

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

IN RE:           Precise Care, LLC of Bridgeport, CT  
                  d/b/a Precise Care, LLC  
                  2449 North Avenue  
                  Bridgeport, CT 06604

CONSENT ORDER

WHEREAS, Precise Care, LLC (hereinafter the "Licensee"), has been issued License No. 0018 to operate a Home Health Care Agency known as Precise Care, LLC, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

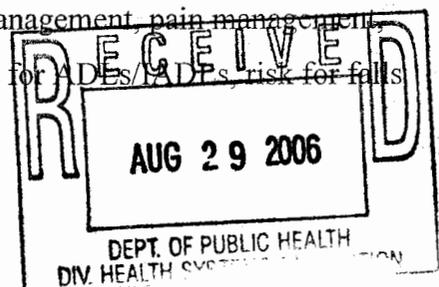
WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on May 9, 2006 and concluding on June 7, 2006 and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated June 13, 2006 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department acting herein and through Joan D. Leavitt, its Section Chief, and the Licensee, acting herein and through Sandra Joseph its Owner, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Order the Supervisor of Clinical Services shall develop and/or review and revise, as necessary, policies and procedures related to patient physical assessments, medication review and management, management of diabetes and cardiovascular disease management, pain management, concerns for safety secondary to dependence on others for ADLs/IADLs, risk for falls and discharge from the agency.



2. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
  - a. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
  - b. Patient assessments and/or re-assessments are performed in a timely, accurate, comprehensive manner and accurately reflect the condition of the patient;
  - c. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
  - d. Each patient's nutritional/hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care; and
  - e. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, deterioration of mental, physical, nutritional/hydration status, cardio-respiratory, immediate care needs and safety.
3. Within twenty-one (21) days of the effective date of this Consent Order, all Facility direct care staff shall be in-serviced, to the policies and procedures identified in paragraphs 1 and 2.
4. The Supervisor of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual patient care plans.
5. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order and submit monthly reports to the Department regarding compliance with the requirements of this document. The name of the designated individual shall be provided to the Department within said timeframe.
6. In accordance with Connecticut General Statute Section 19a-494 (a) (5), the license of Precise Care, LLC is placed on probation for a period of two (2) years.
7. The Licensee shall pay a monetary penalty to the Department in the amount of twelve hundred dollars (\$1,200.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

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

8. The Licensee shall meet with Department staff every month for the initial six (6) months this Consent Order is in effect and every four (4) months thereafter for the duration of this Order.
9. The Licensee shall within forty-five (45) days of the execution of this Consent Order, develop and implement a program to assess staff compliance with the Licensee's policies, procedures and standards of practice. The program shall include, but not be limited to, a mechanism whereby remediation of staff occurs for failure to adhere to facility policy and procedures.
10. 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, 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.
11. 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.
12. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
13. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not

deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

14. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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

PRECISE CARE, LLC OF BRIDGEPORT, CT. -  
LICENSEE

8/17/06  
Date

By: Sandra Joseph  
Sandra Joseph, Owner

STATE OF Connecticut

County of Farfield ) ss August 17, 2006

Personally appeared the above named Sandra Joseph and made oath to the truth of the statements contained herein.

My Commission Expires: \_\_\_\_\_  
(If Notary Public)

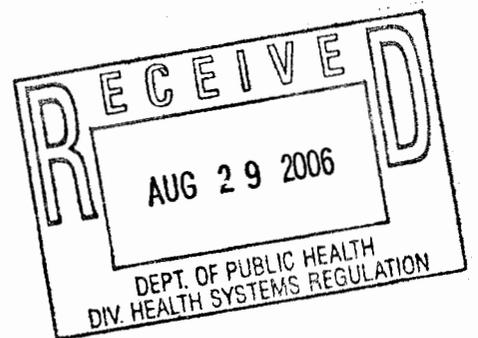
**GORVENS LISERE**  
**NOTARY PUBLIC**  
**MY COMMISSION EXPIRES 5/31/10**

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

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

August 29, 2006  
Date

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





# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A  
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June 13, 2006

Sandra Joseph, RN, Administrator  
Precise Care, LLC  
2449 North Avenue  
Bridgeport, CT 06606

Dear Ms. Joseph:

Unannounced visits were made to Precise Care, LLC on May 9, 10, 11, 2006 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an initial survey inspection with additional information received through June 7, 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 June 27, 2006 at 1:00 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

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

Respectfully,

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

SNC:NC:



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) General requirements.

1. The governing authority failed to assume responsibility for all services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1, 3, 4, 5, 6, 7, 8, 9, 10 & 11 and their families based on the violations listed in this document.

