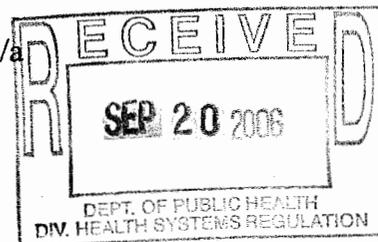


**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

IN RE: Around the Clock Nursing Services, LLC of Vernon, CT d/b/a
 Around the Clock Nursing Services, LLC
 145 Talcottville Road
 Vernon, CT 06066



CONSENT ORDER

WHEREAS, Around the Clock Nursing Services, LLC (hereinafter the "Licensee"), has been issued License No. 0019 to operate a Home Health Care Agency known as Around the Clock Nursing Services, LLC, (hereinafter the "Facility") under Connecticut General Statutes Section 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 April 26, 2006 and concluding on May 2, 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 May 8, 2006 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order in order to settle and resolve the violations identified by FLIS in the May 8, 2006 letter agrees to the conditions set forth herein; and

WHEREAS, the execution of this Consent Order, and any statements or discussions concerning it, shall not be construed to constitute an admission of any liability or violation of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan D. Leavitt, RN, MS its Section Chief, and the Licensee, acting herein and through Evaristus Ejimadu, its Owner, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Order the Supervisor of Clinical Services shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients, management of diabetes and chronic renal failure, pain management and patients at risk for falls.
2. 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. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
 - b. Patient assessments and/or re-assessments are performed in a timely, accurate and comprehensive manner and accurately reflect the condition of the patient;
 - c. Appropriate referrals are made for all services indicated by the patient's comprehensive assessment;
 - d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
 - e. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care; and
 - f. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, deterioration of mental, physical, nutritional, and/or hydration status, cardio-respiratory, fall risk, caregiver's stress and/or ability to cope, immediate care needs and safety.
3. Within twenty-one (21) days of the effect of the Consent Order, all Facility direct care staff shall be in-serviced, to the policies and procedures identified in paragraphs #1 and #2.
4. The Supervisor of Clinical Services shall be responsible for ensuring that all care is provided to patients by all caregivers is in accordance with individual comprehensive care plans.
5. 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.

6. The Licensee shall within forty-five (45) days of the execution of this Consent Order, develop and implement a program to assess staff compliance with the Licensee's policies, procedures and standards of practice. The program shall include, but not be limited to, a mechanism whereby remediation of staff occurs for failure to adhere to facility policy and procedures.
7. The Licensee shall pay a monetary penalty to the Department in the amount of seven hundred fifty dollars (\$750.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (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

8. The Licensee shall meet with Department staff every month for the initial six (6) months this Consent Order is in effect and every four (4) months thereafter for the duration of this Order.
9. 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 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.
10. 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.

11. 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.
12. 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.
13. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.
14. This Consent Order embodies the entire agreement of the parties with respect to the subject matter herein. All previous communications and agreements between the parties, whether oral or written, are superseded unless expressly incorporated herein or made part hereof.

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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.

AROUND THE CLOCK NURSING SERVICES,
LLC OF VERNON, CT - LICENSEE

09-11-06
Date

By: [Signature]
Evaristus Ejimadu, Owner

STATE OF Minnesota)

County of Hennepin) ss September 11, 2006

Personally appeared the above named Evaristus Ejimadu and made oath to the truth of the statements contained herein.

My Commission Expires: 01-31-2010
(If Notary Public)

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



STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

9/21/06
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 7

May 8, 2006

Delia Skranski, RN, Administrator
Around The Clock Nursing Services, LLC
145 Talcottville Road, Suite 1A
Vernon, CT 06066

Dear Ms. Skranski:

Unannounced visits were made to Around The Clock Nursing Services, LLC on April 26, 27, 28, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an initial certification survey with additional information received through May 2, 2006.

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 May 22, 2006 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

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

Respectfully,

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

SNC:NC:



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

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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The following is a violations 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, 3 and 6 and their families as evidenced by the violations listed in this document.

