

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

IN RE:           Vitas Healthcare Corporation Atlantic  
                  777 Commerce Drive, #220  
                  Fairfield, CT 06825

CONSENT AGREEMENT

WHEREAS, Vitas Healthcare Corporation Atlantic (hereinafter the "Licensee"), has been issued License No. 0017 to operate a Home Health Care Agency known as Vitas Healthcare Corporation Atlantic, (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 July 5, 2006 and concluding on August 18, 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 August 23, 2006 (Exhibit A – copy attached); and

WHEREAS, without admitting to any wrongdoing, the Licensee is willing to enter into this Consent Agreement 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 Timothy S. O'Toole, its Chief Executive Officer, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Agreement the Supervisor of Clinical Services for the hospice program shall develop and/or review and revise, as necessary, policies and procedures related to assessment of patients/caregivers/families relative to psychosocial needs, care planning and coordination of all hospice services to meet the total needs of the patient/caregiver/family.

2. Within twenty-one (21) days of the effect of the Consent Agreement all Facility nursing and direct care staff shall be in-serviced pertinent to the policies and procedures identified in paragraph number 1.
3. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator/Supervisor of Clinical Services, Hospice Program Director and Supervisor of Clinical Services (Hospice), shall ensure substantial compliance with the following:
  - a. Sufficient Medical Social Services personnel are available to meet the needs of the patient/caregiver/family;
  - b. All plans of care are individualized and shall include assessment of the patient's/caregiver's/family's individual needs including drug therapies, treatments prescribed by the physician, assessment of patient/caregiver/family needs as they relate to hospice services, plans for interventions and implementation including the management of discomfort and symptom relief and goals of management;
  - c. Hospice services are provided in accordance with each patient's comprehensive plan of care; and
  - d. The Interdisciplinary Group conducts ongoing assessments of the needs of each patient/caregiver/family then, in collaboration, reviews and revises each patient care plan to reflect appropriate interventions, supervises all services provided by the hospice to ensure implementation, coordination and continuity of the plan of care in accordance with applicable federal and state laws and regulations.
4. 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 Agreement. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
5. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the August 23, 2006 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients/caregivers/families and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator/Supervisor of Clinical Services, Hospice Program Director, Supervisor of Clinical Services (Hospice),

and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of two (2) years and made available for review upon request of the Department.

6. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand five hundred dollars (\$2,500.00) 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 Agreement. 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 #12FLIS  
Hartford, CT 06134-0308

7. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
8. 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.
9. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
10. The Licensee understands that this Consent Agreement 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.
11. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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

VITAS HEALTHCARE CORPORATION  
ATLANTIC - LICENSEE

11/20/06  
Date

By: [Signature]  
Timothy S. O'Toole, Chief Executive Officer

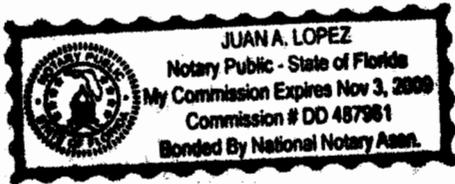
STATE OF Florida

County of Miami-Dade ss November 20, 2006

Personally appeared the above named Timothy S. O'Toole and made oath to the truth of the statements contained herein.

My Commission Expires: Nov 3, 2009  
(If Notary Public)

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



STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

12/5/06  
Date

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



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A  
PAGE 1 OF 17

August 23, 2006

Louise Gardina, RN, Administrator  
Vitas Healthcare Corporation  
777 Commerce Drive, Suite 220  
Fairfield, CT 06825

Dear Ms. Gardina:

Unannounced visits were made to Vitas Healthcare Corporation on July 5, 6, 7, 10, 11, 2006 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting licensing and Hospice certification inspections with additional information received through August 18, 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 September 7, 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

DATE(S) OF VISIT: July 5, 6, 7, 10, 11, 2006 with additional information received through August 18, 2006

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D66(gg) Definitions.

1. Based on clinical record review and staff interviews it was determined that the agency employed a registered nurse to provide patient care services who was not licensed in the State of Connecticut. The findings include:

a. Upon arrival in the Fairfield office on 7/5/06, the surveyor was informed that RN #5 was in charge of the office. In response to surveyor inquiry, RN #5 stated that she was not licensed as a registered nurse in the state of Connecticut.

b. Patient #5: Clinical record documentation by RN #5 on a late entry dated 7/19/06 as an addendum to 7/4/06 stated that the patient's PCG called to request that H-HHA #1 return because (since the aide left) the patient was anxious and trying to climb out of bed. The PCG stated that the patient was calm when the H-HHA was at the home. RN #5 documented that she contacted H-HHA #1 who agreed to return and RN #5 instructed the aide to call the back when she arrived.

When interviewed on 7/20/06, RN #5 stated that she was she was "on call" on 7/4/06 and after she spoke with the patient's PCG, RN #5 directed H-HHA #1 to return to the patient's home and to call upon arrival. RN #5 stated that when H-HHA #1 called from the patient's home she reported that upon her arrival she found the patient sleeping and that a nursing visit was not necessary.

c. On 7/24/06, the Connecticut Department of Public Health verified that RN #5 was not licensed in this state nor had she applied for temporary licensure status.