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

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

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

3. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #s 1, 3, 4, 5, 6, 7, 8, 9, 10 & 11 and their families based on the violations listed in this document.

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

4. Based on clinical record review and staff interviews it was determined that for two (2) of three (3) patients receiving medication administration, the nurse failed to furnish specialized nursing skill to document inclusion of all pertinent information to identify specific medications that had been administered (Patient # s 6, 7). The findings include:

a. Patient #6: During the period from 4/14/06 to 4/29/06 medications were regularly administered by LPN #2, however, there was no consistent documentation to indicate the specific medications and/or doses that were administered. On interview on 5/12/06, the administrator/supervisor stated that the agency had no written policy for documentation of medication administration. See Violation #7.

b. Patient #7's start of care date was 3/5/06 with diagnosis of right thumb infection. Documentation on the certification plan of care ordered skilled nurse 5-7 times a week for administration of Vancomycin. Clinical record documentation determined that Vancomycin was administered to the patient on 3/6/06 and 3/7/06, however there was no documentation to determine who administered the medication. See

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Violation #5.

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, hospital medical record reviews, home visit observation, patient and staff interviews it was determined that for nine (9) of eleven (11) patients agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner as the patient's health and safety status deteriorated and/or to document actions/interventions and/or to document the patient's immediate health care needs and/or to notify the physician managing the home health plan of care of these changes that suggested a need to alter the plan of care (Patient #s 1, 3, 4, 6, 7, 8, 9, 10, 11). The findings include:

a. Patient #1's start of care date was 2/20/06 with diagnoses including osteoporosis, peripheral vascular disease (PVD), right ankle decubitus ulcer and hypertension. A surgical bypass was performed on the left lower extremity on 11/10/05. Documentation on the certification plan of care dated 2/20/06 ordered skilled nurse 2wk x 1, 1 wk x 8 and 4 as needed visits to assess skin integrity, cardiopulmonary, PVD, signs and symptoms of infection, pain, safety, mobility, medications and side effects and to teach the family proper skin care and signs and symptoms to report to the nurse and/or the physician. Ordered medications included Diamox, Atenolol, Norvasc, Percocet, Remeron, Lexapro and Neurontin. Documentation on the certification plan of care by RN #1 dated 2/20/06 identified that the patient's blood pressure was 130/90, she was 85 years old, alert but forgetful, lived with her family on whom she was dependent for assistance with all activities of daily living and instrumental activities of daily living. RN #1 identified that the patient had generalized weakness, required assistance to transfer and she ambulated with a walker.

The admission summary note by RN #1 dated 2/20/06 identified that the patient had a scabbed wound at her (right) ankle and a left thigh incision line 6 inches long with a 1 cm open area without drainage at the distal wound. RN #1 documented that the patient's family had been observed to adequately perform wound care to the open area with normal saline cleanse then a dry sterile dressing. Documentation by RN #1 on the comprehensive assessment dated 2/20/06 identified that the thigh wound was healed and RN #1 also documented on a revisit note dated 2/23/06 that the left thigh wound was healed. Unsigned documentation faxed to the surveyor on 5/24/06 stated that the wound was actually scabbed and was healed by 2/23/06.

Documentation by RN #1 on a nursing visit record dated 2/23/06 identified that blood pressure was 110/70 and that the patient refused to walk with the walker and she was wheelchair bound because of pain in her ankles. RN #1 evaluated that pain was "3" on a scale of 1-10 and she instructed the patient to increase the frequency of pain medication. There was no documentation to support that RN #1 assessed the proximity of the pain assessment to the last dose of pain medication taken, the quality and/or character of the pain and/or to identify how much pain medication the patient had been using. RN #1 also encouraged the patient to do the exercises that she learned from the physical therapist and

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she documented on a verbal order to the physician that the patient refused physical therapy and/or occupational therapy. There was no documentation to support that RN #1 informed the physician that the patient's mobility was decreased due to pain and/or that her blood pressure was lower. There was no revisit until 2/27/06 (4 days later) when RN #1 documented on a nursing visit record that the visit was made after a call from the family; blood pressure was 109/60 and the patient complained of dizziness and generalized weakness, but could not comply with evaluation of orthostasis. RN #1 instructed the family to spread dosing of cardiac medication through out the day. The patient complained of pain in the right ankle after she banged her foot over the weekend. RN #1 identified that the right foot and ankle were slightly edematous and that the right foot was purple with residual bruising at the bottom. Pain increased to 5, but there was no documentation to determine that RN #1 evaluated when the most recent pain medication was taken, the quality and character of the pain, the amount and/or effect of pain medications the patient was taking. RN #1 documented that she reported the patient's status to the physician, but there were no medication changes.