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

2. The administrator failed to organize and direct the agency's on going functions and to ensure the safety and quality of care rendered to Patient #s 1, 3, and 6 and their families as evidenced by the violations listed in this document.

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

3. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #'s 1, 3, and 6 and their families as evidenced by the violations listed in this document.

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13D69(a)(3)(D)(E) Services and/or D73(b) Patient care plan.

4. Based on clinical record review, staff interview, patient interview and home visit observation it was determined that for three (3) of eleven (11) patients the primary care nurse failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action to intervene appropriately in a timely manner as the patient's health and safety status deteriorated and/or to document actions/interventions and/or to document the patient's immediate health care needs and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care (Patient #s 1, 3, 6). The findings include:

a. Patient #1's start of care date was 3/28/06 with diagnoses including insulin dependent diabetes mellitus, acute and chronic renal failure, anasarca, hypertension, obesity and hyperlipidemia. Documentation on the certification plan of care dated 3/29/06 ordered skilled nurse 2 week (#) 1, 2-3 x

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WERE IDENTIFIED

week (#s) 2-6, 1-2 week (#s) 7-9 for general physical assessment, to report systolic blood pressure greater than 160 or less than 90, report blood sugar greater than 120 as obtained by patient four times daily, teach patient to monitor urine output, medication use and safety; homemaker home health aide (H-HHA) 2 x week for personal care. Ordered medications included Aspirin 81 mg daily, Lisinopril 40 mg daily, Lasix 80 mg twice daily, Terasolin 10 mg at hour of sleep, Atenolol 100 mg daily, Norvasc 10 mg daily, Potassium 40 meq daily, Lantus insulin 35 units at hour of sleep and sliding scale insulin as follows: 200-250 - 2 units Regular (R) Insulin

251-300 - 4 units R Insulin

301-350 - 6 units R Insulin

351-400 - 8 units R Insulin

401-450 - 10 units R Insulin

451-500 - 15 units R Insulin

Ordered diet included carbohydrate controlled, no added salt and 1500cc fluid restriction per 24 hours. Documentation by RN #1 on the OASIS/comprehensive assessment dated 3/29/06 stated that this 74 year old oriented, obese patient lived alone, was dependent for most activities of daily living (ADLs) and that his brother was the primary caregiver (PCG). He was deconditioned with decreased range of motion and generalized weakness. RN #1 identified that the patient independently took all prescribed injectable medications, that she observed the patient to "self finger stick", that blood sugar was 345 and instructed the patient to keep a log of blood sugars; there was no documentation to indicate if this was a fasting, random, and/or post-prandial blood sugar value. RN #1 documented on the nurse admission note that she pre-poured medications because the patient was unfamiliar with many that were newly ordered; baseline blood pressure was 110/62, apical pulse was 62 beats/minute and weight was 246 pounds.

During the period from 3/29/06 to 4/21/06, RN #1 visited the patient twice weekly and documented blood sugar ranges from 85 to 492 and there was no consistent documentation to indicate that the patient was compliant with the 1500cc fluid restriction as ordered by the physician. There was no documentation to support that the physician was informed of blood sugars greater than 120.

Documentation by RN #1 on the nursing visit note dated 4/21/06 stated that blood pressure was 132/78, apical pulse was 59 and blood sugar was 492 with symptoms of hyperglycemia (symptoms were not specifically documented). RN #1 identified that the patient was alert and oriented, but had not taken his blood sugar that morning and had not taken medications on 4/19/06. RN #1 spoke with the patient's brother who promised to remind Patient #1 to take the medications, perform the blood glucose tests and to administer his insulin.

The next revisit was 4/24/06 (3 days later) when RN #1 identified in the nursing visit note that blood pressure was 136/64, weight was 232 [minus fourteen (14) pound weight discrepancy from 3/29/06], blood sugar ranged from 230 to 310, and that the patient had been compliant with medications, blood sugar monitoring and showed that he was administering insulin as ordered. However, documentation on the blood sugar chart recorded by Patient #1 determined that on 4/24/06, his blood sugar was 398 and he took 10 units (of regular insulin) instead of the ordered 6 units.

