

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

IN RE: Caring, Inc. of Stamford, CT d/b/a
 Caring, Inc.
 733 Summer Street
 Stamford, CT 06901

CONSENT ORDER

WHEREAS, Caring, Inc. (hereinafter the "Licensee"), has been issued License No.C85963 to operate a Home Health Care Agency known as Caring, Inc., (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 May 15, 2006 and concluding on September 14, 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 violation letters dated June 26, 2006 (Exhibit A – copy attached); August 3, 2006 (Exhibit B – copy attached); August 31, 2006 (Exhibit C – copy attached); and September 21, 2006 (Exhibit D – copy attached); and

WHEREAS, the Licensee notified the Department on September 25, 2006 via a teleconference of its willingness to relinquish its License as a Home Health Care Agency and that all patients receiving home health care services will be transferred to other licensed health care entities, and

WHEREAS, the Licensee is willing 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 Patricia J. Riggs its President, hereby stipulate and agree as follows:

1. The Licensee shall immediately upon execution of this Consent Order transfer all patients to other Home Health Care Agencies as appropriate and surrender its license to operate a Home Health Care Agency on or before October 12, 2006.
2. The Licensee shall provide the Department with a listing identifying each patient transferred and the receiving agency.
3. The Licensee shall provide the Department with the location designated to store medical records and the name of the contact person who will retrieve the records upon request.
4. Patricia J. Riggs agrees that henceforth she will not own, operate or perform administrative functions in any health care facility licensed by the State of Connecticut Department of Public Health.
5. This Consent Order is not an admission of liability or wrongdoing by Licensee or any officer or employee of Licensee.
6. 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.
7. 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.
8. The Licensee has had the opportunity to consult with an attorney prior to signing this document.

*

*

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.

CARING, INC. of STAMFORD, CT

11/2/06
Date

By: *Patricia J. Riggs*
Patricia J. Riggs, President

STATE OF Connecticut

County of Fairfield) stamford.
) ss Nov. 2, 2006

Personally appeared the above named Patricia J. Riggs and made oath to the truth of the statements contained herein.

My Commission Expires: *Carmelita Minkler*
(If Notary Public)

CARMELITA MINKLER
Notary Public
Fairfield County, Connecticut
My Commission Expires June 30, 2009

Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

11/9/06
Date

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

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June 26, 2006

Patricia Riggs, RN, Administrator
Caring, Inc.
733 Summer Street
Stamford, CT 06901

Dear Ms. Riggs:

Unannounced visits were made to Caring, Inc. on May 15, 16, 17, 18, 19, 22, 23, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through June 14, 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 July 11, 2006 at 10:00 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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WERE IDENTIFIED

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

1. The governing body failed to assume responsibility for services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 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 (c)(2) General requirements and/or D76 (a)(c)(4).

2. Based on review of the minutes of the Quality Assurance Program/Professional Advisory Committee and the clinical record reviews for the period of July 1, 2005 through May, 2006, it was determined that the agency failed to implement its quality assurance program. The findings include:

a. For fiscal year 2006, there was no documentation of a review of agency policies, and/or an annual process and outcome report for review and recommendations and/or subsequent 120-day report and/or annual documentation of clinical competence.

b. During an interview with the Administrator on 5/22/06, she stated that the agency was small and because she "wore many hats and juggled numerous balls" simultaneously, some things were not always done on a timely basis.

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

3. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 as evidenced by the violations listed in this document.

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

4. Based on observation, clinical record review, staff interviews and agency policy review, it was determined that for two (2) of two (2) behavioral health patients, the agency failed to comply with accepted professional standards and procedures that apply to the pre-pouring and administration of medications (Patient #s 6 and 7). The findings include:

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a. Patient #6 had a start of care of 08/01/92 with a diagnosis of chronic paranoid schizophrenia. For the recertification dated 03/08/06 to 05/06/06 skilled nursing was ordered twice a day to administer medications, monitor effects, instruct patient of signs and symptoms of adverse reactions and supervise the home health aide.

i. On 05/16/06 at 11:15am, two (2) surveyors observed RN #1 pre-pouring Patient # 6's medications into small envelopes at her desk. When interviewed on 05/16/06, RN #1 stated she was only doing what her supervisor told her to do; she was helping her supervisor; she was pre-pouring the patient's medications for the nurses who administer them to Patient #6; the patient's medications were stored in a locked file cabinet in the office.

The agency administrator/supervisor stated on interview on 05/16/06, that she usually pre-poured the patient's medications for the nurses to pick-up and bring to the home for administration; it was easier for the nurses if she pre-poured the medications; the nurses usually come in once a week and pick up the pre-poured doses for the visits they would make; the nurses did not use a medication administration record (MAR) after administering medications; the agency did not have written permission to have possession of the patient's medications. On 05/19/06 at 4:05pm, a surveyor observed the agency administrator pre-pouring Patient #6's medications in RN #1's office at the agency.

ii. The nursing notes by RN #3 for the twenty-three (23) visits she made to Patient #6 for medication administration in April 2006, documented "prescribed medications pre-poured by (agency) office; administered medications". There was no documentation of a MAR in the clinical record. RN #3 stated on interview on 05/19/06, that her supervisor pre-poured Patient #6's medications in the office for her because that is the way it is at this agency; RN #3 picked up his medication envelopes at the office; RN #3 was not the primary care nurse (PCN); not sure who the PCN was, however her supervisor told her it was RN #2; her job was to administer medications to Patient #6 two times a day; she did not use a MAR and/or did not document the specific medications she administered at each visit.

iii. RN #2 documented in her nursing notes for nine (9) visits she made to Patient #6 in April 2006, "administered medications". There was no documentation of a MAR in the clinical record. RN #2 stated on interview on 05/19/06, that the patient's medications were kept in the agency office; my supervisor pre-poured them for me, that's how she wanted it done; RN #2 went to the agency one time a week to pick up the medications; RN #2 used to visit the patient more frequently; now sees him 3-5 times a week; other nurses also see him; RN #2 probably was considered the "main nurse", but she was not the PCN, her supervisor was; patient's medications were kept in the office as the patient lives in a boarding house with a roommate; the patient had been victimized in the past with his medications.

iv. The agency did not have a policy and procedure concerning medication pre-pouring and administration.

v. The accepted standard for administering medications by nurses requires that the nurse preparing the medication for administration is the same nurse who administers the medication. That nurse must ensure she has the right drug, right dose, right time, right route and right client. (Summarized from textbook Fundamentals of Nursing, Sixth Edition, 2000).

b. Patient #7's most recent start of care date was 5/2/06 with a primary diagnosis of tachycardia, and secondary diagnoses of esophageal disorder, diabetes mellitus type II, hypertension, paranoid

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schizophrenia and obesity. Review of the clinical record identified that the patient had been intermittently on service by the agency since 3/14/05 with periodic hospitalizations related to hearing voices and paranoid delusions. The physician's orders for certification period 5/2/06 through 6/30/06 identified that the patient was to have skilled nursing visits two times per day to administer medications, monitor effects and instruct the patient regarding recognizing and responding to adverse reactions, to assess the patient's physical and mental status, instruct the patient regarding fluid and nutritional needs, and report changes to the physician.

During a visit to the agency office on 5/16/06, two (2) surveyors observed that RN #1 was removing medication bottles from a file drawer, filling small brown envelopes with Patient #7's medications and labeling them. During an interview with RN #1 on 5/18/06, she stated that she or the SCS would pre-pour the medications and another nurse would take it to the patient's home to administer.

Review of the clinical record of Patient #7 identified that most of the visits were noted on "behavioral health medication administration" visit sheets, which did not document the medications given to the client or provide any reference to a med sheet listing the most current medications ordered by the physician. Review of the visit sheets from 5/2/06-5/15/06 noted that on thirteen (13) occasions, the nurse documented that the "prescribed meds were pre-poured by the agency office and were self-administered under RN supervision". Additionally, there were no medication administration records (MAR) in the clinical record.

During an interview with the administrator/SCS on 5/19/06, she stated that they stopped using MARs approximately 3 months earlier. On 5/22/06 during an interview with LPN #1, she stated that once a week she picks up a supply of the patient's medications, from the agency office, which have been pre-poured by the SCS. She "carries them in her purse until the correct day to administer them and visually verifies that they are correct before handing them to the patient".

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-G 140 D68(e)(3)(A)(B) General requirements.

5. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and their families as evidenced by the violations listed in this document. In addition, on 5/19/06 the SCS was not able to identify a mechanism which identified the schedule of nursing visits and/or who was responsible for the visits; the nurses call in to report who they are going to see and when.

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

6. Based on clinical and personnel record review and staff interviews it was determined that the agency's administrator/supervisor of clinical services was not functioning full time in that role from 9/10/05-10/10/05 and from 11/16/05-5/24/06. The findings include:

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- a. The agency failed to employ a primary care nurse from 9/10/05 to 10/10/05 and 11/16/05 to 5/24/06.
- b. Review of clinical records from 6/5/05 to 5/24/06 indicated that the administrator/SCS was completing most of the physician's plans of care and most of the OASIS comprehensive assessments.
- c. Interviews from 5/15/06 to 6/1/06 were conducted with RN #s 1, 2, 3, 4. They all stated that they were not the primary care nurse for the agency patients and were only per diem nurses who made visits and provided treatments for the patients; the administrator/SCS was the primary care nurse and wrote the physician's plans of care and most often completed the OASIS comprehensive assessments.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(1)(3)(A) Services and/or D66(dd) Definitions.

7. Based on clinical record review and staff interviews it was determined that for Patient #s 1 and 11 a registered nurse failed to complete the initial assessment in order to determine the care needs of the patient. The findings include:

- a. Patient #1 had a start of care date of 2/2/06 with diagnoses including chronic leg ulcer, osteoarthritis and hypertension. The plan of care included skilled nursing twice a day to assess the wound on the right leg and provide wound care; home health aide services 5-7 x a week to assist with ADLs and IADLs. The patient was discharged from a skilled nursing facility on 2/1/06. Review of the clinical record indicated that the licensed practical nurse conducted the initial assessment and bid nursing visits on 2/2/06 in lieu of a registered nurse. The administrator/ supervisor of clinical services conducted a PM nursing visit to the patient on 2/3/06 and completed the start of care comprehensive OASIS assessment. The administrator stated on 5/16/06 that although the LPN made the initial visit on 2/2/06, she saw the patient in the PM of 2/3/06 and an RN did see the patient alternately with the LPN starting 2/6/06. A registered nurse failed to complete the initial assessment visit.
- b. Patient #11 had a start date of 4/2/06 with a diagnosis of "intramuscular injection". Review of the clinical record included a physician's order for a nurse to administer progesterone 1cc IM at 6PM on 4/1, 4/2 and 4/3/06. The clinical record indicated that a RN conducted a visit on 4/2, 4/3 and 4/4/06 and administered the medication. The record lacked documentation explaining the delay in the start of service. The clinical record lacked documentation to support that a comprehensive assessment was completed including diagnoses, medication review, accurate history etc., lacked documentation that teaching occurred regarding medication side effects/adverse reactions, appropriateness of self-injection technique and/or who would resume the injections after agency discharge, lacked a physician's plan of care and lacked a discharge summary. The receptionist and administrator identified the patient as a short-term patient who did not require a comprehensive assessment.

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RN #4 stated on 5/25/06 that she did not know anything about completing an admission visit since she only made one visit on 4/2/06 and "according to the patient someone else came before me." She stated that she was only assigned to give the patient the injection at a certain time since the office did not have anyone else to visit the patient. RN #4 stated that the patient told her that the injection was to get pregnant. She stated that she did not go over side effects with the patient because she was well-educated.

The nurse failed to conduct and complete a comprehensive for a patient who was admitted to the agency for progesterone injections.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(4) Services and/or D68(e)(2) General requirements.

8. Based on clinical record review and staff interviews it was determined that for two (2) of two (2) patients receiving private duty nursing, primarily by LPNs, the agency failed to ensure that the LPN worked under the direction and supervision of an RN at all times to assure and maintain the quality of private duty clinical care and services (Patient #s 10 and 12). The findings include:

a. Patient #10 was admitted to the agency on 5/23/2000 with diagnoses of muscular dystrophy and cardiomyopathy. Physician's orders for the certification period of 2/25/06 through 4/25/06 direct that the patient have private duty nursing 16-23 hours per day to "place on ventilator", suction as needed, assess cardio-respiratory status, nutritional fluid status and signs and symptoms of infection, and to maintain skin integrity and to report to the supervising RN who will coordinate services and report to the physician. On a day-to-day basis, Patient #10 is primarily staffed using LPNs with occasional shifts being provided by a RN when an LPN is not available. The last documented LPN "supervision visit" to the home by the agency SCS was dated 5/12/03; all subsequent entries by the SCS were regarding contacts for approval of hours from the Department of Social Services and not related to care. The last entered note dated 5/23/06 identified that the LPN reported that the patient had been started on Amoxicillin for a virus. During an interview on 5/30/06 at 12:00 noon with LPN #2 who works approximately 112 hours per week at Patient #10's home, she stated that the patient is alert and oriented, ventilator dependent and requires continuous care for suctioning, tube feedings, skin care, turning and positioning, socialization and activities of daily living (ADL). LPN #2 further stated that she has been taking care of the patient for nine years, that she trains all relief care givers regarding the ventilator, emergency procedures and care needs and will never allow a relief care giver to work independently until she determines they are competent and comfortable with all aspects of Patient #10's care. Additionally, LPN #2 identified that she has not had a nurse supervisor from the agency visit the home for approximately two (2) years, that she (LPN #2) made all calls to the physician regarding any change in the patient's status and that although the Administrator/SCS was available by phone in an emergency, she would probably not call her because the Administrator/SCS "did not understand the ventilator". Review of the personnel file of LPN #2 on 6/14/06 identified that the annual evaluation of clinical competence for 5/05 and 5/06 entitled "LPN skills competencies" were completed by the

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administrator/SCS who had not visited the home for approximately 2 years while LPN #2 was providing care.

b. Patient #12 was re-admitted to the agency on 12/1/05 with diagnoses, which included muscular dystrophy, insertion of a tracheotomy and gastric tube, and a history of pneumonia and a closed fracture of the femur. Physician's orders for the certification period 3/31/06 through 5/29/06 direct to provide private duty RN/LPN 24-hours daily to attend to the ventilator, administer medications and feedings via the gastric tube, manage the status of the respiratory system by suctioning as needed, keeping the trachea clear, observing for symptoms of respiratory distress and reporting to the physician, cleansing the G-tube and trach sites, following wound care instructions and reporting any symptoms or changes to the RN (agency). Review of the clinical record failed to provide any documentation that the private duty nurses, primarily LPNs, who were employees of the agency, were working under the supervision of the RN in all care provided to this patient. During an interview on 5/30/06 at 11:15 AM with LPN #3 who cares for this patient on the 7 AM to 3 PM shift at least 40 hours per week, she stated that Patient #12 is alert and oriented, ventilator dependent and chair bound and requires continuous care for ventilator management and monitoring, feeding, wound/skin care, emergency care and all ADLs. She further stated that although she used to have supervisory visits by the agency RN, she has not had any since before the patient was last admitted to the agency, but believes that RN #1 will now be making supervisory visits.

