient but had not offered the patient again the opportunity for an aide since she appeared very independent.

The supervisor of clinical services stated on 5/11/05 that the patient did not receive aide services from the assisted living facility.

The nurse failed to reassess the patient's functional status and the ongoing need for an aide to assist the patient in bathing and/or the patient's willingness to accept aide services.

b. Patient #4 had a start of care date of 4/8/05 with diagnoses including cellulitis, total hip replacement, myeloma and bronchitis. The plan of care included skilled nursing to perform wound care, assess VS, nutrition/hydration, skin integrity, medication regime and side effects, diet teaching and pain management; home health aide to assist with ADLs; the nurse referred for OT due to a torn rotator cuff, which had occurred a month previously.

The summary to the physician indicated that the patient did not want to take narcotics or non-narcotic pain relievers as they increased gastrointestinal distress. The patient's weight on admission was 122lbs. The patient lived alone, had good family support, ambulated with a walker and was independent prior to hospitalization.

The patient was readmitted to the hospital on 4/23/05 with purulent bronchitis.

On the resumption of care summary to the physician of 4/29/05 the nurse noted the patient's weight as 117lbs. and the patient stated that her appetite was improving. The patient ambulated with a walker, had minimal range of motion to the right shoulder, had moderate pain but refused an analgesic. The patient was instructed to push fluids and monitor her temperature.

The patient had lost 5 lbs. from 4/8/05 to 4/29/05. Review of the clinical record lacked documentation to support that the patient's weight was assessed during the subsequent visits on 5/2/05 and 5/5/05 and/or any nutritional evaluation was conducted in order to assess the patient's weight loss/gain.

The manager of clinical services stated on 5/12/05 that the nurse had not identified the 5 lb. weight loss, as an issue so therefore did not continue to assess the patient's weight and nutritional status.

The nurse failed to reassess a patient's nutritional status for a patient who had experienced weight loss an/or was at risk for weight loss.

c. Patient #5 had a start of care date of 2/12/05 with a diagnosis of a post-operative infection of an abdominal wound. The plan of care dated 2/12/05 to 4/12/05 included skilled nursing 7x a week to perform wound care. The wound care procedure was to cleanse all wounds with normal saline and apply dry dressing, abdominal combine dressing, Montgomery straps and an abdominal binder. The

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admission note of 2/12/05 indicated that the patient had staples extending down her abdomen and 4 to 5 open areas were noted. The patient was hospitalized a MRSA infection from 3/4/05 to 3/9/05. The patient's resumption of care orders indicated that the wound was to be cleansed with normal saline then packed with the corner of 4 x 4 gauze into the large wound and cover. The nurse instructed the patient to perform the PM wound care. On 3/16/05 the nurse sent an order to the physician to have the nurse decrease her visits to 5x a week and for the patient to continue to do wound care in the PM and twice a day on weekends and holidays. On 4/13/05 nursing visits were decreased to 3x a week with the patient continuing with BID wound care.

Review of the clinical record from 2/12/05 to 5/4/05 lacked documentation of consistent weekly measurement of the patient's wounds, description of the number of wound/openings and/or when or if they healed and/or exact wound care procedures that were performed. Review of the wound measurement flow sheet indicated that from 3/28/05 to 5/4/05 Wound #1 increased in size but the nurse did not address the increase in size, as such, in the clinical record. The nurse failed to notify the physician of her observations and/or discuss the need to possibly change her visit frequency in response to the increase in size but decreased her visit frequency to the patient. The nurse documented on her visit of 4/25/05 that the patient had a new pin sized site below the wound site. On 4/27/05 the nurse noted that the patient had developed 3 pin size holes down the incision line and on 5/3/05 the nurse noted that the patient had more foul smelling drainage and 2 new small holes that have recently developed; the covering physician was notified. The nurse did not indicate the change in wound status on the wound care flow sheet. The wound care procedure was not changed until 4/27/05 to ½ hydrogen peroxide and ½ water; a visit frequency was not noted on the order of 4/27/05.

The manager of clinical services stated on 5/12/05 that the wound is presently decreasing in size. She stated that there were many inconsistencies in the documentation related to the number of wound openings and date the wound sites healed. The agency did not have a wound care policy but utilized a procedure manual.

The nurses failed to consistently and/or accurately evaluate the deterioration and/or the number of wound openings and/or to change her plan of care appropriately.

d. Patient #6's start of care date was 3/10/02 with diagnoses including type 2 diabetes mellitus, acute ill-defined cerebral vascular accident, hypertension, obesity and hypercholesterolemia. Documentation on the certification plans of care dated 2/22/05 to 4/22/05 and 4/23/05 to 6/21/05 ordered skilled nurse 1 time every other week to pre-pour medications, assess/instruct/supervise vital signs, nutrition/hydration, complications of disease, medication regimen, side effects, home safety, signs and symptoms to report, visits as needed for changes in condition/complications, and diabetic management. Documentation on the nurse's 60-day summary stated that the patient was Mandarin speaking, lived alone and that she had right-sided hemi-paresis. The patient depended on her son to pre-fill insulin syringes, which she injected independently and she monitored her own finger-stick blood sugars on a Glucoscan machine. Ordered medications included Norvasc 5 mg daily, Aspirin 325 mg daily, Lipitor 20 mg every night, Diovan 160 mg daily, Dyazide 37.5/25 mg. every Monday, Wednesday and Friday if ankle edema was present on day of VNA visit, Avandia 8 mg daily and Glucotrol XL 10 mg daily. Documentation on the re-certification plan of care dated 2/22/05 identified and ordered for Lantus 15

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units before lunch and the re-certification plan of care dated 4/23/05 ordered Lantus 20 units daily before lunch.

Review of clinical record documentation determined that the follow up OASIS/comprehensive assessment by RN #5 (PCN) dated 2/10/05 that was completed for the re-certification plan of care dated 2/22/05, identified that the patient's blood sugar on 2/6/05 was 64 and on 2/7/05 was 68. The nurse documented on the 60-day summary note that she called the physician and left a message. However there was no clinical record documentation to support that RN #5 followed up to communicate with the physician about low blood sugars.

Documentation by LPN #2 dated 2/24/05 stated that fasting blood sugar was 69, but that blood sugar readings in the Glucoscan were within normal limits. LPN #2 gave the patient orange juice and pre-poured the ordered medications. When interviewed on 5/9/05 LPN #2 stated that the patient's blood sugars were usually "on target" so that she thought the low blood sugar occurred because the patient had not eaten. LPN #2 stated that she reported these findings to the case manager, but not to the physician.

Revisit documentation by RN #5 dated 3/10/05 stated that fasting blood sugars during the period from 3/4/05 to 3/8/05 ranged from 69 to 81 and that the patient continued independent with insulin injections drawn up by her son. Documentation by RN #5 on the revisit note dated 3/10/05 stated that the patient refused to let the nurse pre-pour aspirin as ordered and that RN #5 contacted the physician for "verification of medication changes, whether or not aspirin had been discontinued," but there was no documentation to determine that RN #5 clarified all of the medications and/or that she reported the patient's current status.

Documentation on 3/24/05 by RN #6 stated that fasting blood sugars from 3/2/05 to 3/24/05 ranged from 69 to 189 and on 3/20/05 a random blood sugar was 69, but did not state proximity to food intake and/or medication dosing. On 4/7/05 LPN #1 documented that she could not assess blood sugar history since the last nursing visit because the patient's Glucoscan needed batteries, but on that date documentation on a physician's interim order increased Lantus insulin to 20 units daily. There was no clinical record documentation to determine that agency nurses discussed the ordered increased Lantus dose and the lowered blood sugar ranges that occurred during March 2005.

On 4/22/05 SCS #2 revisited and documented that the fasting blood sugar was 143, but that blood sugar history on the Glucoscan was within normal limits. During a joint visit on 5/8/05 RN #5 stated that the Glucoscan memory did not indicate time and/or dates of the blood sugar levels recorded. Review of computerized clinical record documentation for the period from 10/9/02 to 1/13/05 determined that agency nurses regularly monitored blood sugars recorded in the Glucoscan memory, but did not always indicate the timing or food proximity; during that period blood sugar levels ranged from 78 to 465 with only three blood sugars below 100 and none less than 78. During the period from 2/6/05 to 4/22/05 the patient's fasting blood sugar ranged from 64 to 189 which was a lower range than her past fasting blood sugar levels, however during that time, agency nurses failed to communicate with the patient's son and/or the physician to collaborate about the patient's changed status and/or to investigate medication regime compliance/non-compliance and/or to obtain new acceptable blood sugar parameters from the physician.

During a joint nursing visit with the surveyor on 5/5/05, the patient's son visited and told the nurse that

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the patient told him that she was not taking insulin all of the time because she felt weak and sick. RN #5 told the surveyor that agency nurses had been unable to determine the patient's medication compliance because they don't usually know when the son fills the insulin syringes and/or how many he fills and that some of the time as the medication boxes are emptied, the son and/or the patient refilled them so that it was not always known to agency nurses if the patient was medication compliant since she speaks only Mandarin. The surveyor observed that the nurse instructed the patient's son regarding the need for testing blood sugar before insulin administration and insulin/medication dosing, but that a language barrier was present and the son expressed inaccurate comprehension several times during the conversation. Frequently, during the visit the son required clarification of the nurse's teaching about several of the medication's appropriate uses, effects and side effects.

