

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

IN RE: Hebrew Health Care Home Health Care Agency of West Hartford, CT.
One Abrahms Boulevard
West Hartford, CT 06117

CONSENT AGREEMENT

WHEREAS, Hebrew Health Care Home Health Care Agency, Inc. of West Hartford, CT ("Licensee"), has been issued License No. C9410505 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 August 3, 2005 up to and including September 23, 2005 for the purpose of conducting a licensing inspection; and

WHEREAS, the Department during the course of the aforementioned inspection identified violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated September 26, 2005 (Exhibit A – 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 proceedings; 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, the Licensee is willing to enter into this Consent Agreement and agrees to the conditions set forth herein without admitting any wrongdoing.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut acting herein and through Joan D. Leavitt, its Section Chief, and the Licensee, acting herein through Bonnie B. Gauthier, its President and CEO, hereby stipulate and agree as follows:

1. The Licensee understands and agrees this Consent Agreement, and the violations contained therein, shall be admissible as evidence in any subsequent proceeding before the Department in which (1) the Licensee's compliance with this same Consent Agreement is at issue, or (2) the Licensee's compliance with any state or federal statute and/or any state, federal, or departmental regulation is at issue; and
2. The Licensee understands that this Consent Agreement fully and completely resolves the allegations referenced above without any further proceeding before the Department.
3. The Licensee waives the right to a hearing on the merits of this matter.
4. The Licensee understands this Consent Agreement is a matter of public record.
5. The Licensee within seven (7) days of the execution of this Consent Agreement shall designate an individual within the Facility who has responsibility for the implementation of this Consent Agreement. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
6. Effective upon execution of this Consent Agreement, the Licensee through its Governing Body, Administrator and Supervisor of Clinical Services shall ensure that:
 - a. All patients are initially assessed in a timely and comprehensive manner and all subsequent re-assessments are accurate, comprehensive and appropriate including the immediate care and support needs of the patient and completed as often as necessary depending on the condition of the patient.

- b. All patients shall have a comprehensive plan of care developed and/or revised which is based on the individual patient's assessment/re-assessment and is reflective of the needs of the patient and includes all appropriate interventions for complete care to the total patient; prompt action shall be taken regarding any patient's change in condition and deteriorating health and/or safety status.
 - c. 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.
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 and/or in accordance with the facility's plan of correction, review or develop and/or revise all policies and procedures as necessary, 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 and/or in accordance with the Facility's plan of correction, 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 Section 10 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 five hundred fifty dollars (\$550.00). 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 \$550.00 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. The Licensee may request that the Department agree to terminate the Consent Agreement at any time after the end of the first twelve (12) month period. The Department may, in its sole discretion, grant such

request, taking into consideration the Licensee's compliance with this Consent Agreement over the first twelve (12) month period.

15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
16. 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.
17. The Licensee has had the opportunity to consult with an attorney prior to signing this document.
18. 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.

HEBREW HEALTH CARE HOME HEALTH CARE AGENCY OF WEST HARTFORD, CT.

6/27/06
Date

By: Bonnie B. Gauthier
Bonnie B. Gauthier, President and CEO

SIGNED AND SUBMITTED WITH ATTACHMENTS: COVER LETTER & POC'S 6/27/06

State of CONNECTICUT
County of HARTFORD

ss JUNE 27TH 2006

Personally appeared the above named BONNIE B. GAUTHIER and made oath to the truth of the statements contained herein.

My Commission Expires: 11/30/2009

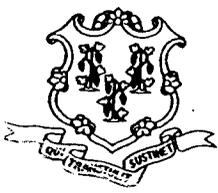
David A. Houle
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

DAVID A. HOULE
NOTARY PUBLIC
MY COMMISSION EXPIRES NOV. 30, 2009

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

6/27/06
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 12

September 26, 2005

David Houle, Administrator
Hebrew Home & Hospital Home Health Agency
One Abrahms Boulevard
West Hartford, CT 06117

Dear Mr. Houle:

Unannounced visits were made to Hebrew Home Hospital Home Health Agency on August 3, 4, 5, 8, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing, inspections with additional information received through September 23, 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 October 17, 2005 at 1 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

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

Respectfully,

A handwritten signature in black ink that reads "Victoria V. Carlson".