During an interview with the Administrator/SCS on 5/23/06 regarding Patient #s 10 and 12, she stated that although she has not made home visits to supervise the nurses, she has talked to them on the phone and is available to them at any time. Review of the personnel file of LPN #3 on 6/14/06 identified that the annual evaluation for 5/05 and 5/06 entitled "LPN skills competencies" were completed by the administrator/SCS who had not visited the home since 12/05 or before while LPN #3 was providing care.

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

9. Based on clinical and personnel record review and staff interviews it was determined that the agency failed to employ a full-time primary care nurse from 9/10/05 to 10/10/05 and from 11/16/05 to 5/24/06. The findings include:

- a. The agency's only full time primary care nurse resigned on 9/9/05. Another nurse was hired on 10/11/05 but was terminated on 11/15/05. The agency did not hire another full time nurse until 4/10/06, however RN #1's personnel record lacked documentation of a letter of appointment and/or a job description indicating the position for which RN #1 was hired.
- b. RN #1 stated on 5/23/06 that she did not sign a job description on hire but was told that she was hired to assist the SCS and not as a primary care nurse.
- c. RN #2 stated on 5/23/06 that she was a per diem nurse and not the primary care nurse and/or case

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manager for her patients since she worked at another full time job. Review of the agency's clinical records indicated that frequently the physician's orders, comprehensive assessments were written by the administrator/ SCS and not by the nurse who conducted the patient visit.

d. The administrator stated on 5/23/06 that aside from shift nurses, the nurses that conducted the intermittent home visits were per diem nurses who did not work for the agency full-time but had other full time employment and often made home visits in the evening to the agency's patients. The agency failed to employ a full time primary care nurse to provide nursing services.

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

10. Based on clinical record review and staff interviews it was determined that for four (4) of eight (8) patients a registered nurse failed to complete the follow-up comprehensive visit to the patient and/or the nurse who conducted the assessment home visit, did not complete the follow-up assessment and /or the follow-up assessments were not fully completed to accurately reflect the health status and nursing needs of the patient (Patient #s 1, 3, 9, 10). The findings include:

a. Patient #1 had a start of care date of 2/2/06. The recertification physician's plan of care dated 4/3/06 to 6/1/06 included skilled nursing 1-2x a week to observe the patient's wound and instruct the family. The follow-up OASIS/comprehensive assessment was documented as completed on 4/4/06 by the administrator/SCS and LPN # 1.

Review of the clinical record indicated that from 3/6/06 to 4/17/06 the LPN completed all visits to the patient. The LPN and not an RN conducted the follow-up comprehensive assessment visit of 3/30/06. The administrator/SCS stated on 5/23/06 that she conferred often with the LPN and occasionally would make patient visits herself. She wrote the follow-up OASIS/assessment in coordination with the LPN's visit.

A registered nurse failed to complete the follow-up comprehensive assessment visit for the patient.

b. Review of eight (8) follow-up OASIS/comprehensive assessments from 6/30/06 to 5/25/06 indicated that for four (4) of eight (8) patients (Patient #s 1, 3, 9, 10) the follow-up assessment was not completed by the nurse who conducted the follow-up assessment home visit but, was completed by the administrator/ SCS.

c. Review of the eight (8) follow-up comprehensive assessments indicated that for four (4) of eight (8) patients (Patient #s 1, 3, 9, 10) the assessments were not fully completed and/or did not consistently accurately reflect the health status of the patient and/or the nursing needs of the patient.

The administrator/SCS stated on 5/23/06 that she completed the follow-up assessments since many of the nurses worked other jobs during the day but she did consult with them.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69

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(a)(3)(D) Services.

11. Based on clinical record review, staff interviews, agency policy review and home visit observations, it was determined that for six (6) of twelve (12) patients, the nurse failed to accurately and/or appropriately and/or consistently re-evaluate the patient's health status and nursing needs and/or to notify the physician of a change in condition that suggested a need to alter the plan of care, including the interventions to address changes in the patient's condition (Patient #s 1, 3, 5, 7, 8, 9). The findings include:

a. Patient #1 had a start of care date of 2/2/06 with diagnoses including chronic skin ulcer, pancreatic disease (diabetes), osteoporosis and hypertension. The plan of care dated 2/2/06 to 4/2/06 included skilled nursing bid to assess wound on right leg and provide wound care with normal saline and Silvadene; home health aide 5-7x a week to assist with IADLs and ADLs.

i. Review of the clinical record from 2/2/06 to 2/16/06 indicated that the wound was measured and identified as a stage 2 decubitus on the admission visit by the LPN on 2/2 and 2/3/06. The clinical record lacked documentation that the wound was measured again after the 2/3/06 visit and/or that the wound was described including a specific location and/or the patient's temperature was assessed. The nurse only visited the patient BID Monday through Friday but the clinical record lacked documentation that the nurse assessed who was responsible to do the wound care on the weekend. On her 2/13/06 AM visit RN #4 documented that the lower extremity was slightly edematous and that the old dressing was dated 2/10/06 and was saturated with yellow serosanguinous drainage. The record lacked documentation that the nurse assessed why the dressing had not been changed over the weekend and/or who was responsible for wound care on the weekend.

ii. On 2/16/06, the nurse documented that the wound care was changed by the wound care clinic to Silvercel and Hydrofera blue, every other day. The nurse did not visit every other day as ordered between 2/20/06 and 2/24/06 and did not identify who was performing wound care QOD. On her visit on 2/24/06 RN #4 documented that she cleansed the wound with saline, applied Hydrafera blue and Vaseline gauze and instructed the home health aide regarding wound care. The subsequent nursing visits from 3/1/06 to 5/10/06 were completed by the LPN 1-2x a week and documented by the LPN as wound care completed by the home health aide. The nursing note lacked documentation that LPN #1 ever observed the patient's wound since the dressing change was documented as done by the aide. The wound was not measured/described since 2/3/06 and patient's temperature was never taken. See G 225

iii. The administrator/SCS stated on 5/23/06 that the patient's family was very involved with the patient and they performed the wound care on the weekends, however the clinical record lacked documentation to support that the family was instructed and/or performing the wound care on the weekends.

iv. LPN #1 stated on 5/22/06 that she did not have a thermometer to take the patient's temperature and that she initially shared the patient's visits with the RN. She stated that she did perform wound care until the aide was taught to do the wound care by the RN. Since 3/1/06, she did not assess the wound but thought that occasionally she looked under the patient's dressing. On a home visit with the administrator on 5/17/06, the patient's right lower extremity appeared much reddened but the wound appeared almost healed. Subsequent to surveyor's inquiry, RN #1 visited the patient on 5/18/06 to

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assess the patient's health status and documented in her note of 5/18/06 that the patient's wound care was changed to bacitracin ointment QOD.

v. RN #4 stated on 5/25/06 that the office told her to teach the aide the wound care procedure "since they are not going to pay anymore for the nurse to do it" so I taught the aide. She stated that she did not have any contact with the patient's family or any responsibility of medication review. RN #4 stated that the LPN admitted the patient and she only shared the wound care responsibility with the LPN for a short while. She stated that she was not the primary care nurse, she just helped out. She stated that she never measured the patient's wound; it was done at the wound care clinic.

vi. Review of the clinical record indicated that the medication list had not been updated since 2/1/06 and the medication list was different from the physician's orders of 2/2/06 and 4/3/06. The administrator stated on 5/18/06 that she did not know the exact medications that the patient was taking because the family was responsible for the patient's medications. Subsequent to surveyor's inquiry, RN #1 conducted a visit to the patient on 5/18/06 and assessed the patient's medications, which were different from the physician's orders of 4/3/06, and the medication list. The nurse confirmed the patient's medications with the physician. The nurse failed to consistently and accurately assess the patient's wound status, VS and/or medications/side effects. See Violation #s 18 and 19.

b. Patient #3 had a start of care date of 12/23/04 with diagnoses including CVA, hypertension and cardiac arrhythmia. The recertification plans of care dated 2/16/06 and 4/17/06 included skilled nursing 1-2x a week to assess mental and physical statuses, nutritional/hydration needs, medication compliance, change the Foley catheter every month, teach the family s/s of adverse reactions and to report/maintain skin integrity.

Review of the nursing note of 3/1/06 indicated that the patient had a bump on the sole of her foot near the heel and the note lacked documentation that the bump was reported to the physician. The nurse spoke to the patient's daughter by phone and encouraged her to see the physician. The patient was not visited again by the nurse until the subsequent nursing visit of 4/10/06. The 4/10/06, nursing note lacked any mention of the patient's alteration in skin integrity and/or the result of the physician's visit/interventions.

RN #4 stated on 5/25/06 that the patient's daughter called the agency about the patient's bump on the foot and the administrator told RN #4 to tell the daughter to take her to the physician. The subsequent visit on 4/10/06 was to just change her Foley catheter and she did not assess her foot or the outcome of the physician's visit.

c. Patient #5 had start of care dates of 01/04/06 and 02/10/06 with a principal diagnosis of endocarditis (onset 12/22/05) and secondary diagnoses of DM II, depression, gout, hypertension, hypothyroidism, mitral valve disorder and heart valve replacements in 1991 and 2000. The hospital discharge summaries dated 01/04/06 and 02/10/06 documented the patient also had a history of CHF and rheumatic heart disease.

i. The plan of care dated 01/04/06, ordered skilled nursing 2-3 times a week to assess mental and physical status, nutritional and fluid needs, safety in the home, medications and compliance and instruct on dietary and fluid intake. Fluid needs and intake parameters were not identified.

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ii. The administrator/supervisor stated on interview on 05/22/06, they (the agency) did not have any orders/certification/plan of care for the 02/10/06 start of care. Subsequent to surveyor inquiry on 06/01/06, the receptionist faxed the 02/10/06 plan of care (POC) to the surveyor. The 02/10/06 POC was not signed by the nurse, nor was it signed by the physician. The first page of the 02/10/06 POC was identical to the 01/04/06 POC except nursing was decreased to 1-2 times a week. Page two of the POC did not correspond to the 02/10/06 admission, though it was dated 02/10/06; page two discussed 50mg of allopurinol to start 11/02/05 for 14 days, then 100mg for 14 days, then 200mg daily; allergy to iodine was listed on both the first and second pages.

Home health aide service was ordered 5-7 days a week to give personal care, maintain good skin integrity, assist AM and PM with elastic stockings, encourage fluid intake and encourage ROM exercises.

iii. Review of the clinical record found no documentation by RN #2, the only nurse to provided documented visits to the patient, of nursing admission notes or medication lists for the 01/04/06 and 02/10/06 admissions. The comprehensive assessment completed by RN #2 dated 01/04/06 lacked a weight and did not discuss fluid intake as indicated on the POC. Seven (7) nursing visits made by RN #2 from 01/06/06 to 02/03/06 lacked documentation that a weight was obtained. On 01/06/06, 01/13/06, 01/16/06, 01/20/06 and 01/31/06, RN #2 documented "teaching interventions - fluid intake requirements".

On 01/20/06 RN #2 documented "left ankle edematous, orthopnea"; on 01/23/06 RN #2 documented "patient reports that her physician reviewed and renewed her medications; "additional dose of lasix per MD for lower leg edema"; on 01/27/06 RN #2 documented "lower leg edema of left ankle"; on 01/31/06, RN #2 documented the patient "complained of fatigue and weakness with restlessness, orthopnea"; on 02/03/06 at 6:45pm, RN #2 documented "patient increased edema and is going to hospital for evaluation in ED, additional lasix ordered by MD, met with granddaughter, called (agency) on call staff; instruction given to patient and aide". The patient was admitted to the hospital at noon on 02/03/06. The agency located the 02/03/06 nursing note for 6:45 PM on 05/23/06; it was filed in RN #2's personnel file, not in the patient's clinical record.

iv. RN #2 stated on interview on 05/22/06, that she always writes a nursing note; she doesn't know where the admission notes and medications lists were; they should be in the chart; she has never called the doctor/clinic because she works late at night; if needed, she would call the home care agency and leave a message for her supervisor. RN #2 didn't feel a call to her supervisor was necessary following her 01/31/06 visit; she does not make patient care decisions; she is just a nurse who gets an assignment from management. She didn't weigh the patient as she was weighed at IV therapy every day; she didn't know if the patient or the agency had a scale nor did RN #2 bring one with her. The administrator/supervisor stated on interview on 05/22/06, that the patient received so much care at the clinic, sometimes daily, that it wasn't necessary for the agency to weigh her. Review of the hospital IV therapy department nursing notes documented that the patient's weight was obtained weekly.

v. The administrator/supervisor stated on interview on 06/06/06, that RN #2 absolutely did not visit with the patient on 02/03/06; RN #2 made a visit to the home in the evening on 02/03/06 and found out from the granddaughter the patient was hospitalized; RN #2 used incorrect grammar; RN #2 probably meant she taught the granddaughter; RN #2 pre-filled the patient's medications thinking the patient

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would not be admitted to the hospital; RN #2 called our office and spoke to the on-call person (billing clerk) and wanted to know why no one called her to say the patient was hospitalized. RN #2 was not available to interview concerning her 02/03/06 nursing visit report.

The billing clerk stated on interview on 06/06/06 that she received a call on the evening of 02/03/06 from RN #2 who was unhappy she had not been informed that the patient was at the hospital and she wanted to be paid for her visit.

The hospital discharge summary dated 02/10/06 documented the patient was admitted on 02/03/06 with CHF, hypoxia and fluid overload; diuresed well (weight 162 lbs. on admission to 146lbs. at discharge); discharged home with oxygen and increased lasix.

vi. Physician #2 stated on interview on 06/05/06, that following the patient's 01/04/06 discharge from the hospital, he saw her in his clinic on 01/18/06 and 01/24/06 at which time the patient's weight was obtained; the patient was not seen every few days at the clinic. He stated the home care nurse did not inform him of the patient's deteriorating status on 01/31/06. He stated he has never received a call from the agency nurse concerning the patient's physical status.

