STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE QUALITY AND SAFETY BRANCH

Re: Huemanity Home Care of Connecticut, LLC
d/b/a Huemanity Home Care of Connecticut, LLC
409 Canal Street
Milldale, CT 06467

Home Health Care Agency License Number 9915713

VOLUNTARY SURRENDER OF LICENSE AGREEMENT

WHEREAS, Huemanity Home Care of Connecticut, LLC d/b/a Huemanity Home Care of Connecticut, LLC ("HHCC") is licensed by the Connecticut Department of Public Health ("Department") to operate a Home Health Care Agency, and it holds license number 9915713;

WHEREAS, W. Bruce Staebler, Christopher A. Parrella, and Carlos Alberto Leon comprise a majority of the members of HHCC (the "HHCC Members");

WHEREAS, the Department issued a Notice of Violation Letter to HHCC, dated September 25, 2013 that is attached hereto as Exhibit A; and

WHEREAS, HHCC has ceased operation as a Home Health Care Agency and desires to voluntarily surrender its license issued by the Department.

NOW THEREFORE, HHCC agrees to surrender its license on the following terms.

1. The HHCC members are duly authorized to enter into this Surrender of License Agreement, and by this Agreement HHCC voluntarily surrenders its license to operate a Home Health Care Agency in Connecticut.

2. The HHCC Members understand and agree that if they seek to reinstate HHCC's license at any time in the future, or if one or more of the HHCC Members seek a new Home Health Care Agency license as individuals or as part of a different corporate entity within the State of Connecticut, that the allegations contained in the Violation Letter dated September 25, 2013 attached as Exhibit A to this Agreement will be deemed true. The HHCC Members further understand that any such application must be made to the Department which shall have absolute

discretion as to whether said license shall be issued or reinstated and, if so, whether said license shall be subject to conditions.

3. HHCC and the HHCC Members expressly deny the allegations contained in the Violation Letter dated September 25, 2013 attached as Exhibit A and enter into this Agreement solely to avoid the expense and risk of a contested hearing regarding the allegations contained therein.

4. HHCC and the HHCC Members hereby waive any right to a hearing that HHCC or the HHCC Members may have regarding any request that HHCC's license be reinstated or that a new license be issued to HHCC and also waives any right that HHCC or the HHCC Members may have to appeal or otherwise challenge the disposition of any such request.

5. HHCC and the HHCC Members understand and agree that this Agreement and the case file are public documents unless protected by state or federal law, and that the HHCC Members are executing this Agreement to terminate the risk of proceedings against HHCC regarding the allegations in Exhibit A.

6. HHCC and the HHCC Members understand that this surrender constitutes disciplinary action and will be so classified in public disclosures and reporting by the Department and the National Practitioners Data Bank.

7. HHCC and the HHCC Members understand that this document has no effect unless and until it is executed by the Department; and that, upon execution, the Department will dismiss the allegations against HHCC.

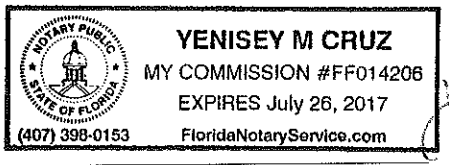
8. HHCC and the HHCC Members have consulted with attorneys prior to signing this Agreement.

9. HHCC and the HHCC Members understand that the execution of this document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.

10. HHCC and the HHCC Members understand that the purpose of this Agreement is to terminate the pending matters against HHCC's license and is not intended to affect any civil liability or defense.

W. Bruce Staebler
Member
Huemanity Home Care of Connecticut, LLC

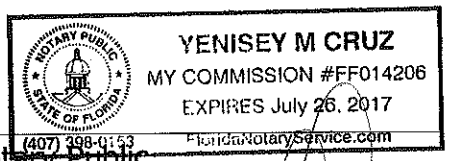
Subscribed and sworn to before me this 24 day of April, 2014.



Notary Public
Commissioner of Superior Court

Christopher A. Parrella
Member
Huemanity Home Care of Connecticut, LLC

Subscribed and sworn to before me this 24 day of April, 2014.



