

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

FEB 13 2007

**IN RE:** Visiting Nurse Services, Inc. of Southern Connecticut of Hamden, CT d/b/a  
Visiting Nurse Services, Inc. of Southern Connecticut  
1684 Dixwell Avenue  
Hamden, CT 06514

CONSENT ORDER

WHEREAS, Visiting Nurse Services, Inc. of Southern Connecticut of Hamden (hereinafter the "Licensee"), has been issued License No. C9815510 to operate a Home Health Care Agency known as Visiting Nurse Services, Inc of Southern Connecticut, (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 September 18, 2006 and concluding on October 23, 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 October 25, 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 FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Kathleen Danler, its President, 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:
  - a. Pressure ulcers/wound care management including: physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and

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- tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, and nutritional approaches;
- b. Development, implementation and revision of the plan of care, including procurement and adherence to physician orders;
  - c. Referral for additional services and coordination of services with all involved in the plan of care;
  - d. Role of the home health aide related to pertinent aspects of the patient's condition to be observed and reported to the nurse, teaching and supervision.
2. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number 1.
  3. The Facility shall contract with a credentialed Wound Care RN. The certified Wound Care RN shall serve a minimum of six (6) hours a week for a three (3) month period and shall assess and audit the clinical records and plans of care of all current patients requiring wound care management, review agency policies/procedures pursuant to wound care management, evaluate the implementation of the Facility's wound care management procedures, conduct training, provide oversight to nursing and all direct patient care staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores or vascular sores.
  4. The Department shall retain the authority to extend the period of the certified Wound Care RN functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers and wounds. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in skin condition, and/or failure to provide care and treatment to patients identified with skin integrity issues and/or failure to implement physician orders. Determination of compliance with federal and state laws, and regulations will be based upon findings.
  5. The certified Wound Care RN contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity and/or recommendations. Said reports shall also be forwarded to the Facility's Professional Advisory Committee and governing authority for review and evaluation at their next scheduled meeting.

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6. The certified Wound Care RN shall have a fiduciary responsibility to the Department.
7. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
  - a. Sufficient nursing personnel are available to meet the needs of the patients and to promote coordination and continuity of care;
  - b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
  - c. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
  - d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
  - e. All services provided to patients shall be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care and shall be integrated with all other entities involved in the patient's care. All coordination activities shall support effective communication and interchange and be reflective of effective case management;
  - f. All home health aides are appropriately supervised in the care of each patient and written instructions for the home health aide accurately reflect patient needs;
  - g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status; and
  - h. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice.
8. The Supervisor(s) of Clinical Services shall be provided with the following:
  - a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;

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- b. A training program which clearly delineates each clinical supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation; and
  - c. The Supervisor(s) of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans and standards of practice.
9. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
10. 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.
11. 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 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

12. 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

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and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

13. 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.
14. 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.
15. 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.
16. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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CERTIFICATION REGULATIONS

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.

Visiting Nurse Services, Inc. of Southern,  
Connecticut of Hamden, CT

2/2/07  
Date

By: Kathleen Danler, Pres.  
Kathleen Danler, President

STATE OF Connecticut

County of New Haven ) ss Hamden 2007 February 2<sup>nd</sup>

Personally appeared the above named Kathleen Danler and made oath to the truth of the statements contained herein.

My Commission Expires: \_\_\_\_\_  
(If Notary Public) Kelly A. Thibault  
**KELLY A. THIBAUT** Notary Public   
**NOTARY PUBLIC** Justice of the Peace   
**My Commission Expires May 31, 2009** Town Clerk   
Commissioner of the Superior Court

2/14/07  
Date

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH  
By: Joan D. Leavitt  
Joan D. Leavitt, R.N., M.S., Section Chief  
Facility Licensing and Investigations Section

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# STATE OF CONNECTICUT

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EXHIBIT A  
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October 25, 2006

Jo Ann Davis, RN, Administrator  
Visiting Nurse Services, Inc. of Southern CT  
1684 Dixwell Avenue  
Hamden, CT 06514

Dear Ms. Davis:

Unannounced visits were made to Visiting Nurse Services, Inc. of Southern CT on September 18, 19, 20, 21, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through October 23, 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 November 8, 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 violation(s) to be presented at this conference.

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

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

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

Respectfully,

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

SNC:NC:

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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: September 18, 19, 20, 21, 2006 with additional information received through October 23, 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-D68(b)(1) General requirements.

1. The governing body failed to assume responsibility for services provided by the agency and to ensure the safety and quality care rendered to Patient #s 2, 6 and 12 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 ongoing functions ant to ensure the safety and quality of care rendered to the Patient #s 2, 6 and 12 . 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) General requirements.

3. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #s 2, 6 and 12 and their families as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(1),(3)(D),(3)(E) Services and/or D73(b)(d) Patient care plan.

4. Based on clinical record reviews, staff interviews, patient/family interviews, physician interview, agency policy review and home visit observations, it was determined that for two (2) of six (6) patients requiring wound care management, the nurse failed to accurately, consistently and appropriately re-evaluate the patient's physical status and/or continuing nursing needs and/or to notify the physician of a change in condition that suggested a need to alter the plan of care including interventions to address changes in the patient's condition and/or needs (Patient #s 2, 6). The findings include:

a. Patient #2 had a start of care date of 6/29/06 with diagnoses including decubitus ulcer of the buttocks and ankle, anemia and arthritis. The patient was referred to the home care agency by the Area Agency on Aging due to a Stage 2 decubitus of the right ankle. The initial plan of care dated 6/29/06 included skilled nursing 2x a week x 1, 5-7x a week x 2, 2-3x a week x 2, 1-2x a week x 2 to assess/instruct: gait/mobility/transfers/safety, vital signs, nutrition/hydration, bowel pattern, medication compliance, urinary incontinence management and family's compliance with responsibilities in the patient's care. The nurse was to perform wound care and notify the physician of the wound status every 14 days. Home health aide was scheduled 1-2 hours 3-5x a week to assist with ADLs, transfers,

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT  
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WERE IDENTIFIED

maintain safety. The patient also was receiving homemaker/companion services 3-5x a week for 4 hours through the Area Agency on Aging.