There was no revisit to re-evaluate the patient's status within a timely manner. Documentation dated 3/2/06 stated that the family called to report that the patient was admitted to hospital. Documentation on the emergency room record dated 3/1/06 identified the admitting diagnosis of cellulitis of the leg. When interviewed on 5/9/06 H-HHA #1 stated that the patient did not hit her foot; that she was crying about her leg and foot before she got out of bed the day the nurse was called (2/27/06). Upon arrival at the patient's home, the nurse assessed that blood was not circulating well (in the lower extremity). H-HHA #1 stated that the patient continued to have pain over the next few days, completely stopped walking and told her family that the limb was worsened on 3/1/06 when she was brought to hospital and admitted.

Documentation on a progress note dated 3/2/06 stated that the family called to report that the patient was admitted to hospital with increased pain in her right foot.

Documentation by RN #1 on an addendum note dated 5/9/06 stated that on 2/27/06 after conversing with the physician about the right ankle, the patient refused to go for x-rays and the family was instructed to apply an ace bandage to the ankle, elevate the patient's leg and to take pain medications every 6 hours as ordered and to report the effectiveness.

Unsigned documentation faxed to the surveyor on 5/24/06 identified that RN #1 reported the lowered blood pressure to the physician on 2/27/06 and no medication changes were ordered, however, RN #1 did not inform the physician that the patient complained of dizziness and weakness.

Review of hospital admission records dated 3/1/06 stated that the patient presented in the emergency room with right lower extremity pain after twisting her ankle. She had right lower extremity erythema and swelling, right calf warmth, a purulent ulcer on her right ankle and ecchymosis of the right foot. Diagnosis was right lower extremity cellulites.

Agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient to and/or to take prompt action and/or to intervene appropriately in a timely manner and/or to document actions/interventions and/or to document the patient's immediate health care needs when the patient's blood pressure dropped to 109/60 and she complained of dizziness and weakness and/or when the patient's mobility was decreased due to lower extremity pain and/or when lower extremity pain increased and/or to notify the physician of these changes that suggested a need to alter the plan of care.

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b. Patient #3's start of care date was 4/20/06 with diagnoses including Insulin dependent diabetes mellitus (IDDM), chronic renal failure and hypertension. Documentation on the certification plan of care dated 4/20/06 to 6/20/06 ordered skilled nursing visits 1 x per week and 4 as needed visits to assess/instruct IDDM, medications, side effects, diet compliance, symptoms of hypo-hyperglycemia and safety status. Ordered medications included Lantus 36 units subcutaneously (sc) in morning if blood sugar less than 150 or 44 units if BS is greater than 150. Lantus 44 units sc each evening, NPH Insulin 10 units sc in evening if small dinner, NPH Insulin 16 units if large dinner, Plavix, Avapro, Hydrochlorothiazide, Norvasc, Lipitor, Metoprolol, Aspirin, Oscal, Iron, Colace, Centrum and Clonidine.

Documentation by RN #1 on the OASIS/comprehensive assessment dated 4/20/06 identified that the patient was alert and oriented, lived alone, had been using Insulin since 2000, tested her blood sugar three to four times daily and that her blood sugar ranged from 80-400. Documentation by RN #1 on the admission summary note dated 4/20/06 identified that the patient was admitted for home health care for diabetic management in the home, that she was having difficulty managing stable blood sugars and she required emergent care on 4/18/06 for hypoglycemia. The patient's fasting blood sugar on 4/20/06 was 174 and was 268 after a meal. Documentation on the nurse visit note dated 4/20/06 stated that the patient had all of the pre-filled Insulin syringes (different doses) in the same container; RN #1 assisted to separate the syringes to prevent wrong dosage and instructed the patient about the ordered 1800 calorie ADA, no added salt diet. The next revisit was 4/27/06 (seven days later). RN #1 documented on a nurse note dated 4/27/06 that the blood sugar ranged from 69 – 246 and that the patient had a lowered blood sugar of 80 that week. The patient reported that that she was more compliant with Insulin since the syringes were separated by dose and RN #1 continued to teach about diet. The next revisit was 5/4/06 (seven days later) and the blood sugar ranged from 200-237 with some lowered blood sugars ranging from 86-140 from 5/1 to 5/4/06.

During the period from 4/20/06 to 5/4/06, there was no clinical record documentation to indicate the time of day and/or proximity to meals that blood sugars were tested, how much Insulin the patient was using and/or food intake to monitor dietary compliance and/or patient's activity level.