The agency failed to employ a registered nurse with a license to practice as a registered nurse in Connecticut.

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

2. The governing body failed to assume responsibility for the services provided by the agency to ensure the safety and quality of care rendered to all patients 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 & D68(e)(2)(3)(A)(B)(C) General requirements.

3. Based on staff interview and clinical record it was determined that the administrator/supervisor failed to ensure and maintain the quality of care and services rendered to eleven (11) of eleven (11) patients and their families (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11) as evidenced by the violations listed in this document.

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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

4. Based on clinical record review, medication policy review and staff interviews it was determined that for one (1) of one (1) patient the nurse failed to furnish specialized nursing skill to document inclusion of all pertinent information to identify specific medications that had been administered and/or pre-poured (Patient #7). The findings include:

a. Patient #7's start of care date was 6/2/06 with diagnoses including pancreatic cancer, anxiety, benign prostatic hypertrophy with trans urethral resection and insomnia. Documentation on the certification plan of care ordered skilled nurse 1-3 times a week to assess and manage symptoms. Ordered medications included Prevacid daily, Flomax daily, Miralax twice daily, Calcium daily, Vitamin D daily, Zinc daily, Vitamin C daily, Ferrous Sulfate daily, Colace three times a day, Creon with each meal and snack, Senokot as needed, Prochlorperazine as needed, Metoclopramide four times a day, Lorazepam as needed, Mageserol four times a day and Ambien at hour of sleep. Documentation by RN #1 on the initial assessment note identified that the patient requested that the nurse pre-pour the medications because he was so anxious. During the period from 6/2/06 to 7/3/06 agency nurses visited the patient 1-2 times per week, but there was no consistent documentation to determine that the nurses pre-poured the medications and/or how the patient managed if the medications were not pre-poured. When interviewed on 7/27/06 the administrator stated that the nurse failed to document that she pre-poured the medications weekly. Documentation by RN #1 on 6/8/06 and 6/26/06 identified that she pre-poured the medications, however, there was no consistent documentation to indicate the specific medications and/or doses that were poured and/or the time frames for which the medications were pre-poured. When interviewed on 7/10/06 the administrator stated that agency nurses seldom pre-pour medications and must have forgotten that they were instructed to document medication pre-pours explicitly reflecting what medications were poured and for the specific time frame. The administrator was unable to determine if the medications had been pre-poured weekly and the nurse was not available for interview.

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

5. Based on clinical record review, staff interview and agency policy review, it was determined that for seven (7) out of ten (10) patients the medical social worker failed to report to the physician a summary of the medical social services provided to the patient within ten days of admission and/or failed to document that a summary was communicated to the physician with ten (10) days after admission (Patient #s 1, 2, 3, 4, 5, 6, 7, 8). The findings include:

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Review of clinical records for Patient #s 1-8 who had a start of care dates after 5/5/06 indicated that documentation was lacking of notification of the physician within ten days of admission, either in writing or verbally, of the patient's psychosocial status following the provision of medical social service.

When interviewed on 7/8/06 the administrator stated that a copy of the IDG minutes were sent to the physician in each case, but it was not realized that a summary of medical social services was not included.

When interviewed on 7/8/06 MSW #1 stated that she thought she called the physician for each of these patients, but failed to document the calls. On 7/8/06 MSW #1 gave the surveyor copies of post dated communication notes for each patient that indicated that she provided each physician with summaries of her findings.

Review of agency policy indicated that copies of clinical summary reports are to be sent to the physician within ten days of admission.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(A)(xvii), (G) Patient care policies and/or D73(a)(3), (c)(1)(2) Patient care plan.

6. Based on clinical record review and staff interview it was determined that for eleven (11) out of eleven (11) patients the agency failed to establish a written plan of care for each individual admitted to the hospice program, individualized to meet the specific needs of the patient and caregiver and/or that the care provided was in accordance with the plan (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11). The findings include:

a. Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11: The plans of care established by the agency for these patients included orders that were not individualized to address the patient's specific identified needs in that the plans of care all read as follows: team members visit as often as needed to provide, within the scope of their practice: support, comfort, personal care, counseling, education and/or skilled care.

When interviewed on 7/7/06 the acting hospice supervisor stated that the physician signs the "standard orders" in order to provide flexibility for the hospice when added services are necessary but when additional services are provided, the information is documented in the IDG minutes and a copy is sent to the physician.

b. Patient #1's start of care date was 5/6/06. Documentation on the certification plan of care dated 5/6/06 ordered skilled nurse 1-3 times per week, H-HHA 2-4 times per week, social worker evaluation, chaplain as needed and volunteer to be assessed.

Clinical record documentation indicated that the nurse visited the patient on 6/8/06, however there was no clinical record documentation to support that a nurse revisited until 6/20/06 and/or that the physician was informed of the change in the plan of care.

When interviewed on 7/27/06 the administrator stated that some of the nurses erred in determining the accurate period between visits.

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c. Patient #8's start of care date was 5/17/06. Documentation on the certification plan of care dated 5/17/06 ordered skilled nurse 1-3 times per week, social worker to assess, H-HHA 2-4 times per week, chaplain assessment and evaluation for volunteers. Clinical record documentation determined that the medical social worker did not visit to evaluate the patient until 6/9/06 and that the nurse visited the patient on 5/18/06, but failed to revisit until 5/30/06.