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

SNC:NC:VVC

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

DATE(S) OF VISIT: August 3, 4, 5, 8, 2005 with additional information received through
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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

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

1. The governing authority failed to assume responsibility for the services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 3, 9 and 10 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. The administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 3, 9 and 10 and their families based on the violations listed in this document.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(2),(3)(A),(B) 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 as evidenced by the care and services rendered to Patient #s 3, 9 and 10 based on the violations listed in this document.

4. Based on observations, clinical record review and staff interviews for one (Patient #3) of two patients in the survey sample with pressure sores, the Supervisor of Clinical Services failed to coordinate and manage the care and service needs of the client. The findings include:

a. Patient #3, who required care over the twenty-four period had a start of care of 4/28/05 with diagnoses including an open wound of the left buttock, a spinal fusion approximately 12 years earlier and left sided paralysis. The initial certification dated 4/28/05 to 6/26/05 identified that the patient was oriented with good memory, incontinent of bowel and bladder, able to partially weight bear, required daily wound care by a skilled nurse (SN) and home health aide (HHA) services 1-2 times per day for personal care and showers. A care plan dated 4/28/05 identified problems of self-care deficits for bathing and hygiene with a goal of assisted self-care; skin integrity with a goal of wound healing and closure; and reflex incontinence with a goal to maintain skin integrity. Skilled nursing visit notes regarding the wound located on the 3 x 3 x 4 cm with a small amount of purulent drainage; which increased to a non healing stage IV wound measuring 4 x 3.3 x 4.9 with a red/purple wound bed on 5/16/05. The measurements continued to be documented at that size through 8/3/05. Skilled nursing notes dated 5/24/05 identified an incontinence assessment noting that the patient's functional incontinence could be deferred by scheduled time voiding. Based on a conversation with the patient on

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8/3/05 and Physician #2 on 8/10/05, the physician was unaware of the patient's pain, which prevented optimal turning to promote healing of left buttock identified that: on admit on 4/28/05 that it was a stage III circular area measuring the patient's wound.

The Supervisor of Clinical Services failed to ensure that staff were available consistently over the twenty-four period to provide all necessary care and services to meet the needs of Patient #3 and/or to maintain the patient's safety at all times.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(B),(C),(D),(E),(G)(i),(H) Services.

5. Based on observations, clinical record review and staff interviews for one (Patient #3) of two patients in the survey sample with pressure sores, the facility failed to initiate appropriate preventive interventions to prevent the sore from getting worse. The findings include:

a. Patient #3's start of care was 4/28/05 with diagnoses including an open wound of the left buttock, a spinal fusion approximately 12 years earlier and left sided paralysis. The initial certification dated 4/28/05 to 6/26/05 identified that the patient was oriented with good memory, incontinent of bowel and bladder, able to partially weight bear, required daily wound care by a skilled nurse (SN) and home health aide (HHA) services 1-2 times per day for personal care and showers. Skilled nursing visit notes regarding the wound located on the left buttock identified that when admitted on 4/28/05, it was a stage III circular area measuring 3 x 3 x 4 cm with a small amount of purulent drainage and it increased to a stage IV measuring 4 x 3.3 x 4.9 with a red/purple wound bed on 5/16/05 and continued to be documented at that size through 8/11/05. On 5/29/05, the wound had been identified as non-healing, the surrounding skin was blistered and there was a lesion on the right buttock, which was identified as blistered and excoriated, was 2 x 0.5 cm with a small amount of serosanguinous drainage. On 6/3/05 a skin assessment identified that the open area on the right buttocks had healed, that the coccyx was red and intact, skin was cool, purple colored and moist; interventions included to turn with a turning sheet every two hours and support with a pillow and air mattress. During a joint home visit observation of the patient on 8/3/05 at 1:45 PM, the patient was lying on her left side on an alternating pressure mattress covered by a sheet and a cloth incontinent pad. During an interview with the SALSA at that time she stated that the air mattress had been put on the patient's bed when she was admitted to the agency. Although the air mattress had been put on the patient's bed on admission, review of the patient record from admission to 8/3/05 failed to provide evidence that preventive interventions were developed and or consistently performed such as frequent turning and positioning (including 11:00 PM to 7:30 AM when there was no nursing and/or aide staff in building); scheduled position changes in the tilt wheelchair; frequent, timed voiding twenty-four hours per day; and/or protection of other bony prominences.