On 5/5/05 the surveyor observed as RN #5 pre-poured medications using the current agency medication list displayed on the lap top computer screen. After the medications were pre-poured, the patient asked her son to have the nurse show her which medications had been pre-poured. The nurse told the surveyor that she had a new medication list that she obtained from the patient's clinic that morning and the surveyor observed that RN #5 used the updated list that was documented on paper to identify the medications she had pre-poured. RN #5 had pre-poured Glucatorl, but then realized that this medication was not on the updated list. She contacted the clinic and was informed that Glucatorl had been discontinued during the patient's visit there on 2/2/05.

Review of clinical record documentation by agency nurses during the period from 2/10/05 to 5/8/05 determined that Glucatorl was consistently pre-poured after the physician discontinued the drug on 2/2/05.

When interviewed on 5/9/05, RN #5 stated that the patient was unable to tell nurses when medications were changed by the physician and that the son had not been reliable for reporting changes, but RN #5 had expected that the clinic would inform the home health agency when medication orders are changed. Clinical record documentation was lacking to support that there was communication, coordination and/or a plan for the physician's office to contact the home health care agency about changes made during the patient's appointments. RN #5 stated that during the visit on 5/5/05 she realized that the patient had not been taking medications properly and that the patient's/son's comprehension was unclear and that she planned to change the care plan to visit more frequently in order to address these issues. Agency staff sent a fax to the surveyor dated 6/2/05 that stated that the patient was a chronic and stable CCCI patient and that Glucatorl was discontinued on 2/10/05, but that it was pre-poured by agency (staff) until the survey visit (5/5/05).

When interviewed on 7/5/05 the primary physician (PMD) stated that during the period from February into March, the endocrinologist raised the Lantus from 15 units at lunchtime to 20 units at lunchtime and the son reported that the patient was starting to run low blood sugars. The PMD stated that she thought the Glucatorl was the reason that the blood sugars dropped and that she told the son to discontinue the Glucatorl at that time, but she also stated that the son had language barriers. The PMD could not recall speaking with the home health care agency about discontinuing these medications. Agency nurses failed to accurately and/or appropriately re-evaluate and/or to document accurate re-evaluation of the patient's diabetic status when fasting blood sugars began to consistently fluctuate below her normal ranges and/or failed to communicate with the physician about this change in status

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that suggested a need to alter the plan of care and/or to effectively reassess the patient's medication compliance and/or barriers to medication compliance.

e. Patient #7: During the period from 3/10/05 to 5/9/05 agency nurses failed to appropriately re-evaluate the patient's progress when she consistently complained of break through symptoms of nausea and/or reflux while she was taking medications that should have alleviated these symptoms and/or failed to report these symptoms to the patient's physician in a timely manner. Also, as of 5/9/05, agency nurses failed to appropriately assess the patient's use of and/or response to Reglan when she experienced nausea. See Violation # 9.

f. Patient #16's start of care date was 3/16/05 with diagnoses including syncope and collapse (3/16/05), cardiovascular disease, congestive heart failure, cerebral vascular disease, cardiovascular accident with hemiplegia (5/02), speech disturbance, dysphagia and reflux esophagitis, depressive disorder, sleep disturbance, constipation, back disorder and bladder disorder. Documentation on the certification plan of care dated 3/16/05 to 5/14/05 ordered skilled nurse 1 wk x 1, 2 wk x 1, 1 wk x 7 with 2 as needed visits to assess residual effects from old CVA, aphasia and to monitor PEG tube site for signs and symptoms of infection, assess proper nutrition; assess/instruct/supervise vital signs, complications of disease, medication regimen, side effects, discharge planning, psychosocial needs, bowel regimen, diet teaching, pain and symptom management, cardio-pulmonary status, rest/activity and sleep; homemaker home health aide (H-HHA) 2 x wk for 1-2 hours per visit for personal care and activities of daily living (ADL); physical therapy, occupational therapy and medical social services evaluation. Medications included Catapres three times a day, Ambien at hour of sleep, Tylenol with Codeine four times a day, Norvasc daily. Documentation on the certification plan of care dated 3/16/05 identified that new medications ordered included: Coumadin at hour of sleep, Altace twice daily, Lopressor daily, Prevacid daily, Zocor daily, Ecotrin daily, Valium daily, Soma daily, Calcium Carbonate daily. Documentation by RN #1 on the start of care OASIS/comprehensive assessment stated that the patient was 73 years old, alert and oriented, but forgetful and that her vital signs were as follows: T-97.4, P-64, R-24, BP-110/60. The patient lived with her elderly spouse (Primary Care Giver - PCG) who had independently provided total care for her for the previous two years. RN #1 documented that the patient received Ultracal (also a new order) and intermittent water as well as all of her medications through a gastrostomy tube (G-tube). Patient #16 was incontinent of urine and sometimes bowel and she was totally dependent for all activities of daily living (ADL) and instrumental activities of daily living (IADL). RN #1 documented that the patient was non-ambulatory, but that she was able to stand to pivot transfer.

RN #1 documented in the admission note dated 3/16/05 that the patient was admitted to the agency after discharge from hospital after treatment for a syncopal episode. PCG was very attentive, competent and willing to care for the patient and that he reported that he did not see much of a change in her condition from when she entered the hospital, but that he was receptive to the H-HHA services for bathing the patient. There was no clinical record documentation to determine that the nurse observed the PCG's ability to provide the tube feedings and/or medications and/or any other total care needs the patient had. Documentation by RN #1 dated 6/1/05 stated that she observed as the PCG stood

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the patient so that the nurse was able to assess the condition of the buttock skin, however, there was no documentation to indicate that RN #1 observed the patient's/PCG's ability to transfer the patient. Clinical record documentation by RN #1 on 3/16/05 determined that the nurse planned to revisit the following week and there was no documentation to support a plan for re-evaluation of the appropriateness of the care plan before that visit. The nurse was not available for interview. Review of agency policy determined that the care plan is dynamic based on the data from patient assessments. Planning for care includes monitoring and evaluating the effectiveness of care planning and provision of care, treatment and service.

When interviewed on 5/13/05 the agency manager of clinical operations (MCO) stated that H-HHA was offered only two times per week because the agency was having scheduling problems and could not provide more hours. The MCO stated that the PCG/patient were not informed about other home health care agencies because "he was OK with that."

When interviewed on 5/27/05 SCS #1 stated that although the agency was limited on the amount of H-HHA services that could be provided, the case was opened late in the day and it was better to take the case than to just leave the patient/PCG hanging.

Documentation by RN #1 dated 6/1/05 stated that she contacted the physician on 3/16/05 to report the start of the plan of care, however there was no documentation to support that RN #1 informed the physician of the agency's limited ability to provide H-HHA services to Patient #16.

Review of agency policies determined that circumstances that may render a patient ineligible for agency services include: need exceeds the availability of services to be provided in the home; non-availability or unwillingness of family when 24-hour care is needed, and when it is determined by the SCS that the agency is unable to render service, a communication will be made with the physician of record and patient and/or the nurse will assist patient in obtaining such service as needed by referring to appropriate agencies or sources of service.

Documentation by RN #1 dated 6/1/05 stated that the PCG was extremely knowledgeable and that he verbalized his knowledge and comfort with the patient's care and that he told the nurse that he cared for the patient independently for the previous 2 years, including tube feedings, medication administration and flushing via the g-tube. There was no documentation to determine that the nurse observed the PCG's ability to perform these functions and/or that she followed up in a timely manner after the patient's return home to assess that the patient was tolerating the feedings and/or the new medications.

Documentation by RN #1 dated 3/16/05 stated that she planned to revisit in one week to monitor patient status, medications, endurance and safety. There was no clinical record documentation to indicate how the nurse planned to re-evaluate that the plan of care was appropriate and/or adequate during the immediate period following hospital discharge.

Patient #16 was admitted to the nursing home on 3/18/05 and documentation by nursing home staff on the initial nursing assessment dated 3/18/05 stated that the patient's blood pressure was 98/54 and documentation in the narrative nurse notes dated 3/18/05 by the nursing home admitting nurse stated that the patient's blood pressure had been low and the PCG had held back the blood pressure medications.

When interviewed on 5/27/05 the PCG stated that he took care of the patient independently for the past two years. The PCG stated, however, that during this admission, while the patient was still in hospital,

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that he told the hospital caseworker there that he thought that she was too weak to return home and that he did not think that he could care for the patient at home. The PCG stated that he didn't feel like people were listening to him and that caseworker told him that the patient would do fine at home with home care services. The PCG stated that the patient had a lot of new medications when she was discharged and that while she was home he did not give her blood pressure medications because the pressure was low. The PCG also stated that the patient had no strength and was unable to stand and he had difficulty moving her. The PCG stated that he had back surgery several years ago so that he had to rely on the patient's ability to stand when it was necessary to move her. The PCG could not recall if he told the home health nurse these things.

Documentation by SCS #1 the following morning (3/17/05) stated that the case manager from the hospital called to inform the home care agency that the patient's husband called her to say his wife was too difficult to care for at home and he was requesting that she be admitted to a rehabilitation facility. Home health aide service had not begun as of 3/17/05. No nurse and/or home health aide was sent to the home the morning of 3/17/05 in response to the phone call from the hospital case manager that identified the PCG's inability to care for Patient #16 in order to ensure the patient's care and safety until transfer to an extended care facility was accomplished. Documentation by SCS #1 on a case communication report dated 5/26/05, as an addendum to 3/17/05, stated that she contacted MSW #1 who was at the rehabilitation facility where the PCG requested placement. There was no bed available at the facility, but the admissions director stated that there was room in the "sister" facility and assured SCS #1 that she would follow up with the patient and expected to admit the patient to the facility that same day or the next day.