The 6/29/06 summary to the physician noted that the patient was alert and oriented x 3 but forgetful at times, incontinent of bowel and bladder and required a bed to chair Hoyer lift transfer. The patient had a right ankle decubitus and 2 small open areas noted on the patient's right gluteal fold, although the weekly wound assessment sheet dated 6/29/06 listed 3 open areas on the patient's right buttocks. The nurse performed wound care to the right ankle and applied Duoderm to the gluteal fold wounds. No family member was willing/able to perform wound care. The nurse instructed the aide to turn and reposition the patient every 2 hours in order to prevent further skin breakdown. The patient's appetite was good with fair hydration. The patient resided with her son who worked during the day.

The initial admission comprehensive assessment of 6/29/06 identified the patient as a fall risk and a total assist for her ADLs and IADLs except for eating which she could do independently if she had a meal set up. The initial referral form dated 6/23/06 identified the patient's weight as 95 lbs. The nurse did not make a referral for PT evaluation.

The plan of care, comprehensive assessment, nursing visit note and wound care assessment sheets of 6/29/06 lacked documentation regarding use of pressure relieving devices that the patient had in the home and/or needed. The patient had contractures of lower and upper extremities.

Review of the nursing visit notes from 6/29/06 to 8/4/06 lacked documentation of consistent and accurate re-evaluation of the location and description of the patient's actual wounds including references to the following: right ankle, right foot, right buttocks, right gluteal fold, right hip, left buttock, left gluteal fold and left heel. The weekly wound assessment sheet lacked consistent and accurate documentation as to which decubitus was identified as Wound #1, 2, 3 and/or 4 and the accurate location of the patient's decubiti. The plan of care indicated that the wound care to the patient's ankle was to be performed daily, however the nurse visited the patient 3-4x week. The clinical record lacked documentation as to who was performing wound care in the absence of the nurse and/or documentation that the person was capable/instructed on the patient's wound care with a return demonstration. The nurse's visit notes consistently indicated that the nurse instructed the family on proper nutrition/hydration, repositioning and obtaining booties to protect the patient's feet, and that the family was not compliant; the booties were never obtained per staff interview. The nurses noted that the patient often preferred to sit up in her wheelchair all day and evening and the family was not compliant in repositioning her and/or putting her to bed and/or performing wound care. The patient was always identified as being incontinent although she was alert and oriented. The clinical record lacked documentation to support that the nurse notified the physician of the family's noncompliance; that she suggested to the physician the use of vitamin C and/or zinc as a supplement for wound healing and/or to alter the plan of care based on the assessment of the family's non compliance i.e.: increased aide coverage and nursing visits, logs for nutrition/hydration and positioning, instructed the aide regarding a toileting plan to prevent incontinence and further skin breakdown, assessed the need for and ordering of pressure relieving devices; and/or failed to refer for PT to increase mobility and instruct in proper transferring and/or failed to refer for a MSW to assist with the family dynamics.

On 7/31/06 a new primary care nurse/case manager (RN #1) visited the patient and noted an additional decubitus on the patient's left buttocks, Stage 2, for which new orders were obtained. On the

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subsequent visit of 8/2/06, RN #1 noted that the right hip dressing was saturated with green-gray, foul smelling fluid and undermining was noted; the physician was updated but no change in treatment was noted. On 8/4/06 the right buttock wound had increased in size and the patient was sent to the ER for evaluation; the patient was hospitalized at that time.

The resumption of care comprehensive assessment of 8/9/06 indicated that Patient #2 was admitted to the hospital for an incision and drainage (I&D) of the right ischial tuberosity and the decubitus was now a Stage 4. The patient was identified as a moderate nutritional risk, incontinent of bowel and bladder and another son was now the primary caregiver who demonstrated that he could accurately perform the dressing procedure.

The orders from the hospital dated 8/8/06 included wound care three times a day to the right buttocks and the Stage 2 left buttocks. The patient refused ECF short-term placement and the son offered to assist with the dressing changes. The patient's albumin was 2.7 in the hospital, which indicated a poor nutritional status, and Ensure was ordered bid. The patient's weight was 90 lbs. a weight loss of 5 lbs. from the initial referral of 6/23/06.

The agency resumption of care orders to the physician dated 8/9/06 included skilled nursing 2-3x a week and home health aide 3-5x a week. The nurse failed to increase the frequency of her visits or the aide's visit in response to deterioration of the patient's health status and skin integrity and/or failed to refer for PT and MSW services to assist the patient/family. Review of the nurses notes from 8/9/06 to 9/13/06 lacked documentation that wound care was provided to the patient's left buttocks and/or that the decubitus had healed, lacked quantifiable data regarding the patient's nutritional intake, lacked documentation of a log regarding repositioning of the patient and the amount of time spent up in the wheelchair and lacked documentation of an assessment of the patient's incontinence and a toileting schedule to prevent incontinence. The patient exhibited pain during the wound care packing but the nurse failed to provide appropriate pain management by assessing the patient's schedule for taking her pain medication and the need to alter the schedule (take her pain medication ½ hr. prior to the dressing change) and/or to assess the need to change her pain medication.