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

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6. Based on observations, clinical record review and staff interviews for two (2) of two (2) patients in the survey sample with pressure sores, the facility failed to coordinate services to meet the care needs for the patient's pressure sore (Patient #s 3, 9). The findings include:

a. Patient #3, who required care over the twenty-four period, had a start of care of 4/28/05 with diagnoses including an open wound of the left buttock, a spinal fusion approximately 12 years earlier and left sided paralysis. The initial certification dated 4/28/05 to 6/26/05 identified that the patient was oriented with good memory, incontinent of bowel and bladder, able to partially weight bear, required daily wound care by a skilled nurse (SN) and home health aide (HHA) services 1-2 times per day for personal care and showers. Skilled nursing visit notes regarding the wound located on the left buttock identified that when admitted on 4/28/05, it was a stage III circular area measuring 3 x 3 x 4 cm with a small amount of purulent drainage and it increased to a stage IV measuring 4 x 3.3 x 4.9 with a red/purple wound bed on 5/16/05 and continued to be documented at that size through 8/11/05. On 6/3/05 a skin assessment identified interventions including to turn with a turning sheet every two hours and support with a pillow and air mattress. During an interview with Patient #3 on 8/3/05 at approximately 2:00 PM, she stated that she could only lie on her left side because of the pain from her spinal fusion, was unable to turn herself, spent from approximately 7AM to 1:30 PM and 3:30 PM to 8 or 9PM up in her electric wheelchair and the rest of the time in bed on her left side. She further stated that she was not incontinent except at night when there was no one to get her up to the bathroom/commode. During an interview with RN #1/SALSA on 8/5/05 at 10:15 AM, she stated that there were no staff available to toilet the patient during the night.

The agency failed to coordinate care with the Assisted Living Services Agency and/or others to ensure the patient's safety, that staff were available to meet Patient #3's needs at all times and to ensure the quality of care over the 24-hour period.

b. Patient #9 had a start of care date of 5/20/05 with diagnoses of multiple myeloma and right great toe decubitus. The plan of care of 5/20/05 included skilled nursing 7x a week, aide 3x a week and refer for PT. The patient resided in an ALF with his debilitated wife.

PT did not evaluate the patient until 6/1/05 when he refused further visits; the nurse was notified. The clinical record lacked documentation to support that the nurse conferenced with the patient regarding the importance of PT since the patient's skin integrity was compromised and deteriorating.

The patient's health status continued to deteriorate and he became increasingly depressed. The MSW evaluated the patient on 6/19/05 and identified that the patient's emotional and behavioral status was poor, he had an apathetic attitude, mood was depressed and sad and the patient was grieving due to illness, was extremely fatigued due to medications. The patient's ability to cope was inadequate. The MSW visited the patient on 7/6 and 7/19/05 and noted that the patient was depressed, exhibited frustration and he was withdrawn with a blunted affect and had a dull and gloomy character.

PT was referred again and evaluated the patient on 7/7/05 and noted on her evaluation visit and subsequent visits that the patient was emaciated, had contractures, was bedridden, had disuse atrophy and very weak.

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The clinical record lacked documentation that the nurse, MSW, PT, family, patient and ALF staff conferenced regarding the patient's deteriorating health status and or developed a plan based on mutual goals for the patient.

RN # 2 stated on 8/8/05 that although the record lacked documentation regarding interdisciplinary conferences, she did speak with the PT and MSW.

The nurse failed to document interdisciplinary conferences with all persons involved with the patient's care and/or to develop an interdisciplinary plan of care addressing the patient's resistance to care and non-compliance with instructions.

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

7. Based on observations, clinical record review and staff interviews for one (Patient #3) of four patients with pressure sores, the agency failed to failed to inform the physician of changes in the patient's condition. The findings include:
 - a. Patient #3's start of care was 4/28/05 with diagnoses including an open wound of the left buttock, a spinal fusion approximately 12 years earlier and left sided paralysis. The initial certification dated 4/28/05 to 6/26/05 identified that the patient was oriented with good memory, incontinent of bowel and bladder, able to partially weight bear, required daily wound care by a skilled nurse (SN) and home health aide (HHA) services 1-2 times per day for personal care and showers. Skilled nursing visit notes regarding the wound located on the left buttock identified that: on admit on 4/28/05 that it was a stage III circular area measuring 3 x 3 x 4 cm with a small amount of purulent drainage and it increased to a stage IV measuring 4 x 3.3 x 4.9 with a red/purple wound bed on 5/16/05 and continued to be documented at that size through 8/11/05. Pain assessments completed on 4/28/05 and repeated on 8/12/05 identified that although the patient did not always have pain, on a scale of one to ten with ten being the worst pain, it had increased from a 2 - 3.5 to an 8 especially during procedures and, although nursing note interventions identified every two hour turning and toileting, the patient was unwilling to lie on the right side for longer than a few minutes required for the dressing change, and there was no nursing staff in the building from 11:30 PM to 7:00 AM to toilet and/or attempt to change the patient's position. During an interview with the patient's physician, Physician #2, on 8/10/05 at 1:30 PM, he stated that he had not been made aware that the patient was unable to turn on the right side because of continual pain and that the wound was causing discomfort when she was sitting up. The agency failed to notify and/or coordinate care with the physician regarding the patient's pain, inability to turn independently and/or off the left side where the stage IV wound was located, and nocturnal incontinence with no caregiver to provide incontinent care. During an interview with RN #1/SALSA on 9/23/05, she was able to provide evidence that the physician was notified of the change in the size of the wound on 5/16/05.