When interviewed on 6/27/06 the administrator stated that the MSW actually visited on 5/30/06, but did not complete her documentation until 6/9/06. The administrator stated that the nurse missed visits because she scheduled them incorrectly.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(F)(i)(iii), (G)(iii) Patient care policies.

7. Based on clinical record review, patient interview, surveyor observation and staff interview, it was determined that for six (6) out of eleven (11) patients the Interdisciplinary Group (IDG) failed to conduct an ongoing assessment of each patient's and/or caregiver's and/or family's needs and/or failed to supervise the care and services provided by the hospice (Patient #s 1, 3, 4, 5, 6, 7). The findings include:

a. Patient #1's start of care date was 5/6/06 with diagnoses including dementia, status post hip fracture and depression. Documentation on the certification plan of care dated 5/6/06 ordered skilled nurse 1-3 times per week for symptom management, social worker evaluation, H-HHA 2-4 times a week, chaplain as needed and assessment for volunteer. Documentation by RN #1 on the nurse's initial assessment dated 5/6/06 identified that this 95-year-old patient was confused and forgetful with hearing loss and aphasia. She lived in a nursing facility, was non-ambulatory and was totally dependent for all activities of daily living.

Documentation by MSW #1 on the psychosocial assessment dated 5/10/06 identified that the patient's diagnosis included dementia, depression and anxiety and that she (Patient #1) nodded her head "yes and no" but that she was otherwise nonverbal and communication was difficult. MSW #1 identified that the patient was uncooperative, frustrated and withdrawn, was isolated, lonely, and lacked support systems. Documentation by MSW #1 on a verbal order dated 5/30/06 stated that she planned to visit 1-2 times a month to decrease loneliness and isolation. During the period from 5/11/06 to 7/5/06, MSW #1 revisited once on 6/10/06 and documented that the patient's problems of loneliness and isolation continued and that she expressed helplessness. There was no clinical record documentation to determine that MSW #1 communicated with the facility social worker, the patient's family, the IDG and/or the physician to alter the plan of care to include appropriate interventions focused on increasing social service visits and/or chaplain visits and/or H-HHA visits and/or adding volunteer visits and/or appropriate interventions focused at alleviating the patient's loneliness and/or isolation.

When interviewed on 7/7/06 MSW #1 stated that she was currently the agency's only social worker and that she had to spread her visits in order to see all of the patients. She stated that she had not thought to

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enlist the assistance of the other members of the IDG in order to meet the patient's needs. MSW #1 stated that she failed to document that she requested that the nursing staff bring the patient out of her room more often and/or that early in the treatment period, the IDG concluded that volunteer visits were not warranted because of the patient's communication difficulties.

Documentation by RN #2 on a nurse visit note dated 5/26/06 identified that the patient's daughter was recovering from chemotherapy and that she had not been able to visit the patient for a while. On a nurse visit note dated 6/23/06 RN #2 documented that the patient's daughter was being treated for breast cancer and that the patient was not aware. During a joint visit with the surveyor on 7/5/06, RN #2 stated that she frequently updated the daughter about the patient's status because the daughter could not visit for periods of time due to her low immunity induced by the chemotherapy that she received regularly. RN #2 told the surveyor that she did not know what the patient had been told about her daughter's absence, but that at the least, the daughter routinely called and spoke to the patient. Clinical record documentation indicated that during the period from 5/10/06 to 6/28/06 the IDG met on 5/10, 5/17, 5/31, 6/14, and 6/28/06, however, the minutes of those meetings lacked documentation to determine that the patient's coping problems and/or her daughter's health status and/or coping problems were discussed and/or that changes to the care plan were initiated. When interviewed on 7/8/06 the agency administrator stated that these issues were probably discussed at the IDG meetings, but were not documented.

b. Patient #3's start of care date was 5/21/06 with diagnoses including end stage cardiac disease, congestive heart failure, abdominal aortic aneurysm, cardiomyopathy, gout and arthritis. Documentation on the certification plan of care dated 5/21/06 ordered skilled nurse 1-3 times per week to assess and manage symptoms, social worker evaluation, volunteer evaluation, chaplain as needed and physician as needed. Clinical record documentation by RN #1 on the initial nursing assessment dated 5/21/06 identified that this 93-year-old patient was alert and oriented, walked with a steady gait and she was independent with all activities of daily living. The patient complained of feeling poorly, dizzy and short of breath. During a joint visit to the patient on 7/7/06, the surveyor learned that the patient lived alone and her niece (PCG) visited frequently. Documentation on the psychosocial assessment by MSW #1 dated 5/24/06 identified that the patient was withdrawn, experiencing anticipatory grief, lacked support systems and was lonely and isolated. Patient #3 endured multiple losses within the past five years, some of which remained unresolved, including the death of her brother one year earlier. The patient complained of not sleeping well at night. MSW #1 identified that the patient required counseling for end of life issues. A verbal order dated 5/31/06 documented by MSW #1 ordered medical social services 1-2 times per month to decrease loneliness and/or isolation. During the period from 5/24/06 to 7/7/06 there was no clinical record documentation to support that MSW #1 reported and/or discussed the patient's psychosocial status with the IDG, and/or that she revisited the patient, and/or that she implemented interventions to assist the patient with the identified psychosocial/bereavement issues, i.e. increased social services, volunteer visits, coordination with the chaplain to increase visits, and/or that she communicated with the PCG and/or other family members about the patient's needs.