When interviewed on 5/9/06 RN #1 stated that on the visit sheets she documented ranges for blood sugars the day of the visits starting with the fasting blood sugars. RN #1 stated that continued blood sugar fluctuations were due to dietary noncompliance and because the Insulin syringes with different doses were stored together. In response to surveyor inquiry RN #1 stated that she did not know exactly the amounts of Insulin the patient took because while the patient kept a log of her blood sugars, she did not regularly write in how much Insulin she was using.

On 5/10/06, the surveyor made a home visit with RN #1. The surveyor observed that during the period from 4/26 to 5/10/06 the patient's blood sugar log reflected that she tested her blood sugar four times daily and that blood sugars were often elevated and fluctuated from 74 to 288. Documentation of amounts of Insulin taken was frequently in conflict with dosages prescribed by the physician and/or was absent. The patient told the surveyor that she had problems following the written diet left by RN #1 and that she usually tried to eat a lot of greens and some meat. She also ate pasta and some sweets. Some days she stayed at home and other days, she walked more, but did not realize that the activity could

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change her blood sugar.

In response to surveyor, inquiry RN #1 stated that she sent each visit note to the physician to keep him informed, but that there was no documentation of this in the record. RN #1 stated that she visited the patient only weekly because the patient went to the diabetic clinic during the week and that a goal of the home health plan was to decrease the frequency of the patient's (diabetic) clinic visits.

When interviewed on 5/10/06 the patient told the surveyor that she goes to the diabetic clinic about one time monthly. RN #1 failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient's blood sugars, Insulin dosing and dietary compliance and/or to take prompt action and/or to intervene appropriately in a timely manner when the patient's blood sugar continued to fluctuate and remained elevated and/or to document actions/interventions and/or to document the patient's immediate diabetic care needs and/or to notify and/or to document that she notified the physician of these changes that suggested a need to alter the plan of care.

c. Patient #4's start of care date was 4/15/06 with diagnoses including lumbar disc displacement, spinal stenosis, reflux esophagitis, hypertension and she was status post multiple fractures. A laminectomy was performed 3/18/06. Documentation on the certification plan of care dated 4/15/06 to 6/14/06 ordered skilled nursing 2 x week x 1, 1 x wk 1, every 2 weeks for 60 days to assess and instruct pain management, cardio-pulmonary status, mobility and safety and medication effects; Oxycodone was ordered for pain; goals included prevention of further fractures or injuries and maintenance of patient safety in the home environment; physical therapy evaluation and treat and H-HHA three days per week to assist with activities of daily living and personal care.

Documentation by RN #1 on the admission summary note dated 4/15/06 identified that the patient had a history of frequent falls, one of which occurred on 10/5/05 that caused a left arm fracture and back injury.

Documentation on the OASIS/comprehensive assessment dated 4/15/06 determined that the patient was 89 years old and lived alone in an assisted living facility, but she did not receive assisted living services. She had an unsteady gait and used a walker for ambulation. There was no documentation to determine that the comprehensive assessment included a fall risk assessment and/or assessment of the cause of the patient's multiple falls.

When interviewed on 5/9/06 RN #1 stated that the patient was admitted to the agency for post laminectomy. RN #1 stated that she did not inquire about why the patient had fallen so often, but that she assumed the falls were due to loss of balance.

RN #1 failed to accurately and/or consistently assess and/or to re-assess the patient in that the comprehensive assessment lacked information pertinent to the patient's fall history and/or RN #1 failed to collaborate with the physician about this issue in order to establish a plan of care to accurately address the patient's health care needs.

d. Patient #6's start of care date was 4/14/06 with diagnoses including quadriplegia and Insulin dependent diabetes. Documentation on the certification plan of care dated 4/14/06 to 6/14/06 ordered skilled nursing visits 1x month to supervise LPN and H-HHA; LPN visit daily for medication administration and to assist H-HHA with bowel regimen and ADLs, assess vital signs, report change to

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RN and to the primary physician.

There was no clinical record documentation to determine that a comprehensive assessment dated 4/14/06 included assessment of factors pertinent to the patient's diabetic status/management including nutritional status, blood sugar testing and ranges, type of Insulin and dosing, occurrences of hyper/hypoglycemia and management of related manifestations.