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

8. Based on clinical record review, staff interviews and home visit observation, it was determined that for three (3) of four (4) patients who were provided wound care, the nurse failed to consistently and/or accurately reassess and/or to document the reassessment of the patient's health status and nursing needs (Patient #s 3, 9,10). The findings include:

a. Patient #3's start of care was 4/28/05 with diagnoses including an open wound of the left buttock, a spinal fusion approximately 12 years earlier and left sided paralysis. The initial certification dated 4/28/05 to 6/26/05 identified that the patient was oriented with good memory, incontinent of bowel and bladder, able to partially weight bear, required daily wound care by a skilled nurse (SN) and home health aide (HHA) services 1-2 times per day for personal care and showers. A care plan dated 4/28/05 identified problems of self-care deficits for bathing and hygiene with a goal of assisted self-care; skin integrity with a goal of wound healing and closure; and reflex incontinence with a goal to maintain skin integrity. The plan of care dated 4/28/05 to 6/26/05 directed to irrigate the left buttock wound with ½ strength H2O2 and normal saline (NSS), rinse with NSS, pack with aquacell and cover with a sterile 2x2 daily. The only skilled nursing visit notes regarding the size and condition of the wound located on the left buttock identified that: on admit on 4/28/05 it was a stage III circular area measuring 3 x 3 x 4 cm with a small amount of purulent drainage; on 5/2/05 it remained a stage III, 3 x 3 x 4 cm with a moderate amount of purulent drainage; on 5/4/05 it was a stage IV measuring 3 x 3 x 4.9 cm with tan, purulent drainage; on 5/16/05 it was a stage IV measuring 4 x 3.3 x 4.9 with a red/purple wound bed. Skilled nursing notes dated 5/24/05 identified an incontinence assessment noting that the patient's functional incontinence could be deferred by scheduled time voiding but that the patient uses 2 underpads and three adult diapers per day. On 5/29/05, the stage and measurements of the left buttock wound were the same but the wound was identified as non-healing, the surrounding skin was blistered and the dressing had a moderate amount of tan drainage and was saturated and soiled (there was no identification of what soiled the dressing). Additionally there was a lesion on the right buttock which was identified as blistered and excoriated, was 2 x 0.5 cm with a small amount of serosanguinous drainage. On 5/30/05 the wounds were unchanged. Intervention through this period identified the technique for daily wound care. On 6/3/05 a skin assessment identified that the open area on the right buttocks had healed, that the coccyx was red and intact, skin was cool, purple colored and moist; interventions included to turn with a turning sheet every two hours and support with a pillow and air mattress. Prior to 6/3/05, there was no documentation in the clinical record identifying that preventive measures/interventions had been implemented (see G 175). On 6/3/05 it was also noted that the patient used a power wheel chair to assist with mobility. A skilled note dated 6/3/05 and written by the home care nurse, RN #1, who was also the supervisor of the assisted living services agency (SALSA) identified no change regarding the left buttock wound but identified that the patient was to request pain medication from her physician and/or to ask nursing to assist further if the need for pain med noted. Notes and measurements on 6/10, 6/23 and 6/24/05 reflected no change in the size of the wound. A plan of care dated 6/27/05 to 8/25/05 directed to change the wound care procedure to irrigate with NSS,

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pack loosely with sterile 2x2, cover with ABD pad, 4x4, and address and apply duoderm (or similar) to excoriated areas. On 7/26/05, a wound vac was ordered to be applied to the left buttock wound and changed every 48 to 72 hours. Nursing notes dated 8/3, 8/8 and 8/11/05 continued to identify the wound as 4 x 3.3 x 4.9 cm with a moderate amount of tan wound drainage.