SCS #2 who admitted the patient on 6/29/06 and was initially the patient's primary care nurse stated on 9/20/06 that the patient did have a HIL-ROM mattress on her bed since admission. The patient's electric wheelchair was broken so she was using a regular wheelchair and she was not sure if she had a cushion on the wheelchair. She stated that the aide was with the patient for six hours a day but functioning as a homemaker and companion for 4 hours and as an aide for 2 hours. SCS #2 stated that she oriented the aide to incorporate her aide time throughout the 6 hours however; this was not occurring initially during patient care therefore the patient was out of bed for a long period. The SCS was not aware that nurses were not documenting the wound sites accurately. She was not sure why the patient was incontinent since she was alert and oriented but did note that the patient did have a commode in her room and probably could have been toileted regularly. She stated that the patient wanted to stay up for long periods of time and the family, being noncompliant with her care, allowed her to sit up in the wheelchair. The patient had three (3) sons. On admission of 6/29/06 one son was responsible for the wound care which she thought he had been taught in the hospital; however following the patient resumption of care admission to the agency on 8/9/06 from the hospital for the wound infection, another son became her caregiver and appeared to be compliant. SCS #2 stated that

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she did not think about referring for PT or MSW. SCS #2 stated that from July to August 2006, she was the SCS and case manager for approximately 58 patients due to a staffing issue in the agency and this proved to be very difficult to do.

During a home visit to the patient on 9/21/06 the patient appeared very thin with contractures of her upper and lower extremities, alert and oriented, had a HIL-ROM mattress on her bed and had a commode in her room. Home Health Aide (HHA) #2 stated that her appetite was good as she ate the same meals every day. She stated that until she was hospitalized she only got her out of bed once and she would stay up for a long period of time; following hospitalization she would get her in and out of bed frequently and change her position often. She stated that initially the patient's electric wheelchair was broken and she was sitting in her regular wheelchair, which did not have a cushion. The aide noted that the patient could tell her when she needed to have a bowel movement and would use the commode but often she would be incontinent of urine in her diaper. The aide was not instructed in a toileting plan to prevent the incontinence. The patient stated during the visit that often she experienced pain when the nurse/son packed her wound.

The nurses failed to consistently and accurately re-evaluate the patient's health and wound status and/or nursing needs for Patient #2 who was at risk for skin breakdown and whose decubitus deteriorated from a Stage 2 to a Stage 4 in one month and whose family was identified as non-complaint. The nurse failed to alter the plan of care by communicating with the physician to increase nursing and/or home health aide visits; and/or to develop a toileting plan, to supervise the aide appropriately, to refer for PT and MSW to assist the patient and family, to accurately assess the patients intake and/or failed to document an accurate assessment of the patients decubiti.

b. Patient #6 had an original start of care of 03/14/06 with a principal diagnosis of advanced dementia and secondary diagnoses including malignant breast cancer, hypothyroidism, hypoxemia and legal blindness due to glaucoma. On 06/27/06, the patient was given a new start of care date as the patient was no longer chronic and stable; Patient #6 had developed a stage II left sacral decubitus and had become essentially bed bound requiring a two (2) person transfer to commode and bedside chair. For the recertification period dated 05/13/06 – 07/11/06 skilled nursing was ordered two (2) times a month to assess cardiac, respiratory, orientation, memory, behavior and skin integrity; supervise home health aide. Aide service was ordered six (6) times a week for personal care and ADL assistance.

The nursing clinical note for 06/08/06 by RN #1 documented the patient's skin condition as: coccyx area red, not open, treated with Bacitracin ointment after gentle soap and water cleansing, no dressing; nurse to revisit in two (2) weeks. All previous bi-monthly nursing notes documented skin condition as clear, dry and intact.

When interviewed on 09/21/06, RN #1 stated that on 06/08/06, the patient's daughter asked RN #1 to "look at her mother's bottom". RN #1 stated she had not been assessing the patient's coccyx and/or other pressure point areas because the patient would not let her touch her due to the patient's advanced dementia. RN #1 stated that when she documented skin condition as clear, dry and intact it was based on observation of exposed skin areas; RN #1 had never observed H-HHA #1 perform the patient's personal care nor had she asked the H-HHA about the patient's sacrum; H-HHA #1 never informed her that the patient's coccyx was reddened; the patient's daughter was already using Bacitracin ointment, so

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RN #1 continued with the Bacitracin ointment treatment. RN #1 stated she did not report the change in the patient's skin condition to Physician #1 because the patient's daughter was taking care of the reddened area; she did not know what stage the decubitus was before reopening. RN #1 stated, in hindsight, she should have visited the patient much earlier than two (2) weeks later.

i. Review of the H-HHA care plans dated 02/22/06, 03/14/06 and 06/26/06 instructed the H-HHA to report skin changes to the nurse. There was no clinical record documentation by H-HHA #1 for the period 06/01/06 – 06/30/06 that identified reddened skin areas. H-HHA #1 was not available for interview.

ii. When interviewed on 09/21/06, the patient's daughter stated she asked RN #1 to look at her mother's bottom because there was a red area that would not go away even when she was positioned on her side. The patient's daughter stated she called Physician #1 when the area opened up and asked if the physician would order supplies for her.

On 06/21/06 at 1:45PM, SCS #1 documented the physician's nurse called to ask the measurement of the reddened/excoriated area on the patient's buttocks so that dressing supplies could be ordered from the pharmacy; SCS #1 informed Physician #1's nurse that a nurse would go out Friday (06/23/06) to assess the area the daughter was caring for.