The agency receptionist stated on interview on 06/06/06, that she did not receive a phone call or voice mail message the night of 01/31/06 from RN #2 concerning the patient's health. See Violation #19.

d. Patient #7's most recent start of care date was 5/2/06 with a primary diagnosis of tachycardia, and secondary diagnoses of esophageal disorder, diabetes mellitus type II, hypertension, paranoid schizophrenia and obesity. Review of the clinical record identified that the patient had been intermittently under the service of the agency since 3/14/05 with periodic hospitalizations related to hearing voices and paranoid delusions. The physician's orders for the certification period of 5/2/06 through 6/30/06 identified that the patient was on a low fat diet with no concentrated sweets, required safety measures including fall and neutropenic precautions, as well as safety in activities of daily living (ADLs); skilled nursing visits were ordered two times per day to administer medications, monitor effects and instruct the patient regarding recognizing and responding to adverse reactions, to assess the patients physical and mental status, instruct the patient regarding fluid and nutritional needs, and report changes to the physician. The goals identified for the same certification period included to prevent further hospitalizations, that the patient's cardio-respiratory status will be within normal limits, and that the patient's breath sounds will be clear.

Review of the clinical record notes from 5/2/06 through 5/16/06 failed to provide documentation regarding vital signs, breath sounds, weight, fasting blood sugars, fluid and nutritional needs, implementation of fall and/or neutropenic precautions. During an interview with RN #3 on 5/19/06 at 1:20 PM, she stated that she does not monitor obesity and/or diabetic status and/or other conditions because although she could monitor them, she is just visiting to give medications and monitor their effects and the patients psychological status; however she does ask the patient what her blood sugars are after seeing the physician. During an interview on 5/22/06 at 10:55 AM with LPN #1, she stated that she visited to give meds and did nothing regarding the patient's diabetic status and/or other conditions.

The nursing staff failed to re-assess the patient based on the patient's individual condition and physician orders regarding diabetic status, weight, cognitive status and psychiatric signs and symptoms.

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e. Patient #8 had start of care dates of 02/02/06 and 02/19/06 with a principal diagnosis of chronic paranoid schizophrenia and secondary diagnoses of inguinal hernia repair on 02/02/06, COPD, HTN, prostate disorder and gout. The seventy-seven year old patient was forgetful and confused to person at times throughout the day. He resided in a rooming house with a roommate.

The plan of care dated 02/03/06 to 04/03/06 ordered skilled nursing 3-5 times a week to assess mental/physical status, nutritional/fluid status, respiratory status, maintain skin integrity, assess anxiety, mood and behavior changes and instruct medication use. The plan of care (POC) dated 02/19/06-04/19/06 was identical to the 02/03/06 POC except nursing was ordered 4-5 times a week. Both certifications ordered home health aide service was 2-3 hours/day, seven days a week to provide personal care, encourage fluid intake (adding honey thickener consistency), maintain skin integrity and remind patient to take his medications.

i. There was no documentation on admission by RN #3 concerning SOB, lung sounds and hydration. RN #3 documented on 02/04/06, 02/05/06 and 02/06/06 the patient's lungs were clear, no cough, dyspnea or orthopnea and SOB with minimal activity, which was his baseline pre-hospitalization. There was no documentation of a complete hydration assessment for these visits. On 02/03/06 RN #3 documented the patient's skin was warm and dry; on 02/04/06 RN #3 documented "adequate fluid intake".

For the nursing visits of 02/07/06, 02/08/06 and 02/09/06 there was no documentation by RN #2 of respiratory assessments except for respiratory rate, nor was there a complete hydration assessment except for "adequate fluid intake". On 02/08/06 RN #2 documented "encouraged thickened fluids". On 02/07/06 RN #2 documented the patient had a "cough with wheeze". On 02/15/06 RN #2 documented at 7:15pm the patient's "respiratory status poor; moist rales audible in chest". RN #2 documented with a check mark on 02/07/06, 02/08/06, 02/09/06 and 02/15/06 she had communication with the boarding house. On 02/16/06, Patient #8 presented himself to the hospital ED and was admitted. Review of the hospital discharge report dated 02/19/06 stated the patient was admitted with an exacerbation of COPD and dehydration.

ii. RN #3 stated on interview on 05/24/06, that she only saw the patient for a short time; her supervisor told her to see the patient to check his surgical site and give him pain medications; she was unsure how much fluid the patient drank, but she knew it was adequate; she was not the PCN, her supervisor was. RN #2 stated on interview on 05/26/06, that she knew his fluid intake was adequate because he was not on I & O, he had meals on wheels, she offered him fluids and she would bring him fluids sometimes like a milkshake. Concerning her 02/15/06 visit when the patient's respiratory status was poor, RN #2 stated she left an inhaler by his bedside since "he is a chronic COPDer"; she didn't call the doctor; she talked to the staff at the boarding house and told them he should go to the clinic if they felt it was needed; she always calls her supervisor if she has any findings and RN #2 stated she believes she spoke to her supervisor about the 02/15/06 visit.

iii. The patient's medical physician, Physician #1 stated on interview on 05/24/06, that the hospital's ambulatory medical center and herself were not notified by any nurse from the agency of the patient's deteriorated respiratory status. It is her expectation that the visiting nurse would report abnormal findings to the medical center, even after hours as the hospitalists at the hospital cover for them.

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Physician #1 further stated she would have expected a revisit by the visiting nurse early the next morning.

iv. Home Health Aide (HHA) #6 stated on interview on 05/26/06 that he visited the patient two times a day to cook him breakfast, make sure he ate his meals on wheels and remind him to take his medications. Review of the aide's plan of care dated 02/03/06 did not instruct the aide to remind the patient to take his medications nor was there instruction for the aide to encourage fluids. The aide plan of care dated 02/20/06 instructed the aide to force/encourage thickened fluids (no cup amount was written in next to the preprinted activity) and observe use of inhaler. HHA #6 stated while he is with the patient he drinks a total of 4 cups of liquid, usually milk, orange juice and punch; he forces the patient to drink the fourth cup which is water; the patient doesn't like the thickener in his drinks so he hasn't used it in a long time; he didn't tell RN #2 about this. HHA #6 stated he puts an expensive lotion all over the patient's body following his shower so his skin is never dry. HHA #6 stated he was not aware of any inhaler medication the patient was to take; didn't know it was on his care plan; nor were there any inhalers in his room (Combivent and Advair inhalers were listed on both certifications.) HHA #6 stated he could not remember how the patient felt the morning of 02/15/06 and he did not know the patient went to the ED.

v. On 02/02/06, the patient had an inguinal hernia repair. The certification and plan of care dated 02/03/06-04/03/06 did not include pain assessment from the inguinal hernia surgical site or medications the patient was to take for the pain. On 02/03/06 RN #3 documented the patient complained of pain at the surgical site; she administered Percocet 2 tabs and Cipro 1 tab. On 02/04/06 at 10:15am, RN #3 documented patient complained of surgical pain, Percocet 2 tabs and Cipro 1 tab given. On 02/04/06 at 9:50pm, RN #3 documented the patient complained of surgical pain, Percocet 2 tabs and Cipro 1 tab given. On 02/05/06 at 9:50am, RN #3 documented patient complained of surgical pain, Percocet 1 tab and Cipro 500mg given; spoke with the director of the boarding house; director to administer phosphate soda laxative po, approximately 45cc bottle to patient at 12noon on 02/06/06. On 02/05/06 at 9:50pm, RN #3 documented Percocet 2 tabs and Cipro 500mg given. On 02/06/06 at 8:50pm, RN #3 documented complained of surgical pain, Percocet 2 tabs and Cipro 500mg administered. On 02/07/06 at 8:15pm, RN #2 documented the patient denies pain except for incision site. On 02/08/06 at 7:15pm, RN #2 documented she reminded the patient to take analgesics for pain as ordered. On 02/09/06 at 8:30pm, RN #2 documented the patient expresses decreased pain at incision site. Interview with RN #3 on 05/24/06, she stated she has a full time job during the day; she could only visit the patient in the morning and evening; though the patient had pain when she arrived, she did not know what intensity and for how long; Percocet and Cipro bottles were in the patient's room on her first visit; the director at the boarding house told her the patient came home from the hospital with them; she did not call the doctor to confirm the medications; the medications were kept at the agency office and pre-poured for the patient; she did not know why the patient was on Cipro. RN #2 stated she was told by her supervisor that the agency had no one available on 02/05/06 to administer the phosphate soda; her supervisor told her it was RN #3's job to report to the boarding house director she had to administer the phosphate soda on 02/06/06 because the patient was to have abdominal CAT scan on 02/07/06. RN #2 stated on interview on 05/26/05, that by the time she started seeing the patient on 02/07/06, there was an empty Cipro bottle in the patient's room; she did not know why the patient had taken that

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medication; his medications were pre-poured by her supervisor at the agency; the aide knew the patient used an inhaler because the aide handed it to her at a visit; her supervisor has the aide drop off medications for the day; she did not know there wasn't a medication list in the chart; the patient had dysphagia at one time probably from a TIA and she was not aware HHA #6 had not been using the thickener in fluid. RN #2 further stated she is a per diem nurse for the agency, not a primary care nurse; she is just a fill-in as she has a full-time job elsewhere; her supervisor manages the cases; if RN #2 has any questions or findings, she calls the agency and leaves a message on the receptionist or the billing clerk's answering machines at their homes; she assumed her messages were given to her supervisor. See Violation #s 16 and 19.

f. Patient #9 had a start of care date of 1/22/04 with diagnoses including multiple sclerosis and hypertension. The plan of care dated 3/12/06 to 5/10/06 included skilled nursing 1-2x a month to assess mental and physical statuses, instruct caregiver on dietary/hydration needs, maintain skin integrity, change Foley catheter q 1 month and assess medication use; home health aide 5x a week to assist with personal care, maintain skin integrity, encourage fluids and monitor swallowing ability. Review of the follow-up comprehensive assessment of 3/11/06, completed by the administrator/SCS, indicated that the patient was totally dependent for her ADLs although her ability to ambulate and ability to bathe were not completed on the assessment form.

Review of the nursing notes of 3/10/06 and 4/12/06 indicated only that the patient was verbally responsive and alert, RN # 4 changed the catheter without discomfort obtaining clear yellow urine and she instructed the aide and patient to increase fluids. The nurse checked off instruction was given to the aide and that the patient was bedbound and chair fast. The clinical record including the plans of care, visit notes and/or the aide care plan failed to indicate the frequency that the patient was out of bed, who stayed with the patient when the aide left after 2 hours i.e., was the patient safe at home alone, if the aide utilized the Hoyer lift for transfers and/or failed to assess the patient's nutrition/hydration status. The monthly visit notes of 3/10/06 and 4/12/06 lacked documentation that the nurse assessed the patient's vital signs including temperature, the frequency that the patient was out of bed, who stayed with the patient when the aide left after 2 hours i.e., was the patient safe at home alone, transfers of the patient by the aide including the Hoyer lift and/or the patient's nutrition/hydration status. Review of the progress sheet note dated 4/30/06 noted that the patient was admitted to the hospital with a urinary tract infection.

RN #4 stated on 5/25/06 that she was not the primary care nurse for the patient but only went to change her catheter once a month when she visits the patient with a paper that included the patient's name and date of birth. She stated that she did not have orders or a medication list when she visited the patient. RN #4 stated that the patient was always in bed when she visited and that the patient could not be left alone. The patient employed a private aide who RN #4 would instruct during the visit. RN #4 did not instruct the agency's aide because she never met the aide due to the time of day she visited the patient (evening visit). The clinical record lacked documentation that the agency aide was ever supervised by an agency nurse. RN #4 stated that she normally would monitor the patient's VS but never took her temperature since the agency did not provide thermometers and the patient did not have one. The nurse failed to accurately assess the patient's health status and nursing needs.

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

12. Based on review of clinical records and staff interviews it was determined that for Patient #1 the nurse failed to appropriately delegate activities which could safely be performed by the home health aide. The findings include:

a. Patient #1 had a start of care date of 2/2/06 with diagnoses including chronic skin ulcer, pancreatic disease (diabetes), osteoporosis and hypertension. The plan of care dated 2/2/06 to 4/2/06 included skilled nursing bid to assess wound on right leg and provide wound care with normal saline and Silvadene; home health aide 5-7x a week to assist with IADLs and ADLs. The plan of care for 4/3/06 to 6/1/06 included skilled nursing 1-2x a week to observe the patient's wound; HHA 5-7x a week to assist with IADLs and ADLs.

On 2/16/06, the nurse documented that the wound care was changed by the wound care clinic to Silvercel and Hydrofera blue, every other day. The nurse did not visit every other day as ordered between 2/20/06 and 2/24/06 and did not identify who was performing wound care QOD. On her visit of 2/24/06, RN #4 documented that she cleansed the wound with saline, applied Hydrafera blue and Vaseline gauze and instructed the home health aide regarding wound care. The subsequent nursing visits from 3/1/06 to 5/10/06 were completed by the LPN 1-2x a week and the LPN documented that the wound care was performed by the aide. The nursing note lacked documentation that the patient's wound care was performed by the LPN and/or was assessed/observed by LPN #1 since the dressing change was documented as done by the aide.

RN #4 stated on 5/25/06 that the office told her to teach the aide the wound care procedure "since they are not going to pay anymore for the nurse to do it" so I taught the aide to provide the wound care on 2/24/06.

LPN #1 stated that she did perform wound care until the aide was taught to do the wound care. Since 3/1/06, she did not provide wound care and/or assess/observe the wound.

The nurse failed to appropriately and safely delegate activities to the home health aide.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69
(d)(4)(C) Services.

13. Based on staff interviews and personnel records it was determined that the agency failed to employ a full-time supervisor whose primary responsibility was the management of the homemaker-home health aide program from 9/10/05 to 5/24/06 and/or from 9/10/05 to 10/11/05 and 11/16/05 to 5/24/06, a nurse who may have other responsibilities, to be responsible for the home health aide program. The findings include:

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- a. The agency's home health aide employee list included 28 active aides.
- b. The administrator/ supervisor of clinical services (SCS) stated on 5/18/06 that the receptionist was the supervisor of the aide program and that she, the administrator/SCS, was also the nurse with other responsibilities who assisted in the aide program.
- c. Review of the receptionist's personnel record failed to include a job description and/or a letter of appointment indicating that the receptionist was the supervisor of the homemaker-home health aide program. The agency failed to employ a full-time supervisor whose primary responsibility was the management of the homemaker-home health aide program and/or failed to assign a full-time nurse with other responsibilities to assist in the aide program for the 28 aides actively employed by the agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)(1)(B)(D)(E)(F), (b)(4) Personnel policies.