During a joint home visit observation of the patient on 8/3/05 at 1:45 PM, the patient was observed to be lying on her left side on an alternating pressure mattress covered by a sheet and a cloth incontinent pad; two aides assisted the patient to turn to the right side. It was noted that there was no dressing on the wound which was not measured. The wound vac dressing was applied and secured with tegaderm-like tape. The skin below the wound was reddish/purple in color. After the dressing change the patient was repositioned on the left side (lying on the wound) with a pillow supporting the back. During an interview with Patient #3, after the nurse had departed, she stated that it hurt to raise her head and grimaced several times while talking. She stated that she could only lie on her left side because of the pain from her spinal fusion, was unable to turn herself, spent from approximately 7AM to 1:30 PM and 3:30 PM to 8 or 9PM up in her electric wheelchair. She further stated that she had pain in her left buttock all the time she was up in the wheelchair, but had learned how to endure it; that she had talked to her physician about pain meds because the Neurontin made her feel strange, the physician had not ordered any other pain meds and the nurses had not asked her about it; that she was able to use the toilet with help from the aides but that there was no aide and/or nurse in the building at night from 11:30 PM to 7:00 AM so she was incontinent during that time and wore an incontinent brief. During an interview with the primary care nurse (RN #1) on 8/5/05 at 10:15 AM she stated that the patient was up in a wheel chair from 8:00 AM till 1:30 PM, went back to bed till 3:30 and was up from 3:30 PM till bed time; was toileted 4-5 times per day but that no one was available to toilet her at night (11:30 PM -7:00 AM); that she could not tolerate being on her right side because of pain; that she doesn't want a lot of meds and refused pain meds. During an interview with the Acting Agency Director on 8/8/05, she stated that the agency did not have a policy and procedure for wound care and/or incontinent care. During an interview with the patient's physician on 8/10/05 at 1:30 PM, he stated that although he had been made aware that the wound was getting bigger and gave the order for the use of the wound vac, he had not been made aware that the patient was unable to turn on the right side because of continual pain and that the wound was causing discomfort when she was sitting up. The Agency failed to re-evaluate the decline of the wound and/or to initiate preventive interventions; and/or did not follow the care plan regarding turning/positioning, and/or did not notify the physician regarding the patient's inability to turn due to pain and interventions to address the pain, and/or did not provide/coordinate the necessary care and services at night thus not ensuring the patient's safety at all times over the twenty-four hour period and leaving the patient in an unsafe situation and at risk for deterioration of her wound.

b. Patient #9 had a start of care date of 5/20/05 with diagnoses including multiple myeloma, right great toe wound, PVD, TIA, essential hypertension, BKA, and hypercalcemia. The plan of care dated 5/20/05 to 7/18/05 included skilled nursing 7x a week to provide instruction related to constipation, medications, nutrition/hydration, pain management and to provide wound care to the right great toe and interventions for mobility; home health aide 3x a week for safety problems. The nurse referred for a PT

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evaluation. Rehabilitation potential was noted as good. The summary to the physician dated 5/20/05 stated that the patient had a stage 2 circular wound of the right great toe which measured 0.6cm in length, 0.8cm. in width and 1.1 cm in depth and was cleansed with normal saline and Panafil spray was applied. The wound did not have any drainage or odor present. The patient had been hospitalized on 4/21/05 with dehydration and hypercalcemia, went to a rehabilitation facility and presently resided in an assisted living facility (ALF) with his wife.

The interagency referral form of 5/19/05 from the skilled nursing facility noted that the right great toe wound was healing well.

The comprehensive start of care assessment of 5/20/05 noted that the patient's appetite was fair, he was alert and oriented and without signs of depression, was independent with his medications, had moderate generalized weakness, did not feel fatigued, was a medium safety risk, needed assist with dressing and bathing but was able to toilet and transfer independently. The patient was chair-fast in a wheelchair but prior to hospitalization was ambulating with assistance using a prosthesis. The patient lived in an ALF with his spouse who only provided psychosocial support. PT was referred ASAP.

The nurse noted in her admission visit on 5/20/05 that she discussed with the patient his acceptance of resources and mutual goals and that he was in agreement and acceptance and compliance were good.

i. Review of the clinical record indicated that the nurse performed wound care daily and on 5/27/05 indicated that the patient complained of increasing fatigue related to a medication and was experiencing moderate depression due to frustration with the limits of his medical condition. The patient's appetite was noted as good and he dined out for meals. The patient complained of back pain as he spends most of his time in a wheelchair. The nurse reviewed the use of a cushion and importance of changing positions.

