

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

IN RE: Home & Community Health Services, Inc. of Enfield, CT
d/b/a Enfield Visiting Nurse Association
101 Phoenix Avenue
Enfield, CT 06083

CONSENT ORDER

WHEREAS, Home & Community Health Services, Inc. d/b/a Enfield Visiting Nurse Association (hereinafter the "Licensee"), has been issued License No. C80187 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on January 30, 2006 and concluding on March 27, 2006; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated April 3, 2006 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing, without admitting any wrongdoing and expressly denying liability, to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Alfred A. Lerz, its President, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Agreement the Supervisor of Clinical Services shall develop and/or review and revise, as necessary, policies and procedures related to:
 - a. Pressure ulcers;
 - b. Development, implementation and revision of the plan of care;

- c. Policies and procedures including, but not limited to, wound care management, cardiovascular disease management, mental health/psychiatric care and management;
 - d. Mobility status and needs, referral for medical social work services, medication administration, coordination of services including services provided in collaboration with all agency staff and other entities involved in care to the patient; and
 - e. Role of the home health aide related to pertinent aspects of the patient's condition to be observed and reported to the nurse, teaching and supervision.
2. Within thirty (30) days of the execution of this Consent Agreement all Facility nursing staff, including home health aides, shall be inserviced, to the policies and procedures identified in paragraph number 1.
 3. Within thirty (30) days the Facility shall contract with a registered nurse who has credentials in wound care management. The Wound Care Consultant (WCC) shall serve a minimum of twenty (20) hours a week for a two (2) month period and shall assess and audit the clinical records and plans of care of all current patients requiring wound care management, review agency policies/procedures pursuant to wound care management, evaluate the implementation of the agency's wound care management procedures, conduct training, provide oversight to nursing and all direct patient care staff, maintain weekly statistics, observe all pressure sores, and monitor preventative protocols.
 4. The Department shall retain the authority to extend the period of the Wound Care Consultant functions as required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers and wounds.
 5. The WCC contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity and an assessment and/or recommendations. Said reports shall also be forwarded to the agency's Professional Advisory Committee and governing authority for review and evaluation at their next scheduled meeting.
 6. The WCC shall have a fiduciary responsibility to the Department.

7. The Licensee shall within thirty (30) days of the execution of this Consent Order incorporate into the agency's current quality assurance program, a quarterly clinical record review program to consist of a random audit of fifteen per cent (15%) of the agency's current patient caseload who require wound care management services.
8. The Licensee shall within ninety (90) days of the execution of this Consent Order 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.
9. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
 - a. Sufficient nursing personnel are available to meet the needs of the patients and to promote coordination and continuity of care;
 - b. 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;
 - c. 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 change in patient's condition and/or deteriorating health and/or safety status;
 - d. All services provided to patients shall be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care and shall be integrated with all other entities involved with the patient's care. All coordination activities shall support effective communication and interchange and be reflective of effective case management;
 - e. All medications shall be administered only as ordered by the patient's physician and all discrepancies in medications shall be clarified with the physician prior to administration and/or pre-pour;
 - f. All home health aides are properly trained, oriented and supervised in the care of each patient;
 - g. Home health aide assignments accurately reflect patient needs;

- h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status; and
 - i. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice.
10. Supervisor(s) of Clinical Services shall be provided with the following:
- a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
 - b. A training program which clearly delineates each clinical supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation; and
 - c. Supervisor(s) of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans and standards of practice.
11. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
12. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand dollars (\$2,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

13. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
14. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
15. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
16. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
17. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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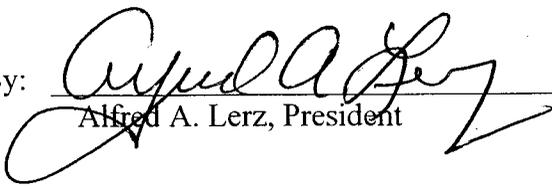
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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

HOME & COMMUNITY HEALTH SERVICES,
INC. OF ENFIELD, CT - LICENSEE

6/23/06
Date

By: 
Alfred A. Lerz, President

STATE OF Connecticut

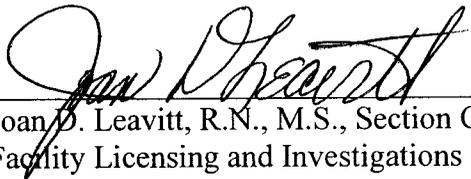
County of Tolland) ss June 23, 2006

Personally appeared the above named Alfred A. Lerz, President and made oath to the truth of the statements contained herein.

My Commission Expires: 05/31/2010
(If Notary Public) 
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

6/27/06
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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April 3, 2006

Nancy Thompson, RN, Administrator
Home & Community Health Services, Inc.
101 Phoenix Avenue
Enfield, CT 06083-1199

Dear Ms. Thompson:

Unannounced visits were made to Home & Community Health Serviv, Inc. on January 30, 2006, February 3, 28, March 1, 2, 3, 6, 7, 8, 9, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and licensing inspection with additional information received through March 27, 2006.