SCS #1 later (on 3/17/05) called the patient's home and was assured that the facility admissions person had contacted the patient to facilitate the admission on that day and the PCG agreed to admit the patient. SCS #1 informed RN #1 of the patient's transfer to an extended care facility and to enter a transfer OASIS.

In response to surveyor inquiry, SCS #1 faxed the surveyor an addendum note dated 5/19/05 that stated that (on 3/19/05) SCS #1 contacted the admissions director of the facility and was informed that the patient's admission there that was originally anticipated on 3/17/05 was actually delayed until 3/18/05 when the PCG chose another facility.

During the period from 3/17/05 to 3/19/05 there was no clinical record documentation to indicate that agency professional staff communicated with the patient/PCG and/or the skilled nursing facility to ensure the patient's admission to the facility had been accomplished as planned and/or the PCG's ability to provide for the patient's total care needs while awaiting placement in the nursing home.

The primary care nurse failed to accurately and/or appropriately re-evaluate and/or to appropriately document the patient's status and/or the PCG's ability to provide total care and/or failed to re-assess in a timely manner in order to determine that the plan of care was appropriate to meet the patient's needs and/or failed to inform the physician that the agency was unable to provide more than 1-2 hour twice weekly H-HHA to an elderly patient who required total care/assist with all ADLs.

g. Patient #19's start of care date was 2/3/04 with diagnoses including uncontrolled diabetes mellitus with peripheral circulatory disorders, atherosclerosis of extremity arteries with intermittent

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claudication, essential hypertension, and hypercholesterolemia. Documentation on the interagency referral report (W-10) dated 2/2/04 stated that on 1/29/04 a left lower extremity angioplasty was performed with debridement of left foot gangrene. Documentation for wound care was unclear in that the W-10 ordered Bacitracin to the left toes and "daily cleanse area with normal saline, apply Bacitracin and dry sterile dressing (DSD)" and to teach the patient and spouse. Documentation on the certification plan of care dated 2/3/04 to 4/2/04 ordered skilled nurse 3 x week 1, 2 x week x 2, 1 x week x 6 for wound care using clean technique, cleanse with normal saline, apply Bacitracin, cover with dry sterile dressing (DSD). Review of the clinical record determined that there was no documentation to indicate that agency nurses clarified the specific wound care orders as stated on the W-10 and/or the re-certification plan of care to determine if the treatment ordered applied to all of the patient's wounds and/or how frequently the wound care should be provided.

i. The certification plan of care dated 2/3/04 to 4/2/04 ordered skilled nurse to measure wounds weekly, teach wound care to patient/spouse, enterostomal (ET) therapist evaluation, wound care evaluation, teach patient signs and symptoms of infection to report to physician/nurse, assess/ instruct/ supervise pulse ox as needed, vital signs, nutrition/hydration, skin integrity, diabetic management including assist with blood glucose monitoring, complications of disease, diet teaching, medication regime, side effects and effects of medications and physical therapy (PT) evaluation; medications included Lipitor, Atenolol, Lisinopril, Cephalexin, Glipizide, Plavix, Children's aspirin, Vitamin E, and Percocet,

ii. Clinical record documentation on the OASIS/comprehensive assessment dated 2/3/04 by RN # 2 (PCN) stated that the patient was 73 years old, alert and oriented, lived with her spouse who was her primary caregiver (PCG). She required assistance to bathe and dress, ambulated with a walker, but with unsteady gait and poor balance and she had multiple wounds as follows:

Wound #1: left lateral lower extremity was a 13.5 centimeter (cm) long surgical incision with staples, pink/red granulating wound bed and red/inflamed surrounding skin with ecchymosis.

Wound #2: left lower extremity medial aspect was a 7.75 cm long surgical incision with pink/red granulating wound bed, scant serosanguinous drainage and red/inflamed surrounding skin with ecchymosis. RN #2 removed the soiled dressings from Wound #s 1 and 2 and applied a DSD.

Wound #3: left foot second toe, 1 cm surgical wound with small purulent yellow/tan drainage, pink red granulation and loose yellow/tan slough and red/inflamed surrounding skin. RN #1 cleansed this wound with normal saline and applied Bacitracin followed by DSD.

Wound # 4: right lower extremity, medial aspect, 37 cm long surgical incision with staples, pink/red granulating wound bed, scant serous drainage and red/inflamed surrounding skin with ecchymosis and a DSD was applied.

Documentation by RN #2 in the nurse's admission note dated 2/3/04 stated that the patient also had redness of the first three left toes and the large toe was bluish colored. The patient had decreased sensation of the left foot and pedal pulse was impalpable. Pedal pulse was decreased on the right foot and pedal edema was 1+ bilaterally, but both feet were warm with good color. Pain was slight and the patient expressed reluctance to take Percocet.

iii. RN #2 revisited on 2/4/04 and assessed that lungs were clear, pedal edema was unchanged, pedal pulses were weak. RN #2 documented on a routine visit note dated 2/4/04 that she instructed on wound

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care procedures, but that the patient was unable to provide wound care unassisted and the patient's spouse was not available.

The patient complained of increased pain at "5" on a scale of 1-10 in the left foot that was aggravated with ambulation and relieved by rest, but there was no documentation to indicate how much the pain limited mobility and/or if the patient used the pain medication.

RN #2 documented on 2/6/04 that the patient's husband was not available during the visit. RN #2 instructed wound care (to the patient) and evaluated in the return demonstration that the patient was still having difficulty completing wound care because she could not reach her toes and needed RN #2 to assist. During the period from 2/3/04 to 2/6/04 there was no clinical record documentation to determine that the nurse instructed and/or observed the husband's ability to provide appropriate wound care, but RN #2 planned for the patient and/or the spouse to perform wound care over the next two days. There was no clinical record documentation to indicate that RN #2 informed the physician of this plan and/or that the spouse had been instructed and/or observed to provide appropriate wound care.

Also on 2/6/04, pedal edema was increased to 2+ on the right and continued to be 1+ on the left and the patient's breathing was within normal limits, but she had rales in her bilateral lower lobes. RN #2 documented that she notified the physician's service "about respiratory status." There was no documentation to support that RN #2 reported the patient's increased unilateral pedal edema to the physician and/or that she followed up with the physician to collaborate about these changes and/or to inform the physician that the patient was refusing skilled nurse revisits for the next two days.

There was no clinical record documentation to indicate that agency nurses planned to communicate and/or to revisit the patient during the next two week-end days to assess the PCG's ability to assist wound care and/or to assess the changed respiratory status and increased RLE pedal edema.

iv. RN #2 documented in nurse visit notes during the period from 2/3/04 to 2/6/04 that the patient ambulated with a walker with unsteady gait and poor balance. Throughout this time she also complained of numbness and tingling in her left foot and pain at "5" on a scale of 1-10. The pain was aggravated by ambulation and relieved by rest. RN #2 documented on the OASIS/comprehensive assessment dated 2/3/04 that mobility was restricted to short walks and that the patient spent most of her time sitting or resting. RN #2 documented on 2/3/04 that the patient was reluctant to use Percocet and there was no documentation during subsequent nursing visits on 2/4/04 and 2/6/04 to indicate if the patient was using the pain medication and/or if mobility improved.

Documentation by PT #1 dated 2/4/04 stated that she informed RN #2 on that date that the patient refused PT services. There was no clinical record documentation to support that the nurse communicated with the physical therapist and/or the physician regarding the patient's refusal of PT services, in light of her limited mobility, that suggested a need to alter the plan of care. There was no clinical record documentation to determine that RN #2 implemented nursing interventions, i.e. range of motion, quad sets, and/or other measures focused at increasing mobility and/or promoting good circulation. Documentation on a transfer OASIS dated 2/9/04 by SCS #2 stated that the patient was admitted to the hospital on 2/8/04 for emergent care.

Documentation on the hospital emergency room report stated that on 2/7/04 Patient #19 went to the emergency room complaining of shortness of breath. The emergency room physician documented that Patient # 19 had been essentially bedridden since surgery on 1/29/04 and that she had been

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experiencing "orthopnea" at night and that she had noticed swelling in her legs. Patient #19 was diagnosed with congestive heart failure after a myocardial infarction that had occurred days earlier. A Doppler study on 2/11/04 determined that she also had bilateral lower leg deep vein thrombosis.

v. Documentation on the "hospital home care referral form", dated 2/23/04, stated left leg fem-pop healing wounds - apply Betadine; documentation on the W-10 stated to apply Silvadene to leg wound twice daily. Documentation by RN #2 on the resumption of care OASIS/comprehensive assessment dated 2/24/04 described multiple wounds as follows:

- Mid-line sternum incision 24 cm long that was stapled and scabbed;
- Left forearm incision 16 cm long with steri-strips;
- Left heel 2x1cm old callous with yellow/eschar;
- Left lateral foot scab, 1cm crack-like wound;
- Left inner calf scab;
- Left outer calf scab;
- Right leg wound 33 cm long draining large amount of serosanguinous drainage.
- Right lower extremity inner calf with staples and moderate yellow drainage.

There was no clinical record documentation to support that RN #2 communicated with the physician and/or obtained written signed physician's orders to clarify wound care for each wound described above. See Tag G158.