Documentation by LPN #2 on nurse visit notes during the period from 4/15/06 to 4/29/06 identified that the patient's blood sugar was consistently tested by LPN #2 each morning and noon (no indication of proximity to meals), that Insulin coverage (type not stated) was given at varying doses per the patient's request and that Insulin dosing was inconsistent for similar blood sugar levels. The clinical record lacked documentation to support that LPN #2 established the accuracy and/or significance of the patient's blood sugar levels and/or notified the physician and/or RN to collaborate about the patient's diabetic status and appropriate Insulin dosing. See Violation #7.

e. Patient #7's start of care date was 3/5/06 with diagnosis of right thumb infection. Documentation on the certification plan of care ordered skilled nurse 5-7 times a week for administration of Vancomycin, to assess the PICC line site for redness, swelling and/or infection and to change site dressings one time per week. Documentation (unsigned) indicated that Vancomycin was administered on 3/6/06 and 3/7/06, but there was no documentation to support that agency nurses assessed the patient's vital signs, dressings and/or PICC line site.

When interviewed on 5/9/06 the administrator supervisor thought these assessments were done, but she was unaware that assessments were not documented.

Agency nurses failed to accurately and appropriately re-assess and/or to document re-assessment of the patient's status.

f. Patient #8's start of care date was 4/7/06 with diagnoses including diabetes and cataracts. Documentation on the certification plan of care dated 4/7/06 to 6/9/06 ordered skilled nurse 1 x per week and 2 as needed visits to assess blood sugar, fall precautions and safety; to instruct in glucose monitoring, signs and symptoms of hyper/hypoglycemia, standard precautions and long term complications. Documentation by the administrator/supervisor on the admission summary note dated 4/7/06 identified that the patient was 91 years old, alert with some confusion and blind secondary to diabetes. Documentation on the OASIS/comprehensive assessment by the administrator/supervisor dated 4/7/06 identified that Patient #8 was forgetful, had limited endurance with an unsteady gait and she was up as tolerated using a walker and/or wheelchair due to lower extremity weakness. The patient lived with family and depended on her daughter for assistance with all activities of daily living including feeding, transferring, ambulation, toileting, meal preparation and telephone use. During the period from 4/7/06 to 5/5/06, the administrator/supervisor visited the patient regularly and she consistently identified that the patient was alert with some confusion with weakness in her lower extremities. During that time, there was no documentation that the nurse interacted with family members when visiting the patient and/or developed a plan for safety in the absence of family. On 5/10/06, the patient's grandson assisted the nurse and surveyor to enter the home and found the patient alone sitting in a wheelchair. The patient told the nurse that her daughter was working and her granddaughter had gone to school. In response to surveyor inquiry Patient #8 stated that she could not

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walk and/or transfer to the toilet independently and that she was unable to use the telephone without assistance. The grandson stated that usually another family member was home with the patient and he could not determine why she was home alone on the day of the visit.

When interviewed on 5/10/06 the administrator/supervisor stated that she was aware that the patient was alone much of the time, and that attempts to get Lifeline support services had failed because no one was home when installation could be scheduled. The administrator/supervisor stated that she and family members did not discuss the safety risk of leaving the patient alone and/or that the agency had no plan for the patient's safety when she was left home alone.

The agency administrator/supervisor failed to accurately and/or consistently re-assess the patient's safety and/or to document re-assessment of the patient's safety when no family member was present in the home for a patient who was frequently confused, non-ambulatory and unable to use a telephone independently and/or to take prompt action and/or to intervene appropriately to collaborate with family members to provide a safe plan of care and/or failed to inform the physician of the patient's status that necessitated alterations to the existing plan of care.

g. Patient #9's start of care date was 4/20/06 with diagnoses including Insulin dependent diabetes mellitus, hypertension and cerebral vascular accident. Documentation on the certification plan of care dated 4/20/06 to 6/20/06 ordered skilled nursing visits 1 x week and 2 as needed visits to assess blood sugar, instruct glucose monitoring, symptoms of hyper and hypoglycemia and to report to physician blood sugar lower than 80 and greater than 400. Documentation on the OASIS/comprehensive assessment by RN #1 dated 4/20/06 stated that this 83-year old patient was alert but confused and lived with family on whom he was dependent for all activities of daily living. Documentation on the OASIS/comprehensive assessment by RN #1 dated 4/20/06 identified that the patient's blood sugar was tested daily by family members and ranged from "< 70 to > 250". Documentation by RN #1 on the admission summary dated 4/20/06 stated that the patient's fasting blood sugar was 30, orange juice was given and after 20 minutes the blood sugar rose to 102, then he was given breakfast. There was no clinical record documentation to determine that RN #1 assessed why the hypoglycemic event occurred and/or that she assessed the blood sugar during her visit at 10 AM. RN #1 documented that she informed the physician, however there was no change to the plan of care. The next revisit was 4/27/06 (seven days later) when RN #1 documented that blood sugar was normal at 106, without documentation of proximity to meals. RN #1 instructed family members about the ADA diet and they planned to relate the information to the patient's daughter (PCG). RN #1 revisited one week later on 5/4/06 and identified that the patient's blood sugar was 186 without identifying proximity to meals. The PCG stated that she did not give the sliding scale Insulin (as ordered by the physician) and there was no documentation to support that RN #1 gave the Insulin. The daughter reported that the patient had extra pasta the night before and the nurse instructed the daughter regarding the patient's diet and to record when she used the sliding scale. During the period from 4/20/06 to 5/4/06, there was no clinical record documentation to support that RN #1 assessed the blood sugar levels during the week between nursing visits, the amounts of Insulin the patient was taking and/or his food intake and/or his activity level. When interviewed on 5/9/06 RN #1 stated that multiple family members were attempting to learn about the patient's care and that more frequent visits would probably have helped. RN #1 failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of