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

An office conference has been scheduled for April 19, 2006 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,

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

SNC:NC:

- c. Complaint # CT 5046
Elizabeth Andstrom, RN, SNC



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
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

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

1. The governing body failed to assume responsibility for the services provided by the agency to ensure the safety and quality of care rendered to Patient #s 1, 10, 12, 13, 15, 16, 17, 18, 19, 22, 23, 27 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 and maintain the quality of care and services rendered to Patient #s 1, 10, 12, 13, 15, 16, 17, 18, 19, 22, 23, 27 and their families as evidenced by the violations listed in this document.

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

3. The supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and their families by direct service staff as evidenced by the care and services rendered to Patient #s 1, 10, 12, 13, 15, 16, 17, 18, 18, 22, 23, 27 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(2) Services and/or D73(b) Patient care plan.

4. Based on clinical record review and staff interviews, for one patient, Patient #1, the agency failed to assess the patient in accordance with the patient's plan of care. Findings include:

a. Patient #1 had a start of care date of 2/6/02. Patient #1, who was chair bound, had diagnoses that included spinal bifida. The plan of care for certification period 9/18/05 through 11/16/05 directed skilled nurse (SN) visits 1-3 times weekly and 3 as needed visits. The SN plan of care included assessment of skin integrity.

Homemaker-Home Health Aide (H-HHA) visits were 5-7 times weekly, 1-1.5 hours in the AM and 1

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hour in the PM to assist the patient with tasks that included personal care.

The patient's medical history included a stage III right ischial decubitus, status post (s/p) flap that healed prior to the patient's admission to the agency.

The re-certification OASIS/comprehensive assessment dated 5/20/05 identified that Patient #1 was chairfast, had very limited ability to respond meaningfully to pressure related discomfort and very limited ability to change body position.

RN #1, Case Manager, stated that she visited Patient #1 on 9/23/05 to assess the patient and conducted a H-HHA supervisory visit. Although RN #1 stated that she assessed an open area on the left great toe, she assessed the patient's skin area related only to that issue and did not conduct a full body skin audit because it was impossible to do. As part of peri care, the H-HHA's were expected to observe the patient's skin, including the sacral area and no signs or symptoms of pressure areas were reported by the H-HHA's or the patient.

H-HHA documentation was reviewed from 9/1/05 through 10/8/05. H-HHA's #3, #5, #6, #7, and #8 stated upon interview on 2/3/06 that they did not provide peri care for Patient #1. The patient either refused peri care or did it herself and no observations of the patient's skin regarding her buttocks were done.

Nurses progress notes dated 8/31, 9/9, 9/21, 9/28 & 10/5/05 identified that the skilled care provided included an assessment of the patient's skin integrity.

Nurses notes of 9/28 and 10/5/05 identified that the patient's skin was pink, warm and dry and intact. LPN #1 stated that she visited the patient on 9/28/05 and 10/5/05. Although the nurses progress notes of 9/28/05 identified the patient was in bed, LPN #1 stated she didn't have time to assess the skin on the patient's buttocks or sacral area because the patient immediately got out of bed. Although she documented that the patient's skin was intact, LPN #1 stated the documentation addressed the patient's toe, face, hands and legs. LPN #1 did not assess the patient's buttocks or sacral area on 10/5/05 because the patient was already dressed and out of bed.

Nursing notes of 10/6/05 identified the patient with a 1.2 X .08 cm right inner leg abrasion. LPN #2 stated that she visited the patient on 10/6/05 to check an area on the patient's right lower leg. The patient did not report any abnormal issues with her skin and there was no indication to conduct a skin assessment of any other areas.

Nurses progress notes of 10/8/05 identified the patient with a 9 X 10 cm stage III open area of the right buttock. The wound was foul smelling, had tan slough and was bleeding. 911 was called and the patient was transported to the hospital emergency department.

H-HHA #2 stated that when she visited the patient on 10/8/05 she observed that Patient #1 had an open area of the coccyx that was the size of a grapefruit. The area was bleeding, had a foul odor with green drainage and she notified RN #2.

LPN #3 stated that RN #2 requested that she visit Patient #1 on 10/8/05 to assess an area on the patient's buttocks. LPN #3 observed a 9 X 10 cm wound of the sacral area. The wound was foul smelling, had sero sanguinous drainage and tan slough. Patient #1 was upset and crying, her temperature was 100.1 and pulse was 120. LPN #3 called an ambulance and the patient was transported to the hospital.

The patient's hospital emergency record dated 10/8/05 identified Patient #1 with bilateral stage IV

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gluteal decubitus ulcers. The right gluteal ulcer measured 10 X 7 cm with necrotic tissue which was foul smelling and extended all the way to the bone. The left gluteal ulcer measured 6 X 5 cm with necrotic tissue and slough. Debridement was done and the patient was administered IV antibiotics. The patient was subsequently admitted to the hospital. A review of the hospital record revealed that following an assessment by a plastic surgeon, it was determined that the option of reconstruction was not possible as there was bone involvement. The patient was transferred to a skilled nursing facility on 10/19/05 for wound care and antibiotic therapy and expired in January 2006.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-1069(a)(3)(C) Services.