When interviewed on 7/7/06, MSW #1 stated that the patient was very distraught about her brother

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during the visit on 5/24/06, but that MSW #1 was the only social worker at the agency for at least a month and was unable to visit all of the patients, as she would have preferred. MSW #1 stated that she was not sure if she offered H-HHAs and that it had not occurred to her that IDG members could have been involved in the MSW care plan.

i. During the period from 5/21/06 to 7/7/06 agency nurses consistently documented that the patient had a history of falls including a fall one week prior to admission to the hospice on 5/21/06 and that she had trouble sleeping although Ativan and Restoril were ordered. Documentation on 7/5/06 by RN #1 on an interdisciplinary progress note stated that RN #1 called the patient's niece because the patient's status was deteriorating with increased weakness, signs, and symptoms of congestive heart failure, having more bad days than good. RN #1 and the niece discussed that the patient should not be living alone and the niece offered to take Patient #3 into her home, but the patient refused. During a joint visit on 7/7/06 the patient told the surveyor that she had fallen off of the sofa about one week earlier, had skinned her knee and re-injured her upper arm. The patient also conveyed numerous stories about her deceased family and that she spent many hours alone. During the period from 5/24/06 to 7/5/06 the IDG met on 5/24, 6/7, 6/21, and 7/5/06 and documentation on those care conference summaries by agency nurses consistently stated the identified problems, however there was no documentation to determine that the IDG considered a physical therapy evaluation and/or that the team revised the plan of care to adequately include the services of the social worker, the chaplain and/or volunteers to intervene to meet the patient's psychosocial needs.

When interviewed on 7/8/06 the agency administrator stated that the IDG meetings should have discussed the possible increased use of core and/or ancillary hospice services, but had not documented that the discussions occurred and/or the outcome.

The IDG failed to develop an appropriate patient family plan of care to address multiple identified psychosocial needs and/or to update the plan of care and/or failed to document the review of the patient's care plans at the IDG meetings.

c. Patient #4's start of care date was 6/9/06 with diagnoses including ovarian cancer, bone metastasis, hypertension, diabetes and arrhythmia. Documentation on the certification plan of care dated 6/9/06 ordered skilled nurse 1-3 times a week for symptom management and medical social service evaluation. Documentation by MSW #1 on the initial psychosocial assessment dated 6/14/06 identified that this 75 year old patient was alert and oriented, that she recently returned home from a skilled nursing facility, that her spouse (PCG) was withdrawn and also had health problems, and that the patient was frustrated and overwhelmed by the loss of independence and all that was occurring in her life, including daily radiation therapy. The patient stated that the physician had told her it was time for palliative care. MSW #1 documented on the bereavement assessment of the same date that one of the patient's children lived in Georgia, had three children and he was currently getting a divorce; a 14 year old son had been killed in a car accident within the previous five years and her daughter was engaged to be married. Patient #4 also was dealing with concurrent life cycle changes in that her spouse (PCG) had multiple medical problems; the patient's death would result in the loss of the spouse's constant companion and cause changes in his living environment. During the period from 6/14/06 to 7/7/06 the social worker did not revisit and/or contact the patient.

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When interviewed on 7/10/06 MSW #1 stated that the patient was visited on 6/14/06 by a social worker from the Waterbury office and that she planned to visit the patient that day (7/10/06) because the nurse "was worried about her" (the patient).

The medical social worker failed to establish a plan of care to adequately identify interventions to meet the needs identified in the psychosocial/bereavement assessment.

During the period from 6/9/06 to 6/26/06 agency nurses visited the patient at least twice weekly and consistently documented that the patient was anxious and had multiple pain control problems. On 6/26/06, RN #4 identified that the patient appeared overwhelmed by her medications and that she was emotionally drained.

During the period from 6/9/06 to 6/21/06, the IDG met on 6/14 and on 6/21 however there was no documentation to determine that the patient's anxiety was discussed. On 7/5/06, RN #4 documented that the patient remained anxious at times, but there was no documentation to support that the IDG altered the plan of care. During the period from 6/14/06 through 7/5/06 there was no documentation to determine that the IDG discussed the patient's psychosocial status identified by MSW #2 on 6/14/06 and/or that social services were not provided since 6/14/06.

When interviewed on 6/21/06 RN #4 stated that she might have mentioned the patient's anxiety at the IDG, but it was not documented.