When interviewed on 09/22/06, RN #1's supervisor, SCS #1, stated she could not recollect if she read RN #1's 06/08/06 nursing clinical note concerning the change in the patient's skin condition; SCS #1 first learned on 06/21/06 from Physician #1's nurse that the patient had a reddened/excoriated area on the buttocks that was now open; the patient's daughter had called Physician #1's office requesting authorization to the pharmacy for dressing supplies; SCS #1 told RN #1 to visit the patient on 06/21/06 instead of 06/23/06; SCS #1 did not know why the patient wasn't seen by RN #1 on 06/21/06.

ii. Documentation of the nursing visit for 06/22/06 by RN #1 documented left sacrum/coccyx stage II decubitus ulcer; length 1cm, width 2cm, depth 0.25cm, wound bed yellow; red area 10cm x 4cm, stage I around the stage II decubitus; cleanse area with normal saline, pat dry, apply 4" x 4" duoderm hydrocolloid; change dressing every five (5) days; area is a pre-existing decubitus that opened up; daughter is caregiver and was taught dressing procedure; Physician #1 called for treatment order; patient stays on her back and left side; instructed daughter to position patient on right, off left side to promote healing; instructed daughter about hydration and increase protein to promote healing. RN #1 did not revisit the patient until 06/27/06 and documented that the stage II coccyx/left sacrum decubitus measured length 2cm, width not documented, depth 0.25cm, wound bed red; red area 16cm long x 6cm wide, stage I around the stage II decubitus; need to position patient off area; incontinent of urine; wears pull-up diapers, skin macerated. RN #1 documented on 06/27/06 she had a case conference with SCS #1 and skilled nursing visits were increased (frequency not documented). The new certification and plan of care dated 06/27/06 ordered skilled nursing three (3) times a week. When interviewed on 09/21/06, RN #1 could not recollect why the patient was not visited on 06/21/06; RN #1 did know why she waited so long to revisit the patient. When interviewed on 10/19/06, RN #1 stated during the 05/25/06 visit she recollects asking the patient's daughter if there were any problems with mom's buttocks; the daughter told RN #1 that the skin was clean, dry and intact. RN #1 stated though she never observed H-HHA #1 render personal care, she remembered at some point before the decubitus re-opened, H-HHA #1 told her there were no skin problems. RN #1 stated H-HHA #1 did not

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follow the 02/22/06, 03/14/06 and 06/26/06 H-HHA care plans to report to the nurse any reddened/open areas on the skin.

When interviewed on 09/20/06, Physician #1's nurse stated that on 06/13/06, Physician #1 received an order from RN #1 which stated gentle cleansing to coccyx/peri-anal area; apply Bacitracin to irritated areas with each episode of peri-care until healed; Physician #1 signed these orders after calling the patient's daughter inquiring about the status of the coccyx; patient's daughter called Physician #1 on 06/21/06 to tell him the reddened coccyx area had opened and she had already called RN #1 to visit. Physician #1's nurse stated the patient saw Physician #1 on 07/07/06; Physician #1 ordered treatment to sacral decubitus: cleanse with normal saline and apply Telfa dressing which was least irritating for the patient; on 07/11/06 the treatment was changed to cleanse with hydrogen peroxide, pat dry, cover with Telfa pad; Physician #1 ordered an alternating pressure mattress on 07/17/06; CAT scan done in 04/06 showed the metastasis to the lungs had grown; hormonal medication was changed; patient had been hospitalized in 03/06 with hypoxia, probably due to the lung cancer; patient's increased confinement to bed may be due to both the advancing dementia and the metastasis to the lung. When interviewed on 09/21/06, RN #1 stated she was not aware that there was metastasis to the lung nor had she ever called the doctor to discuss the patient's diagnoses and/or prognosis related to the cancer change.

iv. Review of the agency policy concerning nursing assessment stated that ongoing nursing assessments are reflective of ongoing observations and all changes in patient status based on on-going assessments by nursing are to be communicated to the physician. RN #1 failed to notify the physician of a change in condition that resulted in a stage II left sacral decubitus; RN #1 failed to re-evaluate the patient in a timely manner after assessing a change in condition; RN #1 failed to put preventative measures in place prior to the development of a stage II left sacral decubitus. RN #1 failed to supervise the H-HHA appropriately.

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

5. Based on clinical record review, agency policy, staff interviews and home observations, it was determined that for three (3) of six (6) patients requiring wound management the nurse failed to coordinate services, inform the physician and other personnel of changes in the patient's condition and needs (Patient #s 2, 6, 12). The findings include:

a. Patient # 2 had a start of care date of 6/29/06 with diagnoses of decubitus ulcers of the buttocks and ankle, anemia and arthritis. The initial plan of care dated 6/29/06 included skilled nursing to perform wound care, assess nutrition/hydration and incontinence management and home health aide 2hrs. 3-5x a week to assist with ADLs, transfers and safety. The patient was also receiving homemaker and companion services from the Area Agency on Aging 4 hours/day 3-5 x a week.

Review of the clinical record from 6/29/06 to 9/18/06 indicated that the patient's wound status deteriorated from a stage 2 buttock decubitus to a stage 4. The patient's albumin level was 2.7 during a

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hospitalization of 8/06 and the patient was identified as alert and oriented but incontinent. The clinical record lacked documentation of any preventive devices in the home but did indicate that the nurse instructed the aide and family to turn the patient every two hours.