5. Based on clinical record review and staff interviews, it was determined that for two (2) of twenty-five (25) patients, the nurse failed to maintain liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care (Patient #'s 10, 12). The findings include:

a. Patient #10 had a start of care date of 12/14/05 with diagnoses including diabetes mellitus type 2, open wound to lower leg, cellulitis, "chronic airway obstruction" and hypertension. The plan of care dated 2/12/06 to 4/12/06 ordered skilled nursing 3 to 5 times per week to assess vital signs, cardiac status, respiratory status, assess edema to lower extremities, skin integrity, and diabetic status. Skilled nurse to provide wound care to LLE per wound care protocol 3 to 5 times per week; may shower, wash legs with soap/water, apply Aquaphor to both legs, apply Aquacel to wound base, cotton batting, Tubigrip followed by lymphedema pump sleeve. Review of the physician orders dated from 12/14/05 to 2/7/06 documented that the "pressure boots" (lymphedema pump) were to be held on 12/14/05 and 1/30/06 and then to resume the use of the lymphedema pump on 12/30/05 and again on 2/7/06. Evidence was lacking within the home care record to verify that the boots were applied and/or removed as ordered by the physician. On interview 3/7/06, RN #12 stated that Patient #1 was also receiving care and services through the assisted living program at the managed care facility in which Patient #10 resides. Although RN #12 stated that she frequently reviews Patient #10's plan and care with the SALSA (Supervisor of Assisted Living), documentation was lacking in Patient #10's clinical record that coordination of services occurred with the ALSA to ensure that the lymphedema pumps were implemented and/or withheld in accordance with the physician orders in the plan of care and/or documentation was lacking of the outcome of the treatment modality for the utilization of the lymphedema pumps.

b. Patient #12 had a start of care date of 1/20/06 with diagnoses including abnormality of gait, total hip replacement, congestive heart failure and organic brain syndrome. The plan of care dated 1/20/06 included skilled nursing to assess vital signs, cardiopulmonary, GI, GU, behavioral statuses, skin integrity, diabetic status, activity and management of pain; referral for OT and PT was ordered.

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Medications ordered included lisinopril, coreg and lasix for hypertension and edema.

The nursing admission note of 1/20/06 identified the patient's blood pressure was 114/80 and listed his weight at 135 pounds as stated by wife who weighed him daily due to a history of CHF.

Review of the skilled nursing visits from 1/20/06 to 2/28/06 (the discharge visit) identified that six (6) different nurses completed the patient's nine (9) nursing visits. The patient's BP ranged from 98/50 to 132/60. On 2/28/06, the patient was discharged from nursing services with PT still active. The patient's BP on discharge was only 98/52.

RN #8 stated on 3/8/06 that although the patient's BP was 98/52 on discharge, PT was still active with the patient and the patient was not taking in many fluids. Review of the PT notes indicated that the PT never checked the patient's BP during her visits. The nurse stated that she did not inform PT on nursing discharge that the patient was hypotensive.

The nurse failed to communicate and/or coordinate with the PT at nursing discharge to assess the patient's BP since the patient was hypotensive on discharge and was taking anti hypertensive medications.

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

6. Based on clinical record review, staff interviews, home visits and agency policy, it was determined that for eight (8) of thirty-two (32) patients the nurse failed to consistently and/or accurately reassess the patient's health status and/or nursing needs and/or to provide services per the plan of care (Patient #s 1, 12, 13, 15, 16, 17, 19, 22). The findings include:

a. Based on clinical record review and staff interviews for Patient #1, the facility failed to accurately re-evaluate the patient's status and/or nursing needs regarding skin assessments. Please refer to violation #4.

b. Patient #12 had a start of care date of 1/20/06 with diagnoses including abnormality of gait, total hip replacement, congestive heart failure and organic brain syndrome. The plan of care dated 1/20/06 included skilled nursing to assess vital signs, cardiopulmonary, GI, GU, behavioral statuses, skin integrity, diabetic status, activity and management of pain; referral for OT and PT was ordered; medications ordered included lisinopril, coreg and lasix for hypertension and edema. The nursing admission note of 1/20/06 identified the patient's blood pressure was 114/80 and listed his weight at 135 pounds as stated by wife who weighed him daily due to a history of CHF. Review of the skilled nursing visits from 1/20/06 to 2/28/06 (the discharge visit) identified that six (6) different nurses completed the patient's nine (9) nursing visits. The patient's BP ranged from 98/50 to 132/60. The patient's weight on the admission was 135lbs. as stated and on 2/5/06 was 145lbs. actual which appeared to be a 10 lb. weight gain in 3 weeks; the nurse instructed the wife to weigh the patient with the same clothes on and at same time and instructed the wife in s/s of CHF. The clinical record

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lacked documentation to support that the nurse established the accuracy and/or significance of the patient's weight gain and/or notified the physician regarding the weight gain. The patient's weight was not identified on the next visit of 2/9/06 but on 2/14/06, the patient's weight was documented as 142 lbs. (not identified as actual or stated).

The patient was not visited on 2/21/06 as was projected on the 2/14/06 visit note but was visited on 2/28/06 and discharged that day from nursing services with PT still active. The patient's BP on discharge was only 98/52, FBS was 203 and his weight was not documented. RN #8 stated on 3/8/06 that although the patient's BP was 98/52 on discharge, PT was still active with the patient and the patient was not taking in many fluids. Review of the PT notes indicated that the PT never checked the patient's BP during her visits. The nurse stated that she did not inform PT, on nursing discharge, that the patient was hypotensive. RN #8 stated that she was not aware that the patient had gained 10 lbs in 3 wks. She had not identified with the physician any parameters for weight gain and/or blood sugars. She felt the patient was stable on discharge.