14. Based on review of the agency's personnel files and staff interviews it was determined that the agency failed to complete an orientation program when they hired the only primary care nurse/supervisor assistant. The findings include:

- a. RN #1's date of hire was 4/10/06. Review of RN #1's personnel record lacked documentation to support that the nurse was oriented to patient care policies and procedures, description of patient population and geographic area served, applicable state and federal regulations, position description and/or failed to maintain in her personnel file a current license and a signed contract and/or letter of appointment.
- b. RN #1's orientation list was only checked as oriented to philosophy of patient care, goals and objectives and organizational structure which was signed by the administrator/SCS on 3/26/06. RN #1 stated on 5/23/06 that she did not receive a letter of appointment and did not receive a job description. She thought that she was hired to assist the administrator/SCS and to admit/assess new patients but did not think she was hired as the primary care nurse.
- c. The administrator/SCS stated on 5/23/06 that RN #1 was hired to assist the administrator and to serve as primary care nurse. Subsequent to surveyor's inquiry RN #1's hours were increased from 27.5 hrs. to 35 hrs. The administrator stated on 5/23/06 that RN #1 did not have a total orientation, yet, since she was only hired 5 weeks ago and was making patient visits in order to be acquainted with the patients.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)(2)(5) Personnel policies.

15. Based on a review of agency policy and the personnel files of five (5) home health aides (HHA), it was determined that the agency failed to provide timely physicals and PPD tests and/or in-service education of an annual average of one hour per month. The findings include:

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- a. HHA #1's hire date was 4/31/01. Review of the personnel file identified that a physical examination had not been performed since 2/4/04 and that she had received less nine (9) of the required twelve (12) hours of in-service for the previous year.
- b. HHA #2's date of hire was 2/24/05. The agency could not provide evidence that a pre-hire of annual physical and PPD had been done and/or that the employee had received more than four (4) of the required twelve (12) hours of in-service for the previous year. Subsequent to surveyor's inquiry, the employee was taken off duty until a physical, PPD was completed, and she was found to be free from communicable disease.
- c. HHA #3's hire date was 7/15/04. The agency could not provide evidence that the employee received more than eight (8) of the required twelve (12) hours of in-service in the previous year.
- d. HHA #4's hire date was 10/18/02. The agency could not provide documented evidence that the employee received more than eight (8) of the required twelve (12) hours of in-service in the previous year.
- e. HHA #5's hire date was 4/2/05. Review of the employee's pre-hire physical and PPD test identified that they were done on 6/3/05 (2 months after the hire date). The agency could not provide evidence that the employee did or did not work before this date and stated that it took so long to get them done because the physician was not cooperative.
- f. Agency policy states that both physical examinations and PPD tests will be performed annually.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(2)(C) Patient care policies.

16. Based on review of the clinical record and staff interviews it was determined that for six (6) twelve (12) patients the nurse failed to send a written summary report to the physician at least every 60 days and/or failed to write a 60-day summary report inclusive of but not limited to pertinent factors of a patient's clinical notes and progress notes, total progress i.e., social, emotional, or behavioral adjustments relative to the diagnosis, treatment, rehabilitation potential, and anticipated outcomes toward recovery or further debilitation (Patient #s 1, 2, 3, 6, 8, 9). The findings include:

- a. Patient #1 had a start of care date of 2/2/06 with diagnoses including chronic skin ulcer, pancreatic disease (diabetes), osteoporosis and hypertension. The plan of care dated 2/2/06 to 4/2/06 included skilled nursing bid to assess wound on right leg and provide wound care; home health aide 5-7x a week to assist with IADLs and ADLs. The recertification of the plan of care dated 4/3/06 to 6/1/06 included skilled nursing 1-2 x a week to observe the wound and instruct the family on diet for diabetes; home health aide 5-7x a week to assist with ADLs and IADLs
- Review of the recertification of the plan of care of 4/3/06 and the clinical record lacked documentation to support that a written 60-day summary report for the patient was sent to the physician. The administrator/SCS stated on 5/17/06 that the agency policy is that the written 60-day summary report to the physician is written on the recertification plan of care. She stated that since she was

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responsible for writing the patient's plan of care she must have forgotten to include a 60-day report for Patient #1 on the 4/3/06 recertification plan of care.

b. Patient #2 had a start of care date of 1/7/05 with diagnoses including chronic obstructive lung disease, hip replacement, syncope, hypotension and atrial fibrillation. The physician's plan of care dated 3/3/06 to 5/1/06 included skilled nursing 1-2 x a week to assess cardiopulmonary status, assess skin integrity and mobility and supervise the aide.

Review of the recertification plan of care dated 3/3/06 to 5/1/06 and the clinical record lacked documentation to support that a written 60-day summary report was sent to the physician.

The administrator/SCS stated on 5/17/06 that the agency policy is that the written 60-day summary report to the physician is written on the recertification plan of care. She stated that since she was responsible for writing the patient's plan of care she must have forgotten to include a 60-day report for Patient #2 on the 3/3/06 recertification plan of care.

c. Patient #3 had a start of care date of 12/23/04 with diagnoses including CVA, hypertension and cardiac arrhythmia. The recertification plans of care dated 2/16/06 to 4/16/06 and 4/17/06 to 6/15/06 included skilled nursing 1-2x a week to assess mental and physical status, nutritional/hydration needs, medication compliance and change the Foley catheter every month.

Review of the clinical record and the recertification plans of care dated 2/16/06 and 4/17/06 lacked documentation to support that a written 60-day summary report was sent to the physician.

The administrator/SCS completed the recertification plans of care for 2/16/06 and 4/17/06.

d. Patient #6 had a start of care of 08/01/92 with a diagnosis of paranoid schizophrenia. The plans of care dated 01/07/06-03/07/06 and 03/08/06-05/06/06 ordered skilled nursing BID to assess physical/mental status, administer medication, monitor effects, instruct patient of signs and symptoms adverse reactions to report and supervise the home health aide. Review of the plan of care dated 01/07/06-03/07/06 and the clinical record lacked documentation to support that a written sixty (60) day summary report for the patient was sent to the physician. Review of the plan of care dated 03/08/06-05/06/06 only stated the patient was "stable at this time". The administrator/supervisor stated on interview on 05/17/06 that she was responsible for writing the patient's plan of care and she must have forgotten to write the 01/07/06 sixty (60) day report.

e. Patient #8 had start of care dates of 02/02/06 and 02/19/06 with a principal diagnosis of chronic paranoid schizophrenia and secondary diagnoses of inguinal hernia repair on 02/02/06, COPD, HTN, prostate disorder and gout. The seventy-seven year old patient was forgetful and confused to person at times throughout the day. He resided in a rooming house with a roommate.

The certification and plan of care dated 04/20/06-06/18/06 ordered skilled nursing 4-5 times a week to assess mental/physical status, nutritional/fluid status, respiratory status, maintain skin integrity, assess anxiety, mood and behavior changes and instruct medication use. Both certifications ordered home health aide service 4-5 times a week to provide personal care, encourage fluid intake (adding thickener to honey consistency), maintain skin integrity and remind patient to take his medications.

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Review of the clinical record and the recertification plan of care dated 04/20/06-06/18/06 lacked documentation to support a written sixty (60) day summary report was sent to the physician.

f. Patient #9 had a start of care date of 1/22/04 with diagnoses including multiple sclerosis and hypertension. The plans of care dated 1/11/06 to 3/11/06 and 3/12/06 to 5/10/06 included skilled nursing 1-2x a month to assess mental and physical status, instruct caregiver on dietary/hydration needs, maintain skin integrity, change Foley catheter q 1 month, assess medication use; home health aide 5x a week to assist with personal care, maintain skin integrity, encourage fluids and monitor swallowing ability.

Review of the clinical record and the recertification plan of care for 1/11/06 lacked documentation to support that a written 60-day summary was sent to the physician and the recertification plan of care for 3/12/06 only stated that the patient was stable.

The administrator/SCS completed the recertification plans of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(2)(C) Patient care policies.

17. Based on clinical record reviews and staff interviews, it was determined that for three (3) of twelve (12) patients the nurse failed to send a ten (10) day written summary report to the physician and/or failed to write a ten (10) day report inclusive of but not limited to pertinent factors of a patient's clinical notes and progress notes, total progress i.e., social, emotional or behavioral adjustments relative to their diagnosis, treatment, rehabilitation potential and anticipated outcomes toward recovery or further debilitation. (Patient #s 4, 5, 8). The findings include:

a. Patient #4 had a start of care of 03/29/06 with a principle diagnosis of dementia and secondary diagnoses of anemia, hypertension and pneumonia (02/02/06). The plan of care dated 03/29/06 ordered skilled nursing 1-2 times a week to assess status, instruct aide on diet and supervise aide. The administrator/supervisor documented the ten (10) day report on 03/29/06 on the plan of care as follows: "Patient pleasant, calm woman needs stimuli. Patients' family members in conflict with each other."

b. Patient #5 had start of care dates of 01/04/06 and 02/10/06 with a principal diagnosis of endocarditis and secondary diagnoses of DM II, gout, depression, hypertension, hypothyroidism and heart valve replacement in 1991 and 2000. Skilled nursing was ordered 2-3 times a week to assess mental, physical status, nutritional and fluid needs and medication compliance. Review of the ten (10) day report on the plan of care dated 01/04/06, written by the administrator/supervisor, documented "Patient goes to the hospital to receive IV therapy. The agency nursing sees that her transportation is managed. Her status is extremely fragile". Review of the clinical record and the plan of care dated 02/10/06-04/10/06 lacked

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documentation to support that the physician received a ten (10) day summary report.

c. Patient #8 had start of care dated of 02/02/06 and 02/19/06 with a principal diagnosis of chronic paranoid schizophrenia and secondary diagnoses of inguinal hernia repair on 02/02/06, COPD, HTN, prostate disorder and gout. Review of the ten (10) day report on the plan of care dated 02/03/06, written by the administrator/supervisor, documented "Patient is not homebound. He continues to smoke cigarettes. He had surgery for hernia repair this month".

The patient was hospitalized from 02/16/06-02/18/06 with COPD exacerbation and dehydration. Review of the ten (10) day report on the plan of care dated 02/19/06, written by the administrator/supervisor, documented the "Patient is still smoking. Orders for medications after discharge also include Prednisone and Zithromax".

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

18. Based on clinical record review and staff interviews it was determined that for five (5) of twelve (12) patients the nurse failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of alterations to the plans of care (Patient #s 1, 2, 3, 4, 7). The findings include:

- a. Patient #1 had a start of care date of 2/2/06 and diagnoses including chronic skin ulcer, pancreatic disease and hypertension. The plan of care dated 2/2/06 included skilled nursing twice a day to assess the right leg wound and provide wound care. Review of the clinical record from 2/2/06 to 2/18/06 indicated that the nurse only visited the patient Monday through Friday (5 x a week) bid to perform wound care and failed to document in the record who was providing wound care on the weekend and/or any teaching of others to provide wound care.
 - i. On 2/22/06 wound care orders from the wound care clinic included Silvercel and Hydrofera blue dressings to be done QOD. On 2/24/06, the RN taught the aide the dressing procedure and the nurse only visited 1-2x a week from 2/24/06 to 5/10/06 and did not perform wound care as ordered QOD.
 - ii. The signed interagency referral form/orders from the skilled nursing facility dated 2/1/06 included a referral for physical therapy and occupational therapy. The patient's clinical record lacked documentation to support that the PT and/OT referrals were made and/or that the physician was notified as to why these services were not referred.
 - iii. The plan of care dated 2/2/06 included skilled nursing bid to assess the patient's wound and provide wound care. The plan of care dated 4/3/06 included skilled nursing 1-2 x a week to observe the patient's wound. Review of the clinical record and nursing notes from 2/24/06 to 5/10/06 indicated that the nurse only observed an intact dressing; the aide performed the wound care and/or lacked documentation that the nurse ever observed the wound itself and/or provided wound care.
 - iii. The administrator/SCS on 5/17/06 stated that referrals for PT and OT were not made and the physician was not notified but these disciplines were not included in the plan of care of 2/2/06.

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LPN #1 stated on 5/23/06 that the RN taught the aide the dressing procedure and she stated that she, LPN #1, was the only nurse visiting the patient between 3/3/06 and 5/10/06 and that she did not assess the wound during her visits. She stated that she did not have a thermometer so she did not take her temperature.

RN # 4 stated on 5/26/06 that she was told by the office to teach the aide the wound care on 2/24/06. The nurse failed to follow the physician's plan of care.

b. Patient #2 had a start of care date of 1/7/05 with diagnoses including chronic obstructive lung disease, hip replacement, syncope, hypotension and atrial fibrillation. The physician's plan of care dated 3/3/06 to 5/1/06 included skilled nursing 1-2 x a week to assess cardiopulmonary status, assess skin integrity and mobility and supervise the aide. The plan of care of 3/3/06 lacked orders for a home health aide. Review of the clinical record indicated that the patient received aide services 4-5x a week from 3/1/06 to 4/27/06.

The administrator/SCS stated on 5/17/06 that she wrote the physician's plan of care and must have forgotten to include the orders for the home health aide.

c. Patient #3 had a start of care date of 12/23/04 with diagnoses including CVA, hypertension and cardiac arrhythmia. The recertification plans of care dated 2/16/06 and 4/17/06 included skilled nursing 1-2x a week to assess mental and physical statuses, nutritional/hydration needs, medication compliance and change the Foley catheter every month.

Review of the clinical record from 3/1/06 to 4/28/06 indicated that the nurse visited the patient only on 3/1/06 and 4/10/06 to change the patient's Foley catheter and not 1-2x a week as stated on the physician's plans of care.

The administrator /SCS stated on 5/17/06 that she wrote the physicians plans of care and must have forgotten to change the visit frequency.

d. Patient #4 had a start of care of 03/29/06 with a principle diagnosis of dementia and secondary diagnoses of anemia, hypertension and pneumonia (02/02/06). The plan of care dated 03/29/06 ordered skilled nursing 1-2 times a week to assess status, instruct aide on diet and supervise aide. There was no clinical record documentation a visit was made to the patient on 03/29/06. On 03/30/06 the administrator/supervisor documented she supervised an agency aide in the home. On 03/31/06, the administrator/supervisor filled out, signed and dated the incomplete start of care OASIS that was co-signed by RN #4. No nursing visits were made for the weeks of 04/02/06 and 04/09/06. RN #1 made a nursing visit on 04/17/06. Review of the agency's Medicare billing for Patient #4 documented RN #4 made a skilled nursing visit on 03/29/06. Interview with RN #4 on 05/18/06 she stated she wasn't able to see the patient for the first time until the night of 03/31/06 as she had a full time job during the day; she worked part-time for the agency and made visits to do tasks; RN #4 thought she was only responsible for the admission and no further visits; RN #4 was not responsible for the plan of care; no one told her she was to continue visiting the patient.

While interviewing the agency administrator/supervisor on 05/18/06, the agency receptionist stated she knew why Medicare was billed for the 03/29/06 nursing visit; the administrator/supervisor went to visit

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Patient #4 to have papers signed and check out the home; the supervisor felt the patient's bed needed to be downstairs.