On 5/31/05 the nurse documented that the wound size of the toe had slightly increased, was a stage 2 with scant drainage and without odor. The nurse noted that a skin assessment of the entire body was completed.

On 6/1/05 the nurse indicated that the patient now had a partially opened stage 2 wound of the coccyx measuring 0.2cm x 0.2cm.x 0.1cm. No drainage or odor was present. The nurse was to apply duoderm q 3-4 days and as needed. The visit note lacked documentation that any preventative devices were in place and/or ordered for the patient except for a wheelchair cushion which was in place. The nurse's note lacked documentation as to the quantity of time the patient spent up in his wheelchair vs. in his bed.

Review of the PT evaluation of 6/1/05 indicated that the patient refused physical therapy, was sleeping on the couch and using a belt that was hooked up to a file cabinet to pull himself up to sit. The PT discussed the patient's resistance to PT at this time with the nurse. The clinical record lacked documentation that the nurse conferenced with the patient and/or family regarding the importance of PT for increased mobility and functional status in order to promote and/or to maintain adequate skin integrity and/or that a MSW referral was requested and/or that aide coverage was increased for positioning/nutrition.

On 6/2/05 the nurse noted that the patient had 2 new areas on the coccyx which were reddened and excoriated. The nurse continued to instruct the patient to rest in bed during the day and the importance of diet supplements but the record lacked documentation to support if the patient's bed had a pressure

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relieving mattress and/or how many hours the patient was up in his wheelchair/bed and the amount of supplements taken per day and/or a dietary log. She did note that compliance was now poor related to instruction.

The 6/4/05 nurse's note indicated that the coccyx wound was a stage 2 measuring 1.2 x 1.0 and duoderm was applied q 3-4 days

Review of the daily nurse's notes from 6/4/05 to 6/17/05 lacked documentation that the coccyx decubitus was measured and staged. The nurse's note of 6/14/05 noted that the dressing to the sacral spine fell off in the shower and the area appeared very irritated and scabbed over. The hydrocolloid dressing was reapplied. The client was diagnosed with Shingles on 6/9/05 and treated with Famvir. The patient's appetite was now identified as poor, the patient was depressed and MSW was referred on 6/13/05. The clinical record lacked documentation to support that the nurse quantified the patient's nutritional/hydration statuses and/or urinary output and/or addressed that the patient was sleeping on the couch and/or his functional status or positioning routine. Additionally, the toe wound treatment had not been changed since readmission on 5/20/05 despite the fact that the wound was not responding and was getting worse.

On 6/18/05 the nurse noted that the coccyx wound was now 8.0cm.x 8.0cm.and the wound character was necrotic, with eschar, foul smelling and in need of debridement.

The right toe wound was still noted as a stage 2 decubitus measuring 1.2cm.x 1.0cm.x 0.2cm on 6/10/05. The physician stated on 8/25/05 that he saw the patient on 6/14/05 for the right toe wound and considered amputation. The right toe wound was not measured again until 6/20/05 when the nurse noted that the right toe wound had increased in size to 2.5cm. x 3.0cm. x 1.0cm. and no improvement was noted in the sacral decubitus. The treatment for the toe wound was still the same; a referral was initiated with a wound clinic.

On 6/22/05 the nurse noted that the right toe and coccyx wounds were not healing, the coccyx wound was cultured and the nurse called the physician to report a decline in status and general concerns.

The clinical record from 5/20/05 to 6/22/05 lacked documentation to support that the nurse increased the frequency of the home health aides and/or adjusted the patient's care plan in response to the patient's decline in his health status.

The nurse's note of 6/23/05 identified the patient's right toe wound was now a stage 3 and the nurse conferenced with the patient's physician who recommended 24-hour coverage either by a paid attendant or hospitalization.

On 6/24/05, the wound clinic ordered Accuzyme daily to sacral decubitus, Iodiflex paste and Algisite qod to right great toe, calorie count for 3 days, Hill-rom bed ASAP, elevate right foot at all times and waffle boot to right foot.

On 6/26/05 the nurse identified the sacral wound as now a stage 4 and the right toe as a stage 3 and noted on 6/27/05 that the patient had a private aide who prepared his meals, supplemented by Boost, provided immobility care with repositioning q 2 hours and provided elevation of his extremities. The record lacked documentation regarding the quantity of the nutritional supplements/hydration and or nutritional intake.