The nurse failed to accurately and/or consistently assess the patient's change in weight and BP in a patient with a history of CHF and presently taking medications for his hypertension and fluid retention.

c. Patient #13 had a start of 2/24/06 with diagnoses including abnormality of gait, pelvic fracture, edema and osteoarthritis. The plan of care dated 2/24/06 included skilled nursing 1-3x a week to assess vital signs, cardiopulmonary status, skin integrity, mentation, pain, activity tolerance, home safety, medication regime, diabetic management and to perform wound care two times a day by applying baza cream to open areas in the patient's gluteal fold; the RN was to teach medication regime, home safety and wound care to the caregiver. Decubitus ulcer to the gluteal fold was not listed as a diagnosis on the physician's plan of care of 2/24/06.

The admission nursing note of 2/24/06 indicated that the patient had fallen and fractured her pelvis and right wrist and ambulated with a walker. The nurse documented that the patient had a stage 2 blister on her left gluteal fold and baza was applied. The nursing note lacked documentation to support that the nurse taught the patient's caregiver wound care, failed to identify the need for preventative devices and failed to identify a diet consistent with wound healing. The wound care protocol dated 2/24/06 stated to apply baza cream to stage 2 ulcer in gluteal fold. The wound assessment and documentation sheet on 2/24/06 listed the wound measurement and description. On the subsequent visit of 2/26/06, the nurse failed to assess the patient's gluteal ulcer. On 3/1/06, the nurse documented that she instructed the caregiver on skin care and described the area on the gluteal fold as a scaly patch; the nurse failed to measure and/or to accurately describe the ulcer. The nurse failed to assess the patient's mobility regime and/or need for preventative devices i.e., cushion for chair/mattress for bed. The nurse visited the patient on 3/3/06 due to a possible URI and did not document an assessment of her gluteal wound. On a client care note of 3/5/06 the nurse spoke with the patient's daughter who reported that the patient had an open area on her buttocks and the nurse was to make a visit on 3/5/06 instead of 3/6/06. The nursing note of 3/5/06 stated that the patient had a pea sized open area in her left buttock region from scratching; she applied duoderm for protection. The clinical record lacked documentation to support that the nurse accurately described the wound and/or spoke with the physician regarding the application of duoderm. Subsequent to surveyor's inquiry, an order was sent to the physician on 3/8/06.

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During a home visit to the patient with the PT on 3/1/06, the surveyor observed that the patient was sitting in a recliner without a special cushion, had difficulty ambulating with the walker due to her fractured pelvis and wrist and was alert but forgetful.

Review of the aide's care plan noted that the care plan had been signed by the nurse as reviewed and revised on 2/20/06 but had not been updated after her ER visit, fall and newly acquired skin breakdown. The patient's case manager, RN #4, stated on 3/6/06 that she did not admit the patient and did not visit the patient until 3/1/06. She stated that on 3/1/06 she did instruct the patient's daughter on the wound care and did assess the wound. She did not instruct the daughter on increasing her protein, vitamin C intake etc. to promote wound healing and did not test the patient's BS since the patient had a monthly blood test per her physician. She did not assess for preventative devices because she did not think Medicare would reimburse for a cushion. She stated that the patient usually ambulated to the commode every few hours and took a nap in the afternoon.

RN #5 who visited the patient on 2/26/06 and 3/5/06 stated on 3/6/06 that she did not assess the patient's gluteal ulcer on 2/26/06 since she was more concerned with her safety. On 3/5/06, she noted that the patient had a pea size opening in her gluteal area. She stated that she did not document that it was like a scab and did not have any drainage present. She called the physician's answering service to inform the physician about the duoderm but she had not yet sent an order out to the physician.

Subsequent to surveyor's inquiry, an order for the duoderm was sent to the physician on 3/8/06.

Subsequent to surveyor's inquiry, RN #4 visited the patient on 3/7/06 and documented wound measurement/description, nutritional teaching and proper positioning.

The nurse failed to consistently and/or accurately assess the patient's wound, nutritional status, mobility and the need for preventative devices.

d. Patient #15 had a start of care date of 2/18/06 with diagnoses including organic anxiety, chronic airway obstruction and senile depression following hospitalization in a psychiatric facility from 2/6/06 to 2/17/06. The plan of care dated 2/18/06 included skilled nursing 1-3x a week to assess general condition, vital signs, all systems, s/s of depression, behavioral status, diet, functional status, safety and teach medication regime. The patient was taking many psychiatric medications. The patient was visited on 2/18, 2/20, 2/24, 2/27/06 by four (4) different nurses and her chief complaint was uncontrolled anxiety. The clinical record lacked documentation to support that a psychiatric assessment was completed and/ or that a mini mental test was performed and/or that the patient's psychiatric complaints and medications were assessed. The patient's children provided 24-hour care due to her being a safety risk.

On a home visit to the patient on 3/1/06, the patient told the surveyor that her only complaint was uncontrolled anxiety, which the patient's daughter stated she has had most of her life.

SCS #1 stated 3/7/06 that the patient was very appropriate for the psychiatric program and she would be evaluated for their psychiatric program.

Subsequent to surveyor's inquiry, the patient was assessed, including her anxiety level, by a psychiatric nurse on 3/8/06 with appropriate suggestions to the patient and/or family for coping skills and/or some suggestions for decreasing anxiety.