The IDG failed to develop an appropriate initial patient family plan of care to address identified psychosocial needs and/or to update the plan of care and/or failed to document the review of the patient's care plans at the IDG meetings.

d. Patient #5: Documentation by MSW #1 on the psychosocial assessment dated 7/3/06 identified that the patient was unaware of her terminal diagnosis and that the daughter (PCG) reported that the patient was frustrated, withdrawn, anxious, agitated, depressed and exhibited anticipatory grieving. There was no clinical record documentation to support that MSW #1 assessed the patient for these symptoms and/or that she assessed the PCG's coping. However, on 7/3/06, MSW #1 identified that the patient lacked support systems, expressed helplessness, loss of autonomy and needed closure/healing. The bereavement assessment documented by MSW #1 on 7/3/06 identified multiple losses within the previous five years that included a brother, a sister, friends and relatives. MSW #1 indicated that volunteer services would be possible in the future and that the social work plan of care was to visit one time a month to provide supportive counseling through the end of life. Documentation on an Interdisciplinary Case Conference Summary dated 7/5/06 (author not identified) identified that the patient's PCG had called the agency frequently and that she responded well to emotional support and guidance. Documentation on this form by MSW #1 identified that the daughter seemed to need additional support and that she was provided with referrals for private pay companies. There was no documentation to support that MSW #1 discussed the patient's psychosocial status and/or coping needs with the interdisciplinary group and/or the physician and/or that she established an appropriate plan of care that included measures to effectively intervene to assist the patient/family to cope and/or to alleviate stressors, i.e. volunteer referral for visits and/or telephone contact, coordination with chaplain visits, family conferences, and/or increased frequency of medical social work visits for counseling, and/or increased frequency and/or length of time of home health aide visits .

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When interviewed on 7/8/06 MSW #1 stated that she had numerous patients to visit and that she had not thought to augment her plan of care with other members of the IDG. Documentation by RN #4 on the IDG case conference summary dated 7/12/06 identified that additional help was privately hired to enable the PCG to have more time away, that Ativan was controlling the patient's anxiety, but that agitation reoccurred at times and the patient was not sleeping at night. Clinical record documentation failed to establish an interdisciplinary plan of care that adequately addressed the patient/family's psychosocial care needs and/or to intervene when the PCG expressed feelings of being overwhelmed and required increased respite and/or failed to intervene to alter the plan of care to address that the family was paying privately for respite care that was relative to the patient's terminal disease status and/or to intervene to relieve the PCG during the night hours when the patient's wakefulness continued. See Tag L136.

e. Patient #6's start of care date was 5/19/06 with diagnoses including chronic obstructive pulmonary disease, respiratory failure, chronic paranoid schizophrenia, diabetes mellitus, hypertension, depression and agitation. Documentation on the certification plan of care ordered skilled nurse 1-3 times per week, medical social worker evaluation, H-HHA 2-4 times per week and chaplain evaluation. Documentation by RN #2 on the initial assessment note dated 5/19/06 identified that the patient was readmitted to hospice after in-patient psychiatric care secondary to increased anxiety related to paranoid schizophrenia. Documentation by MSW #1 on a psychosocial assessment dated 5/22/06 stated that the patient was less anxious and/or agitated upon return (to the nursing home where she lived). However, MSW #1 assessed that this 75-year-old patient's mental status was altered and she manifested multiple psychological needs including withdrawal, irritability, depression and weepiness. In addition, the patient was struggling with meaning, expressed helplessness and loss of dignity, needed closure/healing, was lonely and isolated and lacked support. MSW #1 planned to visit 1-2 times a month for counseling. There was no clinical record documentation to support that the patient's status and/or plan of care was discussed with the physician, the IDG, the patient's daughter and/or the social worker at the nursing home. During the time from 5/22/06 to 7/21/06 agency nurses visited weekly, the chaplain visited on 6/8/06 and H-HHA services were provided twice weekly. MSW #1 revisited on 6/8/06 and no other social service interventions were implemented to appropriately address the patient's needs that were identified in the psychosocial assessment.

When interviewed 7/10/06 MSW #1 stated that the patient's daughter was not very involved and because the agency had only one social worker it was not possible to revisit more often. MSW #1 stated that she could not recall if she involved the nursing home social worker and/or that she had not thought to involve the IDG members, i.e. increased frequency of revisits from the chaplain and/or home health aide and/or to add volunteers to intervene to address the psychosocial problems and/or to strengthen the patient's support system and lessen her loneliness and/or isolation.

Clinical record documentation indicated that during the period from 5/19/06 to 7/21/06 the IDG met on 5/24, 6/7, 6/21, 7/5/06 and 7/19/06. Documentation of the minutes of those meetings indicated that the MSW planned to revisit the patient, however, there was no documentation to indicate that the patient's coping status and/or her daughter's health status and/or coping problems were discussed and/or that MSW #1 did not revisit during the period from 6/8/06 to 7/19/06 and/or that changes to the care plan

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were initiated to appropriately intervene to address the patient's psychosocial problems. When interviewed on 7/8/06 the agency administrator stated that the IDG discusses many issues that are probably not documented.