Documentation by RN #2 on the 2/24/04 nursing notes stated that she applied a DSD to both of the right lower extremity wounds and Silvadene to the left inner calf wound.

RN #2 revisited on 2/27/04 and documented that wound care was provided as per the plan of care to the left inner thigh and right lower inner calf and that she applied Silvadene to "right lower extremity" wound and to the left inner thigh wound.

There was no documentation to indicate the nurse's assessment of and/or wound care provided to the right lower extremity inner calf wound, the left outer calf scab, the left heel and/or the left lateral foot wounds. RN #2 documented that she instructed wound care and stated that she evaluated return demonstrations of the wound care by the patient and spouse which they performed, however there was no clarification of the type of care instructed to them and/or performed by them.

Documentation on 3/2/04 by a student nurse stated that she applied a dry clean dressing to the left leg inner calf wound and provided wound care to the right inner calf wound per the plan of care and there was no documentation of assessments of the other wound sites.

On 3/5/04 RN #2 revisited and documented that staples were removed from the right lower extremity wound, there was a small amount of drainage at the lower portion of the wound which was slightly open and the nurse applied a dry dressing. The left upper calf was healing well, but no other wound assessments were described.

Documentation by RN #2 in an addendum note dated 3/19/04 (referring to the events of 3/5/04) stated that a 6.5 cm area of the wound dehisced when the physician removed the staples on 3/4/04 and steri-strips were applied. There was no measure of the wound's width. RN #2 called the nurse in the physician's office and was told that the appropriate wound care was a dry sterile dressing and Keflex would be ordered to prevent infection. On 3/5/04 the edges around the dehiscence were pink and the wound was draining moderate amounts of serosanguinous drainage. The next physician's appointment

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was scheduled for 4/1/04. RN #2 also documented on (3/19/04) that the patient stated that she and her spouse were fully capable of caring for the wound and that she preferred the nurse to revisit only one time a week. There was no documentation to determine that RN #2 communicated with the physician to determine how often he wanted the nurse to observe the newly dehisced wound and/or there was no documentation that the nurse re-evaluated and/or provided care to the remaining lower extremity and foot wounds.

RN #2 documented in a revisit note dated 3/9/04 that the midline chest wound was healed and/or scabbed, the right lower extremity wound was 6.5 (cm) long and "¾ wide" but she stated that there were no new complications. The left inner thigh wound edges were pink and the wound had hard black eschar. The nurse provided wound care as per the physician's plan of care. There was no documentation of the nurse's assessments of the remaining lower extremity wounds and/or the foot wounds except to say that the patient's wounds were free of infection.

RN #2 also documented on 3/19/04 on the addendum note that on 3/15/04 the patient called to report that the wound had dehisced further, secretions were white and drainage increased. There was no clinical record documentation to indicate that agency nurses had revisited the patient since 3/9/05; a period of six days.

On 3/15/04 RN #3 visited and documented "infected dehisced surgical wound to right lower leg" that measured 12 cm long and 3 cm wide, was draining moderate amounts of "clearish"/yellowish drainage and the wound bed was "whitish" with nonviable tissue. The left thigh wound edges were red/inflamed and the wound bed was soft black eschar. Documentation on a fax from the agency to the surveyor dated 6/2/05 stated that clinical record documentation indicated that agency nurses provided instructions about the wounds and that the patient continually verbalized understanding of complications, however RN #3 documented that patient stated that the wound opened more the past couple of days and that she had been changing the wound daily with DSDs "per MD order of 2/24/04." RN #3 failed to document why the patient did not call the physician and/or skilled nurse when further complications occurred and/or to clarify the specific wound care that the patient was performing.

RN #3 documented on 3/15/04 that she provided wound care per the physician's plan of care. There was no documentation of the nurse's assessments of the patient's remaining lower extremity wounds and/or the foot wounds. RN #3 reported the patient's status to the physician.

RN #2 documented on 3/19/04 that she called the patient on 3/16/04 and was told that the physician could not see her until the following day and the patient refused a nursing visit, but there was no documentation that the physician was informed that the nurse was unable to revisit to assess the wound and/or that the patient had not been reliable to contact the physician and/or the nurse when complications occurred.

During the period from 2/9/04 to 3/15/04 the registered nurse failed to accurately and appropriately assess all of the patient's wounds and/or the specific wound care performed by the nurse and/or the patient and/or failed to communicate with the physician when the wounds deteriorated and the patient's wound care status deteriorated and the patient was limiting the frequency of skilled nursing assessments that suggested a need to alter the plan of care.

vi. Documentation on the certification plan of care dated 2/3/04 identified skilled nurse orders that included an 1800 calorie ADA diet, diabetic management, instruct/assist with blood glucose

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monitoring/frequency, complications of disease, medication regime, side effects, diet teaching and disease process. Goals included that the patient/caregiver will demonstrate knowledge of disease process and self care management. Patient/caregiver will verbalize s/s of diabetic complications, preventative measures and actions to take. Patient will demonstrate blood glucose levels within normal limits. Documentation by RN #2 in the nurse's summary dated 2/3/04 stated that the patient was capable of taking her own blood sugar independently and that the random (RBS) was 221. The patient admitted non-compliance with the ADA diet and refused a dietary consult. During the period from 2/4/04 to 3/15/04 agency nurses consistently documented elevated fasting blood sugars ranging from 173 to 277. Clinical record documentation by RN #2 during this period reflected that the nurse repeatedly evaluated the patient's inconsistent compliance with the ADA diet and that the nurse reinforced education to the patient however, there was no clinical record documentation to determine that when the fasting blood sugars remained elevated that RN #2 contacted the physician to make him aware of the consistently high blood sugars, with possible implications for wound healing, despite documented periods of dietary compliance and/or noncompliance and patient diabetic education and/or to collaborate on interventions focused upon acceptable diabetic management including dietary concerns.

When interviewed on 5/19/05 SCS #2 stated that he was aware that RN #2 was new to home health care and because she required added orientation, he met with her and/or reviewed her clinical records often. SCS #2 stated however, that he was unaware that RN #2 had problems case managing for Patient #19 until the patient was admitted to hospital with bilateral leg wound infections on 3/17/04.

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

8. Based on clinical record reviews, hospital, primary physician and agency staff interview, it was determined that for Patient #'s 6 and 19 agency professional staff failed to provide drugs and/or treatments only as ordered by the physician. The findings include:

a. Patient #6: Clinical record documentation on the Medication Profile sheet printed 6/10/05 determined that medications, including Glucatorl XL 10 mg was discontinued by the physician on 2/22/05. During a joint visit to the patient on 5/8/05, RN #5 contacted the clinic the patient attended and was told that Glucatorl XL 10 mg. and Dyazide 37.5mg.had been discontinued. RN # 5 told the surveyor that Glucatorl XL was discontinued in February 2005, but that she did not know when the Dyazide was discontinued. Clinical record documentation in the nurse visit notes during the period from 2/2/05 to 4/22/05 determined that agency nurses regularly pre-poured these medications. When interviewed on 7/5/05 the primary physician (PMD) stated that back in June 2004 the patient was complaining of dizziness and not feeling well and Dyazide was discontinued at that time. The PMD stated that the patient and her son were insightful about some of the medications that she was taking,

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but that there were language barriers and communication with the home health care agency may have been lacking. The PMD thought, however, that since the problem improved, the patient and/or her son may have removed the Dyazide from the medication boxes after it was pre-poured by agency nurses. During the period from 5/8/05 to 6/9/05 agency staff were unable to identify for the surveyor when the physician discontinued the Dyazide. Agency professional staff failed to provide drugs and/or treatments only as ordered by the physician. See Violation # 9.

b. Patient #19: Clinical record documentation by RN #2 on the OASIS/comprehensive assessment dated 2/24/04 determined that the patient was discharged from hospital on 2/23/04. Documentation on a hospital W-10 dated 2/23/04 determined that the admitting diagnosis was an initial subendo infarct and a double coronary artery bypass was performed on 2/16/04. Documentation on an unsigned W-10 from the hospital dated 2/23/04 included the patient's status and recommended nursing interventions for each diagnosis and wound care. Clinical record documentation during the period from 2/24/04 to 3/15/04 determined that agency nurses visited the patient regularly and provided skilled nursing assessments, wound care and teaching including wound care, diet, disease processes and diabetic management. However, clinical record documentation was lacking to support that physician orders were obtained for treatments provided by the agency staff.

When interviewed on 5/26/05 the director of clinical operations stated that she reviewed the clinical record and found only the unsigned W-10 (dated 2/23/04) that was used for the resumption of care on 2/24/04, but that there was no written/signed physician orders for the resumption of care starting 2/24/04.

Documentation of an interim order dated 2/24/04 and signed by SCS #1 on 5/27/05 stated the resumption plan of care for 2/24/04, however the order did not include the physician's name and/or signature. Documentation of this order signed by the physician was received by the agency on 6/7/05 and faxed to the surveyor by the MCO on that date. The MCO noted on 6/10/05 that the order was not previously sent to the physician. Agency professional staff failed to provide drugs and/or treatments only as ordered by the physician after the patient's discharge from hospital. See Violation #s 7 and 9.

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

9. Based on clinical record reviews, agency policy review and staff interview it was determined that for eight (8) of nineteen (19) patients the agency 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 3, 5, 7, 10, 11, 17, 18, 19). The findings include:

a. Patient #3 had a start of care date of 4/2/05 with diagnoses including traumatic hip fracture, muscle weakness, diarrhea, hypovolemia and breast cancer. The patient was discharged from a skilled nursing facility to an assisted living facility on 4/1/05.