SCS #1 stated on 3/27/06 that the patient's diagnoses and the availability of behavioral health nurses

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assist the agency in determining if a patient is admitted to the behavioral health program. She stated that although Patient #15 had been discharged from a psychiatric facility, she had the diagnosis of anxiety for 40 years.

The nurses failed to accurately assess the patient's health status and/or behavioral needs/medications.

e. Patient #16 had a start of care date of 1/5/06 with diagnoses including abnormality of gait, organic brain syndrome, malaise and fatigue, acute renal failure and fluid depletion. The plan of care dated 1/5/06 included skilled nursing 1-3x a week to assess general condition, all systems, behavioral status, hydration, home safety, environment and mobility; PT 1-3x a week and OT 1-3x a week were ordered. The patient was admitted from a skilled nursing facility. The admission comprehensive assessment of 1/5/06 identified the patient as having mental confusion, unsteady gait, lived alone; appetite was poor, yet the nutritional assessment was not completed; decision making was impaired, was weak, was a fall risk and ambulated with a walker. The admission nursing note of 1/5/06 listed the patient's services as nursing, PT, OT, HHA and MSW due to being a safety and fall risk, inappropriate use of walker, some memory impairment, and the need for transportation such as Dial-a-Ride. On the PT admission evaluation and the OT admission evaluation of 1/5/06 the need for Lifeline and MOW were identified due to the patient's unsteady gait, risk for falls and mental status.

Review of the clinical record identified that an order was sent to the physician for MSW to start on 1/5/06 and that the MSW did not commence until 1/15/06. The MSW noted in the admission note of 1/15/06 that the patient could benefit from Lifeline, MOW, transportation and may qualify for the Connecticut Home Care Program for the Elders (CHCPE); MSW to visit the patient 1-2x a month. The clinical record lacked any further MSW documentation and/or visits after 1/15/06. The nurse informed the MSW on 1/19/06 that the patient qualified CHCPE. The nursing note on 1/26/06 noted that the patient enjoyed her MOW, which she had been receiving for 2 weeks. The clinical record lacked documentation that the nurse assessed if Lifeline had been instituted and/or if transportation had been arranged.

RN #9 stated on 3/8/06 that she noted on her last visit that the patient had Lifeline. She stated that she had been trying to get CHCPE for the patient since admission and when she referred for MSW the patient had not as yet qualified. She did not know why the MSW did not initiate services until 1/15/06. The administrator stated on 3/9/06 that they are in the process of hiring an MSW because the current MSWs are per diem. Subsequent to surveyor's inquiry as to why there were no further visits from the MSW, an addendum was sent by the MSW on 3/8/06 for a note dated 1/15/06 that stated that the MSW called to start the process for CHCPE and learned that the patient was already a client and her case worker was referring for MOWs, Lifeline and transportation and a second MSW visit was no longer needed.

i. A client care note dated 1/31/06 stated that the agency received a call from the patient's aide which stated that the patient had fallen last week while putting pans away, bruises were noted with no other apparent injuries. The subsequent nursing visit on 2/2/06 noted that the patient had fallen last week with no apparent injuries except a bruise to right buttocks.

The administrator stated on 3/8/06 that an incident should be written for all witnessed or unwitnessed falls but an incident report regarding Patient #16's fall could not be found.

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RN #10 stated on 3/8/06 that she thought that the patient fell when cooking with her homemaker and she bent down to get a pan however she should have fallen forward and not backwards bruising her buttocks.

The nurse failed to assess safety measures initiated for the patient and the delay of MSW services and failed to accurately/comprehensively assess the patient's fall.

f. Patient #17's start of care date was 2/1/06 with diagnoses including abnormality of gait, congestive heart failure, volume depletion, gastroenteritis, acute renal failure, hypertension, cerebral vascular accident and atrial fibrillation. Documentation on the certification plan of care dated 2/1/06 to 4/1/06 ordered skilled nurse 1-3 times per week to assess general condition, vital signs, cardio-pulmonary status, gastrointestinal status, skin integrity and ability to perform activities of daily living (ADL) and instrumental activities of daily living (IADL); physical therapy 1-3 times per week for therapeutic exercise and gait training; ordered medications included Aspirin, Coreg, Lasix 40 mg daily and Potassium Chloride. Documentation by RN #4 on the OASIS/comprehensive assessment dated 2/1/06 stated that this 81 year old patient lived alone, was independent in most ADLs, but required assistance to prepare meals and to manage his home; the patient's son was his primary caregiver (PCG) and lived in an adjoining home; RN #4 also identified that Patient #17's blood pressure was 124/70, weight was 220 pounds, cardio-pulmonary status was within normal limits, though dyspnea occurred when walking greater than 20 feet and that he had mild (1-2+) pedal edema. Documentation by LPN #3 on the nurse visit notes dated 2/5 and 2/8/06 identified that blood pressure increased to 138/84 on 2/5 and 142/80 on 2/8/06; no weights were assessed and there was no documentation that the physician was contacted. The patient was seen by the physician on 2/7/06 and Lasix was increased to 80 mg daily until 2/10/06 then to 40 mg daily. Documentation by LPN #4 on a nurse visit note dated 2/14/06 identified that the patient was seen the previous day by the physician who increased Lasix to 60 mg daily. LPN #4 documented on 2/14/06 that the patient's blood pressure was 152/70, weight increased 10 pounds to 230 pounds, lung sounds were clear, but the patient reported he was short of breath and could not sleep the previous night; LPN #4 identified that cardio-pulmonary status was within normal limits and instructed the patient regarding daily weights and signs and symptoms to report to the physician. Clinical record documentation on nurses notes by three (3) different LPNs determined that revisits were on 2/17/06, then 2/21 and 2/24. During the period from 2/17/06 to 2/24/06, the patient consistently complained of shortness of breath while ambulating and which also inhibited sleep, inability to swallow, abdominal distention and eating poorly. Blood pressure ranged from 130/70 to 140/80, but there was no documentation to indicate that daily weights were consistently assessed. Clinical record documentation by each LPN indicated that they reported to the PCN (RN #4), however there was no documentation to determine that the physician was informed of the patient's status. On 3/1/06, RN #4 revisited and identified that the patient was moderately dyspneic, but lungs were clear and that he had fallen that day because his knee gave out. RN #4 documented that she reported the fall to the physician, but there was no documentation to support that the patient's respiratory status was reported. During a joint visit with the surveyor on 3/3/06, Patient #17 expressed that since RN #4's last visit, he was very short of breath, spent nights in his recliner due to inability to breathe while lying, that he felt hungry for air and he was coughing white sputum that was red in the early morning. Patient #17 stated