During a home visit on 4/27/06, the surveyor reviewed the patient's record of blood sugar readings for the period from 3/29/06 to 4/25/06. Blood sugar readings were inconsistently documented including gaps of time from 4/1 to 4/5, 4/8 to 4/18 when no blood sugars were recorded, consistently elevated

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blood sugar levels, documentation of incorrect doses of regular insulin in response to the blood sugar on 4/7, 4/23, 4/24, and 4/25, and blood sugar testing done only one time a day from 3/30/06 to 4/27/06. When interviewed on 4/27/06 RN #1 stated that she was unable to contact the physician, but spoke with a (non-medical) caseworker at the physician's office, specific date not recalled, who stated that testing the blood sugar twice daily would be acceptable as long as it provided accurate information.

In response to surveyor inquiry during the home visit on 4/27/06 Patient #1 stated that he sometimes forgot to test his blood sugar and/or he forgets to test it before meals and would do it after eating. When the surveyor asked about compliance with the fluid restrictions the patient stated that he had cut down on fluids, but did not measure his intake.

Documentation of the joint home visit with the surveyor by RN #1, dated 4/27/06 at 8:30 AM, identified that the patient was mildly confused and forgetful, blood pressure was 200/98, apical pulse was 60, weight was 242 (10 pound increase from 4/24/06); blood sugar, monitored by self, documented as 181-581 and that the patient was non-compliant with medications as ordered. RN #1 contacted the PCG who stated that he had been unable to remember to remind the patient to take his medications.

When interviewed several hours later on 4/27/06, RN #1 stated that she reported the patient's status to the (non-medical) case manager at the physician's office and that she contacted another of the patient's relatives to request monitoring of the patient's compliance with blood sugar monitoring and medication administration that evening. In response to surveyor inquiry RN #1 acknowledged that this plan would not enable her to assess the patient's blood sugar and/or blood pressure that evening and that RN #1 did not know the relative's capabilities regarding blood sugar testing. RN #1 obtained a physician's order on 4/27/06, to increase skilled nursing visits to twice daily to meet the patient's immediate needs.

Documentation by RN #1 on 4/27/06 at 7 PM identified that the patient continued to be mildly confused and forgetful and he complained of headaches; blood pressure was 189/72 and blood sugar was 530. RN #1 was unable to contact the physician and Patient #1 was transferred to the emergency room; Patient #1 was subsequently discharged back home early the next morning (4/28/06).

Documentation by RN #1 on the nursing visit note dated 4/28/06 at 10 AM identified that the patient was oriented, blood pressure was 120/74 and blood sugar was 270.

RN #1 documented on 4/28/06 at 6:30 PM that she found the patient on the floor and that his brother stated the patient had fallen just prior to the her arrival. RN #1 identified that the patient was confused, lethargic and (verbal) responses were inappropriate; blood pressure was not palpable, apical pulse was 42 and blood sugar was 237. RN #1 called 911 and Patient #1 was transported to the emergency room and subsequently was admitted to hospital.

When interviewed on 4/27/06 RN #1 stated that she recognized that the patient failed to document blood sugar daily, but he told her he was doing it and she accepted the blood sugar values that he stated. RN #1 stated that on 4/21/06, the patient started to be somewhat confused and the care plan was no longer working so she asked the brother to remind the patient to test blood sugars and to take his medications appropriately, but did not realize that the brother was having memory problems himself. RN #1 stated that she did not contact the physician about the patient's changed mental status and/or consistently elevated blood sugars and/or the altered care plan in that Patient #1 was unable to independently manage his diabetic status and medications.