Notary Public

SUNY at YORKTOWN
ADMINISTRATION LIBRARY
TRUSTEES OF THE
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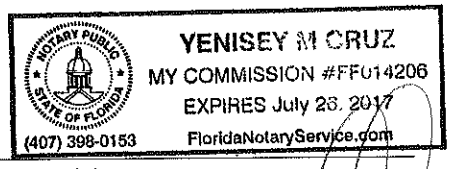
SUNY at YORKTOWN
ADMINISTRATION LIBRARY
TRUSTEES OF THE
[illegible]

Carlos Alberto Leon
Member
Huemanity Home Care of Connecticut, LLC

Subscribed and sworn to before me this 24 day of April, 2014.



Notary Public

Accepted: Wendy H. Furniss
Wendy Furniss, R.N.C., M.S.
Branch Chief
Healthcare Quality and Safety Branch

5/5/2014
Date

JOHN F. KENNEDY
POSTGRADUATE EDUCATION IN
TRAUMA CLINICS
Postgraduate Department

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

September 25, 2013

Ms. Joan Domack, Administrator
Huemanity Home Care Of Connecticut
409 Canal Street
Milldale, CT 06467

Dear Ms. Domack:

Unannounced visits were made to Huemanity Home Care Of Connecticut on August 8, 9, 19 and September 3, 2013 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 September 17, 2013.

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 October 15, 2013 at 2PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by October 10, 2013 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan D Nguyen

Loan Nguyen RN, MSN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

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: August 8, 9, 19 and September 3, 2013

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 General requirements (e) Supervisor of Clinical Services (4) and/or 19-13-D69 Services (a)(2) and (3).

1. Based on review of clinical records and interview with agency personnel, for four of twelve patients (Patients # 3, 4, 5 and 9) in the survey sample, the Supervisor of Clinical Services/Administrator failed to function in a full-time capacity as the Supervisor of Clinical Services/Administrator. The findings include:

A. Patient #3 had a start of care date of 11/19/12 and diagnoses that included a stasis ulcer of the lower right leg, venous insufficiency and hypertension. Physician orders for the period of 11/19/12 to 01/17/2013 included daily skilled nursing visits to perform wound care with normal saline, Bactroban ointment, 4x4 gauze, and Kerlix wrap.

Interview and review of the nursing notes with the Office Manager on 08/08/13 indicated that the agency business hours were from 9:00 a.m. to 5:00 p.m, that the Supervisor of Clinical Services/Administrator conducted nursing visits from 11/19/12 to 12/10/12 between the hours of 9AM and 12PM, during the agency business hours, registered nurse visiting and/or assessing the patient, and failed to indicate that the Supervisor of Clinical Services/Administrator functioned in a full-time capacity as the Supervisor of Clinical Services/Administrator.

B. Patient #4 had a start of care date of 10/18/12 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders dated 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications one (1) to two (2) times a week, perform assessments and supervise the home health aide every fourteen (14) days.

Interview and review of the nursing documentation with Administrator #2 on 09/11/13 indicated that Administrator conducted skilled nursing visits between the hours of 9:00 AM and 3:15 PM during the agency's business hours, with no other registered nurse visiting and/or assessing the patient, and failed to indicate that the Supervisor of Clinical Services/Administrator functioned

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

in a full-time capacity as the Supervisor of Clinical Services/Administrator.

C. Patient #5 had a start of care date of 09/22/12 and diagnoses that included lung cancer, bladder cancer, iron deficiency anemia, rheumatoid arthritis, chronic bacterial endocarditis and benign prostatic hypertrophy. Physician's orders dated 09/22/12 included skilled nursing services to provide medication management, perform assessments and evaluate the patient's status two (2) times a week. Interview and review of the nursing notes from 09/27/12 through 10/01/12 with Administrator #2 on 09/11/13, indicated that Administrator #1 conducted skilled nursing visits between the hours of 9:00 AM and 3:15 PM during the agency's business hours, with no other registered nurse visiting and/or assessing the patient, and failed to indicate that the Supervisor of Clinical Services/Administrator functioned in a full-time capacity as the Supervisor of Clinical Services/Administrator.

D. Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification period of 11/16/12 to 01/14/13 included skilled nursing visit once for one week, three times for two weeks, twice for two weeks and once a week for five weeks for assessments, teaching and pain management. The start of care visit and the comprehensive assessment was completed by RN #4 on 11/16/12. The nursing documentation indicated that the ten skilled nursing visits dated 11/19/12 through 11/13/12 were conducted by Administrator #1, with five of the ten visits conducted between the hours of 9AM and 11AM, and the remaining five visits with no documented hours.

Interview with Administrator #2 on 09/16/13 indicated that Administrator # 1 functioned as Administrator, Supervisor of Clinical Services, Primary Care Nurse and Supervisor of the Home Health Aide Program at the time of the survey, and failed that the Supervisor of Clinical Services/Administrator functioned in a full-time capacity as the Supervisor of Clinical Services/Administrator in accordance with the Regulations of Connecticut State

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

Agencies.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (1) and/or 19-13-D72 Patient care polices (a) General Program Policies

2. Based on review of the clinical records and interview with agency personnel, for 4 of 12 patients (Patients #2, #3, #6 and # 7) in the survey sample, the agency staff failed to follow the agency's own policies. The findings include:

A. Patient #2 had a start of care date of 04/20/13 and diagnoses that included Stage IV lung cancer with metastasis and deep vein thrombosis. Physician's orders for the period of 04/20/13 to 06/18/13 included skilled nursing visits for assessments, evaluation of needs and medication compliance, and teaching about disease process.

The Licensed Practical Nurse (LPN) documented "N/A" on 04/25/13 and 04/29/13 in the discharge planning section of the skilled nursing visit note. Interview and review with Administrator # 2 on 09/11/13 of the discharge assessment signed on 05/10/13 by the primary care nurse/registered nurse failed to identify the reason for discharge, notification to the physician of the discharge, and documentation of a discharge visit by the primary care nurse.

The agency policy on Nursing Services indicated that patients receiving nursing services will receive appropriate assessments, reassessments, and care-planning with professional nursing services provided by a registered nurse, including planning for the discharge from service.

B. Patient #3 had a start of care date of 11/19/12 and diagnoses that included a stasis ulcer of the lower right leg, venous insufficiency and hypertension. Physician's orders for the period of 11/19/12 to 01/17/2013 included daily nursing visits for perform wound care, record location,

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

dimensions, condition of surrounding skin and wound base, signs of infection and healing.

Interview and review of the nurse's notes with Administrator # 2 on 09/11/13 identified daily nursing visits from 11/19/12 to 12/09/12 with documentation of wound care to the right lower leg stasis ulcer and weekly measurements, but failed to identify documentation of the condition of the surrounding skin and wound base including drainage and odor.

The agency's wound care policy directed the documentation of the condition of the wound at each visit, appearance of the wound bed, wound measurements (at least weekly) color, odor, estimated amount of drainage, and inflammation or erythema of the skin around the wound.

C. Patient #6 had a start of care date of 01/30/13 and diagnoses that included stage IV ovarian cancer with metastasis, malignant pleural effusion, depression and anxiety. Physician orders for the period of 01/30/13 to 05/29/13 included skilled nursing services to assess all body systems and care for a pleural catheter.

Review of the nurse's notes with Administrator # 2 on 09/11/13 identified skilled nursing visits conducted on 01/30/13. 01/31/13, 02/01/13, 02/02/13, 02/06/13, 02/08/13, 02/13/13, 02/15/13, 02/17/13, 02/22/13, 02/24/13, 02/27/13, 03/06/13, 03/09/13, 03/14/13, 03/22/13 03/29/13, 04/06/13, 04/13/13, 04/19/13 and 05/01/13 but failed to identify documentation of discharge planning, failed to identify a nursing visit by the primary care nurse for the purpose of discharge from home care services, and failed to identify notification to the physician of the patient's discharge.

Review of the agency policy on Nursing Services indicated that patients receiving nursing services will receive appropriate assessments, reassessments, care-planning and established outcomes performed, with professional nursing services provided by a registered nurse, including planning for the discharge from service.