SCS # 2 who admitted the patient on 6/29/06 stated on 9/20/06 that the patient had a HIL-ROM bed in the home, a broken electric wheelchair so she was using a regular wheelchair and was not sure if the wheelchair had a cushion. She stated that she instructed the aide during orientation to incorporate her aide hours into her homemaker and companion hours so that the patient's position could frequently be changed. She stated that the patient was alert and oriented and she did not know why the patient was incontinent. The patient did have a commode in her room and probably could have been regularly toileted.

During a home visit to the patient on 9/21/06 the aide stated that until the patient was hospitalized in 8/06 she only got her out of bed once and she would stay up for a long period of time because she liked to stay up in the wheelchair. She stated that initially the patient's electric wheelchair was broken and she would sit in her regular wheelchair, which did not have a cushion. The aide stated that the patient could tell her when she needed to have a bowel movement but would often be incontinent of urine in her diaper. She stated that she was not instructed in a toileting plan to prevent incontinence and was not instructed by the nurse to keep a log for intake and output. The patient ate the same foods every day and her appetite appeared to be adequate.

The nurse failed to coordinate services with the home health aide and appropriately supervise the aide and/or appropriately revise the aide's care plan to meet the changes in the patient's condition and needs.

b. Patient #6 had an original start of care of 03/14/06 with a principal diagnosis of advanced dementia and secondary diagnoses including malignant breast cancer, hypothyroidism, hypoxemia and legal blindness due to glaucoma. On 06/27/06, the patient was given a new start of care date as the patient was no longer chronic and stable; Patient #6 had developed a stage II left sacral decubitus and had become essentially bed bound requiring a two (2) person transfer to commode and bedside chair. For the recertification period dated 05/13/06 – 07/11/06 skilled nursing was ordered two (2) times a month to assess cardiac, respiratory, orientation, memory, behavior and skin integrity; supervise home health aide. Aide service was ordered six (6) times a week for personal care and ADL assistance.

Patient #6 developed a stage I left sacral decubitus ulcer on 06/08/06. RN #1 failed to alert Physician #1 of this change in the patient's condition. When interviewed on 09/21/06, RN #1 stated she did not report the change in the patient's skin condition to Physician #1 because the patient's daughter was taking care of the reddened area.

Review of the H-HHA care plans dated 02/22/06, 03/14/06 and 06/26/06 instructed the H-HHA to report skin changes to the nurse. There was no clinical record documentation by H-HHA #1 for the period 06/01/06 – 06/30/06 that identified reddened skin areas. H-HHA #1 was not available for interview.

When interviewed on 09/21/06, RN #1 stated she had never observed H-HHA #1 perform the patient's personal care nor had she asked the H-HHA about the patient's sacrum; H-HHA #1 never informed her that the patient's coccyx was reddened.

i. Review of the agency policy concerning coordination of care stated it involves timely, effective

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communications between all members of the home care team, client and family; communication related to care is the responsibility of all staff involved in providing care for the client.

Review of the agency's policy concerning H-HHA supervision stated when skilled nursing care is being provided, H-HHA supervision will be conducted every two (2) weeks or less, whether the aide is present to observe and assist or when the aide is absent to assess relationships and determine whether goals are being met.

RN #1 failed to notify the physician of a significant change in condition that resulted in a stage II left sacral decubitus. RN #1 failed to appropriately supervise and communicate with H-HHA #1 to effectively coordinate and support the objectives in the nursing and H-HHA plans of care.

c. Patient #12 had a start of care date of 3/10/06 with diagnoses including congestive heart disease, diabetes, chronic renal insufficiency (CRI), hypertension and amputation of fingers. The patient was only home from the hospital until 4/5/06 when she was readmitted to the hospital with an exacerbation of CHF and was hospitalized from 4/5/06 to 5/6/06. The patient was readmitted to the home care agency on 5/7/06 with diagnoses including non-healing surgical wound, CHF, CRI and diabetes. The resumption of care comprehensive assessment dated 5/7/06 noted that the patient had 3 wound sites: right upper arm surgical incision, right middle finger surgical site and a stage 2 left inner heel pressure ulcer.

Review of the clinical record indicated that from 5/8/06 to 6/1/06 the nurse failed to document that she followed the physician's order of applying Bacitracin to the right arm incision except for the visits of 5/14/06 and 5/20/06; Zeroform only was documented as being applied. On 5/18/06, the nurse noted that the surrounding skin to the right arm incision was very dark red/swollen and the physician recommended an ER visit and no changes were made to the wound care treatment of the right upper arm at the time of the ER visit. On her visit of 5/22/06, LPN #1 noted that the right arm wound incision was draining small amounts of yellow/tan drainage; Documentation was lacking that LPN #1 communicated this finding to the RN and/or the physician. The patient was apparently admitted to the hospital for elective surgery of a finger amputation on 5/25/06 for less than 24 hours but failed to notify the agency until 5/31/06 that she had returned home. On 6/6/06, the nurse documented that the right arm incision had a hard lump and the patient was to see the physician on 6/7/06 to observe the lump. The patient was admitted to the hospital on 6/7/06 with a surgical infection of the right upper arm A/V shunt.

SCS #2 stated on 9/21/06 that she was not aware that the nurses were not following the appropriate dressing procedure to the right upper arm as ordered by the physician and the agency was not aware of the date for the patient's elective surgery to the patient's fingers since it was difficult to communicate with clinic physicians.

The nurse failed to coordinate/communicate findings/services with the RNs and LPNS visiting the patient and/or patient's physician regarding changes in the patient's wound drainage, health status and nursing needs.