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the patient when hypoglycemia occurred and/or to take prompt action and/or to intervene appropriately in a timely manner and/or to document actions/interventions to consistently monitor factors effecting blood sugar fluctuations including food intake, activity levels and the amounts of Insulin the patient was taking and/or to document the patient's immediate health care needs to visit more frequently in order to accurately assess the patient's home health care needs and/or to collaborate with the physician about necessary changes to the plan of care.

h. Patient #10's start of care date was 4/7/06 with diagnoses including congestive heart failure and pleural effusion. Documentation on the certification plan of care dated 4/7/06 to 6/5/06 ordered skilled nurse 1 x week x 60 days and 2 as needed visits to assess/instruct medication management, fluid retention/edema, cardio-pulmonary status, energy conservation, chest pain and gastrointestinal status. Documentation by the administrator/supervisor on the admission summary stated that the patient was 91 years old, alert with some forgetfulness, complained of fatigue, ambulated with a walker and depended on family with whom she lived for assistance in all activities of daily living. Documentation during the period from 4/14/06 to 5/3/06 by the administrator/supervisor consistently identified that the patient had 2+ bilateral lower extremity edema, that she was weak with balance/gait abnormalities, had limited mobility and ambulated with a walker with difficulty and she was essentially chair bound. There was no clinical record documentation to determine that the patient was evaluated for physical therapy services and/or if this was discussed with the primary physician. When interviewed on 5/9/06 the administrator/supervisor stated that she was focused on the patient's fluid retention issues and physical therapy was not discussed.

Agency nurses failed to accurately and/or consistently re-assess the patient and/or to document re-assessment of the patient and/or to take prompt action and/or to intervene appropriately in a timely manner as the patient's mobility was consistently compromised and/or to document actions/interventions and/or to document the patient's immediate health care needs and/or to collaborate with the physician about the patient's limited mobility that suggested a need to alter the plan of care.

i. Patient #11's start of care date was 3/6/06 with diagnoses including hypertension and dementia. Documentation on the certification plan of care ordered skilled nurse 1 x weekly and 2 as needed visits to assess blood pressure, to call physician with blood pressure greater than 140/90 and instruct on compliance with medication regimen. Goals included control of blood pressure. Documentation on the admission summary by the administrator/supervisor dated 3/6/06 identified that the patient's blood pressure was 140/92 that the physician expressed concern about this elevation and the patient was to be instructed on compliance with metoprolol 25 mg twice daily and low sodium diet. Clinical record documentation by the administrator/supervisor identified that the patient's blood pressure was 146/92 on 3/14/06, instructions were given for medication compliance and diet adherence, and the patient's status was reported to the physician. The next revisit was one week later on 3/22/06 and the administrator/supervisor documented that blood pressure improved to 130/76. On 3/30/06, the administrator supervisor identified that blood pressure increased to 132/88. Documentation on an unsigned discharge transfer dated 3/30/06 stated that the patient was being discharged with goals met for stabilized blood pressure. There was no documentation to support that the administrator/supervisor

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collaborated with the physician to determine optimal blood pressure ranges for Patient #11.

When interviewed on 5/11/06 the administrator/supervisor stated that she did not discuss optimal blood pressure ranges with the physician, but that she thought the patient's blood pressure improved with diet adherence and medication compliance and that she was comfortable with a rapid discharge because she told the patient to call if there were problems.

The administrator/supervisor failed to accurately and/or consistently re-assess the patient when the diastolic blood pressures increased and/or to intervene appropriately to collaborate with the physician regarding optimal blood pressures before discharge and/or to confer with the physician about the appropriateness of discharge on 3/30/06 when the diastolic blood pressure had again started to increase.