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Review of the clinical record indicated the home care nurse admitted the patient on 4/2/05 in the PM after the patient had been sent to the ER in the AM for weakness and diarrhea. The nurse only visited 4/2/05 and the patient was sent back to the hospital by the assisted living facility on 4/5/05 for reoccurrence of diarrhea and weakness. The resumption of care assessment was conducted on 4/7/05 and the orders included skilled nursing 1x a week x 1 week, 2x a week x 2 weeks and 1 x a week x 6 weeks and a PT evaluation. The PT evaluation order of 4/11/05 included PT 2x a week x 7 weeks. Review of the clinical record lacked documentation to support that the nurse visited the patient 2x a week x 2 weeks as per the plan of care and/or that the PT visited the patient 2x a week x 7 weeks as per the plan of care. The PT visited the patient only 1 x a week from 4/11/05 through 4/26/05. The manager of clinical services stated on 5/12/05 that she was not aware that the nurse and the therapist did not visit as per the frequency of the plan of care. The nurse and therapist failed to follow the frequency of visits per the plan of care.

b. Patient # 5 had a start of care date of 2/12/05 with diagnoses including a post-op infection of the abdomen. The plan of care dated 2/12/05 to 4/12/05 included skilled nursing 7x week x 9 weeks to perform wound care. The recertification of 4/13/05 to 6/11/05 included skilled nursing visits 3x a week to perform wound care.

Review of the clinical record lacked documentation to support that visits were made to the patient on 3/12/05, 4/5/05, 4/11/05, 4/15/05 and 4/20/05 as per the plan. The nurse decreased her visits to 2x a week as of 4/26/05 per the patient's insurance company but the clinical record lacked a physician's order to decrease the nursing visits to 2x a week.

The manager of clinical services stated on 5/11/05 that students saw the patient occasionally but the student's visit note of 4/5/05 had not been located. She stated that the patient was often not at home found on the days the nurse was to visit.

The nurse failed to follow the frequency of the visits ordered in the physician's plan of care and/or notify the physician of the change in the plan of care.

c. Patient #7's start of care date was 5/25/04 with diagnoses including abdominal pain, acute gastritis, gall bladder calculi without cholecystitis, anemia, liver abscess, depression and type 2 diabetes. Documentation on the recertification plan of care dated 3/21/05 to 5/19/05 ordered skilled nurse 1 x every other week and 2 times as needed to supervise patient filling medication box times 2 weeks and to call in prescription refills to pharmacy when needed; assess/instruct/supervise vital signs, nutrition, hydration, complications of disease, medication regime, side effects, signs and symptoms to report to RN/physician, pain and symptom management, blood sugars and changes in condition/complications. Ordered medications included Zoloft, multivitamins, Oxycodone, Norvasc, Pepcid, Pravachol, Actigall, Vitamin E, Dipyridamole, Prevacid, and Evista and Reglan four times daily as needed.

i. Clinical record review determined that the patient was visited on 3/24/05 and she was supervised to pre-pour medications as ordered. The next visit was planned for two weeks as ordered, however, the clinical record lacked documentation to indicate that the nurse revisited until 4/22/05 (4 weeks later). In response to surveyor inquiry on 5/9/05, the director of clinical operations stated that she was unable to determine that a visit occurred during that period and that she was unable to locate documentation to

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determine that agency nurses were aware of the missed visit.

Documentation on a case communication report by LPN #1 dated 4/7/05 stated that LPN #1 had contacted the patient's son to arrange to revisit, but the patient was not home when the nurse arrived; documentation stated that LPN #1 called again and left the agency's telephone number for the patient's daughter to call when the patient would be at home. When interviewed on 5/10/05 LPN #1 stated that she informed SCS #1 (who schedules skilled nurse revisits) that Patient #7 was not seen as planned on 4/7/05.

Clinical record documentation by SCS #2 determined that he revisited the patient on 4/22/05 and supervised that she (Patient #7) pre-poured medications, however there was no documentation to indicate if the patient received medications and/or that her medications were ordered from the pharmacy as needed during the month when no nurses re-visited and/or that the physician was informed of the missed visit.

ii. During a joint visit on 5/9/05 RN #5 told the surveyor that the patient did not speak English. The surveyor observed that while RN #5 assisted the patient to pre-pour medications, the patient failed to pre-pour some of the medications in the correct doses and/or for the correct times and she required the nurse's assistance to complete the task accurately. The patient also relied on the nurse to call into the pharmacy when medications required renewal.

Documentation by SCS #2 dated 6/2/05 stated that when he revisited the patient on 4/22/05 he observed that the medication box for that week had been correctly filled by the patient and her family, however there was no documentation to determine if the patient received medications as ordered by the physician during the period from 4/7/05 to 4/21/05 and/or that SCS #2 informed the physician that a nursing visit was missed and/or that a nurse had not supervised the patient's filling of her medication boxes during the period from 4/7/05 to 4/21/05 as ordered by the physician.

iii. Documentation on an incident report dated 6/1/05 by LPN #1 stated that the physician was notified on 6/1/05 that a skilled nursing visit was missed on 4/7/05. When interviewed on 5/9/05 the agency administrator stated that according to agency policy a missed visit is recognized as "an occurrence" and an incident report filing is required. Review of agency policy determined that incidents that are risks to patients will be reported on the day of the occurrence to appropriate supervisor and documented by report and reviewed by the MCO and/or Executive Director, ongoing.

iv. Documentation by RN #5 dated 3/10/05 stated that the patient had heartburn/reflux, the physician was contacted to discuss the plan of care, but there was no documentation to determine that RN #5 reported that the patient complained of heartburn/reflux while maintaining compliance with ordered medications. Documentation by RN #6 dated 3/24/05 stated that the patient complained of intermittent nausea and reflux. On 4/28/05 RN #3 documented that the patient was nauseous. During the time period from 3/24/05 to 5/19/05 agency nurses failed to inform the physician that the patient repeatedly complained of gastro-intestinal symptoms while she continued to maintain compliance with pre-poured medications. Documentation was also lacking that the nurses assessed the patient's use and/or response to Reglan that was ordered to be used if nausea occurred.

The surveyor visited the patient on 5/9/05 with RN #5 and during the visit the patient expressed in Spanish that she had frequent diarrhea and/or vomiting that day. The surveyor observed that the nurse did not inquire about the patient's use of Reglan. In response to surveyor inquiry RN #5 stated that

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agency nurses did not routinely monitor the patient's use of Reglan because it was not pre-poured. The nurse asked Patient #7 if she had been using the Reglan and the patient did not know what this drug was and none could be found in the home.

The agency failed to revisit the patient and/or to pre-pour/re-order medications as ordered by the physician and/or failed to monitor the patient's responses to ordered medications and/or failed to monitor symptom control as ordered in the plan of care and/or failed to inform the physician of these alterations in the plan of care.

d. Patient #10 had a start of care date of 4/2/05 with diagnoses including congestive heart failure, atrial fibrillation, diabetes and angina. The plan of care dated 4/2/05 to 5/31/05 included skilled nursing 4x a week x 1, 2x a week x 2, 1x a week x 7 and 2 prn visits to perform random pulse ox and glucoscan (patient was to check her blood sugar 4x a day), weights to be done daily and report a 2-3 lb. weight gain, assess/instruct/supervise vital signs, nutrition/hydration, skin integrity, medication regime and side effects, CP, GI and GU statuses.

The interagency referral form from the hospital, dated 3/29/05 indicated that the patient's weight was 127.5 lbs. and BP was 109/58; Lasix 20 mg. twice a day and Toprol XL 25mg. daily were included on the patient's medication list. The W-10 noted that the patient was to hold the Lasix for a systolic BP of 85 and Toprol if the systolic BP was below 95 and for a heart rate of below 55. The patient's blood sugar was to be done 4x a day with regular insulin sliding scale coverage and a record was to be given to the home care agency.

A 4/12/05 verbal order from the physician indicated that the patient's daughter was to perform and record blood sugar monitoring QID and weigh the patient QD and report a 2-3 lb. weight gain to the physician.

Review of the clinical record from 4/2/05 to 5/10/05 lacked documentation regarding the insulin sliding scale coverage as per the W-10, assessment parameters for the patient's blood sugar, FBS readings by the nurse and/or the daughter, assessment of the patient's daily weights by the nurse (weights only noted on visits of 4/2/05 and 4/3/05).

On her visit of 4/15/05 the nurse noted the patient's BP to be 90/50. The nursing note lacked documentation to support that the patient's daughter was instructed to hold the Lasix and Toprol as indicated on the W-10 of 3/3/05 and/or that the physician was notified. The nurse did not visit again until 4/20/05 and noted that the patient's BP was 90/60, pulse was 60 and the patient had 2+ lower extremity edema and crackles in her lungs. The nurse told the patient's daughter that the patient should be evaluated by the physician or the ER for a chest x-ray due to possible fluid in her lungs. The daughter spoke to the covering physician who stated that he was not concerned and to give the patient an extra dose of Lasix that evening. The record lacked documentation that the covering physician was aware of the patient's low BP and/or the order on the W-10 to hold the Lasix for a BP below 85 and to hold the Toprol for a BP below 95.