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

6. Based on clinical record review, staff interviews and agency policy review, it was determined that for two (2) of six (6) patients requiring wound management the nurse failed to initiate measures to prevent the development of pressure ulcers (Patient #s 2, 6). The findings include:

a. Patient #2 had a start of care 6/29/06 with diagnoses including decubitus ulcers of the buttocks and ankle, anemia and arthritis. The patient was referred to the home care agency by the Area Agency on Aging due to a Stage 2 decubitus of the right ankle. The initial plan of care dated 6/29/06 included skilled nursing 2x a week x 1, 5-7x a week x 2, 2-3x a week x 2, 1-2x a week x 2; home health aide service was scheduled 1-2 hours 3-5x a week. The patient also was receiving homemaker/companion services 3-5x a week for 4 hours through the Area Agency on Aging.

The plan of care, comprehensive assessment, nursing visit note and wound care assessment sheets of 6/29/06 lacked documentation regarding the use and/or appropriateness of pressure relieving devices that the patient had in the home and/or needed. The patient had contractures of the lower and upper extremities. The nurse instructed the aide and family to turn the patient every two hours, however the family was identified as non-compliant.

SCS #2 who admitted the patient on 6/29/06 and was initially the patient's primary care nurse stated on 9/20/06 that the patient did have a HIL-ROM mattress on her bed since admission. The patient's electric wheelchair was broken so she was using a regular wheelchair and she was not sure if she had a cushion on the wheelchair. She stated that the aide was with the patient for six hours a day but functioning as a homemaker and companion for 4 hours and as an aide for 2 hours. SCS #2 stated that she oriented the aide to incorporate her aide time throughout the 6 hours however; this was not occurring initially during patient care therefore the patient was out of bed for a long period. She was not sure why the patient was incontinent since she was alert and oriented but did note that she had a commode in her room and probably could have been regularly toileted.

During a home visit to the patient on 9/21/06 the patient appeared very thin with contractures of her upper and lower extremities, alert and oriented, had a HIL-ROM mattress on her bed and had a commode in her room. Home Health Aide (HHA) #2 stated that her appetite was good as she ate the same meals every day. She stated that until she was hospitalized she only got her out of bed once/day and she would stay up for a long period of time; following hospitalization she would get her in and out of bed frequently and change her position often. She stated that initially the patient's electric wheelchair was broken and she was sitting in her regular wheelchair, which did not have a cushion. The aide stated that she was not instructed in a toileting plan to prevent incontinence.

The nurse failed to initiate appropriate preventive devices/measures and procedures to prevent further deterioration of the patient's wound status.

b. Patient #6 had an original start of care of 03/14/06 with a principal diagnosis of advanced dementia and secondary diagnoses including malignant breast cancer, hypothyroidism, hypoxemia and legal blindness due to glaucoma. On 06/27/06, the patient was given a new start of care date as the patient

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was no longer chronic and stable; Patient #6 had developed a stage II left sacral decubitus and had become essentially bed bound requiring a two (2) person transfer to commode and bedside chair. For the recertification period dated 05/13/06 – 07/11/06 skilled nursing was ordered two (2) times a month to assess cardiac, respiratory, orientation, memory, behavior and skin integrity; supervise home health aide. Aide service was ordered six (6) times a week for personal care and ADL assistance.

On 04/19/06, RN #2 documented the patient's skin was dry and intact, good skin turgor with no open areas and had poor mobility. RN #2 revisited three (3) weeks later on 05/09/06. RN #2 documented the patient transferred from bed to chair with maximum assist; essentially chair-fast; skin was dry and intact. On 05/25/06, RN #1 documented the patient does not ambulate; daughter stated her mom's buttocks were clean, dry and intact; daughter was totally responsible for the patient's care. The nursing clinical note for 06/08/06 by RN #1 documented the patient's skin condition as: coccyx area red, not open, treated with Bacitracin ointment after gentle soap and water cleansing, no dressing; nurse to revisit in two (2) weeks. By 06/21/06, the patient's stage I decubitus ulcer had progressed to a stage II decubitus ulcer. Following RN #1's telephone call to Physician #1 about the decubitus ulcer status, Physician #1 ordered an alternating pressure mattress.

Between 04/19/06 and 06/08/06 there was no clinical record documentation RN #1 and RN #2 discussed with the patient's daughter and/or with H-HHA #1 the importance of turning and repositioning the patient every two (2) hours and how to minimize the effects of shearing force; teaching the daughter the importance of adequate nutrition to maintain skin health and the need for pressure relief aids to prevent pressure ulcers. There was no clinical documentation by RN #1 and/or RN #2 from 04/19/06 until 07/06/06 when physical therapy was instituted, that they assessed the need for physical therapy to teach the daughter and H-HHA passive range of motion (ROM) exercises and ensure proper transfer techniques.

When interviewed on 09/21/06 RN #1 stated she did not discuss prevention of pressure ulcers with the daughter prior to the 06/08/06 stage I left sacral decubitus ulcer nor was RN #1 aware the patient had a history of sacral decubitus ulcers. RN #2 was not available for interview.

Review of the agency policy concerning nursing assessment stated all nursing interventions are based on nursing assessment and physician orders are obtained as appropriate.

RN #1 and/or RN #2 failed to initiate measures to prevent a decubitus ulcer in a timely manner, in an essentially immobile, bed bound patient.