Interview with the agency administrator/supervisor on 05/18/06, she stated she visited the patient on 03/29/06 only "to look at the home environment and have the patient sign required authorizations". The administrator/supervisor stated RN #4 completed the OASIS the evening of 03/31/06 as that was the first time RN #4 could make a visit to the patient; she could not remember why RN #4 co-signed the OASIS; RN #4 misunderstood me and thought she was to visit the patient every two (2) weeks; the patient was to have her medications pre-poured weekly by the nurse; the two (2) weeks we didn't see the patient her private aide took care of the medications; I didn't critique the private aide; the doctor was not notified the patient wasn't visited for two (2) weeks; I was without a primary care nurse for several months and had to wear many hats. The administrator/supervisor stated because the agency is small, the receptionist who is also the home health aide supervisor and filer, knows all about their patients.

e. Patient #7's most recent start of care date was 5/2/06 with a primary diagnosis of tachycardia, and secondary diagnoses of esophageal disorder, diabetes mellitus type II, hypertension, paranoid schizophrenia and obesity. Review of the clinical record identified that the patient had been intermittently under the service of the agency since 3/14/05 with periodic hospitalizations related to hearing voices and paranoid delusions. The physician's orders for certification period 5/2/06 through 6/30/06 identified that the patient was on a low fat diet with no concentrated sweets, required safety measures including fall and neutropenic precautions, as well as safety in activities of daily living (ADLs); skilled nursing visits were ordered two times per day to administer medications, monitor effects and instruct the patient regarding recognizing and responding to adverse reactions, to assess the patient's physical and mental status, instruct the patient regarding fluid and nutritional needs, and report changes to the physician. The goals identified for the same certification period included to prevent further hospitalizations, that the patient's cardio-respiratory status will be within normal limits, and that the patient's breath sounds will be clear.

Review of the clinical record notes from 5/2/06 through 5/16/06 failed to provide documentation regarding vital signs, breath sounds, weight, fasting blood sugars, fluid and nutritional needs, implementation of fall and/or neutropenic precautions. During an interview with RN #3 on 5/19/06 at 1:20 PM, she stated that she does not monitor obesity and/or diabetic status and/or other conditions because although she could monitor them, she is just visiting to give medications and monitor their effects and the patient's psychological status; however she does ask the patient what her blood sugars are after seeing the physician. During an interview on 5/22/06 at 10:55 AM with LPN #1, she stated that she visited to give meds and did nothing regarding the patient's diabetic status and/or other conditions. The nursing staff failed to follow the physician's written plan of care.

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

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19. Based on clinical record review and staff interviews, it was determined that for five (5) of twelve (12) patients the nurse failed to include a review of all medications the patient was currently using in order to identify any potential adverse reactions (Patient #s 1, 2, 5, 8, 12). The findings include:

a. Patient #1 had a start of care date of 2/2/06 with diagnoses including chronic skin ulcer, pancreatic disease (diabetes), osteoporosis and hypertension. The plan of care dated 2/2/06 to 4/2/06 included skilled nursing bid to assess wound on right leg and provide wound care with normal saline and Silvadene; home health aide 5-7x a week to assist with IADLs and ADLs.

Review of the clinical record indicated that the medication list had not been updated since 2/1/06; the medication list was different from the physician's orders of 2/2/06 and 4/3/06. The administrator stated on 5/18/06 that she did not know the exact medications that the patient was taking because the family was responsible for the patient's medications. Subsequent to surveyor's inquiry, RN #1 conducted a visit to the patient on 5/18/06 and assessed the patient's medications in the home which identified that they were different than the physician's orders of 4/3/06 and the medication list; the nurse confirmed/clarified the patient's medications with the physician. The nurse failed to consistently and accurately assess the patient's medications/side effects.

b. Patient #2 had a start of care date of 1/7/05 with diagnoses including chronic obstructive lung disease, hip replacement, syncope, hypotension and atrial fibrillation. The physician's plan of care dated 3/3/06 to 5/1/06 included skilled nursing 1-2 x a week to assess cardiopulmonary status and medication use. Review of the patient's medication record indicated that the medications were last reviewed on 1/7/05. Toprol XL 50 mg. qd. was listed on the medication record but was not listed on the physician's plan of care of 3/3/06.

The administrator/SCS who wrote the plan of care of 3/3/06 stated on 5/23/06 that she did not know if the patient was still taking the Toprol since the family is responsible for his medications.

RN #4 stated on 5/25/06 that the administrator/SCS did not tell her about his medications and RN #4 stated that she only saw the patient's daughter once and did not review his medications since she (RN #4) had nothing to do with his medications and was only a per diem nurse. The nurse failed to conduct a review of the patient's medications.

c. Patient #5 had start of care dates of 01/04/06 and 02/10/06 with a principal diagnosis of endocarditis and secondary diagnoses of DM II, gout, depression, hypertension, hypothyroidism, mitral valve disorder and heart valve replacements in 1991 and 2000. Skilled nursing was ordered 2-3 times a week on the 01/04/06 plan of care and 1-2 times a week on the 02/10/06 plan of care to assess mental and physical status, nutritional and fluid needs, medications and compliance.

i. Review of the medications documented on the unsigned 02/10/06 POC were not reflective of the medications the patient was discharged home with from the hospital. Review of the hospital discharge medications documented lasix 80mg BID, prandin 2mg TID before meals, lisinopril 40mg qd and colchicine 0.6mg every 48 hours. The 02/10/06 POC documented lasix 40mg BID, prandin 1 mg and lisinopril 5mg qd; colchicine was not listed.

ii. Review of the clinical record found no medication list or admission note for both plans of care. The agency administrator/supervisor stated on interview on 05/22/06, that she was unable to find the

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medication lists and admission notes; she did not know where they could be.

iii. RN #2 stated on interview on 05/22/06 that the medication lists should be in the chart as she writes a list when she admits a patient; it must be a documentation and filing issue; she pre-poured the patient's medications each week from a medication sheet; she no longer has the sheet as the patient is deceased; she only had the medication sheet when she went into the home, nothing else; it's not like I worked off of the chart; I'm just a per diem nurse who helps out; I do not make the decisions, only recommendations; I'm just a nurse who gets an assignment from management; since I work for the agency in the evening, I would leave a message at the agency if I found a new bottle of medication in the patient's home; I would call the pharmacy to confirm the medication; I do not call the patient's doctor to confirm the medication or send him a short order; I presumed my supervisor did that; if I had any medication questions I would leave a note for the patient to take to the doctor; I never call the doctor as I work nights.

d. Patient #8 had start of care dates of 02/02/06 and 02/19/06 with a principal diagnosis of chronic paranoid schizophrenia and secondary diagnoses of inguinal hernia repair on 02/02/06, COPD, HTN, prostate disorder and gout. The seventy-seven year old patient was forgetful and confused to person at times throughout the day. He resided in a rooming house with a roommate.

i. The initial certification and plan of care dated 02/03/06 to 04/03/06 ordered skilled nursing 3-5 times a week to assess mental/physical status, nutritional/fluid status, respiratory status, maintain skin integrity, assess anxiety, mood and behavior changes and instruct medication use. The initial certification and plan of care dated 02/19/06-04/19/06 was identical to the 02/03/06 orders except nursing was ordered 4-5 times a week. Both certifications ordered home health aide service 2-3 hours/day, seven days a week to provide personal care, encourage fluid intake (adding thickener to honey consistency), maintain skin integrity and remind patient to take his medications.

ii. Review of the clinical record indicated that there was no medication list for the certification period 02/03/06-04/03/06. The medications listed on the 02/03/06-04/03/06 plan of care did not include the medications Percocet and Cipro that were administered by RN #3 from 02/03/06 thru 02/06/06. RN #3 stated on 05/24/06 the patient was sent home from the hospital after his 02/02/06 inguinal hernia repair with these medications; she was not the primary care nurse, her supervisor was; she did not write a medication list as her supervisor is in charge of that. The clinical record medication list dated 02/19/06 was different than the plan of care dated 02/19/06-04/19/06; allopurinol 300mg BID was listed on the clinical record medication list and not on the 02/19/06 physician orders. RN #2 stated on interview on 05/19/06 that she found the allopurinol medication in the patient's home which he brought home from the hospital; she did not write the plan of care, her supervisor did that; she did not know the allopurinol listed on the 02/19/06-04/19/06 certification was incorrect; RN #2 could not remember if she left her supervisor a message about the allopurinol.

e. Patient #12 was re-admitted to the agency on 12/1/05 with diagnoses including muscular dystrophy, insertion of a tracheotomy and gastric tube, and a history of pneumonia and a closed fracture of the femur. Physician's orders for the certification period 3/31/06 through 5/29/06 direct to provide private duty RN/LPN 24-hours daily to attend to the ventilator, administer medications and feedings via the

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gastric tube, manage the status of the respiratory system by suctioning as needed, keeping the trachea clear, observing for symptoms of respiratory distress and reporting to the physician, cleansing the G-tube and trach sites, following wound care instructions and reporting any symptoms or changes to the RN (agency). Review of the clinical record failed to provide any documentation that the private duty nurses who were employees of the agency, had documented the medications that they administered to the patient. According to LPN #2, during an interview on 6/1/06, she stated that the other nurses knew what medications the patient was on, that she and the other nurses did not use an MAR or any other form of documentation each time they gave the medications and that at least one time per week she would document in the notes that the medications, their dosage and frequency had not changed.



DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B
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August 3, 2006

Patricia Riggs, RN, Administrator
Caring, Inc.
733 Summer Street
Stamford, CT 06901

Dear Ms. Riggs:

Unannounced visits were made to Caring, Inc. on July 31, 2006 and August 1, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a certification follow-up inspection.

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 10, 2006 or if a request for a meeting is not made by the stipulated date, the violation(s) shall be deemed admitted.

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

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

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

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

Respectfully,

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

SNC:NC:



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

1. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 13 and 14 as evidenced by the violations listed in this document. The administrator continued to conduct admission visits and to list herself as the case manager of patients.

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

2. The supervisor of clinical services (SCS) failed to ensure the safety and quality of care rendered to Patient #s 13 and 14 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-D69 (a)(3)(A) Services.

3. Based on clinical record review and staff interviews it was determined that for one (1) of one (1) patient the registered nurse failed to complete an initial assessment in order to determine the immediate care needs of Patient #13. The findings include:

a. Patient #13 had a start of care date of 7/20/06 with a diagnosis of fractured humerus - closed. The plan of care dated 7/20/06 included skilled nursing visit to assess physical and mental status, mobility of the fingers in right arm and assess vital signs. The nurse was to instruct the patient on medication regime, safety measures, bowel regime and instruct the aide in s/s to report to the nurse. The nurse was to report to the physician any edema in the affected area. The plan of care lacked frequency for the nursing visits. The aide was to visit 3 hours each day prior to surgery and after discharge would resume care 3 hours 5x a week to assist with ADLs and IADLs and to hydrate the patient.

The clinical record lacked documentation to support that an initial comprehensive assessment was completed by the administrator who conducted the admission visit. The clinical record contained only an admission nursing note dated 7/20/06. The administrator noted in the progress note of 7/26/06 that the patient was referred by her insurance company and was to have surgery on 7/21/06.

The administrator stated on 7/31/06 that there was no one else available to admit the patient and she did not know that she needed to complete an assessment for insurance patients.

DATE(S) OF VISIT: July 31 and August 1, 2006

EXHIBIT B

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

4. Based on clinical record review and staff interviews it was determined that for two (2) of four (4) patients the nurse failed to appropriately and/or accurately reassess the patient's health status and/or nursing needs, and/or to notify the physician of a change in condition on a timely basis that suggested a need to alter the plan of care, including interventions to address the change in condition (Patient #s 13 and 14). The findings include:

a. Patient #13 had a start of care date of 7/20/06 with a diagnosis of fractured humerus - closed. The plan of care dated 7/20/06 included skilled nursing visit to assess physical and mental status, mobility of the fingers in right arm and assess vital signs. The nurse was to instruct the patient on medication regime, safety measures, bowel regime and instruct the aide in s/s to report to the nurse. The nurse was to report to the physician any edema in the affected area. The plan of care lacked frequency for the nursing visits. The aide was to visit 3 hours each day prior to surgery and after discharge would resume care 3 hours 5x a week to assist with ADLs and IADLs and to hydrate the patient.

The nursing note and the progress note of 7/20/06 indicated that the patient sustained a fracture of the right humerus caused by a traumatic fall, was taking percocet ordered by her physician, exhibited discoloration of her right upper arm which was in a sling and which alleviated some of her discomfort. The administrator instructed the patient to drink water and add roughage to her diet since she had been constipated for 4 days.

The administrator failed to assess the patient's level of pain and/or pain medication management, mobility and functional status, failed to assess the fall in order to assess the patient's safety and failed to reassess the patient's bowel status and constipation.

The subsequent visit of 7/26/06 noted that the patient had surgery to repair her fractured right humerus, complained of constipation since her last bowel movement was on 7/23/06 and had taken Metamucil with poor relief, had seen her physician who removed clips from the incision which was clean and dry. The nurse noted that the patient's shoulder was swollen and warm to touch. The nurse stated that the plan was to continue with the home health aide and continue an RN visit in 1 week to assess discontinued IV site, safety and constipation. The next visit to be determined after discussion with the insurance company.

The nurse failed to indicate the surgical procedure the patient had on 7/21/06, failed to reassess the circulation of the right hand, mobility/functional status and adequate pain management. The nurse failed to inform the physician of the patient's ongoing constipation in order to obtain appropriate relief. The patient's nutritional/hydrational status had not been assessed in order to promote wound healing and/or to prevent constipation.

A resumption of care comprehensive assessment had not been completed for the patient during the nursing visit of 7/26/06 following the patient's hospital discharge of 7/24/06.

As of 8/1/06, the patient had not received another nursing visit since the 7/26/06 visit.

Review of the clinical record indicated that the administrator called the patient on 7/29/06 and she stated that she still needed care even though the insurance company had not authorized more visits so the patient stated she would pay for the aide on 7/31/06.

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The nurse failed to reassess the patient's health status, nursing needs including pain management and constipation and failed to revisit the patient to assess the patient's needs.

The administrator stated on 8/1/06 that she was waiting for orders from the patient's physician who was away until 8/1/06 before conducting another nursing visit.

b. Patient #14 had a start of care date of 4/8/05 with current diagnoses including decubitus ulcer, congestive heart failure (CHF), depressive disorder, gout, neurogenic bladder and obesity. The patient was totally dependent, confused at times, had an indwelling catheter, incontinent of stool, non ambulatory requiring the assist of two (2) for transfers via a mechanical lift, and lived at home with her son as the primary care giver (PCG), and a private aide from 9AM - 5 PM. According to the nursing notes dated 8/5/05, the patient was admitted with a stage II decubitus on the coccyx, which would heal and periodically reopen. A skin break-down risk assessment was done on admission and never repeated. The recertification dated 6/2/06 - 7/31/06 identified that skilled nursing visits would be made 1 to 2 times per month to assess physical and mental status, monitor and change the indwelling catheter monthly and PRN, and to supervise the aide. The 60-day summary on the certification identified that the decubitus on the coccyx/sacral area, which was reported on 4/10/06, was healed as of 6/1/06 and that A&D ointment would be applied daily and the site would be monitored. Additionally the recertification identified that a home health aide would provide personal care 1 - 2 hours per day 4-5 days per week.