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that he reported these symptoms to his son the previous evening and was waiting for his daughter-in-law to come from work to transport him to the physician. RN #4 assessed that Patient #17's lungs were clear, but that he had abdominal and sacral edema as well as increased pedal edema. She reported these findings to the physician's office, but did not contact the family before leaving. When interviewed on 3/6/06 RN #4 stated that after the patient was admitted (2/1/06) she was assigned to be "Acting Supervisor" in the office and all of her patient's were revisited by agency nurses. RN #4 stated that she did not receive detailed reports from the nurses who visited Patient #17. She stated that she did not report the patient's cardio-pulmonary status to the physician when the patient fell on 3/3/06 because she was unaware that documentation in the clinical record identified cardio-pulmonary status changes. RN #4 stated that during the month of February 2006, she did not review the patient's clinical record and revisits were assigned when staff was available rather than according to the patient's acuity level.

Agency nurses failed to consistently and/or accurately re-evaluate the patient's cardio-pulmonary status during the period when the physician was altering doses of Lasix and/or when Patient #17 consistently reported symptoms that could indicate cardio-pulmonary decompensation and/or failed to inform the physician of the patient's changing health status. The primary care nurse failed to properly supervise all nursing staff that delivered nursing care to the patient to ensure the quality of clinical care provided.

g. Patient #19 had a start of care date of 5/21/04 with diagnoses including schizoaffective disorder, intestinal obstruction, hypertension and diabetes. The plan of care dated 1/11/06 included skilled nursing x a week to assess vital signs, psychosocial status, emotional status, safety, s/s of decompensation and potential for violence, medication compliance, ability to access community services, nutrition and diabetic status. The nurse was to teach medication action, administer medications and pre-fill the medication box x 7 days. The plan of care of 1/11/06 lacked a 60-day summary to the physician.

The nursing note of 1/27/06 indicated that the patient had a suicide attempt on 1/23/06 and had 7 sutures in his left wrist which was described as clean. The note stated that he had been out with his son playing pool and had "4 beers" when he attempted suicide and went to the ER but was not admitted. The nurse noted that the patient's medication box was delivered by the pharmacy. The nurse checked off that he was appropriate, anxious and depressed, denied substance abuse, suicidal/homicidal ideation, safety was maintained and that he was clear and coherent. The visit note lacked documentation to support that the nurse conferred with the physician, ER, crisis center and/or case worker regarding possible interventions for the suicide attempt. The visit note lacked a comprehensive suicidal assessment tool and lacked the appropriate agency protocol per policy for crisis intervention, which included documented contract for safety. The patient was not reassessed again for one week, until 2/3/06, when the nurse documented that safety was maintained and that the patient had removed his own sutures and the area was healed.

The clinical record lacked documentation of any communication with the patient's primary physician regarding the suicide attempt and/or the need to change the patient's plan of care. Subsequent to supervisor's inquiry an addendum was written by the supervisor which stated that on 1/27/06 the supervisor spoke with the patient's case worker re: the patient cutting himself 4 days ago. The

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caseworker stated that she had not heard about this episode and was surprised because the patient was one of their stable patients. She then called the supervisor back to report that she found the paperwork from the ER and the patient had an appointment on 1/30/06. The nursing note of 2/3/06 lacked documentation regarding the patient's visit to the clinic on 1/30/06 and/or any communication with the physician.

RN #7 stated on 3/8/06 that she had not spoken to the ER or the patient's physician following his suicide attempt but only left a voice message with the patient's caseworker. She did not do a contract with the patient since she felt he was safe and the reason he attempted suicide was that he had been drinking with his son. She felt no need to increase his visits following the attempt and/or to change his plan of care.