D. Patient #7 had a start of care date of 11/08/12 and diagnoses that included acute myeloid leukemia, cholecystostomy (11/01/12), general anxiety disorder, hypertension, morbid obesity

and immunosuppressed therapy. Physician's orders dated 11/08/12 included skilled nursing services for assessment, evaluation of all body systems, monitoring for signs and symptoms of infection post- surgery, instruction on new medications, teaching home safety and fall precaution measures.

Interview and review of agency documentation with Administrator #2 on 09/11/13 identified a "Memo Regarding Discharge Notification for Patient #7" written to the physician by Administrator #1 on 11/14/12, but failed to identify the completion of a discharge summary by the agency staff.

Interview and review of the agency policy on Discharge Criteria with the Office Manager/Assistant (Acting) Administrator on 08/09/13 indicated that the nurses were to complete a Discharge Summary form when the patient was discharged.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (3) (G) (ii) and/or 19-13-D74 Administration of Medicines (a)(3)

3. Based on review of the clinical record for two of three patients (Patients # 4 and 6) who received home health aide services, the agency nurse failed to safely determine which activities may be delegated to the home health aide. The findings include:

A. Patient #4 had a start of care date of 10/18/12 and 05/15/13 and diagnoses that included

unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders dated 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications, perform assessments and supervise the home health aide (HHA) every fourteen (14) days, with HHA services three (3) times a week for personal care and medication reminder.

i. Interview and review of LPN #3's visit note dated 06/19/13 with Administrator #2 on 09/11/13 indicated that the patient was anxious and disoriented, respiration rate was 25, the home health aide gave Alprazolam 0.25mg, and failed to indicate that the home health aide functioned within the scope of practice.

ii. Interview and review of the aide documentation with Administrator #2 on 09/11/13 identified documentation by the HHA # 3 from 10/19/12 to 01/17/13, HHA #4 from 01/22/13 to 02/16/13, HHA #5 from 02/19/13 to 03/14/13 and HHA #2 from 03/19/13 to 08/07/13 of the patient's pain level on a scale from one (1) to ten (10), and failed to identify appropriate determination by the registered nurse of tasks to be delegated to the home health aides.

B. Patient #6 had a start of care date of 01/30/13 and diagnoses that included stage IV ovarian cancer with metastasis, malignant pleural effusion, depression and anxiety. Physician orders for the period of 01/30/13 to 05/29/13 included skilled nursing services for assessments and nursing care to a pleural catheter (keep drain sterile and dry, drain twice a week, record output amount and quality for review by physician, follow universal precautions and aseptic techniques when changing the chest tube dressing)

Physician orders for the period of 01/30/13 to 05/29/13 included home health aide services to assist with personal care, obtain the patient's temperature, pulse, respiration and pain level at every visit, and inform the nurse of new symptoms, temperature of 100.4 F or above, respiratory rate above 22 or below 12 respirations per minute, and heart rate above 100 or below 60 beats per minute.

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

Review of the home health aide assignment sheet with Administrator # 2 on 09/11/13 identified instructions for the aide to inspect or reinforce the chest tube dressing, to notify the nurse if the chest tube dressing was changed, and failed to identify proper determination by the nurse of aspects of care that could be delegated to the aide.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D73 Patient care plan (a):

4. Based on review of the clinical record for 4 of 10 patients (Patients #1, 3, 4 and #6) in the survey sample, the agency staff failed to follow the physician's orders. The findings include:

A. Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy. Physician's orders dated 11/09/12 through 07/07/13 included skilled nursing services to pre-pour medications one (1) or two (2) times a week, perform complete assessment and evaluation of all body systems, notify physician of significant findings and teach diet.

Interview and review of the nursing notes from 11/09/12 through 08/06/13 with Administrator #2 on 09/11/13 failed to identify documentation of medication pre-pouring during the nursing visits for the nine months of service.