Nursing notes written by the SCS dated 6/1/05, identify that the open area had healed, however it was also noted that there was an "excoriated area approximately 6 cm. in diameter" and A&D ointment would be applied. Nursing notes by the SCS on 6/5/06 noted that (a) she instructed the patient's son to purchase the A&D ointment and, (b) a DME supplier was contacted to provide a pressure relief device for the wheelchair and bed. Additionally on 6/5/06, the SCS sent medication orders to the physician (PCP) for clarification because the meds in the home disagreed with the previous orders. The PCP signed the orders but did not date them however the long standing order for Lipitor was omitted. On 6/13/06, the SCS wrote a note that the patient's primary care physician (PCP) stated that he had "not seen the patient in a long time". On 6/13/06, the SCS instructed the son to schedule a medical appointment with his mom's PCP.

During this follow-up visit, the surveyors only looked at data from the time frame inclusive of 7/17/06 to 8/1/06. The previous information serves as background.

A skilled visit by the PCN, completed on 7/18/06 from 11 AM to 11:42 AM, identified that the patient had two Stage II open areas, one on the left buttocks that was 2.5 x 4 cm and one on the right buttocks that was 2 x 5 cm. A nursing note for that day documented that there was no A&D ointment in the patient's home. There was no notation on either form that the PCP had been contacted and or treatment orders obtained. A late entry nursing note for 7/18/06 identified that the patient's son had not made an appointment for the patient to be seen by PCP. A visit note dated 7/19/06 between 4:15 PM and 5 PM identified that the PCN revisited and cleaned and covered the wounds with a gauze dressing; the note documented that the agency was waiting for the PCP to give dressing change orders. Orders dated 7/19/06 were sent to the PCP for duoderm dressing changes every 72 hours and PRN. The orders were signed by the PCP but not dated. A nursing note dated 7/20/06 identified that the 'dressing' plan of care was discussed with the MD and a message was left for the son on his answering machine that

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the patient needed to see her doctor, that her medications needed to be clarified and that the decubitus needed to be treated.

A note and a signed physician order dated 7/20/06 documented that the physician ordered MSW services to address home issues.

A skilled visit note dated 7/21/06 identified that a duoderm dressing was applied after providing incontinent care for stool and that the patient had "loose stool constantly".

A skilled visit note by RN #5 dated 7/24/06 from 5 PM to 5:45 PM identified that the wounds had combined to one measuring 7 x 8 cm.

On 7/26/06, it was noted that the MSW contacted the agency to inform them she would no longer be making visits. A note on 7/28/06 identified that the PCP was notified by the SCS that there was a hold on the MSW visit and that the "agency will continue to seek another MSW".

During an interview with the SCS and the Administrator on 7/31/06, it was stated that despite frequent conferences with the son he was non-compliant with setting up a medical appointment for the patient with her PCP and for clarifying the patient's medications which he managed. The SCS further stated that these were the reasons she felt it necessary to call in an MSW, however the MSW left the agency before seeing the patient and as yet, they had not identified a replacement. There was no communication with the PCP during the initial 6 days after the order was written and/or the fact that the agency had to hire someone. It was also stated by the SCS that the agency was aware that the pressure relieving mattress did not fit the bed and that it was removed and not replaced. Additionally, they stated that the PCP was not contacted until the day after the wounds were discovered on 7/18/06, and that no protection was put on the wound when it was first discovered.

During an interview with RN #5 on 8/1/06 with the SCS and Administrator in attendance, she stated that she was being oriented to the patient through a joint visit with the SCS that day and thought that the SCS would call the PCP. Additionally there were no supplies in the home and that she returned later that evening to do a wet to dry treatment. She could not recall the exact day she started using duoderm.

During an interview with Home Health Aide (H-HHA #2) on 8/1/06, she stated that, although she did not remember the date, she had notified the agency that the pressure relieving mattress did not fit the bed and had been removed and that she was sure that the patient's skin was absolutely clear on 7/17/06 and there was no indication that the skin was starting to break-down or she would have reported it. She further stated that when the SCS and RN #5 made a morning visit on 7/18/06, they just looked at the patient's wound and then she and the private aide washed the patient and transferred her to a chair via the a mechanical lift with no protection on the wound.

The agency failed to reassess the patient's needs regarding prophylactic interventions to prevent recurrent skin break-downs, and/or working with the PCG to schedule and plan transportation to the PCP, and/or to accurately clarify the medications the patient was receiving, and/or to notify the PCP when the decubiti were first discovered and/or to protect the wound when it was first observed and/or to take the needed steps to ensure the patient's safety and well being with a non-compliant caregiver.

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

5. Based on clinical record review and staff interviews it was determined that for one (1) of one (1) patient the nurse failed to complete a comprehensive assessment for Patient #13 within 48 hours following a hospital admission. The findings include:

a. Patient #13 had a start of care date of 7/20/06 with a diagnosis of fractured humerus - closed. The plan of care dated 7/20/06 included skilled nursing visit to assess physical and mental status, mobility of the fingers in right arm and assess vital signs. The nurse was to instruct the patient on medication regime, safety measures, bowel regime and instruct the aide in s/s to report to the nurse. The nurse was to report to the physician any edema in the affected area. The plan of care lacked frequency for the nursing visits. The aide was to visit 3 hours each day prior to surgery and after discharge would resume care 3 hours 5x a week to assist with ADLs and IADLs and to hydrate the patient

The administrator who admitted the patient on 7/26/06 noted in the progress note of 7/26/06 that the patient was referred by her insurance company and was to have surgery on 7/21/06.

The subsequent nursing visit was conducted on 7/26/06, which indicated that there was no charge for the visit due to a lack of insurance authorization. The nurse noted that the patient had a right humerus repair on 7/21/06 and was discharged home on 7/24/06. The nurse assessed the patient's right arm, the discontinued IV site and bowel status and documented that the aide would continue and a RN would visit in 1 week to assess the IV site, safety and constipation. The nursing note stated that the next nursing visit to be determined after discussion with the insurance company.

The clinical record lacked documentation to support that the nurse conducted a comprehensive assessment following the patient's discharge from the hospital in order to identify the patient's current health status and nursing needs.

The administrator stated on 8/1/06 that she was not aware that a comprehensive assessment was to be completed for insurance cases.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71
(a)(2)(5) Personnel policies.

6. Based on a review of personnel files and personnel policies, for one (1) of one (1) employee hired in July 2006, the agency failed to obtain a pre-hire physical and/or tuberculin(TB) test prior to assigning the employee to the care of a patient (H-HHA #7). The findings include:

a. H-HHA #7's hire date was 7/11/06. Review of the employee's file identified that there was no physical and/or TB test performed within one year of hire per the agency's policy. A report dated 7/24/06 identified that the employee had a TB test on that date. An appointment notation in her file documented that she was scheduled for a physical on 8/11/06. Review of agency documentation identified that she had been assigned to provide direct care as of 7/13/06. During an interview with the H-HHA supervisor on 8/1/06, she was unable to state why she was prematurely assigned to a case other

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EXHIBIT B

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than the fact that she was needed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72
(a)(2)(C) Patient care policies.

7. Based on clinical record review and staff interviews, it was determined that for one (1) of one (1) patient the nurse failed to send an appropriate 10-day summary report to the physician and/or failed to write a 10-day report inclusive of but not limited to pertinent factors of a patient's status (Patient #13). The findings include:

a. Patient #13 had a start of care date of 7/20/06 with a diagnosis of fractured humerus – closed. The plan of care dated 7/20/06 included skilled nursing visit to assess physical and mental status, mobility of the fingers in right arm and assess vital signs. The nurse was to instruct the patient on medication regime, safety measures, bowel regime and instruct the aide in s/s to report to the nurse. The nurse was to report to the physician any edema in the affected area.

The 10-day summary report to the physician stated only that “the patient had received authorization for a home health aide to 8/4/06 and see notes from the insurance company.

Physician had approved RN and home health aide visits.” The 10-ten day summary lacked pertinent information regarding the patient's status.

The administrator stated on 7/31/06 that she conducted the visit since no one else was available to conduct the visit

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

8. Based on clinical record review and staff interviews it was determined that for two (2) of four (4) patients the nurse failed to follow the physician ' s orders and/or failed to obtain appropriate physician ' s orders (Patient #s 13 and 14). The findings include:

a. Patient #13 had a start of care date of 7/20/06 with a diagnosis of fractured humerus. The physician ' s plan of care included skilled nursing visit to assess vital signs, systems, medication regime, right arm and instruct the patient and aide on safety, symptoms to report and bowel regime. The nurse would report to the physician. The plan of care lacked the visit frequency for the nursing visits. Review of the nursing note of 7/20/06 indicated that the patient ' s arm exhibited discoloration of the right arm which was considerably edematous. The fracture was due to trauma. The patient had a sling to alleviate her discomfort. The patient was encouraged to increase roughage since she had not had a bowel movement in 4 days.

The clinical record lacked documentation to support that the nurse notified the physician of the patient ' s constipation as indicated in the plan of care and/or failed to have orders regarding mobility of the patient ' s arm with protocol for the sling.

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The subsequent nursing note of 7/26/06 indicated that the patient had surgery on 7/21/06 and returned home on 7/24/06. The note stated that the patient was constipated, since her last bowel movement was on 7/23/06. The patient's right arm was in a sling since her right humerus repair on 7/21/06; she had clips removed when she went to see the physician and presently had steri-strips in place on the incision which was identified as clean and dry.

The clinical record lacked an interagency referral form from the hospital (W-10) and/or any resumption of care orders from the physician regarding the patient's plan of care following surgery and/or identification of the patient's surgical procedure.

The initial agency intake form dated 7/16/06 indicated that the patient would need skilled nursing, home health aide services and physical therapy. The clinical record lacked documentation to support that PT was referred.

The administrator stated on 8/1/06 that she had not notified the physician of the patient's constipation but told the patient to inform the physician. She stated that the hospital had not sent a W-10 and she had not called the hospital. She stated that the patient's physician was away until 8/1/06 so she had not obtained resumption of care orders from the physician following her hospitalization for surgery. She did not know the exact surgery that the patient had on 7/21/06. The administrator was going to ask the physician when he was back from vacation if he wanted the patient to have PT services but thought that he had PT services in his office.

b. Patient #14 had a start of care date of 4/8/05 with current diagnoses including decubitus ulcer, congestive heart failure (CHF), depressive disorder, gout, neurogenic bladder and obesity. The patient was totally dependent, confused at times, had an indwelling catheter, incontinent of stool, non ambulatory requiring the assist of two (2) for transfers via a mechanical lift, and lived at home with her son as the primary care giver (PCG) and a private aide from 9AM - 5 PM. According to the nursing notes dated 8/5/05 the patient was admitted with a stage II decubitus on the coccyx, which would heal and periodically reopen. The recertification dated 6/2/06 - 7/31/06 identified that the excoriation on the coccyx/sacral area (previously reported to be a stage II open area on 4/10/06 and healed as of 6/1/06) would have A&D ointment applied daily and the site would be monitored. Nursing notes by the SCS on 6/5/06 noted that she instructed the patient's son to purchase the A&D ointment. Additionally on 6/5/06, the SCS sent medication orders to the PCP for clarification because the meds in the home disagreed with the previous orders. On 6/13/06, the SCS instructed the son to schedule a medical appointment with his mom's PCP because the PCP stated on that day that he had not "seen the patient for a long time". There was no notation as to the noncompliance regarding this request and/or notification of the PCP. A note and a signed physician order dated 7/20/06 documented that the physician ordered MSW services to address home issues. On 7/26/06, it was noted that the MSW contacted the agency to inform them she would no longer be making visits. A note on 7/28/06 identified that the PCP was notified by the SCS that there was a hold on the MSW visit and that the "agency will continue to seek another MSW".

During an interview with the SCS and the Administrator on 7/31/06, it was stated that despite frequent conferences with the son, he was non-compliant with setting up a medical appointment for the patient with her PCP and for clarifying the patient's medications, which he managed. The SCS stated that was the reason she felt it necessary to call in an MSW, however the MSW left the agency before seeing the

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patient and as yet they had not identified a replacement. There was no communication with the PCP regarding the fact that they had to hire someone. They further stated that they were aware that the pressure relieving mattress did not fit the bed so it was removed and not replaced. There was no documentation that the PCP had been notified regarding this fact. Additionally, they stated that the PCP was not contacted until the day after the wounds were discovered on 7/18/06. The agency failed to notify the physician in a timely manner regarding change of condition and their inability to follow the care plan.

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

9. Based on a clinical record review and staff interviews it was determined that for two (2) of four (4) patients the agency failed to develop a current and accurate medication list. (Patient #s 13,14). The findings include:

a. Patient #13 had a start of care date of 7/20/06. The plan of care dated 7/20/06 listed only percocet and senokot as the patient 's current medications. The patient 's medication record dated 7/20/06 listed the same medications. Review of the nursing note of 7/26/06 noted that the patient had taken metamucil 15 cc daily for her constipation with poor results. The medication record lacked documentation that the medication was added to the medication record. The administrator stated on 8/1/06 that it must have been an oversight by the nurse.

b. Patient #14 had a start of care date of 4/8/05 with current diagnoses including decubitus ulcer, congestive heart failure (CHF), depressive disorder, gout, neurogenic bladder and obesity. The patient was totally dependent, confused at times, had an indwelling catheter, incontinent of stool, non ambulatory, required the assist of two (2) for transfers via a mechanical lift and lived at home with her son as the PCG, and a private aide from 9AM - 5 PM. On 6/5/06, the SCS sent medication orders to the physician (PCP) for clarification because the meds in the home disagreed with the previous orders. Review of the certification dated 6/2/06 through 7/31/06 identified that there was a discrepancy between the meds listed and the clarification orders sent to the PCP. Review of the medication list in the record identified that it was the admission medication list dated 4/8/05 which was not in agreement with the current certification and/or orders signed by the PCP. During an interview with the SCS on 7/31/06, she stated that she thought she had updated the medication list but was unsure what had become of it. The agency failed to work from an accurate medication list which clearly identified the medication, dosage, and frequency that the patient should get to enable the skilled nurse to assess the effectiveness and/or lack of therapeutic response and/or adverse reaction.



August 31, 2006

Patricia Riggs, RN, Administrator
Caring, Inc.
733 Summer Street
Stamford, CT 06901

Dear Ms. Riggs:

This letter reflects revisions to the letter dated August 24, 2006 identifying violations cited at the time of the August 22, 2006 visit.