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

6. Based on clinical record review and staff interviews it was determined that for two (2) of eleven (11) patients the agency failed to provide services and/or failed to document that services were provided as ordered by the physician and/or that the physician was informed of these alterations to the plan of care (Patient #s 5, 8). The findings include:

a. Patient #5's start of care date was 5/1/06 with diagnosis of Parkinson's disease. Documentation on the certification plan of care dated 5/1/06 to 6/29/06 ordered skilled nurse 1 time per week with 2 as needed visits to assess/instruct exacerbation of Parkinson's symptoms, cardio pulmonary status, medication action, side effects and compliance and long term disease complications. Clinical record documentation and patient interview determined that the patient's medication list on the plan of care dated 5/1/06 did not include all of the medications the patient was taking. There was no documentation to determine that the nurse revisited once per week, as ordered, to assess/instruct current medication actions, side effects and/or compliance; documentation was also lacking of communication with the physician to clarify the medication discrepancies to ensure that the patient was taking the correct medications as ordered by the physician. When interviewed on 5/26/06 the administrator/supervisor stated that she arranged for the patient's local physician to see the patient on 5/12/06 and was planning to revisit after that appointment. See Violation #8.

b. Patient #8's start of care date was 4/7/06 with diagnoses including diabetes and cataracts. Documentation on the certification plan of care dated 4/7/06 to 6/9/06 ordered skilled nurse 1 x per week and 2 as needed visits to assess blood sugar, fall precautions and safety; to instruct in glucose monitoring, signs and symptoms of hyper/hypoglycemia, standard precautions and long term complications. During the period from 4/7/06 to 5/5/06 documentation was lacking to indicate that the agency had developed a plan for the patient's safety as ordered by the physician, which included interventions for when the patient, who was walker/wheelchair dependent and totally dependent for assistance with ADLs and telephone usage, is left alone without a family member present in the home. See Violation #5.

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

7. Based on clinical record review and staff interviews it was determined that for Patient #6, agency professional staff failed to provide drugs and/or treatments only as ordered by the physician. The findings include:

a. Patient #6's start of care date was 4/14/06 with diagnoses including quadriplegia and Insulin dependent diabetes. Documentation on the certification plan of care dated 4/14/06 to 6/14/06 ordered skilled nursing visits 1x month to supervise LPN and H-HHA; LPN visit daily for medication administration and to assist H-HHA with bowel regimen and ADLs, assess vital signs, report change to RN and to the primary physician. The admission summary note on the plan of care documented by the administrator/supervisor on 4/14/06 stated that this 42-year old patient was alert and oriented, totally dependent for all ADLs and IADLs. He lived with his wife and three children and attended outpatient therapy 4x per week.

Ordered medications included Multi-vitamin 1 daily, Colace 100 mg daily, Insulin 16 units subcutaneously 4 times daily, Neurontin 300 mg four times daily, Prevacid 30 mg, Valium 5 mg daily, Baclofen 20 mg daily and Calcitonin 1 tablet daily. Documentation by the administrator/supervisor on the medication profile dated 4/14/06 indicated discrepancies in the medications and/or doses as follows: Insulin 16 units subcutaneously every evening, Oxycodone 50 mg at hour of sleep and as needed, and Calcitonin 200 units nasal (spray) daily. When interviewed on 5/17/06 the administrator/supervisor stated that she reviewed the medications with the primary physician and was unsure why the lists differed.

i. Documentation by LPN #2 on nurse visit notes during the period from 4/15/06 to 4/29/06 identified that the patient's blood sugar (BS) was consistently tested by LPN #2 each morning and noon (no indication of proximity to meals) and that Insulin (type not stated) was given at seemingly random, different doses per the patient's request as follows:

|          |                         |                                  |
|----------|-------------------------|----------------------------------|
| 4/15/06: | AM BS-113-no coverage;  | Noon BS-200- 8 units of Insulin; |
| 4/17/06: | AM BS-104-no coverage;  | Noon BS-144-12 units;            |
| 4/18/06: | AM BS-82 - no coverage; | Noon BS-75 - 6 units;            |
| 4/19/06: | AM BS-174-no coverage;  | Noon BS-263- 12 units;           |
| 4/20/06: | AM BS-101-no coverage;  | Noon BS-138- 14 units;           |
| 4/21/06: | AM BS-101-no coverage;  | Noon BS-155- 11 units;           |
| 4/22/06: | AM BS-141-no coverage;  | Noon BS-189- 4 units;            |
| 4/24/06: | AM BS-247-no coverage;  | Noon BS-269- 14 units;           |
| 4/25/06  | AM BS-114-no coverage;  | Noon BS-246- 5 units;            |
| 4/27/06  | AM BS-114-no coverage;  | Noon BS-181- 9 units;            |
| 4/28/06  | AM BS-222-no coverage;  | Noon BS-not stated.              |

There was no clinical record documentation to determine that LPN # 2 questioned the appropriateness of the random, specific insulin doses used for different blood sugar levels and/or that he informed the physician and/or RN that he was administering Insulin per the patient's request.