The manager of clinical services stated on 5/12/05 that the nurse told her that there was no need for a sliding scale for insulin at home however she failed to document this fact. The nurse told the manager of clinical services that she did not tell the patient's daughter to hold the Lasix and Toprol on 4/15/05 and 4/20/05 because the orders on the W-10 of 3/30/05 were not included on the orders to the

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physician's plan of care of 4/2/05. The nurse told the manager that the patient's weights were only taken on 4/2 and 4/3/05.

The nurse failed to assess the patient's weight, FBS and/or to implement and/or to clarify implementation of the specified criteria for interventions related to a low BP as per the W-10 and/or communicate with the patient's physician regarding changes in the patient's health status.

e. Patient #11 had a start of care date of 4/13/05 with diagnoses including lymphoma, kidney transplant, total hip replacement and hypertension. The plan of care dated 4/13/05 to 6/11/05 included skilled nursing 2x a wk. x 3 and 1x a wk. x 6 to assess random pulse ox, weight, nutrition/hydration, VS, skin integrity, medication regime and side effects, pain management and safety.

Review of the clinical record from 4/13/05 to 4/25/05 indicated that the nurse failed to visit as noted in the plan of care dated 4/13/05. The nurse visited 2x the first week and 1x a week until discharge.

The patient's weight was 150 lbs. on admission and the patient's weight was not assessed again as per the plan of care.

The manager of clinical services did not know why the visit frequency differed from the plan of care or why the patient's weight was not assessed again after admission.

The nurse failed to follow the visit frequency as per the plan of care and/or to weigh the patient as noted in her plan of care.

f. Patient #17 had a start of care dated of 4/30/05 with diagnoses including diabetes, atrial fibrillation, hypertension and syncope. The physician's plan of care dated 4/30/05 included skilled nursing 2x a week x 2 weeks, 1x a week x 7 weeks to assess/instruct/supervise vital signs, nutrition/hydration, skin integrity, complications of disease, medications, safety, pain, CP, GI and GU statuses. The interagency referral form of 4/29/05 listed as the primary diagnoses digitoxin toxicity, uncontrolled diabetes and dehydration and included referrals for home health aide and physical therapy. Treatments included checking FSBS daily and to keep a diary to bring to the physician appointment on 5/29/05. The patient was to have his INR done on 5/2/05.

The nurse documented on her assessment visit of 4/30/05 that the patient had a relative that visited daily to test his sugar. Blood sugar was 221 this AM and was 129 as taken by the nurse late AM. The nurse instructed the granddaughter who was present how to test her grandfather's blood sugar and she demonstrated that she was able to perform the test. The patient had a physician's appointment on 5/2/05 at which time the INR was to be done.

Review of the clinical record lacked documentation to support that another visit was made to the patient following the admission visit of 4/30/05 until 5/11/05.

A case communication note of 5/6/05 stated that the patient was scheduled for a visit on 5/5/05 (5 days following the admission visit) and the patient did not want a visit. The family was told that a visit would be scheduled for over the weekend.

The manager of clinical services stated on 5/11/05 that the visit over the weekend was never put on the weekend schedule so the patient was not visited on the weekend. The manager then scheduled the patient for a visit today, 5/11/05. The physician had not been notified that the patient had not been visited as per the plan of care.

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The patient had been scheduled for a PT evaluation but as of 5/11/05 the PT had not conducted the evaluation visit and the record lacked documentation to support that the physician had been notified. The manager of clinical services stated on 5/12/05 that PT had been deferred until 5/11/05 per family however the record lacked documentation regarding the delay and/or notification to the physician until 5/11/05.

The nurse failed to visit the patient as per the plan of care and/or notify the physician that the patient was not visited after the admission visit for almost 2 weeks and/or that the PT evaluation had been deferred.

g. Patient #18 had a start of care date of 3/16/04 with diagnoses including leukemia, gastric bypass operation, bilateral mastectomy, decubitus ulcer, herpes zoster and pneumonia. The physician's plan of care dated 3/16/04 to 5/14/04 included, but not limited to, skilled nursing 3x a wk x 1 wk and 7x a wk x 8 wk to perform wound care, measure the wound weekly and notify the physician regarding s/s of infection and assess his ability, assess very closely pain management and close monitoring of how many times daily that patient self-medicated and effectiveness, medication regime/side effects, pain management and symptoms, home safety; refer for home health aide, MSW, OT and PT.

Review of the clinical record from 3/16/04 to 4/23/04 indicated:

i. The nurse measured the patient's stage 4 wound on admission of 3/16/04 and on 3/31/04; on 3/23/04 and 3/24/04 the nurse only documented the measurement of the new tunneling of the wound. The nurse failed to measure the patient's coccyx stage 4 decubitus weekly as ordered on the plan of care of 3/16/04.

ii. On admission the nurse noted that she would clarify what agency (home health agency or oncologist office) would be responsible for the patient's PICC line dressing changes. A verbal order from the home health agency was sent to the physician on 3/18/04, which stated that the home care nurse would change the Hickman catheter dressing and the cap once a week. Review of the clinical record from 3/16/04 to 4/23/04 indicated that the home care nurse changed the Hickman dressing and two caps on 3/20/04 and the Hickman dressing on 3/26/04. On the visit of 3/31/04 the nurse noted that the patient's Hickman dressing was clean, dry and intact and was changed on 3/26/04; she noted that the patient would be going back Monday (? to the physician) to have it changed. During a nursing visit on 4/1/04 the nurse noted that the patient went to the physician every Wednesday for blood work and that the patient had to schedule an appointment to have her Hickman dressing changed. The nurse checked with her supervisor who clarified that the home care agency was actually changing the dressing. The patient had many different nurses visiting throughout her episode of care. The note lacked documentation that the nurse changed the dressing. A case conference note on 4/2/04 indicated that the home care nurse spoke with the nurse at a physician's office and was told that the home care agency was to be changing the Hickman catheter dressing. The clinical record lacked documentation that the nurse changed the patient's Hickman dressing and/or caps weekly as ordered; dressing changes were only documented on 3/20/04 and 3/26/04.

iii. The physician's plan of care dated 3/16/04 included that the nurse would very closely assess the patient's pain management and monitor how many times daily the patient self-medicated and if it was effective; the plan of care did not include any medications for pain. Verbal orders to the physician dated

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3/18/04 included Methadone 5mg q 8 hr and was changed on the same day to Methadone 5mg 2 tablets q 8 hr for pain and Dilaudid strip packs 2mg q 4-6hrs for breakthrough pain. The nurse was to document how many times the patient needed to take the Dilaudid for pain management. Review of the clinical record lacked documentation to support that the nurse accurately and consistently assessed pain management as per the plan of care. The nursing note of 3/25/04 stated that the patient's pupils were pinpoint, she denied the use of Dilaudid, the nurse encouraged the husband to discard the Dilaudid and documented that the patient was taking 5mg of Methadone q8 hrs. and not 10 mg as ordered on 3/18/04. The note lacked documentation that the nurse educated the patient regarding proper pain management. On 3/26/04 the nurse documented that the patient's pain was an "8" for 2 days but she would rather not take break through Dilaudid but only Methadone 5mg BID; pain management was not provided by the nurse i.e. effectiveness of pain medication, dose, frequency, breakthrough medication etc. On 3/29/04 the nurse noted that the patient was in a deep sleep and difficult to arouse, denied use of Dilaudid and stated that she had taken two (2) 5mg of Methadone. During the 3/30/04 visit the patient stated that her pain now was always a "9", the Methadone was not working and she would discuss the pain with her physician at the next visit which was not identified in the visit note. The nurse did not conduct adequate pain management during the visit and/or communication with the physician regarding the patient's inadequate pain control was not documented. On 3/31/04 the patient's pupils were dilated, she was disoriented, she stated she was taking Methadone 10mg.q 8 hr. as ordered, had no concept of time; "as per Dilaudid states is no longer taking but has three less in bottle than last visit". The nurse documented on 4/1/04 that the patient took the last of her Methadone yesterday and threw out her Dilaudid. The clinical record lacked documentation to support that the nurse, as per the plan of care, conducted consistent and accurate assessments of pain management; the nurse performed only occasional pain assessments. The record lacked documentation that the nurse had comprehensive knowledge of the patient's actual pain medication regime since the patient was at times taking the wrong dose of her pain medication and/or documentation of reinforcement of pain management concepts was lacking. The clinical record lacked documentation that a pain management specialist was consulted.

The nurse failed to follow the plan of care regarding the patient's wound care and/or wound measurements and/or Hickman catheter care and/or "assess very closely pain management".

i. Patient #19's start of care date was 2/3/04 with diagnoses including uncontrolled diabetes mellitus with peripheral circulatory disorders, atherosclerosis of extremity arteries with intermittent claudication, essential hypertension and hypercholesterolemia. Documentation on the certification plan of care dated 2/3/04 to 4/2/04 ordered skilled nurse 3 x week 1, 2 x week 2, 1 x week x 6 for wound care using clean technique, cleanse with normal saline, apply Bacitracin, cover with dry sterile dressing (DSD). Review of the clinical record determined that there was no documentation to indicate that agency nurses contacted the physician to determine wound care frequency to complete an acceptable order for wound care.

Physician's orders on the certification plan of care dated 2/3/04 to 4/2/04 also included skilled nurse to measure wounds weekly, teach wound care to patient/spouse, enterostomal (ET) therapist evaluation, wound care evaluation, teach patient signs and symptoms of infection to report to physician/nurse,

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assess/instruct/supervise vital signs, nutrition/hydration, skin integrity, diabetic management including assist with blood glucose monitoring, complications of disease, diet teaching, medication regime, side effects and effects of medications and physical therapy (PT) evaluation; medications ordered included: Lipitor, Atenolol, Lisinopril, Cephalexin, Glipizide, Plavix, Children's aspirin, Vitamin E, and Percocet.