An unannounced visit was made to Caring, Inc. on August 22, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a follow-up certification inspection.

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 September 8, 2006 at 10:00 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.

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

Respectfully,

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

SNC:NC:



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2)
General requirements.

1. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's functions and to ensure the safety and quality of care rendered to Patient #s 13, 16, 17 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
(d)(2)(D) General requirements.

2. Based on review of agency documentation and staff interviews, the administrator failed to provide adequate in-service education for agency staff as included in the plan of correction for the letter dated August 3, 2006. The findings include:

a. The plan of correction accepted by FLIS on 8/21/06 at 5:15 PM documented a compliance date of 8/10/06 to correct the deficiencies identified during a previous follow-up survey dated 8/1/06. The plan of correction included several in-service programs, which should have been completed by 8/10/06, however the agency lacked evidence that they had occurred. Review of agency documentation determined that only six (6) of roughly eighteen (18) identified in-service programs were conducted as stated in the plan of correction. The administrator stated on interview on 8/22/06 that since the consulting agency developed the plan of correction, she (administrator) only had an opportunity to skim it and had not as yet had an opportunity to complete all in-service programs the plan of correction identified as having been completed by 8/10/06.

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

3. The supervisor of clinical services (SCS) failed to ensure the safety and quality of care rendered to Patient #s 13, 16 and 17 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-D69 (a)(2)
Services.

4. Based on clinical record and staff interviews it was determined that for two (2) of four (4) patients the agency failed to assign a primary care nurse (Patient #s 16, 17). The findings include:

a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and

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secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide.

Review of clinical record documentation found the last skilled nursing visit was made on 11/29/05. There was no assigned primary care nurse for this patient. The administrator signed the recertification dated 08/13/06-10/11/06. When interviewed on 08/22/06 the administrator had no comment as to why there was no assigned primary care nurse. She stated "the mother is difficult; the mother is not always with it; I call her". The agency not only failed to assign a primary care nurse to this patient, no nurse visited him since 11/29/05.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that there was an initial certification dated 10/29/05 through 12/27/05 which was signed by the physician on 11/15/05 and directed that the patient receive 3 hours of home health aide (H-HHA) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Review of the clinical record documentation identified that the last skilled nursing visit was on 11/10/05. There was no primary care nurse assigned to this patient. During an interview on 8/22/06, the administrator had no reason as to why this patient did not have a primary care nurse assigned.

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

5. Based on clinical record review and staff interviews it was determined that for two (2) of four (4) patients the registered nurse failed to accurately, appropriately and/or consistently re-evaluate and/or assess the patient's health status and nursing needs (Patient #s 16, 17). The findings include:

a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide (H-HHA); H-HHA service was ordered forty-two (42) hours a week for bathing, dressing, prepare dinner, laundry, toilet training, assist in controlling social behaviors (biting, head butting, pulling hair, pinching) and assist with exercises.

Review of clinical record documentation identified the last skilled nursing visit to this medically complex fifteen (15) year old male was made on 11/29/05. The nursing visit note of 11/10/05 identified the patient was incontinent of bladder and bowel at night, good appetite, ability to speak deficit, drools, now sleeping on bed, medications administered by mother, cooperative with nurse, observed positive interaction with mother. There was no clinical record documentation the nurse assessed the patient's overall behavior, weight gain/obesity, management of food intake, sleep quality and duration; seizure activity and if the aide was present and supervised; no vital signs, including weight were obtained.

The last documented nutritional assessment was completed on 03/16/01 and identified that the patient's

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nutritional intake could not be controlled; patient was gaining weight and was overweight; family has problems limiting portions; must be encouraged to chew; diet as tolerated; minimal nutritional risk; no weight was obtained.

The only documented comprehensive assessment of the total patient was made at the start of care, 03/12/98. At that time the patient was seven (7) years old; weighed 85 pounds; overweight; wore diapers; 15-18 month old coordination; visual deficit with depth perception; lower body hypertonic; upper body hypotonic; body overheats quickly; needs extra fluids; fatigues easily; drools moderate amounts continuously; disoriented after having seizure; poor judgement; non-verbal.

The agency administrator stated on 08/22/06, "the mother is difficult; the mother is not always with it; I call her; the patient should have been seen monthly". The agency receptionist stated "the mother is very difficult; we make appointments with her; she doesn't keep them".

i. The agency failed to have a policy and procedure for comprehensive pediatric assessment and for routine pediatric skilled nursing visits.

Since 11/29/05, the nurse failed to revisit the patient to reassess his physical and mental status, nursing needs and supervise the aide as ordered by the physician.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification dated 10/29/05 through 12/27/05, was signed by the physician on 11/15/05 and directed that the patient receive 3 hours of home health aide (aide) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Further review of the clinical record identified that there were no skilled nursing visits notes after 11/10/05 and/or there were no subsequent recertifications after 12/27/05 and/or there was no initial assessment and/or subsequent reassessments.

i. During an interview on 8/22/06 with the Administrator and the office manager, they identified that they were unable to provide the reason why no nursing visits had been made to the patient after 11/10/05 and/or no assessment of the patient had ever been completed. Additionally, they checked their automated records which documented that a recertification was sent to the physician in December 2005, but could not identify why there was no system to notify the agency that it not been returned and that no future certifications/orders had been sent out and/or received.

ii. The plan of correction accepted by the department on 8/21/06 identified a compliance date of 8/10/06 and documented that the assessment and re-assessment policies were to be inserviced to the administrator and clinical staff by 8/10/06 and that "all patients regardless of payor source would receive a comprehensive assessment".

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

6. Based on clinical record review and staff interviews it was determined that for two (2) of four (4) patients, the agency failed to revise and update the comprehensive assessment at least every sixty (60) days (Patient #s 16, 17). The findings include:

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a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide (H-HHA); H-HHA service was ordered forty-two (42) hours a week for bathing, dressing, prepare dinner, laundry, toilet training, assist in controlling social behaviors (biting, head butting, pulling hair, pinching) and assist with exercises.

The only documented comprehensive assessment of the total patient was made at the start of care, 03/12/98; no subsequent reassessments every 60-days were documented. From 11/29/05, the agency continued to provide H-HHA service, however no skilled nursing visits were made as ordered. The agency administrator stated on interview on 08/22/06, "the mother is difficult; the mother is not always with it; I call her; the patient should have been seen monthly". The agency receptionist stated "the mother is very difficult; we make appointments with her; she doesn't keep them". The agency failed to update and revise the comprehensive assessment at least every sixty (60) days.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification dated 10/29/05 through 12/27/05, was signed by the physician on 11/15/05 and directed that the patient receive 3 hours of home health aide (aide) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Further review of the clinical record identified that there were no documented initial and/or subsequent reassessments every 60 days.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(H)(J),(d)(4)(B) Services.

7. Based on clinical record review and staff interviews it was determined that for two (2) of four (4) patients, the agency failed to perform home health aide supervisions at least every two weeks to monitor the care and services being rendered to the patient (Patient #s 16, 17). The findings include:

a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide. H-HHA service was ordered forty-two (42) hours a week for bathing, dressing, prepare dinner, laundry, toilet training, assist in controlling social behaviors (biting, head butting, pulling hair, pinching) and assist with exercises.

Review of the home health aide notes for the year 2006 did not include documentation the aide assisted in controlling behavioral issues nor that she assisted with exercises.

The last documented home health aide supervision was 05/20/05. The administrator stated on interview on 08/22/06, she "speaks to the aide in the office when she picks up her paycheck". The administrator could not recollect the last time a RN had supervised the aide in the patient's home; she stated at this

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time the patient did not have an assigned primary care nurse and therefore she, the administrator talked with the aide when she came into the office. Since 05/20/05, a primary care nurse failed to supervise the aide not less frequently than every two (2) weeks.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification dated 10/29/05 through 12/27/05 was signed by the physician on 11/15/05 and directed that the patient receive 3 hours of home health aide (H-HHA) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Further review of the clinical record identified that there were no subsequent recertifications beyond 12/27/05 and that the H-HHA's instructions had not been reviewed and/or updated since the patient was admitted to the agency inclusive of the period from 8/10/06 to 8/22/06, the date of the survey. During an interview with the Administrator on 8/22/06, who was acting as the supervisor during the supervisor's vacation, she stated that although there was "some holes" regarding the H-HHA supervisory visits having not been made, overall she felt that the agency gave good care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(2)(C) Patient care policies.

8. Based on clinical record review, staff interview and policy review, it was determined that for two (2) of four (4) patients, the nurse failed to send an appropriate sixty (60) day summary report to the physician and/or failed to write a 60-day report inclusive of but not limited to pertinent factors of the patient's status (Patient #s 16, 17). The findings include:

a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide. H-HHA service was ordered forty-two (42) hours a week for bathing, dressing, prepare dinner, laundry, toilet training, assist in controlling social behaviors and assist with exercises. The written 60-day summary on the home health recertification and plan of care dated 08/13/06-10/11/06, stated, in its entirety, the "patient has multiple functional and behavioral problems; his mother is sometimes overwhelmed with issues of the patient; aide is helpful and has been with the patient many years". The 60-day summary lacked pertinent information regarding the patient's physical or mental status. The administrator was the author of the 60-day summary. The administrator had no comment when interviewed on 08/22/06 concerning the patient's 60-day summary. No nursing visit had been made to Patient #16 since 11/29/05 to form the basis of the summary of the pertinent factors of the patient's status.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification

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dated 10/29/05 through 12/27/05 was signed by the physician on 11/15/05 and directed that the patient receive 3 hours of home health aide (H-HHA) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Further review identified that no further recertifications were completed and therefore there was no 60-day summaries before or after August 10, 2006, which was included as part of the plan of correction with the completion date determined by the agency. During an interview with the administrator on 8/22/06, she stated that when the plan of correction was developed by the independent consultants that the agency hired, she only had time to skim it and even though in several discussions with the surveyors she was told they would be held accountable for all the items listed as completed by August 10, 2006, that the supervisor was on vacation and the agency was unable to complete all the items they had committed to.

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

9. Based on clinical record review and staff interviews it was determined that for three (3) of four (4) patients the agency failed to follow the only signed orders received from the patient's primary care physician (PCP), and/or failed to obtain current orders from the PCP (Patient #s 13, 16, 17). The findings include:

a. Patient #13 had a start of care of 07/26/06 with a principal diagnosis of a fractured right humerus with an ORIF on 07/21/06. Skilled nursing visits were ordered weekly to assess the patient's mental and physical status, instruct patient on medication regime, instruct patient and aide on safety measures, report to physician edema in affected area, assess mobility of fingers, vital signs, instruct on bowel regime.

Review of clinical record documentation showed nursing visits were made on admission (07/26/06) and on 08/10/06. There was no clinical record documentation that nursing visits had been made for the weeks of July 23 and August 13, 2006.

The agency administrator stated on interview on 08/22/06 that there might have been a nursing visit the week of August 13, 2006, but the nurses note may not be handed in yet; she did not know why a nursing visit was not made the week of July 23, 2006.

b. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide.

Review of clinical record documentation found the last skilled nursing visit to this fifteen (15) year old male was made on 11/29/05. The agency administrator stated on interview on 08/22/06, "the mother is difficult; the mother is not always with it; I call her; the patient should have been seen monthly". The agency receptionist stated "the mother is very difficult; we make appointments with her; she doesn't keep them". The RN failed to follow the patient's plan of care for nursing visits and the physician had

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not been notified of the change in the plan of care.

c. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification dated 10/29/05 through 12/27/05, was signed by the physician on 11/15/05, and directed that the patient receive 3 hours of home health aide (aide) services two times per week and a skilled nursing visit every 30 days to monitor skin integrity, mobility, safety with ambulation, review medications and instruct patient as to side effects of medications. Documentation in agency records and invoices developed by the agency, determined that home health aide services, were continually provided through 8/7/06 for personal care; however it was also identified that there were no skilled nursing visits after 11/10/05 and/or there were no subsequent certification plans of care beyond 12/27/05. During a review on 8/22/06 with the Administrator and the office manager, they identified that they were unable to provide the reason why no nursing visits had been made to the patient, and that although their automated records documented that a recertification was sent to the physician in December 2005, they could not identify why there was no system to notify the agency that it not been returned and that no future certifications/orders had been sent out and/or received. The administrator further stated that it was an oversight and that they should have obtained ongoing orders from the PCP.

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

10. Based on a clinical record review and staff interviews it was determined that for two (2) of four (4) patients the agency failed to develop and maintain a current, accurate medication list to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, interactions, duplicate and/or non compliance with drug therapy (Patient #s 16, 17). The findings include:

a. Patient #16 had a start of care of 03/12/98 with a principal diagnosis of Prader-Willi syndrome and secondary diagnoses of epilepsy and sleep disturbance. Skilled nursing was ordered 1-2 times a month to assess physical and mental status, report changes to the physician and supervise the home health aide.

Review of the recertification and plan of care dated 08/13/06-10/11/06 identified there was a discrepancy between the listed medications and the clinical record medication list. The clinical record medication list was last updated on 01/29/04. The clinical record medication sheet included the medication melatonin 3mg at HS; the PM dose of Depakote was documented as 500mg, not 625mg as listed on the 08/13/06 recertification. The administrator stated on interview on 08/22/06, that she had called the patient's mother to obtain the patient's current medications. The agency failed to obtain and maintain a current, accurate medication list.

b. Patient #17 had a start of care of 10/29/05 with diagnoses that included hypertension, affective psychosis and primary arthrosis. Review of the clinical record identified that the initial certification

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dated 10/29/05 through 12/27/05 was signed by the physician on 11/15/05 and directed that the patient receive Lithium 300 mg PO daily, Seroquel 100mg PO at bedtime followed by an additional 25 mg if the first dose is ineffective, Fosamax one tablet PO once weekly and Amitriptyline 10 mg at bedtime. Nursing notes written on 11/10/05 at 10:40 AM, identified that the patient's doctor (Physician #1) identified on the certification as the attending psychiatrist, was giving up her practice and would be contacting the patient's husband to recommend other doctors to assume the patient's care. An additional discussion with the physician noted in the record at 10:45 AM identified that the physician had stated that the patient had a history of manic depression treated with the Seroquel and Lithium and had recently been started on Amitriptyline for sleep. There were no additional nursing notes in the record and/or updates or noted reviews of the patient's medication list since 10/29/05. During an interview with the Administrator on 8/22/06, she did not know why this had occurred other than to say she saw that a mistake had been made and that it was an oversight.



September 21, 2006

Patricia Riggs, Administrator
Caring, Inc.
733 Summer Street
Stamford, CT 06901

Dear Ms. Riggs:

Unannounced visits were made to Caring, Inc. on September 12, 13, 14, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspections.