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When interviewed on 5/15/06 LPN #2 stated that when he started caring for Patient #6 another home health agency was the skilled care provider which had orders for the patient to manage his own Insulin coverage doses. LPN #2 stated that when the home health agency changed to his current employer, he was oriented to the new plan of care by the administrator/supervisor, but that he assumed the orders were the same.

The administrator/supervisor stated that when she supervised LPN #2, on 4/23/06, she reviewed the plan of care, but she was unaware that LPN #2 was giving Insulin per the patient's request rather than according to the physician's orders.

ii. During the period from 4/15/06 to 4/29/06, LPN #2 consistently documented that he applied Silvadene to the patient's stoma, but there was no clinical record documentation to determine that the physician ordered this treatment/medication. When interviewed on 5/15/06 LPN #2 stated that this order was included on the previous home care agency's plan of care. Agency professional staff failed to provide drugs and/or treatments only as ordered by the physician.

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

8. Based on clinical record review, staff and patient interviews and home visit observations it was determined that for two (2) of eleven (11) patients, the registered nurse failed to complete a comprehensive assessment that included an accurate review of all the medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy (Patient #s 5, 6). The findings include:

a. Patient #5's start of care date was 5/1/06 with diagnosis of Parkinson's disease. Documentation on the certification plan of care dated 5/1/06 to 6/29/06 ordered skilled nurse 1 time per week with 2 as needed visits to assess/instruct exacerbation of Parkinson's symptoms, cardiopulmonary status, medication action, side effects and compliance and long term disease complications; ordered medications included Requip 0.5 Gm. daily, Sinemet 50/200 daily and Tylenol 650 mg daily. During a home visit on 5/10/06, the patient told the surveyor that she had just returned from Florida and that she was taking multiple new medications. The surveyor observed that LPN #1 did not have a current list of the patient's medications, inclusive of these new medications. During the visit of 5/10/06, LPN #1 reviewed and documented all of the new medications as follows: Cymbalta 60 mg daily, Norvasc 25 mg daily, Nortriptyline 10 mg daily, Triamterene/hydrochlorothiazide 37.5 mg daily, Gabapentin 300 mg daily, Sinemet 25/100 mgs three times daily, Lipitor 10 mg daily, Plavix 75 mg daily, Atenolol 50 mg daily, Zetia 10 mg every evening, Synthroid 75 mcg daily and Requip 1 mg 2 tablets three times a day.

When interviewed on 5/9/06 the administrator/supervisor stated that a physician in Florida ordered the new medications and that she planned to obtain an accurate list of the patient's medications after she went to see a local physician on 5/12/06. When interviewed on 6/7/06, the administrator/supervisor stated that she was aware that the patient had additional new medications, but she did not view, list

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and/or review them all as some were still packed away. The nurse failed to complete a comprehensive drug regimen review at the start of care.

b. Patient #6's start of care date was 4/14/06. Documentation on the certification plan of care dated 4/14/06 ordered skilled nursing visits 1 x per month to supervise LPN and H-HHA; LPN to visit daily for medication administration. During the period from 4/14/06 to 5/9/06, the administrator/supervisor visited the patient at the start of care and supervised LPN #2 on 4/23/06; LPN #2 visited the patient daily. There was no clinical record documentation to support that the comprehensive assessment conducted at the start of care included a review of all medications the patient was using, including Provigil 200 mg daily, Lantus 12units at hour of sleep, Lispro Insulin 10 units at lunch and dinner, Duragesic patch 75 mcg every three days, Senna 6 tablets daily, Miralax 17 Grams, Lyrica 150 mg twice daily and Tizanidine 66 mg every six hours.

When interviewed on 5/17/06 the administrator/supervisor stated that she reviewed the medications with the primary physician at the start of care and was unsure why the lists differed.

When interviewed the primary physician's nurse stated that the patient also had another physician who ordered additional medications. Upon request by the surveyor for a list of the patient's medications for the period 4/14/06 to 4/30/06 Physician #2 faxed to the surveyor a list of medications including those stated above, all of which were started on 2/8/06 and had been ordered by the primary physician. The administrator/supervisor failed to conduct a comprehensive drug regime review, including all medications the patient was taking, at the start of care and/or during the supervisory visit of 4/23/06. See Violation #7.