B. Patient #3 had a start of care date of 11/19/12 and diagnoses that included stasis ulcer of the lower right leg, venous insufficiency and hypertension. Physician's orders for the period of 11/19/12 to 01/17/2013 included daily skilled nursing visits for wound care with recording of location, dimensions, condition of surrounding skin and wound base, signs of infection and healing stage. The physician's orders also included vital sign parameters for physician notification (systolic blood pressure above 140 mmHg and/or diastolic blood pressure above 89

mmHg).

i. Interview and review of the nursing notes with Administrator # 2 on 09/11/13 identified daily skilled nursing visits from 11/19/12 to 12/09/12 with documentation of wound care provided to the right lower leg stasis ulcer and weekly measurements, but failed to identify a description of the condition of the surrounding skin and wound base, including drainage and odor;

ii. Interview and review of the nurse's notes with Administrator # 2 on 09/11/13 identified the documentation of elevated blood pressures on 12/01/12 (142/86mm Hg), 12/07/12 (144/80mm Hg) and 12/08/12 (148/88mmHg), but failed to identify nursing notification to the physician, in accordance with the physician's orders.

C. Patient #4 had a start of care date of 10/18/12 and 05/15/13 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders dated 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications one (1) to two (2) times a week, assess all body systems, and teach life-style modification including diet and exercise.

Interview and review of the nursing notes from 10/18/12 through 08/05/13 with Administrator #2 on 09/11/13 failed to identify documentation of medication pre-pouring, and/or fail to identify accurate documentation of the names of the medications pre-poured and/or the time frame.

D. Patient #6 had a start of care date of 01/30/13 and diagnoses that included Stage IV ovarian

cancer with metastasis, malignant right pleural effusion, depression and anxiety. Physician's orders for the period of 01/30/13 to 05/29/13 included skilled nursing visits to care for a pleural catheter by keeping the drain sterile and dry, draining twice a week, and recording the output amount and quality for review by physician.

i. Interview and review of the clinical record with Administrator # 2 on 09/11/13 identified skilled nursing visits conducted on 01/30/13. 01/31/13, 02/01/13, 02/02/13, 02/06/13, 02/08/13, 02/13/13, 02/15/13, 02/17/13, 02/22/13, 02/24/13, and 02/27/13, but failed to identify documentation of the quantity and quality of the drainage from the pleural catheter, and/or or notification to the physician of the drainage characteristics as ordered;

ii. Review of the hospital discharge orders dated 01/29/13 indicated that the patient required supervision with mobility, and required home physical therapy. Review of the start-of-care comprehensive assessment (OASIS) dated 01/30/13 identified the use of a fall risk assessment tool where a total score of 15 or greater called for interventions including physical therapy. In addition, the patient's fall risk assessment was scored inaccurately at 10 points because the visiting nurse omitted the presence of cardiovascular/respiratory disease (malignant pleural effusion with pleural catheter, an additional 5 points) and the use of medications affecting blood pressure or level of consciousness, (psychotropic medications, sedatives and narcotics, an additional 5 points) when the patient should have been attributed a total score of 20. Interview and review of the discharge order from the hospital and the home care nursing documentation with Administrator # 2 on 09/11/13 did not identify the initiation of Physical Therapy (PT) and failed to identify compliance with discharge orders from the hospital.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D73 Patient care plan (b):

5. Based on review of the clinical record and interview with agency personnel, for 3 of 12 patients (Patients #2, # 9 and # 11) in the survey sample, the agency staff failed to ensure physician's

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

orders were signed within twenty-one days. The findings include:

A. Patient #2 had a start of care date of 04/20/13 and diagnoses that included Stage IV lung cancer with metastasis and deep vein thrombosis. Physician's orders for the period of 04/20/13 to 06/18/13 included skilled nursing visits for assessments, evaluation of the patient's needs, evaluation of medication compliance, and teaching about disease process.

Interview and review of the physician's orders with Administrator # 2 on 09/11/13 did not identify any physician orders for the period from 04/20/13 to 06/18/13, and failed to identify obtention of signed physician's orders within 21 days.

The patient received nursing services on 04/20/13, 04/25/13, 04/29/13 and 05/10/13 without signed physician orders and was discharged on 05/10/13.