RN #1 failed to accurately and/or consistently re-assess the patient when he failed to document accurate blood sugar testing as ordered by the physician and/or to take prompt action and/or to intervene

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appropriately in a timely manner when blood sugars remained consistently elevated and Patient #1 experienced mental status changes and deterioration of safety status and/or to document actions/interventions focused upon lack of compliance with ordered fluid restrictions and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care.

b. Patient #3's start of care date was 3/2/06 with diagnoses including Parkinson's disease, intractable pain, right calf burn wound, osteoarthritis, hypertension and breast cancer. Documentation on the certification plan of care dated 3/2/06 to 5/1/06 ordered skilled nurse 2x week (#) 1, 3-4 x week (#) 2, 2-3 x week (#) 3, 1-2 x week (#s) 4-6 to educate patient and family on disease process, reportable symptoms, safety measures, nutritional needs, wound care, and pain management; H-HHA 5x week for personal hygiene. Documentation by RN #1 on the OASIS/comprehensive assessment dated 3/2/06 stated that the patient had experienced increased lower extremity pain and immobility, with generalized weakness and atrophy, swollen painful joints of knuckles and spine, decreased range of motion of her right leg, difficulty grasping, limited endurance and ambulation. The patient required assistance with all ADLs and/or instrumental activities of daily living (IADLs). The PCG was the patient's daughter and RN #1 documented on the OASIS/comprehensive assessment dated 3/2/06 that the PCG was required to assist the patient several times during the day and night with personal care, medications, meals, housekeeping, laundry, telephone, finances, psychosocial support and facilitation of patient's participation in appropriate medical care. Documentation by RN #1 on a nursing visit note dated 3/6/06 stated that the patient fell on 3/5/06 while she was transferring from her rolling walker onto the couch. During the period from start of care on 3/2/06 to 3/10/06, there was no clinical record documentation to determine that RN #1 evaluated the patient's need for physical therapy.

Documentation by RN #1 on a nursing visit note dated 3/8/06 stated that she updated the physician about the patient's right leg pain before the patient's scheduled visit that afternoon. RN #1 revisited on 3/10/06 and documented that PT would evaluate the following day and an order for the PT evaluation was documented by RN #1 on a telephone order to the physician dated 4/10/06. Documentation by the agency administrator/supervisor dated 5/2/06 and faxed to the surveyor stated that the nurse communicated the patient's right leg pain to the physician on 3/8/06 at which time the physician ordered physical therapy. When interviewed on 4/28/06 RN #1 stated that she did not refer the patient for physical therapy at the start of care and/or after the patient fell because the patient was having too much pain.

i. Clinical record documentation by RN #1 on the OASIS/comprehensive assessment dated 3/2/06 identified that there was "evidence of potential abuse" in that the daughter was easily frustrated with her mother and there were inappropriate responses to caregivers and/or the clinician. On 3/8/06 RN #1 documented on a nursing visit note that Patient #3 stated that her daughter wanted to put her "in a home because she's tired of working all day then coming home to me." RN #1 documented on a communication note that she spoke with the daughter who stated that she was much less overwhelmed since the patient's pain was controlled. During the period from 3/2/06 to 4/27/06 there was no clinical record documentation to determine that RN #1 evaluated the patient/PCG for medical social services and/or that she informed the physician about the "potential for abuse" of the patient by her daughter and after 4/8/06 there was no further clinical record documentation to indicate that RN #1 re-evaluated the

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status of the "potential for abuse" and/or the daughter's ability to cope consistently with her mother's care needs. When interviewed on 4/28/06 RN #1 stated that the patient's daughter was at "wits end" because of the patient's pain and the situation improved after the pain was controlled.

The primary care nurse failed to accurately and/or to consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner when she identified evidence of "potential abuse" and/or ineffective coping by the PCG and/or to document actions/interventions

and/or to document the patient's immediate health care needs and/or to notify the physician managing the home health plan of care of the patient's/PCG status that suggested a need to alter the plan of care.

c. Patient #6's start of care date was 4/8/06 with diagnoses including diabetes mellitus, peripheral vascular disease, intractable chronic pain, hypertension and colitis. Documentation on the certification plan of care dated 4/8/06 ordered skilled nursing visits 1 x week (#) 1, 2-3 x week (#) 2, 1-2 x week (#s) 3-9 for general assessments including vital signs, blood sugar monitoring, diabetic teaching, disease process and medication pre-pour weekly. Ordered medications included Fentanyl 25 mcg patch, Zoloft 50 mg daily, Lopressor 50 mg twice daily, KlorCon 40 meq daily, Neurontin 300 mg three times daily Remeron 30 mg at hour of sleep, Zocor 40 mg at hour of sleep, Lantus insulin 30 units each morning and regular insulin per sliding scale.