The nurse failed to accurately assess a patient following a suicide attempt according to agency policy and/or failed to communicate with his physician in order to alter the plan of care if appropriate.

h. Patient #22's start of care date was 2/14/05 with diagnoses including manic-depressive disorder. Documentation on the re-certification plan of care dated 2/6/05 ordered skilled nurse 14 times per week to assess vital signs, psychosocial status, emotional status, safety and signs and symptoms of decompensation and violence potential. RN #7 documented on the 60-day summary to the physician that the patient's depression level was 7-8/10, anxiety level was 7-8/10, intrusive thought level was 4-5/10 and consistent suicide ideation at level 1, no plan in place (level 2 signifies plan in place). RN #7 identified that during the previous 60 days the patient had threatened suicide using accumulated Ambien pills, but that she called the crisis help group ("Crisis") instead and now stated to RN #7 that she felt safe and that she would call "Crisis" in the future, if needed. Clinical record documentation during the period from 2/6/06 to 2/16/06 determined that agency nurses revisited twice daily and consistently documented the unchanging levels of depression, anxiety and suicide ideation. The patient inconsistently attended treatment sessions and/or therapy meetings, but she stated that if she developed a plan for suicide that she would call "Crisis" for help. On 2/17/06 during the evening visit at 5 PM, LPN #5 identified that the patient had cut the side of her wrist with a razor earlier that day, but denied any plan of suicide and refused to go to the emergency room. There was no documentation to determine that the nurse assessed why the patient had harmed herself and/or if the patient was alone that day. The patient stated that she felt safe and was calling "Crisis" while LPN #5 was present. LPN #5 documented that she reported to the acting supervisor (RN #11) and to the patient's counseling center, however there was no documentation to support that the primary physician was informed. When interviewed on 3/7/06 RN #11 stated that she received report from LPN #5 about the patient's status late on a Friday and RN #11 conveyed the report to the weekend supervisor.

i. Review of agency policy determined that when a patient demonstrates intent to commit suicide and/or makes an attempt, the nurse must formulate a contract for safety and/or transport the patient to a health care facility. There was no documentation of a contract for safety in Patient #22's clinical record. When interviewed on 3/9/06 LPN #1 stated that when she called, the counseling center was closed for the weekend so she left a message, but that the physician was not notified of the attempted suicide. LPN #5 stated that she did not know why the patient cut herself that morning, but believed that she was reliable when she told LPN #5 that she was safe and would call "Crisis" if needed. LPN #5 stated that

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no one was at home with the patient, but during the visit the patient called "crisis". LPN #5 did not listen to the call nor did she talk with the crisis center, nor did she document a contract for safety with the patient.

Clinical record documentation during the period from 2/18/06 to 3/9/06 determined that the patient was regularly seen by agency nurses and she continued to report consistently high levels of depression and anxiety with suicide ideation, but there was no documentation to support that the physician was informed of the patient ' s suicide attempt on 2/17/06.

Agency nurses failed to accurately assess the patient when she attempted to harm herself and/or to inform the physician of this occurrence and/or to adhere to agency policy to formulate a contract for safety with the patient and/or to transport her to a health care facility per agency policy.

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

7. Based on clinical record review and staff interviews, for one patient, Patient #1, the facility failed to initiate revisions to the plan of care as necessary. Findings include:
Please refer to G 170.

A review of the H-HHA activity sheets dated 9/3, 9/17, 9/18, 9/24, 9/25, 10/1 and 10/2/05 identified Patient #1 refused peri-care.

H-HHA #s 3, 5, 6, 7 and 8 stated that observations of the patient's skin were not done because Patient #1 refused peri-care and preferred to wash herself.

RN #3 stated that Patient #1 was a very private person and refused to allow the presence of the H-HHA staff during showers.

Although staff members stated that Patient #1 was a "private person" and frequently refused to allow staff members to provide peri-care and/or skin observations, the patient's plan of care failed to reflect interventions that addressed the refusal of peri-care and the patient's concern for privacy.

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

8. Based on clinical record review, staff interview and home visit observations it was determined that for six (6) of twenty-five (25) patients, the registered nurse failed to complete a comprehensive assessment that included 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 12, 13, 16, 18, 23, 27). The findings include:

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- a. Patient #12 had a start of care date of 1/20/06 with diagnoses including abnormal gait, total hip replacement (THR) and CHF. The plan of care dated 1/20/06 included skilled nursing 1-3x a week to teach medication regime and side effects.
Review of the interagency referral form from the skilled nursing facility on 1/19/06 included Flomax 4 mg. twice a day. The plan of care dated 1/20/06 and the patient's medication list included Flomax 4mg. weekly. The clinical record lacked documentation that the nurse was aware of the discrepancy and/or that the medication discrepancy was clarified with the physician.
The visit note of 1/23/06 noted that the nurse instructed the wife to bring the medication list from the nursing home to the VA Hospital appointment on 1/24/04 since there was a question between ferrous sulfate and zinc sulfate. On her next visit of 1/26/06, the nurse failed to document the results of the medication discrepancies and the physician visit of 1/24/06. On her visit note of 1/26/06 the nurse documented that the caregiver was overwhelmed and that a call was placed to the physician asking if the patient should take aspirin (not on the medication list) and Plavix; no changes were made to the medication list but the phone call to the physician regarding the plavix and aspirin was not clarified in the clinical record.
RN #8 stated on 3/7/06 that the patient received all medications from the VA Hospital and she thought that the wife clarified the patient's medications when he went to the VA Hospital. RN #8 did not remember if she spoke with the physician regarding the patient's medications.
- b. Patient #13 had a start of care date of 2/24/06 with diagnoses including abnormality of gait and edema. The plan of care dated 2/24/06 included skilled nursing to teach medication regime, side effects and assess pain management. The plan of care and the patient's medication list only included lasix and a potassium supplement.
On the visit note of 3/1/06, the nurse documented that the patient was using a Duregesic patch, hydrocodone and Tylenol with codeine for pain. The medications were not noted in the plan of care and/or on the medication list.
RN #4 stated on 3/6/06 that the patient's plan of care and medication list were incorrect and the patient was taking fifteen (15) medications and not only the two (2) medications as indicated on the plan of care. She stated that since the medications were not identified correctly on the plan of care the nurses were only teaching the caregiver regarding the two medications listed on the plan of care. Subsequent to surveyor's inquiry, a new plan of care was sent to the physician and the medication list was updated.
- c. Patient #16 had a start of care date of 1/5/06 with diagnoses including abnormality of gait, organic brain syndrome and hypertension. The plan of care included skilled nursing 1-3x a week.
Review of the interagency referral form from the skilled nursing facility dated 1/4/06 included lasix 20 mg. po every other day. The plan of care dated 1/20/06 and the patient's medication list noted lasix 20 mg. po every day.
Review of the admission nursing note of 1/5/06 noted that the patient needed to be evaluated and assisted with medications since the patient stated that she took what the bottle said and she had her new and previous medications together. The nurse noted that she was likely taking all the medications in the home.