Upon surveyor's inquiry, the physician's orders were faxed to the agency on 08/09/13, three months after the patient was discharged.

B. Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Interview and review of the physician's orders with Administrator # 2 on 09/11/13 indicated that the orders dated 03/16/13 were not signed until 04/08/13 (25 days later) and failed to identify physician signature within 21 days.

C. Patient #11 had a start of care date of 04/11/2013 and diagnoses that included hypertensive heart disease, chronic ischemic heart disease, and general osteoarthrosis. Interview and review of the physician's orders with Administrator # 2 on 09/16/13 indicated that the orders for the certification period of were still not signed at the time of the survey 09/12/13 (155 days later) and failed to identify physician signature within 21 days.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D73

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

Patient care plan (b) and/or 19-13-D74 Administration of medicines (b)

6. Based on review of the clinical record and interview with agency personnel, for 8 of 10 patients (Patients # 1, #2, # 4, #6, # 7, # 9, # 11 and # 13) who required medication management, the agency nurse failed to follow the physician's orders and/or failed to reconcile the patient's medications. The findings include:

A. Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy. Physician orders for the periods of 11/09/12 through 07/07/13 included skilled nursing services to pre-pour medications once or twice a week.

A nursing note dated 12/04/12 by Licensed Practical Nurse (LPN) #1 indicated that the patient's "medications were reviewed" and a medication list was developed.

i. Interview and review of the nursing documentation with Administrator #2 on 09/03/13 identified the dose of Ferrous Sulfate dosage at 325mg on the 11/09/12 start-of-care certification and on the 11/09/13 Medicine Schedule, while the 12/04/13 nursing note identified the iron dosage as 65mg, and failed to identify reconciliation of medication dosage by the registered nurse (Administrator # 1, also functioning as the Supervisor of Clinical Services, Primary care Nurse and Supervisor of the Home Health Aide Program);

ii. The nursing note dated 12/04/13 also identified three additional medications: Indomethacin ER 75mg as needed for pain, Cinnamon 1000mg daily and Ibuprofen 200mg as needed for pain. Interview and review of the physician's orders with Administrator #2 on 09/03/13 failed to identify a physician's order for Indomethacin, Cinnamon and Ibuprofen;

iii. A subsequent recertification nursing note dated 01/07/13 (over one month later) by RN #1

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

indicated that "Iron 65mg, Indomethacin 75mg and Cinnamon 1000mg were added to treatment". However, interview and review of the signed physician "modification order" dated 01/07/13 with Administrator # 2 on 09/03/13 identified Indomethacin 300mg ER one tablet in the evening (instead of Indomethacin 75mg), and failed to identify nursing attempts to clarify the dosage discrepancy with the ordering physician;

iv. The 60-day summary written on 01/08/13 by Administrator #1 identified "new medications Iron (over-the-counter/OTC), and Ferrous Sulfate discontinuation from treatment", but failed to identify clarification of the dosage and/or discrepancies in the iron treatment initiation or discontinuation;

v. Interview and review of the physician's orders dated 03/09/13 through 05/07/13 and the Medicine Schedule dated 03/06/13 with Administrator # 2 on 09/03/13 failed to identify orders for Indomethacin, Cinnamon, Ibuprofen, the increase in Levoxyl dosage, and the clarification of the Iron dosage or discontinuation.

The agency policy on "Medication Reconciliation" directed the registered nurse (RN) to reconcile the patient's medications at the time of admission and on an ongoing basis, with each new or changed medication. The RN was to create a list of medications including dose, route and frequency, and to reconcile all discrepancies (duplications, omissions, contraindications, and unclear information) with the patient's physician. The nurse was to review the patient's medication profile at each visit, and update the profile as changes occurred.

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

vi. During a joint home visit with Registered Nurse (RN) #1 on 09/03/13 (a Tuesday), the patient indicated that the patient sometimes filled the medication box, and the nurse indicated a family member prefilled the medication box. The patient reported taking a tablet of Cinnamon each day. Surveyor observation of the medication box identified 2 tablets of Cinnamon in the Sunday p.m. compartment, one Cinnamon tablet in the Wednesday p.m. and Thursday p.m. compartments, and 2 tablets of Cinnamon in the Wednesday and Thursday p.m. When RN #1 asked the patient about the missed medications on Sunday p.m., Patient # 1 indicated that the "Sunday p.m. medications were for tonight".