A review of clinical record documentation during the period from 2/3/04 to 2/6/04 determined that wound care provided was not consistent with the plan of care as follows: on 2/3/04 RN #2 documented that wound care to the bilateral lower extremity wounds included only application of dry sterile dressings, on 2/4/04 there was no documentation to indicate that the nurse performed wound care to the left lateral lower extremity wound, and on 2/6/04 RN #2 documented that she assisted the patient with wound care, but there was no documentation of the specific wound care the nurse provided. RN #2 stated that the patient applied a dry sterile dressing to the left lower medial sutures that was not consistent with wound care as ordered by the physician.

Clinical record documentation on an unsigned W-10 dated 2/23/04 recommended wound care with Silvadene to be applied to leg twice daily, but did not specify which leg and/or which wound; and/or wound care for left foot wounds was not specified. There was no clinical record documentation to indicate that agency professional staff contacted the primary physician to clarify the wound care orders. Review of the clinical record determined that there were no signed physician's orders for the resumption of care that began on 2/24/04. In response to surveyor inquiry agency staff faxed the surveyor a verbal order by RN #2 dated 2/24/04 that did not include a physician's name and/or signature, but ordered wound care, cleanse with normal saline, apply Silvadene to right inner scab on LE, cover with DSD, apply DSD to right lower extremity on staple line daily and RN to perform wound care at skilled nurse visit and patient/PCG to provide wound care daily. During the period from 2/24/04 to 3/15/04 agency nurses visited regularly and consistently documented that wound care was provided "per the plan of care," however, there was no clinical record documentation to determine that agency staff communicated with the patient's physician to obtain orders for a revised plan of care to address the patient's changed status.

Review of agency policy determined that service orders are reviewed by licensed clinicians for appropriateness and accuracy prior to care, treatment and service provision.

i. Documentation on the 2/23/04 W-10 stated that the patient had a stage 2 coccyx decubiti and recommended treatment with Tegaserb. During the period from 2/24/04 to 3/15/04 agency nurses consistently documented that skin was "within normal limits," but there was no specific documentation to determine that nurses assessed the patient's coccyx as recommended on the W-10 dated 2/23/04 and/or clarified the notation with the physician. On a fax dated 6/2/05 agency professionals stated that the coccyx decubiti was not identified on the resumption of care nursing evaluation (2/24/04) and because the nurse documented other specific areas i.e. forearm, heel, foot and calf that it could only be assumed that the RN would have noted the coccyx if there was a problem. There was no documentation in the clinical record to determine that the physician was informed that the stage 2 coccyx decubiti (that was identified on the W-10, dated 2/23/04, by hospital staff) had healed and/or that the ordered Tegaserb treatment was discontinued.

ii. Documentation on the W-10 dated 2/23/04 stated that the patient had a rash under her breasts and

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Nystatin was ordered for treatment. Documentation in the clinical record on 2/24/04 and 2/27/04 by RN #2 determined that skin was "within normal limits," but there was no documentation that the physician was informed of the patient's improved status and that Nystatin was discontinued. On 3/2/04 a student nurse visited the patient and observed the presence of a rash under the breasts and she documented that she left a message to report the patient's status to the physician and the primary care nurse (RN #2). However during the period from 3/2/04 to 3/15/04, there was no clinical record documentation to determine that the physician responded to the message and/or that agency nurses contacted the physician to request treatment orders as appropriate. During that period agency nurses consistently documented that the patient's skin was within normal limits, however documentation was lacking to support that the rash under the breast had healed and/or that the physician was informed.

iii. Clinical record documentation on a W10 dated 2/23/04 ordered skilled nurse to assess diabetic status with target range at 150, however there was no documentation that during the period from 2/23/04 to 3/9/04 that RN #2 intervened to inform the physician that fasting blood sugars were consistently elevated above that parameter with consistent patient reports of dietary noncompliance which suggested necessary care plan revision. Also, during the period from 2/3/04 to 3/15/04 there was no clinical record documentation to indicate that the enterostomal therapist evaluated the wounds as ordered by the physician. Documentation on a fax sent to the surveyor on 6/2/05 stated that the wound care specialist was in consultation with the PCN, but did not manage the case between 2/24/04 to 3/15/04 because there were no signs and symptoms of infection from 2/24/04 to 3/9/04. However, there was no documentation to determine that the nurse consulted with the wound care specialist when a right lower extremity wound dehiscd on 3/5/04 and until 3/16/04 after the wound became infected. Clinical record documentation was also lacking to determine that the physician was informed that the wound care specialist did not evaluate the patient's wounds as ordered by the physician on the plan of care dated 2/6/04.

RN #2 was not available for interview. When interviewed on 5/19/05, SCS #2 stated that RN #2 was new to home care and that she had problems adapting, but that she did not mention that she was having problems understanding the plan of care for Patient #19 and that the SCS did not recall reviewing the patient's clinical record.

Agency nurses failed to provide services and/or failed to document that services were provided as ordered by the physician; and/or failed to obtain signed physician orders for a plan of care at the resumption of care when the patient's status was changed; and/or failed to alert the physician that the patient reported consistent dietary noncompliance and blood sugars were consistently elevated above target parameters that were determined by hospital staff and/or that the wound care specialist was not visiting the patient as ordered and/or when the agency discontinued treatments to the coccyx with Tegisorb and/or treatment to the skin under the breasts with Nystatin; and/or failed to clarify with the physician regarding appropriate interventions to address apparent changes in the patient's under breast rash during the period from 3/5/04 to 3/9/04 and/or these changes in the patient's health status all of which suggested a need to alter the plan of care. See Violation # 7.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74 (b) Administration of medicines.

10. Based on clinical record documentation and staff interview, it was determined that for three (3) of nineteen (19) patients, the comprehensive assessment failed to include a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy (Patient #s 5, 6 and 13). The findings include:

a. Patient #5 had a start of care date of 2/12/05 with a diagnosis of a post-operative abdominal wound infection. The plan of care dated 2/12/05 listed the patient's medications as Tylenol with codeine, Amoxicillin 875 mg. q 12 hrs. for 2 weeks and Flagyl 500mg. twice a day; Tylenol with codeine was not listed on the patient's medication profile. The visit note of 2/28/05 indicated that the patient was recently diagnosed with MRSA and was given a new antibiotic last week which she did not fill since she thought she would finish the old one first; the patient was informed to get the new antibiotic as soon as possible. The clinical record lacked documentation as to what antibiotic the patient was to start. The patient's medication profile lacked documentation to support that a new antibiotic was started as indicated in the nursing note of 2/28/05.

The manager of clinical services stated on 5/12/05 that the nurse informed her that Flagyl was the antibiotic restarted. The medication profile listed Flagyl as started on 2/12/05 and ended on 2/12/05, begun on 5/21/05 for two (2) days, ended on 6/1/05 when it was started again for twice a day and ended again on 6/11/05. The medication profile did not correspond with the clinical notes.

Review of the interagency referral form of 3/9/05 listed the patient's medications as Cipro 500 mg. q 12 hrs, Flagyl 500 mg. q 12 hrs. and Vancomycin 750 mg. IV q 12 hrs.; the patient's medication profile did not list Flagyl.

The nursing note of 3/23/04 noted that the physician changed the Vancomycin to a pill form but did not note the frequency or dose of the pill form; the Vancomycin by mouth was not indicated on the patient's medication profile. On 4/4/05 the nurse stated that the patient reported that the physician resumed the Flagyl due to the wound having an odor; the clinical record and/or the medication profile lacked documentation that Flagyl was restarted on or about 4/4/05.

The manager of clinical services stated that she had printed the wrong medication profile for surveyor's review, however the updated medication profile offered for review to the surveyor contained the same discrepancies as the previously printed profile of the patient's medications.

The nurse failed to do conduct an accurate drug regime review at resumption of care and ongoing for a patient that had a MRSA infected wound with continued changes in her wound status.

b. Patient #6: Review of the clinical record determined that documentation was lacking to determine that a medication review was completed for the re-certification period dated 2/22/05 to 4/22/05 that included clarification of medications that were previously discontinued by the physician.

SCS #2 conducted a comprehensive assessment dated 4/22/05 which did not include a review of all of the medications the patient was using as was evidenced by the continued inclusion of medications

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previously discontinued by the physician on the re-certification plan of care dated 4/23/05 to 6/21/05.
See Violation #s 7 and 8.

c. Patient #13 had a start of care date of 4/14/05 with diagnoses including osteoarthritis, osteoporosis, atrial fibrillation, hypertension and depression. The plan of care dated 4/14/05 to 6/12/05 included physical therapy to assess/instruct/supervise the patient's VS, neurological/ muscle skeletal status, discharge planning and pain/symptom management. Review of the clinical record indicated that the plan of care sent to the physician on 4/2/05 and 4/29/05 by the PT and signed by the physician on 4/26/05 and 5/4/05 had multiple medications changed by the physician. The medications changed by the physician included: Pravachol from 10 mg qd. to 40 mg. qd, Amiodarone HCL 200mg.qd.to 200 mg q.o.d., Fosamax 10mg. q week to 70mg. q week.