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by October 10, 2006 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

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

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

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

Respectfully,

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

SNC:NC:



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

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EXHIBIT D

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

1. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's function and/or to ensure the safety and quality of care rendered to Patient #s 17, 20 and 21 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.

2. The supervisor of clinical services (SCS) failed to ensure the safety and quality of care rendered to Patient #s 17, 20 and 21 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) General requirements, 19-13-D69(a)(3)(C) Services.

3. Based on observation, clinical record review and staff interviews it was determined that for Patient #20, the SCS failed to ensure the safety of the patient at all times and left the patient at risk in an unsafe situation. The findings include:

a. Patient #20's start of care date on the most recent certification was 8/31/06 with diagnoses that included cerebral vascular accident, left hemi-paresis, malignant hypertension, arterial-sclerotic cardiovascular disease, and arthritis. Review of agency documentation identified that the patient's actual start of care date was 4/24/96 and that a follow-up assessment was mistakenly recorded as a start of care.

On 9/12/06 at approximately 1:50 PM, this surveyor and the Administrator attempted to make a home visit to Patient #20 after the surveyor had received telephone permission from the patient to visit. A call was placed by the administrator from the lobby of the LLC #1 to the patient's apartment to announce that we would be up, however, according to the agency aide that was on duty with the patient, the physical therapist had just arrived and would be giving the patient a massage for approximately an hour, so the administrator announced that we would not be visiting that day. The following morning, 9/13/06 at 10:00 AM a call was again placed to the patient from the lobby of LLC #1 by a surveyor, requesting permission to visit with an additional nurse surveyor. The patient stated both were welcome to visit. When the surveyors arrived at the apartment, the door was unlocked and the patient was dressed and sitting in a manual wheel chair. Both surveyors observed that the left leg splint was attached by one Velcro strap around the shin and the foot cradle of the one-piece splint was partially dangling and partially resting on the floor at an awkward angle to the foot. The patient was somewhat upset, stating that a nurse had visited that morning, checked her leg and foot by removing the shoe and splint, and then the nurse was unable to put the splint back on and left it dangling from the leg; a

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stockinet sock was on the left foot, which covered up to her mid lower leg. Observation of the left leg by both nurse surveyors, identified that it appeared larger than the right leg with swelling on the outer aspect and that there was a reddened area approximately 5 cm long and 2 cm. wide on the same area. No open areas could be seen above the sock and the surveyors did not remove the shoe and sock. The patient stated that she did not recall recently having a sore on her foot or any area that she put medicine on (Bacitracin). She also stated that she would not be able to see it if she did have a sore because it was difficult to bend down. The surveyor removed the dangling splint, as it appeared that the patient could injure herself if she hit it with her right leg and/or if she attempted to bend over and fix it herself. The patient stated that she knew she could not stand without the splint, that her aide would arrive any moment, however if she had to urinate in the interim she would "go on the floor." The surveyor called Patient #20 less than 15 minutes later (11:00 AM) to assure that the aide had arrived. The patient stated the aide had not arrived; she had to urinate immediately and needed someone to put the splint on. The surveyor contacted the wellness office of LLC#1 and a wellness nurse went to the apartment to assist her. Per an interview with HHA #7 on 9/14/06, she stated that she arrived at the patient's at 11:10 AM but her hours were usually 11:00 AM to 7:00 PM unless the patient had a special appointment. During an interview with the SCS on 9/14/06 at 12:30 PM, she stated that although she had removed the splint to visualize the foot and leg, she was unable to put it back on. She further identified that the patient told her the aide would be in shortly, but that she (SCS) didn't know what time she was scheduled however she felt the patient was oriented enough to know if it was ok to leave her in that manner. The SCS failed to protect the patient from potential injury at all times by leaving her at risk in an unsafe situation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(B)(C)(G), (b) (2), (d)(3)(B) Services.

4. Based on clinical record review and staff interviews it was determined that for Patient #20 the agency failed to coordinate all services the patient was receiving to ensure the development and implementation of a coordinated plan of care. The findings include:

a. Patient #20's start of care date on the most recent certification was 8/31/06 with diagnoses that included cerebral vascular accident, left hemi-paresis, malignant hypertension, arteriosclerotic cardiovascular disease and arthritis. Review of agency documentation identified that the patient's actual start of care date was 4/24/96 and that a follow-up assessment was mistakenly recorded as a start of care.

The assessment completed by the SCS on 8/31/06 documented that the patient was receiving physical therapy services two (2) times per week by a private physical therapist who had been arranged for through the life care community (LCC #1). The SCS got the telephone number of the therapist from the patient, however the patient refused to have the SCS contact the therapist, so the SCS discarded the number.

During a visit to the patient's home by two (2) nurse surveyors on 9/13/06 at 10:00 AM Patient #20 was unable to find the therapist's telephone number but did say it was ok to contact him. The patient further

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stated that the LLC #1 gave her his name. Contacts made on 9/13/06 with LLC #1's Director of Wellness and the personal trainer noted that they had not been involved in referring the therapist to the patient.

During an interview with HHA #7 on 9/14/06 at 11:10 AM, she stated that she had been with Patient #20 for approximately three years; Patient #20 had been using the left lower leg splint all that time and could not support herself to stand, pivot or ambulate without the splint. She stated that the therapist came once a week and practiced ambulation range of motion, stretching exercises and "massage to move body fluids". The aide also stated that she ambulated the patient, and took the patient out in the patient's personal car twice per week. She stated that as long as the patient wore her leg splint she was able to stand and pivot into and out of the car and toilet by herself. HHA #7 also stated that the left leg was often swollen and red, and that she (HHA #7) had taken the patient to the physician approximately every two months and when the patient felt it necessary for recurrent cellulites, explaining that the patient knew when her leg was bothering her and that they would go see the Director of Wellness in LLC#1 who would tell them to see the patient's physician. HHA #7 stated that they did not notify the agency during these occurrences. Review of the recertification plan of care dated 8/31/06, did not identify that the patient must wear the leg splint for safety in transfers and did not identify that the patient ambulated with the aide. There was no documentation of coordination with the therapist and/or the physician regarding the therapist's plan of care and/or to verify that the therapist was working under physician orders.

During an interview with the SCS on 9/14/06 at 12:30 PM, she identified that she felt the patient had a right to refuse to let her contact the therapist, and/or did not feel it was her position to verify the therapist's credentials, and/or did not think about contacting the physician to coordinate services and/or felt the aides knew the patient well enough that they would always use the splint when ambulating and/or transferring.

The agency failed to coordinate services between disciplines to enable the agency to develop a comprehensive, coordinated care plan that identified the client's total needs and instructed the aides (including replacements) to always use a left leg splint for transfers and/or whether the patient should be ambulating and, if so, what safeguards should be used and/or to instruct the aides in signs/symptoms to be reported to the nurse.

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

5. Based on clinical record review and staff interviews it was determined that for Patient # 20 the agency failed to comprehensively assess the patient after a significant change in condition. The findings include:

a. Patient #20's start of care date on the most recent certification was 8/31/06 with diagnoses that included cerebral vascular accident, left hemi-paresis, malignant hypertension, arteriosclerotic cardiovascular disease, and arthritis. Review of agency documentation identified that the patient's actual start of care date was 4/24/96 and that a follow-up assessment was mistakenly recorded as a start

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of care. Based on an interview with the SCS and Administrator on 9/13/06, the 8/31/06 home visit and assessment was made because the SCS had never met the patient before and the Administrator had not seen the patient since the early part of the year since she conducted most aide supervisions in the agency office.

i. The 8/31/06 assessment, certification and updated plan of care identified that the patient had a 0.5 x 1.0 cm x superficial depth open area on the "inner aspect of the left foot". The SCS stated that during her home visit on 8/31/06, she offered to provide more nursing visits to treat and monitor the open area, but the patient refused saying she would treat it with Bacitracin daily as suggested by the SCS. The SCS stated that she directed the aide to: 1) remove the splint daily, monitor the wound and other potential areas for breakdown and report any changes including swelling, redness, poor wound healing and/or worsening of the wound, and 2) keep the patient's legs elevated. Nursing notes and interview indicated that on 8/31/06 the SCS left a message on the physician's answering machine alerting her of the open area but did not get an order for the use of Bacitracin to the wound, and on 9/5/06, the SCS called the aide who stated that the wound was healed.

On 9/13/06 at 10:00 AM a home visit by two nurse surveyors was made to the patient who was dressed and sitting in a manual wheel chair. The left leg splint was attached by one Velcro strap around the shin and the foot cradle of the one-piece splint was resting on the floor at an awkward angle to the foot. The client had a stockinet sock on the left foot, which covered up to her mid lower leg. Observation of the left leg by both nurse surveyors identified that it appeared larger than the right leg with swelling on the outer aspect, and that there was a reddened area approximately 5 cm. long and 2 cm. wide on the same area. No open areas could be seen above the stocking and the surveyors did not remove the shoe and stocking. During an interview with Home Health Aide (HHA) #7 on 9/14/06 at 11:10 AM, she stated that she had been with Patient #20 for approximately three years, she had been using the splint all that time, had taught herself to apply it and that after the splint was put into the shoe, there were two Velcro straps that went across the front of the leg to hold it in place (at approximately the area of the wound identified on 8/31/06 by the SCS). HHA #7 contacted the SCS when she first noticed the wound, which was approximately the size of a pinky nail and about two inches below the knee on the front of the leg; the SCS made a visit on 8/31/06. Although the SCS called to check on the status of the wound a week later, the SCS had not made another visit until the previous day (9/13/06). HHA #7 stated that during the initial SCS visit of 8/31/06, the SCS had applied Bacitracin and left the area open to the air, and that she (HHA #7) had not subsequently applied Bacitracin to the wound and had not seen the patient apply it. During an interview with the SCS on 9/14/06, she identified that the wound was below the knee in approximately the same location that HHA #7 had noted but continued to maintain that the description of the "inner aspect of the foot" was accurate as she described on 8/31/06. She further stated that she was unaware that the patient had a history of cellulites and did not feel the patient's leg was swollen and/or red when she examined the leg approximately a half hour before the surveyors.

b. Review of the medication orders on the assessment and certification dated 8/31/06 identified that the medications were different than the medications listed on the previous certification, which had remained the same on all the certifications for the previous year. There were no additional interim orders in the record. The previous certifications, including the certification dated 7/29/06 to 9/26/06, listed Norvasc, Mevacor, Senekot, KCL, Zolofl and Ecotrin to be taken on a daily basis, whereas the certification dated 8/31/06 only listed Diovan, Lovastatin and Ecotrin.

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During an interview with HHA #7 on 9/14/06 at 11:10 AM, she stated that she had been with Patient #20 for approximately three years, that the patient poured the medications after she (HHA #7) reminded the patient to take her medications and that she (HHA #7) reordered the medications by mail order every 120 days. The aide further offered that because she reordered the meds, she knew that the patient only took Norvasc, Lovestatin, Diovan, and Ecotrin as needed and had taken these medications for some time.

During an interview with the SCS on 9/14/06 at 12:30 PM, she stated that during the assessment visit on 8/31/06 she asked the aide to bring her the current medications to visualize but did not see the Norvasc, had not checked the previous certifications to see if there was any discrepancy, and/or did not know when the other medication orders had changed and/or did not clarify the patient's current medications with the physician.

The nurse failed to comprehensively and accurately assess the wound and/or to get physician's treatment orders for the wound, and/or to reassess the wounds progress within a reasonable time frame, and/or relied on HHA #7 to determine that the wound was healed without benefit of a skilled nursing visit to make that assessment and/or to clarify with the physician the discrepancies in the patient's current medication list.

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

6. Based on clinical record review and staff interviews it was determined that for one (1) of five (5) patients the nurse failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of alterations to the plans of care (Patient # 21). The findings include:

a. Patient #21 had a start of care date of 2/13/06 with diagnoses including cerebral degeneration and hip arthroscopy. The plans of care dated 6/13/06 and 8/12/06 included skilled nursing 2x a month to pre-pour the patients medications and report changes in the patient's status to the physician. The patient was to receive personal care by an aide 7x a week. The patient was receiving antihypertensive medications; medications for sleep and GI discomfort and aspirin 81 mg. po qd. (discontinued as of 6/14/06).

The 8/12/06 summary to the physician indicated that the patient was stable, forgetful and needed reminders to take her medications which the nurse continued to pre-pour. The patient did not go outside the home unless the family took her.

Review of the clinical record from 6/9/06 to 9/7/06 lacked documentation to support that the nurse visited the patient every 2 weeks (2x a month) to pre-pour her medications. The nursing notes from 6/9/06 to 7/18/06 indicated that the nurse visited the patient every 2 weeks or more frequently as indicated to pre-pour the medications. The nursing note indicated the date to when the medications were pre-poured. The nursing note of 7/18/06 stated that the nurse pre-poured the patient's medications until 8/1/06. The clinical record lacked a visit note for 8/1/06. The nurse completed a follow-up comprehensive assessment form on 8/11/06 and documented that she pre-poured the patient's

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STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

medications from 8/4/06 to 8/14/06. The clinical record lacked a nursing note for the apparent nursing visit of 8/4/06 and/or for the 8/11/06 follow-up assessment visit. The subsequent visit note was not until 8/14/06 and the nurse noted that she pre-poured the patient's medications until 8/28/06. The clinical record lacked documentation of an 8/28/06 scheduled nursing visit. The clinical record documented that another nursing visit was not conducted until 9/7/06 and the nurse noted that she pre-poured the patient's medications until 9/28/06 for 3 weeks. The clinical record lacked documentation regarding all the skipped visits and/or how the patient managed without her pre-poured medications and/or lacked communication with the family and notification to the physician regarding the missed visits.

RN #5 stated on 9/13 and 9/14/06 that she thought she visited the patient on 8/4/06 as stated on the follow-up assessment form of 8/11/06 because the patient was waiting for medications from the pharmacy but she wasn't sure about the visit and did not have a nursing note for 8/4/06. She did not know why the patient was not visited on 8/1/06 as noted on the previous nursing note of 7/18/06 as the date to revisit the patient and pre-pour her medications. She stated that she always completed a nursing note with the follow-up assessment visit but the agency could not find the nursing note to accompany the assessment dated 8/11/06. The clinical record lacked and/or the agency could not locate a nursing note for 8/28/06 which was the next scheduled pre-pour date noted on the previous nursing visit of 8/14/06.

The administrator stated on 9/14/06 that the patient had extra medications in the home that were poured by a previous agency prior to 2/13/06. The patient at times did not have all her medications in the home at the time of the nursing visit so the nurse visited on a different date.

The clinical record lacked documentation as to the reason for the erratic timeframes for the medication pre-pours; nursing calendars did not match actual visits and the clinical record lacked an explanation of the discrepancies to ensure that Patient #21 had pre-poured medications available at all time to ensure compliance with the physician's ordered medications.