On 7/9/05 the nurse indicated that the right toe had eschar, was foul smelling and by 7/11/04 the right toe was a stage 4 and measured 2.8 x 3.2 x 2.0; bone exposure was noted. A new area with blisters and

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a black and blue color was also identified on the right lateral aspect of foot.

The nursing visit of 8/1/05 noted that the lateral aspect of the right foot was still a stage 1 area and healing. Wound care to this area consisted of Silvadene.

Review of the clinical record from 7/5/05 to 8/1/05 lacked documentation that the nurse consistently and accurately reassessed the patient's psychosocial status/depression and the effect on his wound healing.

The PT evaluation on 7/7/05 noted that the patient was bedridden, had poor functional endurance and had disuse atrophy. On 7/8 and 7/11/05 the PT noted that the patient had contractures of the RLE and left stump and was weak and emaciated and was unable to do most activities independently.

ii. The patient was noted on admission to have a problem with constipation. The nurse visited the patient daily for wound care. On her visit of 6/13/05 the nurse identified that the patient had not had a bowel movement since 6/7/05 and the physician ordered lactoulose. The clinical record lacked documentation that the nurse assessed the patient's constipation for 6 days (from 6/7/05 to 6/13/05).

iii. On 8/8/05 RN #2 stated that the patient had a stage 2 toe decubitus when he returned from the hospital. She was not sure why the patient was not ambulatory although he did have a prosthesis that he did not use. He was admitted to the hospital for dehydration and hypercalcemia and was then diagnosed with multiple myeloma. She described the patient as alert and oriented, very resistant and not compliant. She did not increase aide coverage since he was getting aide coverage every other day from the assisted living facility. She stated that she instructed the patient to get off his decubitus. RN #2 stated that he could not be weighed and that his nutrition was good or else the staff in the dining room at the ALF would report on his intake. The patient would tell the nurse he was complying with position changes and nutritional supplements but RN #2 stated that you knew he would continue to sit in his chair. The patient's wife was not able to assist the patient due to osteoarthritis. The patient was resistant to a hospital bed, mattresses etc., since he did whatever he wanted to do and slept on the couch; the nurse did not document the specific resistance and/or that the patient was sleeping on the couch. RN #2 stated that she was on vacation when the coccyx wound deteriorated. The patient was deteriorating and had increased fatigue due to the thalidomide therapy for the myeloma. He wanted to die at the point of referral to the wound clinic but now his attitude has changed.

iv. The nurse at the wound care clinic stated on 8/25/05 that the patient was not seen at the wound care clinic following his 4/14/05 hospital admission until 6/24/05. The coccyx decubitus could not be staged on that date due to eschar. On 7/19/05 following chemical debridement the coccyx decubitus was staged as a stage 4 at the wound care clinic.

v. During a joint home visit on 8/29/05 with the SALSA, wound care was done for the sacral wound and it was noted that the area was healing. The toe was wrapped in a kerlix covered dressing to protect a skin graft that was done two weeks ago. The client was on a Hill-rom air mattress on top of a hospital bed and was lying on his side. There was a gel cushion approximately four inches thick in his wheelchair. During an ensuing discussion, the client stated that he was always willing to turn and do things he was told to do but at one point he had become very depressed and "let himself go". The turning point for him was when the doctor and his son told him he might have to have his foot amputated. During an interview with the SALSA on 8/29/05 at 3:10 PM she stated that while the client could have benefited from more services, he was unwilling to pay for them. She stated that he had a

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history of being non-compliant and although she occasionally talked to the family she did not coordinate a family conference and/or get a social worker involved to facilitate the process early on. She was also unable to say why the physician was not consulted about a different treatment for the toe and sacral wounds and/or why an earlier referral to the wound clinic was not obtained.

The nurse failed to implement preventative measures initially for a patient who was non ambulatory, recently diagnosed with multiple myeloma, had a stage 2 decubitus on his right toe on admission, slept on the couch and ate his meals in a ALF dining room. The nurse failed to quantify the patient's nutritional and hydration statuses and to assess the patient's response to teaching. She failed to revise the plan of care when a new pressure area was identified on his coccyx and/or failed to routinely measure his decubiti to identify wound status and progress toward healing (coccyx decubitus deteriorated from a stage 2 to a stage 4 in 2 weeks) and/or to obtain different wound treatment orders and/or to get an earlier referral to the wound clinic. The agency did not have a wound care policy. The nurse failed to have a conference and/or to document conferences and/or to coordinate care with the MSW, PT, ALF staff, patient and family regarding Patient #9's resistance to care, non-compliance and mutual goals for the patient.

c. Patient #10 was admitted to the agency on 5/7/05 with diagnoses including status post resection arthroplasty of the right knee with draining right knee wound infected with MRSA and status post total knee replacement. The plan of care dated 5/7/05 to 7/5/05 ordered skilled nursing visits 5 to 7 times per week to perform wound care daily; wound care to include remove dressing and cleanse wound with sterile saline solution, cover with Xeroform and apply ABD pad and super sponge as a second dressing and secure with 4 inch ace bandage with kerlix; perform nursing interventions for pain management; physical therapy to evaluate and treat.