Interview and review of the surveyor's observations with Administrator # 2 on 09/11/13 failed to identify pre-pouring of medications by the nurse in accordance with the physician's orders, nursing determination of inaccurate pre-pouring by the patient and/or family, and failed to identify nursing determination of the patient's unsafe self-administration of the pre-poured medications;

vii. Observations during the joint visit on 09/03/13 failed to identify the availability of a medication profile or a copy of the physician's orders for pre-pouring. RN # 1 actually did not know there was a physician's order to prefill the medication box, and called the Administrator to request an order from the physician to prefill the weekly medication box. In an interview on 09/03/13, Administrator # 2 verbalized the expectation for the nurses to have copies of the physician's orders and the medication profile at the time of pre-pouring;

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viii. Interview and review of the medication profile (stored in the patient's clinical record) dated 07/03/13 with Administrator # 2 on 09/11/13 failed to identify the inclusion of the medications Cinnamon 1 tablet by mouth daily, and Indomethacin ER 75 mg by mouth daily as needed for pain, in accordance with the physician's orders, and failed to identify reconciliation of the patient's medications.

B. Patient #2 had a start of care date of 04/20/13 and diagnoses that included Stage IV lung cancer with metastasis and deep vein thrombosis. Physician's orders for the period of 04/20/13 to 06/18/13 included skilled nursing visits for assessments, evaluation of the patient's needs, evaluation of medication compliance, and teaching about disease process.

i. The hospital discharge orders dated 04/17/13 included the medications Alprazolam (Xanax) 0.25 mg by mouth every six hours as needed, Docusate Sodium (Colace) 100 mg by mouth daily, Salmeterol/Fluticasone (Advair) Inhaler one puff twice a day, Senna (Senokot) one tab by mouth daily as needed, Tiopropium Bromide one cap inhaler daily and Prednisone 5 mg by mouth daily.

Review of the medication schedule and/or profile indicated that Patient # 2 was taking the following medications: Zofran 8 mg one tablet by mouth every eight hours as needed (not listed on the hospital discharge orders), Compazine 10 mg one tablet by mouth every six hours as needed (not listed on hospital discharge orders), Prednisone 20 mg one tablet daily (the hospital discharge orders listed prednisone 5mg daily) , Advair 250/50 one puff daily (the hospital discharge orders listed Advair one puff twice a day). In addition, the patient's medication list in the home failed to include Docusate Sodium (Colace) 100 mg by mouth daily and Tiopropium Bromide inhaler daily as listed on the hospital discharge orders.

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Interview with Administrator # 2 on 09/11/13 failed to identify reconciliation of medications by the visiting nurse, and/or communication with the physician to clarify discrepancies in medication orders.

ii. A nursing visit note dated 04/25/13 indicated that the patient was taking one tablet of Tarceva daily, but failed to identify a dose for the medication. In addition, interview and review of the medication orders with Administrator # 2 on 09/11/13 failed to identify a physician's order for Tarceva, and review of the medication profile failed to identify listing of the Tarceva.

The agency policy on Medication Reconciliation directed the registered nurse to reconcile the patient's medications at the time of admission and on an ongoing basis, with each new or changed medication. The registered nurse was to create a list of medications including dose, route and frequency, and to reconcile all discrepancies (duplications, omissions, contraindications, and unclear information) with the patient's physician. The nurse was to review the patient's medication profile at each visit, and update the profile as changes occurred.