The clinical record lacked documentation to support that the PT communicated with the physician regarding the patient's medications on admission and/or clarified the change in the medications with the patient when she received the signed physician's plan of care.

The medication profile had not been updated since the patient's admission on 4/14/05.

Subsequent to surveyor's inquiry the PT wrote an addendum, which stated on 4/14/05 she had called the physician regarding the plan of care and all medications in the home.

A narrative by the PT dated 5/12/05 noted that she discussed the medication changes with the patient; the discussion occurred 3-4 weeks after receiving the changes noted by the physician on the plan of care.

The manager of clinical services stated on 5/12/05 that the PT stated that she did review the medications on admission and apparently did not see the signed orders with the changes from the physician until 5/12/05 since the medical records person who would normally alert the manager to changes was on a leave of absence. The therapist told the manager that the patient had been taking the medications initially listed on the plan of care.

The PT failed to promptly clarify the changes in medications with the patient when changes were identified by the physician on the plan of care leading to the patient taking the incorrect medications from 4/26/05 to 5/12/05.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76 (e) Quality assurance program.

11. Based on clinical record review committee minutes in two quarters of fiscal year 2002 - 2003, four quarters for 2003 -2004 and one quarter of 2004 - 2005 and interview with agency staff, it was determined that at least quarterly health professionals in active practice representing at least the scope of the agency's home health services failed to review an appropriate sample of active and closed records to assure that the agency's policies are followed in providing services. The findings include:

a. When interviewed on 5/10/05 the agency's clinical operations manager stated that it was the agency's

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policy to include skilled infant monitoring cases that were not included in the home health agency's census when selecting the total sample of the quarterly clinical record reviews.

b. The clinical record review for the third quarter of FY 02-03, dated April to June 2003, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 563.

c. The clinical record review for the fourth quarter of FY 02-03, dated July to September 2003, consisted of review of 28 clinical records; 19 home health care and 9 maternal child health. The home health agency census was 565.

d. The clinical record review for the first quarter of FY 03-04, dated October to December 2003, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 578.

e. The clinical record review for the second quarter of FY 03-04, dated January to March 2004, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 582.

f. The clinical record review for the third quarter of FY 03-04, dated April to June 2004, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 546.

g. The clinical record review for the fourth quarter of FY 03-04, dated July to September 2004, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 549.

h. The clinical record review for the first quarter of FY 04-05, dated October to December 2004, consisted of review of 25 clinical records; 19 home health care and 6 maternal child health. The home health agency census was 563.

The agency failed to review an appropriate sample of clinical records quarterly to assure that agency policies are followed in providing services as required by agency policy.



STATE OF CONNECTICUT

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October 24, 2005

Mary Ann Faraguna, MPH, RN, Administrator
Danbury VNA, Inc.
4 Liberty Sreet
Danbury, CT 06810

Dear Ms. Faraguna:

Unannounced visits were made to Danbury VNA, Inc. on August 19, 22, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Medicare follow-up survey with additional information received through August 29, 2005.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by November 7, 2005 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

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

Based on clinical record reviews and staff interviews it was determined that for two (2) of ten (10) patients the nurse failed to accurately and/or appropriately re-evaluate and/or to document the re-evaluations of the patient's status (Patient #s 3 and 4). The findings include:

a. Patient #3's start of care date was 8/6/05 with primary diagnosis of breast neoplasm for which the patient underwent a right partial mastectomy with axillary lymph node dissection and chemotherapy was planned. Secondary diagnoses included exacerbation of Insulin dependent diabetes and new onset anxiety with depressive disorder. Ordered medications included Elavil, Lexapro, Lantus Insulin, Avandia and Glucophage. The plan of care included skilled nursing to monitor patient's status, medication regimen and side effects. The start of care assessment indicated that the patient was 57 years old, alert and oriented and that she did not exhibit evidence of anxiety and/or depression; the patient lived with a son who was her primary caregiver. but the home was soiled and cluttered. The admission summary to the physician dated 8/6/05 indicated that the patient did not take her Insulin and/or oral medications as ordered and reasoned that she had not gotten around to it. The patient verbalized that she understood the medication regime and the reasons for the medications, but she expressed that she would just forget and/or take the medicine at different times. They wrote a medication list and contacted the son who agreed to remind the patient to take the medications as ordered. During the period from 8/6/05 to 8/16/05 the nurse's documentation consistently indicated that the patient was non compliant with taking her Insulin and/or oral medications because she regularly forgot. The nurse assessed that blood sugars were frequently elevated and she continued to encourage the patient and to contact the son for assistance. The nurse also contacted the physician who suggested that she continue to encourage the patient to comply with medication orders. There was no clinical record documentation to determine that the nurse and the physician discussed possible causes for the patient's forgetfulness and/or that the nurse consistently altered the plan of care to meet the patient's needs that were indicated by the patient's ongoing medication non compliance and irregular blood sugar levels.

Clinical record documentation was also lacking to support that the nurse consistently assessed the patient's coping status and/or her response to Elavil and/or Lexapro.

The nurse documented on 8/16/05 that she supported the patient's expressed fears and supported positive coping mechanisms, but there was no communication by the nurse with a medical social worker and/or the physician to discuss the patient's ability to effectively cope.

When interviewed on 8/22/05 the supervisor of clinical services stated that the nurse expressed concern for the patient's ability to cope, but that she did not believe the patient would be receptive to social services.

The nurse failed to accurately re-evaluate the patient's non-compliance with medications that suggested

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a need to alter the plan of care and/or failed to consistently and/or appropriately re-evaluate a patient's coping ability that had a new diagnosis of cancer and had undergone surgical procedures that rendered body image changes.

b. Patient #4 had a start of care date of 7/15/05 with diagnoses including knee sprain, loss of weight, retention of urine, blindness in one eye, cancer of the tongue and anorexia. The plan of care dated 7/15/05 to 9/12/05 included skilled nursing 2x a week x 2 and 1x a week x 7 weeks to weigh the patient every visit, assess for urinary retention, and constipation, VS, nutrition/hydration, skin integrity, med regime/side effects, s/s of infection, home safety and changes in condition; refer for aide 2x a week, OT for instruction on medication reminder, schedule for meal planning and use of microwave oven, nutrition consult and MSW for setting up lifeline and appointment for a hearing aide to improve safety. The summary to the physician of 7/15/05 indicated that the patient was a 93-year-old woman who was admitted to the hospital and then a rehab hospital due to a fall at home and a ruptured meniscus. She had a supportive son and a family member who would stay a few months with the patient. The patient was legally blind, had lost 10 lbs. in the last 6 months, and was somewhat unsteady on her feet ambulating with a cane/walker. The patient's son was responsible for pre-pouring the patient's medications.

Review of the nurses notes from 7/15/05 to 8/2/05 indicated that the patient continued to have an unsteady gait and poor balance, had the niece staying with her to assist with meals and medication reminder although the patient was at times non-compliant with her medications due to forgetfulness. The nurse noted on her visit of 7/29/05 that the patient's niece would be leaving on 8/1/05. The OT had expressed concerns to the nurse regarding the patient living alone. The patient had agreed to lifeline and MOW, which the MSW was pursuing, along with a Home Care Program for the Elderly referral. The nurse noted that she had concerns when the niece left, as the patient would be more on her own and a plan needed to be implemented for structure so that the patient would follow the plan of care appropriately.

Review of the physical therapy notes from 7/19/05 to 8/12/05 indicated that the patient was non-compliant with the use of her walker, had difficulty sleeping due to constipation and was very tired. On 8/5/05 the PT noted that the patient received a new medication from the physician and still had not had her audiology appointment as yet.

The OT discharge summary of 8/2/05 noted that she had concerns regarding the patient's safety including meal preparations and tub transfers. The OT discussed with the patient's son, nurse, and MSW that she recommended that the patient had supervision during mealtime and required close supervision for medications and tub transfers. The MSW noted in her assessment note and only visit of 7/24/05 that the patient would need services for meal preparation, housekeeping, an emergency response system and MOW and she would refer for the Home Care Program for the Elderly. On 7/29/05 the MSW left a message for the nurse only regarding referral for the elderly program and referral for the patient's hearing aides.

On her nursing visit of 8/2/05, the day after the patient's niece left, the nurse only noted that the patient was to see her physician tomorrow, 8/3/05 and she was taking Boost supplements 1-2 x during the day. The nurse failed to assess the patient again until 8/12/05 in order to assess the patient's safety,

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medication and diet compliance, additional services needed for the patient, audiology appointment and/or placement of hearing aides for safety, following the patient's caregiver (niece) leaving on 8/1/05. The nurse also failed to assess the effects of the patient's new medication Avapro 300mg.po qd. as of 8/3/05. The nurse did not revise the patient's plan of care by increasing aide coverage until the implementation of services by Home Care Program for the Elderly to promote safety and compliance with the plan of care.

The supervisor of clinical services stated on 8/22/05 that she had a conversation with the patient's son and he was very supportive and visited the patient 3x a day although her conversations were not documented. She stated that she had not received services as yet from Home Care Program for the Elderly but wanted to be independent. The supervisor stated that the niece, who stayed with the patient, was also elderly and did not do much for the patient. She stated that the nurse was compliant with the plan of care visit frequency.

The nurse failed to consistently and accurately assess the patient's compliance with the plan of care including physician and audiology appointments, failed to assess an at risk patient, who lived alone, following the departure of her caregiver for 10 days, failed to assess the effects/side effects of a new medication and /or the reason for the medication.