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The nursing visit of 1/6/06 stated that the nurse pre-filled the patient's medication box and instructed the patient when and how to take the medications. The client was confused with the medications and the nurse noted that she would monitor the patient's medications closely. No refills were in the home and the patient had no one to pick up her medications; the nurse called the pharmacy but no scripts were noted at the pharmacy. Review of the clinical record noted that another prn visit was made to the patient on 1/6/06 to adjust the medication box since after verification of the medications with the physician, the lasix was to be taken every other day and not every day as listed on the patient's medication list.

SCS #1 stated that the protocol for pre-pouring medications on the initial visit included the use of the W-10 and if that was not available to the nurse, the nurse was to verify the patient's medications with the physician before pre-pouring the medications.

d. Patient #18's start of care date was 2/13/06 with diagnoses including congestive heart failure, chronic airway obstruction and non-insulin dependent diabetes mellitus. Documentation on the certification plan of care dated 2/13/06 to 4/13/06 ordered skilled nurse 1-3 times per week to assess cardio-pulmonary status, diabetic status, diabetic management and to teach medication regime and side effects; ordered medications included: Potassium Chloride, Combivent, Coreg, Diovan, Lasix, Theophylline, Colchicine, Aspirin, Cipro and Minitran. Documentation by RN #6 on the OASIS/comprehensive assessment dated 2/13/06 identified that the patient was discharged from hospital on 2/11/06 with a few new medications. The interagency referral report (W10) did not identify any medications and there was no documentation that RN #6 validated the medications with the physician. When interviewed on 3/9/06 RN #6 stated that the list of medications was missing from the W-10 so she asked the patient about medications she was taking and did not contact the physician's office for verification. Clinical record review of skilled nurse visit notes dated 2/13/06 to 2/27/06 identified that several different agency nurses revisited the patient twice weekly and consistently documented that medications were assessed and/or monitored. During a home visit with RN #4 (PCN) the patient stated that she had been taking Actos and that it was ordered by the physician in the hospital before her discharge (on 2/11/06). RN #6 and the surveyor found no documentation of Actos in the clinical record. When interviewed on 3/9/06 RN #6 stated that she had not reviewed the patient's clinical record and that she had not received accurate reports from nurses who revisited the patient. When interviewed on 3/9/06 SCS #1 stated that some nurses told her they did not review the patient's medications and another nurse stated that she did not review all of the medications. Agency nurses failed to complete a comprehensive assessment that included all of the medications that the patient was taking.

e. Patient #23 had a start of care date of 2/1/06 with diagnoses including hip replacement, malignant neoplasm of the prostate, anemia, diabetes and hypertension. Review of the inter-agency patient report (W-10) documented that Patient #23 received the last dose of Prozac 30mg at 9am on 1/31/06 while at Skilled Nursing Facility #1. Review of the admission orders dated 2/1/06 to the home care agency noted that the medication Prozac was omitted from the admission plan of care. The nursing notes dated 2/24/06 documented that Patient #23 began the medication Paxil as prior to admission to the hospital.

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On interview 3/8/06, SCS #1 stated that the medication Prozac was omitted from the admission orders, but was corrected by the 2/24/06 nursing visit. The agency failed to accurately transcribe and/or to clarify in a timely fashion, the medications that Patient #23 was to receive.

f. Patient #27 had a start of care date of 2/3/06 with diagnoses including cellulitis, organic brain syndrome, asthma and hypertension. Review of the inter-agency patient report (W-10) documented that Patient #27 received Lipitor 10mg daily while at Skilled Nursing Facility #1. Review of the admission orders dated 2/3/06 to the home care agency noted that Lipitor 40mg was ordered daily.

On interview 3/8/06, subsequent to surveyor inquiry, SCS #1 assigned a nursing staff member to go the Patient #27's home to review the pre-poured medications, and on return it was verified that Patient #27 did in fact have only Lipitor 10 mg pre-poured, and was only receiving Lipitor 10mg since the discharge from Skilled Nursing Facility #1. The agency failed to accurately transcribe the medications that Patient #27 was to receive.