The nursing narrative note dated 5/8/05 documented that Patient #10 had a partially open surgical wound, 1.5 centimeters in length, 1.0 centimeters in width, and 0.5 centimeters in depth; wound character was blistered with moderate amount of red wound drainage present; two additional raised blisters distal to draining blister.

The nursing narrative note dated 5/9/05 documented that Patient #10 had a "surgical stage 3 wound", a moderate amount watery red drainage, swelling observed around incision area and warm to touch, wound is healing.

The nursing narrative note dated 5/17/05 documented Patient #10 had "blister surgical wound", crusting edges, moderate amount of watery serosanguineous wound drainage, moderate painful tenderness sensation, swollen area warm to touch. The orthopedic surgeon saw Patient #10 yesterday (5/16/05) and Patient #10's wife stated that the surgeon popped the blisters. Blisters intact but appear partially deflated."

The nursing note dated 6/3/05 documented that Patient #10 had "open wound, painful sensation to area, swollen and warm to touch, blisters have expanded in size, large one is 3cm by 2cm and 1cm in height and the small blister is 1cm by 0.5cm by 1cm in height."

The nursing note dated 6/6/05 documented that Patient #10 had a large amount of increased viscous dark red wound drainage, patient feeling pins and needles sensation to area, swelling observed medially and proximal to wound, swollen area warm to touch, dressing saturated. Spoke with Physician #1's

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Office Manager to advise him of increased drainage where there has been none.

The nursing narrative note dated 6/8/05 documented large amount of unchanged dark red, bright red wound drainage, moderate painful feeling of pins and needles with numb sensation to area, swollen area warm to touch, circumference of upper knee is 17inches, and the lower knee is 16inches. Patient #10's wife called the surgeon to report the increased drainage.

The nursing narrative note dated 6/13/05 documented that Patient #10 had a large amount of bright red wound drainage, painful feeling of pins and needles to area, swollen area warm to touch, dressing saturated, wound not healing. Patient saw Physician #1 on 6/10/05, and told Patient #10 that his leg must be amputated or bone fused, there can be no total knee replacement.

On interview 8/8/05, RN #1 stated that she did not speak directly with Physician #1 about the changing wound status and/or perhaps the need to alter the patient's plan of care to address the progression of the wound; RN #1 stated that the physician did not return her calls, that is why Patient #10's wife would call the physician, he would respond to her calls. RN #1 stated that surgeons are usually operating and do not return their phone calls.

RN #1 stated that she was only employed by this agency for the past two months and is in the process of learning the computer system and that is why she began documenting that the wound was not healing starting in June 2005, because she just found the proper key entry to use, in the documentation of Patient #10's wound care.

On interview 8/8/05, the Acting Clinical Supervisor stated that Physician #1 does not usually return his calls.

On surveyor inquiry of the agency's wound management protocol, the Acting Director of the Home Care Agency stated that the agency does not have a wound care policy, it is left to nursing judgement. The registered nurse failed to accurately re-evaluate and/or document re-evaluation of the patient's current and/or continuing nursing needs and/or failed to notify the physician of changes in the patient's condition that may suggest the need to alter the plan of care and/or the agency failed to develop policies and procedures related to wound care management.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71(a)(5) Personnel policies.

9. Based on review of the home health aide (HHA) personnel files, it was determined for two (2) of three (3) recently hired home health aides, the agency failed to obtain a pre-employment statement from the physician that the employee was free from communicable disease prior to the assignment of patient care activities (HHA #s 2, 4). The findings include:

- a. For HHA #s 2 and 4, with a hire date of 5/23/05, the agency failed to have documentation that the employee was free from communicable disease prior to the assignment of patient care activities.
- b. On interview 8/8/05, the acting clinical supervisor stated that the employees did receive physical examinations, but the statement related to infectious disease was not included.