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

7. Based on clinical record review and staff interviews it was determined that for two (2) of five (5) patients requiring wound management the nurse failed to follow the physician's written orders/plan of care (Patient #s 2 and 12). The findings include:

a. Patient #2 had a start of care 6/29/06 with diagnoses including decubitus ulcers of the buttocks and ankle, anemia and arthritis. The patient was referred to the home care agency by the Area Agency on

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Aging due to a Stage 2 decubitus of the right ankle. The initial plan of care dated 6/29/06 included skilled nursing 2x a week x 1, 5-7x a week x 2, 2-3x a week x 2, 1-2x a week x 2 to assess/instruct (A/I): gait/mobility/transfers/safety, vital signs, nutrition/hydration, bowel pattern, medication compliance, urinary incontinence management and family's compliance with responsibilities in the patient's care. The nurse was to perform wound care and notify the physician of the wound status every 14 days. Home health aide service was scheduled 1-2 hours 3-5x a week to assist with ADLs, transfers, maintain safety; the patient also was receiving homemaker/companion services 3-5x a week for 4 hours through the Area Agency on Aging.

The plan of care dated 6/29/06 included wound care as follows: right outer ankle cleanse with NS, F/B Silvadene and DCD; right buttocks wound apply Duoderm.

On the visit notes from 6/29/06 to 7/7/06 the nurse, documented wound care to the right buttocks as cleansed with NS and Duoderm applied. The subsequent visit note of 7/9/06 noted that the nurse covered the right gluteal fold with Xeroform, DCD and a hydrocolloid dressing. The clinical record lacked documentation of orders and/or communication with the physician for the new wound care procedure of 7/9/06 to the buttocks; the physician orders dated 7/24/06 stated discontinue NS, F/B Xeroform and Tegaderm 3x a week and change to NS, F/B Silvadene, DCD and Tegaderm 3x a week. The clinical record lacked documentation of the son being taught the new dressing procedures since he was responsible for wound care in the nurse's absence and/or the orders were not clear as to how often the son needed to perform wound care beyond the 3x a week.

On the visit of 7/17/06, the nurse documented that the right buttock was cleansed with NS and Exuderm was applied. During the visits of 7/21/06 and 7/24/06, the nurse documented application of Silvadene to the right and left buttocks.

New physician orders dated 7/31/06 included cleanse the right ankle with NS, apply Silvadene and DSD, continue care to right buttock with NS, followed by Exuderm and begin care to left buttock with NS and a hydrocolloid dressing. The nursing visit frequency for the new wound care orders was not stated but the nurse included that the family was to change dressings between nursing visits. The clinical record lacked documentation that the family was taught the new procedures and/or that the physician was contacted to clarify the wound care orders.

On 8/4/06, the right buttock decubitus deteriorated and the nurse documented that she packed the wound with alginate rope for which an order was not documented in the record; Patient #2 was sent to the ER, diagnosed with a wound infection and was admitted to the hospital.

SCS #2 stated on 9/20/06 that she was sure there was an order for the Xeroform dressing but she could not find the order. She stated that from July to August 2006, she was the SCS and the case manager for approximately 58 patients due to a staffing issue in the agency, which proved to be very difficult to do. The nurses failed to have physician orders for all treatments and/or to correctly follow physician orders for the patient's wound care.

b. Patient #12 had a start of care date of 3/10/06 with diagnoses including congestive heart disease, diabetes, chronic renal insufficiency (CRI), hypertension and amputation of fingers. The patient was only home from the hospital until 4/5/06 when she was readmitted to the hospital with an exacerbation of CHF and was hospitalized from 4/5/06 to 5/6/06. The patient was readmitted to the home care

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agency on 5/7/06 with diagnoses including non-healing surgical wound, CHF, CRI and diabetes. The resumption of care comprehensive assessment dated 5/7/06 noted that the patient had 3 wound sites: right upper arm surgical incision, right middle finger surgical site and a stage 2 left inner heel pressure ulcer.

The hospital orders of 5/6/06 included: right arm AV fistula incision was to be cleansed and Bacitracin and Xeroform to be applied every 12 hours. Resumption of care orders dated 5/7/06 included: cleanse the AV shunt site in the right upper arm with NS, F/B Bacitracin, F/B Xeroform, F/B DSD and Kerlix daily. Nursing visits were 5-7x a week x 2, 3-5x until the end of the recertification period.

Review of the clinical record indicated that from 5/8/06 to 6/1/06 the nurse failed to document that she followed the physician's order of applying Bacitracin to the right arm incision except for the visits of 5/14/06 and 5/20/06; Xeroform only was documented as being applied. On 5/18/06, the nurse noted that the surrounding skin to the right arm incision was very dark red/swollen and the physician recommended an ER visit and no changes were made to the wound care treatment of the right upper arm at the time of the ER visit. On her visit of 5/22/06, LPN #1 noted that the right arm wound incision was draining small amounts of yellow/tan drainage; documentation was lacking that LPN #1 communicated this finding to the RN and/or the physician. The patient was apparently admitted to the hospital for elective surgery of a finger amputation on 5/25/06 for less than 24 hours but failed to notify the agency until 5/31/06 that she had returned home. On 6/6/06, the nurse documented that the right arm incision had a hard lump and the patient was to see the physician on 6/7/06 to observe the lump. The patient was admitted to the hospital on 6/7/06 with a surgical infection of the right upper arm A/V shunt.

SCS #2 stated on 7/21/06 that she was not aware that the nurses were not following the appropriate dressing procedure to the right upper arm as ordered by the physician and the agency was not aware of the date for the patient's elective surgery to the patient's fingers since it was difficult to communicate with clinic physicians.

The nurses failed to follow and/or to clarify the physician's orders for wound care and/or to notify the physician of a change in the drainage from the wound which suggested a need to alter the plan of care; Patient #12 was later admitted to the hospital and treated for a wound infection.

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

8. Based on clinical record review and staff interviews it was determined that for Patient #2 the nurse failed to administer wound care treatments as only as ordered by the physician. The findings include:

a. Patient #2 had a start of care date of 6/29/06 with diagnoses including decubitus ulcers of the buttocks and ankle, anemia and arthritis. The physician order of 6/29/06 was to apply duoderm to the buttock decubitus.