f. Patient #7: Documentation by RN #1 on the assessment dated 6/2/06 described the patient as 77 years old with extreme anxiety that interfered with his quality of life. RN #1 identified that the patient was so anxious that he remained standing to eat and that he was constantly moving. Documentation by RN #1 on the IDG meeting minutes dated 6/7/06 stated that the hospice physician ordered Klonopin 1 mg twice daily. MSW #1 documented that she would visit to provide supportive counseling to the patient and family. On 6/8/06 MSW #1 documented on a visit note that the patient was anxious during her visit and that the patient's spouse was extremely dependent and that she was anticipating surgery. MSW #1 identified that the patient was frustrated with his medications, withdrawn and depressed. The family system was rigid; he lacked supports and felt lonely and isolated. MSW #1 assessed that the patient struggled with meaning; he expressed helplessness, loss of autonomy and a need for closure/healing. On 6/21/06 MSW #1 identified that the family was feeling overwhelmed with the role changes. His wife was usually the patient, but now she was the caregiver and the patient who was previously independent now was exhausted and depending more on his daughter and son. Documentation on IDG meeting minutes on 6/14/06 and 6/28/06 failed to include a discussion of the patient's and/or family's psychosocial status and/or review of the MSW plan of care. When interviewed on 7/10/06 MSW #1 stated that she may have failed to document discussion about the patient's status and/or reviewed the plan of care at the IDG meetings.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(F)(i)(iii), (G)(iii) Patient care policies.

8. Based on clinical record review and staff interview it was determined that for six (6) out of eleven (11) patients the IDG failed to update the plan of care for the patients/families and/or failed to document the review of the patient's care plans at the IDG meetings (Patient #s 1, 3, 4, 5, 6, 7). The findings include:

a. Patient #1's start of care date was 5/6/06. Clinical record documentation by agency nurses identified that the patient's daughter was unable to visit due to her medical condition and that the patient was unaware that her daughter had been diagnosed with breast cancer and was receiving chemotherapy. There was no clinical record documentation to support that the IDG collaborated about the implications of these issues on the patient/families psychosocial status and/or that changes to the care plan were initiated. See Tag L147.

b. Patient #3: Clinical record documentation by the MSW and agency nurses identified that the patient was dealing with multiple psychosocial and end of life losses, however there was no documentation to determine that the IDG reviewed and/or updated the interdisciplinary plan of care to adequately meet

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the patient's needs i.e. to include medical social work, chaplain and/or volunteer services. See Tag L147.

c. Patient #4: Clinical record documentation by agency nurses and the medical social worker identified that the patient appeared overwhelmed and that she was emotionally drained. However, there was no clinical record documentation to support that the IDG reviewed and/or updated the interdisciplinary plan of care to address identified psychosocial needs of the patient. See Tag L147.

d. Patient #5: Clinical record documentation failed to support update of the interdisciplinary plan of care to adequately address the patient/family's identified psychosocial needs when the PCG expressed feelings of being overwhelmed and required increased respite and/or failed to intervene to alter the plan of care to address that the family was paying privately for respite care that was relative to the patient's terminal disease status and/or to intervene to relieve the PCG during the night hours when the patient's wakefulness continued. See Tags L136 and L147.

e. Patient #6: There was no clinical record documentation to indicate that the patient's identified coping issues and social service needs were discussed by the IDG and/or that changes to the care plan were initiated to provide adequate social service revisits and/or to appropriately intervene to address the patient's psychosocial problems. See Tag L147.

f. Patient #7: Clinical record documentation by agency nurses and the medical social worker determined that the patient and family experienced high levels of stress due to multiple psychosocial factors and end of life issues. Documentation on IDG meeting minutes failed to include discussions about the patient's and/or family's psychosocial status and/or to support that the IDG collaborated about and/or reviewed the MSW plan of care. See Tag L147.

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

9. Based on clinical record review and staff interviews it was determined that for eleven (11) out of eleven (11) patients the plans of care failed to include assessment of the individual's needs that included all drugs and/or treatments required; and/or assessment of patient/family needs as they relate to hospice services; and/or plans for interventions and implementation including the management of discomfort and symptom relief and/or goals of management, and/or that the care provided was in accordance with the plan (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11). The findings include:

a. Patient #1: The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline, appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and treatments required.

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b. Patient #2's start of care date was 5/9/06. Documentation on the certification plan of care dated 5/9/06 ordered skilled nurse 1-3 times per week, social worker evaluation and chaplain as needed. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status.

c. Patient #3's start of care date was 5/21/06. Documentation on the certification plan of care dated 5/21/06 ordered skilled nurse 1-3 times per week, social worker evaluation, and chaplain as needed. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and treatments required.

d. Patient #4's start of care date was 6/9/06. Documentation on the certification plan of care dated 6/9/06 ordered skilled nurse 1-3 times per week, social worker evaluation and chaplain evaluation. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status.

e. Patient #5's start of care date was 6/30/06 with diagnoses including lung cancer with brain metastasis and hypertension. Documentation on the certification plan of care dated 6/30/06 ordered skilled nurse 1-3 times per week, social worker evaluation, chaplain evaluation and home health aide daily. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or appropriate interventions for each discipline and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status.

Medications ordered on the certification plan of care dated 6/30/06 included Decadron, Omnicef, Zithromax, Ativan, ASA, Enalapril and Atenolol. Documentation on the certification plan of care identified that symptoms included anxiety, incontinence, poor appetite and shortness of breath.

Documentation by RN #3 on the nursing assessment dated 6/30/06 identified that the patient was alert but disoriented to time and place, experienced interrupted sleep patterns, was hard of hearing, vision impaired, experienced dizziness, and she was dependent for all activities of daily living including incontinence care for bowel and bladder. Patient #5 was weak with poor coordination and balance, she required assist of two persons to transfer and she was non-ambulatory. Her primary care giver (PCG) was a daughter living in the home and a second daughter assisted in the morning and evening.