Documentation on the OASIS/comprehensive assessment by RN #1 dated 4/8/06 stated that the patient lived with five family members in a one bedroom apartment, that the patient did not always have enough money to buy food and that the family refused meals on wheels because of lack of finances. RN #1 identified that the patient had long-term depression, she was withdrawn with a flat affect and there was evidence of potential financial exploitation. During the period from 4/8/06 to 4/28/06, there was no clinical record documentation to support that RN #1 evaluated and/or referred the patient for MSW services and/or that RN #1 communicated these findings to the physician. When interviewed on 4/28/06 RN #1 stated that she thought the family was too "closed" to accept visits from additional "outsiders"; in response to surveyor, inquiry RN #1 stated that she did not discuss the patient's psychosocial status with a medical social worker and/or the physician.

Documentation by RN #1 on the OASIS/comprehensive assessment dated 4/8/06 stated that the patient had intractable chronic pain at the stump site of a right lower extremity amputation that was done nine (9) months earlier. Patient # 6 was chair-fast, but family would assist with showering. Documentation by RN #1 dated 4/11/06 stated that the patient required extensive assistance into the tub and that the patient had hit her left foot on the wheel chair causing pain. RN #1 documented on 4/11/06 that she contacted the physician about ordering the patient's medications, but there was no documentation to support that she reported that the patient had hit her left foot and/or to request a physical therapy evaluation.

When interviewed on 4/28/06 RN #1 stated that the patient hit her foot when the family was transferring her into the tub, but that RN #1 did not consider that the patient needed physical therapy and she was unable to recall if she reported the incident to the physician.

The primary care nurse failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner when the patient was found living in a crowded environment, reported insufficient funds for

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food and/or when the patient hit her foot during transfer and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care.

The following is a violations of the Regulations of Connecticut State Agencies Section 19-13D 73(b) Patient care plan.

5. Based on clinical record review, staff interviews, patient interview and home visit observation it was determined that for Patient #1 the agency failed to provide services and/or failed to document that services were provided as ordered by the physician. The findings include:

a. Patient #1's start of care date was 3/28/06 with diagnoses including insulin dependent diabetes mellitus, acute and chronic renal failure, anasarca, hypertension, obesity and hyperlipidemia. Documentation on the W-10 dated 3/28/06 ordered occupational therapy (OT) and medical social services (MSW) evaluation. Documentation on the certification plan of care dated 3/29/06 ordered skilled nurse 2 x week (#)1, 2-3 x week (#s) 2-6 week, 1-2 x week (#s) 7-9 for general physical assessment; homemaker-home health aide (H-HHA) 2 x week for personal care. Documentation by RN #1 on the 10-day summary to the physician dated 4/2/06 stated that the patient had limited functional mobility and required physical therapy (PT); PT 2-3 x per week was ordered by the physician on a verbal order documented by RN #1 dated 4/3/06.

There was no clinical record documentation to determine that occupational therapy was provided as ordered by the physician. When interviewed on 4/28/06 RN #1 stated that she evaluated that the patient was adequately functional in his apartment and did not require OT. RN #1 stated that she failed to inform the physician that OT was not provided.

There was no clinical record documentation to determine that the patient was evaluated for medical social services.

During a home visit on 4/27/06, the surveyor observed that RN #1 gave the patient an application for Medicaid to be completed by him. In response to surveyor inquiry the patient stated that the application looked difficult and he was unsure that he was able to complete it. RN #1 stated that the patient needed Medicaid benefits and offered to assist with completion of the application. When interviewed on 4/28/06 RN #1 told the surveyor that upon admission to the home care agency it was apparent that the patient had minimal family support, that he needed finances to obtain services such as grocery shopping and to maintain his home. In response to surveyor inquiry RN #1 stated that she had not realized that MSW was ordered on the W-10, but that she was planning to contact the physician to request a MSW referral.

The agency failed to provide services and/or failed to document that services were provided as ordered by the physician.