On a visit of 7/9/06, the nurse covered the buttock decubitus with Xeroform, DCD and a hydrocolloid dressing. The clinical record lacked documentation of orders and/or communication with the physician

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for the new wound care orders of 7/9/06

Physician's orders dated 7/31/06 included cleanse the right ankle with NS, apply Silvadene and DSD, continue care to right buttock with NS, followed by Exuderm and begin care to left buttock with NS and a hydrocolloid dressing. On 8/4/06, the right buttock decubitus deteriorated and the nurse documented that she packed the wound with alginate rope for which an order was not documented in the record. Patient #2 was sent to the ER, diagnosed with a wound infection and admitted to the hospital.

SCS #2 stated on 9/20/06 that she was sure that there was an order for the Xeroform dressing of 7/9/06 but could not find it. She did not know why the nurse used alginate rope for the 8/4/06 visit since there was not an order for that specific wound care and perhaps she just documented incorrectly and it was a wound care procedure for another patient.

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

9. Based on clinical record review and staff interviews it was determined that for two (2) of six (6) patients requiring wound management the nurse failed to revise the patient's plan of care based on the patient's health status and nursing needs (Patient #s 2, 6). The findings include:

a. Patient #2 had a start of care date of 6/29/06 with diagnoses including decubitus ulcers of the buttocks and ankle, anemia and arthritis. The patient was referred to the home care agency by the Area Agency on Aging due to a Stage 2 decubitus of the right ankle. The initial plan of care dated 6/29/06 included skilled nursing 2x a week x 1, 5-7x a week x 2, 2-3x a week x 2, 1-2x a week x 2, home health aide was service was scheduled 1-2 hours 3-5x a week to assist with ADLs, transfers, maintain safety. The patient also was receiving homemaker/companion services 3-5x a week for 4 hours through the Area Agency on Aging.

The nurse's visit notes from 6/29/06 to 8/4/06 consistently indicated that the nurse instructed the family on proper nutrition/hydration, repositioning and obtaining booties to protect the patient's feet and that the family was not compliant; the booties were never obtained per staff interview. The nurses noted that the patient often preferred to sit up in her wheelchair all day and evening and the family was not compliant in repositioning her and/or putting her to bed and/or performing wound care. The patient was always identified as being incontinent although she was alert and oriented. The clinical record lacked documentation to support that the nurse notified the physician of the family's noncompliance; that she suggested to the physician the use of vitamin C and/or zinc as a supplement for wound healing and/or to alter the plan of care based on the assessment of the family's non compliance i.e.: increased aide coverage and nursing visits, logs for nutrition/hydration and positioning, instructed the aide regarding a toileting plan to prevent incontinence and further skin breakdown, assessed the need for and ordering of pressure relieving devices; and/or failed to refer for PT to increase mobility and instruct in proper transferring and/or failed to refer for a MSW to assist with the family dynamics.

On 7/31/06 a new primary care nurse/case manager (RN #1) visited the patient and noted an additional

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decubitus on the patient's left buttocks, Stage 2 for which new orders were obtained. On the subsequent visit of 8/2/06, RN #1 noted that the right hip dressing was saturated with green-gray, foul smelling fluid and undermining was noted; the physician was updated but no change in treatment was noted. On 8/4/06 the right buttock wound had increased in size and the patient was sent to the ER for evaluation; the patient was admitted to the hospital. The agency resumption of care orders to the physician included skilled nursing 2-3x a week although the patient's wound care was ordered 3x a day and home health aide 3-5x a week. Another of the patient's sons volunteered to perform the wound care 3x a day and as needed. The nurse failed to confer with the physician to increase the frequency of her visits and/or the aide's visit in response to deterioration of the patient's health status and skin integrity and/or failed to refer for PT and MSW services to assist the patient/family.

The patient's albumin was 2.7 in the hospital and ensure was ordered however the nurse failed to revise the plan of care to include daily logs of her nutritional intake.

The nurse failed to revise the patient's plan of care in response to the patient's change in health status and nursing needs by increasing nursing and/or aide frequency of visits due to family non compliance and wound deterioration, failed to refer to other appropriate disciplines, failed to incorporate the appropriate assessment tools in order to assess the patients functional status/ and/or repositioning schedule and nutritional intake.

b. Patient #6 had an original start of care of 03/14/06 with a principal diagnosis of advanced dementia and secondary diagnoses including malignant breast cancer, hypothyroidism, hypoxemia and legal blindness due to glaucoma. On 06/27/06, the patient was given a new start of care date as the patient was no longer chronic and stable; Patient #6 had developed a stage II left sacral decubitus and had become essentially bed bound requiring a two (2) person transfer to commode and bedside chair. For the recertification period dated 05/13/06 – 07/11/06 skilled nursing was ordered two (2) times a month to assess cardiac, respiratory, orientation, memory, behavior and skin integrity; supervise home health aide. Aide service was ordered six (6) times a week for personal care and ADE assistance. Patient #6 developed a stage I left sacral decubitus ulcer on 06/08/06. Not until 06/27/06, six (6) days later, when the patient's left sacral decubitus ulcer deteriorated to stage II, did RN #1 send Physician #1 a revised nursing plan of care to increase nursing visits from two (2) times a month to three (3) times a week.

Review of the agency policy concerning care planning stated the patient's plan of care is to be reviewed and updated with changes in the patient's condition.

RN #1 failed to notify the physician in a timely manner of a significant change in the patient's condition that resulted in a stage II left sacral decubitus ulcer that indicated a necessity to revise the plan of care.