Documentation by RN #1 dated 7/2/06 stated that the patient's daughter (PCG) called the agency to report that the patient was experiencing increased agitation and agency nurses obtained an order from the physician to increase Ativan 0.5 mg (from hour of sleep) to twice daily. Documentation by RN #4 on a skilled nursing progress note dated 7/3/06 identified that the patient had been agitated, but failed to include documentation of an assessment of the patient's sleep patterns. RN #4, however, contacted the physician and obtained orders for additional Ativan 0.5 mg at hour of sleep. RN #4 documented on the

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7/3/06 visit note that the patient's family was "overwhelmed" with the patient's care, but during that visit the H-HHA was decreased to five times a week "because family members were available." There was no documentation to indicate the specific reasons why the family was overwhelmed and/or why the H-HHA was decreased. When interviewed on 7/20/06 RN #4 stated that the family requested that no H-HHA come (at least for that week-end) because multiple guests were expected to visit and that the PCG only "perceived that she was overwhelmed," but that she actually provided adequate care for the patient.

During the 7/3/06 visit, RN #4 also identified that the patient had not had a bowel movement since 6/30/06. The physician was contacted and Senna S was ordered. Documentation by H-HHA #1 on an interdisciplinary progress note dated 7/4/06 identified that the patient's daughter called very upset because the patient was very agitated. H-HHA #1 documented that she went to the patient's home and found the patient asleep, but the daughter continued to be "very upset." On 7/19/06, the agency faxed to the surveyor a post-dated (7/19/06) interdisciplinary progress note by RN #5 that referred to the events of 7/4/06. This document identified that RN #5 received a telephone call from the patient's PCG who requested that the H-HHA come to the home because the patient was less agitated when the aide was present. There was no clinical record documentation to determine that the nurse visited the patient until 7/5/06.

When interviewed on 7/20/06 RN #5 stated that H-HHA #1 called her after visiting the patient and explained that the patient was asleep, the PCG was calm and a nursing visit was not required. RN #5 stated, however, that the PCG called the agency a few hours later in the early evening and asked to speak with a nurse because the patient was agitated a large part of the day and the PCG stated that she was not sure about the medications. The patient's constipation continued and the on-call nurse instructed the PCG to give milk of magnesia (no order), to give prunes and to call the agency in the morning.

On the nurse visit note of 7/5/06 RN #4 identified that constipation continued and required an enema. RN #4 also identified that the Senna S (ordered on 7/3/06) had not yet arrived at the home but, was expected that day.

RN #4 documented on 7/3/06 that the patient had been agitated the previous day and that she was awake twice during the night. The daughter (PCG) continued to provide total care, the family was supportive, but "overwhelmed" and the daughter received help from a sister in the morning and evening to help change the patient. There was no documentation to determine how the PCG provided care and/or moved the patient when no other persons were present and/or that RN #4 discussed with the physician that the agitation continued and that the family continued to be overwhelmed.

When interviewed on 7/10/06 RN #4 stated that family members "went in and out" throughout the day, the patient spent most of her time in bed and that the PCG only moved the patient when she had assistance. When interviewed on 7/20/06 RN #4 stated that on weekends the second daughter assisted more often during the day and that the PCG continued to only perceive that she was overwhelmed. Documentation by RN #4 on the interdisciplinary conference summary dated 7/5/06 identified that the PCG had called the agency frequently and was responsive to soothing talk, but failed to include discussion about the family feeling overwhelmed and/or failed to make changes to the care plan to address this issue.

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Documentation by H-HHA #1 dated 7/6/06 identified that the daughter spoke of "getting more help" and that the patient's agitation continued. Documentation by RN #4 on a skilled visit note dated 7/7/06 identified that the patient's PCG was "looking around for more help," but failed to include documentation of the specific assistance that was needed in order to determine if these needs related to the terminal illness and the hospice care plan. There was no documentation on 7/7/06 to indicate how the patient was sleeping; however, RN #4 contacted the physician to obtain an order for Restoril. On 7/11/06, RN #4 documented on the nurse visit note that the patient continued to be awake some of the nighttime. RN #4 identified that the patient was incontinent at night, that the PCG was reluctant to provide incontinent care and although family members were visiting and/or assisting, the family was getting added support from a private agency.

Documentation on a visit summary faxed to the surveyor on 7/21/06 determined that during the period from 7/1/06 to 7/18/06, the patient received 14 H-HHA visits for varying amounts of time as follows: 4 visits ranging from 2.5 -3.0 hours, 3 visits for 2.0 hours and 7 visits for 1.0 hours or less. When interviewed on 7/21/06 RN #5 stated that H-HHA services were provided to patients for whatever length of time the patient required each visit.

When interviewed on 7/20/06 RN #4 stated that the family was managing the patient's care better, but that the PCG wanted respite time so the family hired a private aid to assist from 8AM to 8PM. In response to surveyor inquiry, RN #4 stated that this was not within the scope of the hospice care plan because provision of respite level of care would require that the patient be placed in a nursing facility and this family would not do that.

The nurse failed to assess and/or to document the assessment of the individual's needs including the management and relief of ongoing constipation as reported to the on-call nurse on 7/4/06 and/or that the services provided met the patient/caregivers needs when the PCG consistently reported that she was overwhelmed and no other options were made available to the family enable PCG respite except to hire private help and/or to provide night care when the patient was consistently awake at night and the PCG was deprived of regular rest and sleep.

f. Patient #6's start of care date was 5/19/06. Documentation on the certification plan of care dated 5/19/06 ordered skilled nurse 1-3 times per week, social worker evaluation, H-HHA 2-4 times per week and chaplain evaluation. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and/or treatments required.

g. Patient #7's start of care date was 6/2/06. Documentation on the certification plan of care dated 6/2/06 ordered skilled nurse 1-3 times per week, social worker evaluation and chaplain evaluation. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and/or treatments required.

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h. Patient #8: The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and/or treatments required.

i. Patient #9's start of care date was 5/18/06. Documentation on the certification plan of care dated 5/18/06 ordered skilled nurse 1-3 times per week, social worker evaluation, home health aide 2-4 times per week and chaplain evaluation. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and/or treatments required.

j. Patient #10's start of care date was 6/19/06. Documentation on the certification plan of care dated 6/19/06 ordered skilled nurse one time per week, social services evaluation, H-HHA 2 times per week and chaplain evaluation. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status.

k. Patient #11's start of care date was 6/22/06. Documentation on the certification plan of care dated 6/22/06 ordered skilled nurse 1-2 times per week, social worker 1 time per week, H-HHA 2 times per week, and chaplain 1 time per week. The plan of care signed by the physician failed to include assessment of patient/family needs as they relate to hospice services and/or for each discipline appropriate interventions and/or goals to address the home health care and/or hospice needs determined by the patient's and/or family's current status and/or medications and/or treatments required. When interviewed on 7/11/06 the agency administrator stated that some nurses attach the medication profile list to the plan of care that is sent to the physician, but that the physician does not usually sign or return that list and (in those cases) the agency does not have a list of the medications signed by the physician. The administrator stated that interdisciplinary assessments and interventions are stated on the interdisciplinary care plans, but these are not sent to the physician for signature.

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

10. Based on clinical record review, patient interviews and staff interviews it was determined that for six (6) out of eleven (11) patients the interdisciplinary group (IDG) failed to develop and/or to revise the patient care objectives and/or to assure coordination and continuity of the plan of care and/or failed to document the exchange of information among staff and/or patients/caregivers and/or families (Patient #s 1, 3, 4, 5, 6, 7). The findings include:

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- a. Patient #1: When medical social services identified multiple psychosocial needs and availability of social services was limited due to staffing issues, and/or when agency nurses identified that the patient's daughter had breast cancer, was receiving treatment and unable to visit the patient, there was no clinical record documentation to determine that the IDG collaborated about these issues and/or about the lack of availability of adequate social services to address the patient/family's identified psychosocial needs and/or that the IDG coordinated their efforts to provide hospice services to effectively assist the patient/family. See Tag L147.
- b. Patient #3: There was no clinical record documentation to determine that the IDG collaborated to identify measures to address the lack of availability of adequate social services and/or to coordinate their efforts to provide hospice services to effectively assist the patient/family when the social service evaluation identified multiple psychosocial issues and the social worker's caseload did not allow for visit frequency adequate to meet identified needs and/or when agency nurses identified the increased risks of the patient's living alone. See Tag L147.
- c. Patient #4: Clinical record documentation determined that MSW #2 and agency nurses identified that the patient, caregivers and family had multiple psychosocial needs, but failed to include documentation to support that the IDG discussed the patient's psychosocial status in order to develop appropriate patient/family care objectives. See Tag L147.
- d. Patient #5: Clinical record documentation determined that MSW #1 identified multiple patient/family needs, but the MSW plan of care ordered only one social service visit per month due to limited social service staffing. There was no clinical record documentation to determine that the IDG collaborated to address the lack of availability of adequate social services to address identified psychosocial needs and/or that they coordinated their efforts to provide hospice services to effectively assist the patient/family to cope and/or to alleviate stressors. See Tags L136 and L147.
- e. Patient #6: Clinical record documentation determined that the social service evaluation identified multiple patient/family psychosocial needs and medical social services were ordered only 1-2 times per month (because of limited agency social service staff). There was no clinical record documentation to determine that the IDG collaborated about the patient's psychosocial status with the attending physician, the patient's family and/or the nursing home social worker and/or that the IDG acted to minimize the effects of the lack of availability of social work services to adequately meet the patient's identified needs through effective coordinated efforts to provide hospice services. See Tag L147.
- f. Patient #7: Documentation by RN #1 and MSW #1 identified that the patient/family had multiple psychosocial stressors, but there was no clinical record documentation to support that the IDG collaborated about these issues and/or that they conducted a coordinated review of the plan of care. See Tag L147.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(J),(M)(i)(ii) Patient care policies.

11. Based on clinical record review and staff interview it was determined that the hospice program director/supervisor failed to ensure the safety and quality of care rendered to eleven (11) of eleven (11) patients and their families (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11) evidenced by the violations listed in this document.