C. Patient #4 had a start of care date 10/18/12 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders for the periods of 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications once or twice a week, assess the patient and teach life-style modification, including diet and exercise, and supervise the home health aide every fourteen days.

i. The Sixty - Day Summary Report written on 02/15/13 by Administrator #1 indicated that effective 01/31/13, the physician discontinued Olanzapine, Metamucil and Clonazepam. However, interview and review of the physician's orders with Administrator #2 on 09/11/13 failed to identify an actual physician's order directing the discontinuation of Olanzapine, Metamucil and Clonazepam;

ii. Interview and review of LPN #5's nursing note dated 02/07/13 with Administrator

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#2 on 09/11/13 identified an increase in the frequency and/or dose of Vitamin D3 to 1000IU to two times a day per physician, and the initiation of Amlactin Ultra Hydrating Body Cream for dry skin on lower extremities, but failed to identify an interim physician's orders directing the change in Vitamin D3 and/or the initiation of the body cream. The subsequent physician's orders for the 60-day recertification dated 02/15/13 did not include the increase in Vitamin D3 and/or the addition of Amlactin Cream.

D. Patient #6 had a start of care date of 01/30/13 and diagnoses that included Stage IV ovarian cancer with metastasis, malignant right pleural effusion, depression and anxiety. Physician orders for the period of 01/30/13 to 05/29/13 included skilled nursing visits to evaluate knowledge and compliance of medication regime.

i. The hospital discharge orders dated 01/29/13 included Paxil 10 mg one tablet by mouth once a day for seven days. Interview and review of the physician's orders for home care dated 01/30/13 to 03/30/13 with Administrator # 2 on 09/11/13 identified Paxil 20 mg one tablet by mouth daily, and failed to identify communication with the physician regarding the dose discrepancy;

ii. An admission summary report dated 01/30/13 identified both Paxil 20 mg by mouth one tablet daily and Paxil 20 mg. by mouth one tablet twice a day. A physician's order dated 02/05/13 identified a correction to the physician's orders dated 01/30/13 by adding Paxil 20 mg by mouth one tablet every 12 hours. However, interview and review of the medication

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profile dated 01/30/13 with Administrator # 2 on 09/11/13 failed to identify the listing of any Paxil;

iii. The physician's orders dated 03/02/13 for the resumption of care indicated that Klonopin 0.5 mg. one tablet by mouth was increased from every twelve hours to every eight hours. Interview and review of the medication profile with Administrator # 2 on 09/11/13 failed to identify updates in the medication profile to reflect the change in the frequency of the medication;

iv. The physician's orders dated 03/02/13 for the resumption of care indicated that the Fentanyl patch and Percocet medications were discontinued. Interview and review of the patient's medication profile with Administrator # 2 on 09/11/13 failed to identify the discontinuation of Fentanyl patch and Percocet;

v. A nursing visit note dated 03/09/13 indicated that the patient was taking Erythromycin 500 mg one tablet two times a day. Interview and review of the patient's medication profile with Administrator # 2 on 09/11/13 failed to identify the listing of Erythromycin.

The agency policy on Medication Reconciliation directed the registered nurse to reconcile the patient's medications at the time of admission and on an ongoing basis, with each new or changed medication. The registered nurse was to create a list of medications including dose, route and frequency, and to reconcile all discrepancies (duplications, omissions, contraindications, and unclear information) with the patient's physician. The nurse was to review the patient's medication profile at each visit, and update the profile as changes occurred.

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E. Patient #7 had a start of care date of 11/08/12 and diagnoses that included acute myeloid leukemia, cholecystostomy (11/01/12), general anxiety disorder, hypertension, morbid obesity and immunosuppressed therapy. Physician's orders dated 11/08/12 included skilled nursing services twice a week for assessments, teaching of new medications, home safety and fall precaution measures.

i. The medication list from the discharging hospital included Senna one tablet daily, and Colace 100mg two (2) times a day. Interview and review of the physician's orders for home care and the medication profile with Administrator #2 on 09/11/13 failed to identify the inclusion of Senna and Colace;

ii. The physician's orders for home care dated 11/08/12 (for sixty days) identified Zovirax, Lisinopril and Lexapro as daily medications. Interview and review of the medication profile with Administrator #2 on 09/11/13 indicated that Zovirax, Lisinopril and Lexapro were ordered for seven days only, and failed to reflect the physician's orders for Zovirax, Lisinopril and Lexapro for sixty days.

The agency policy on "Medication Reconciliation" directed the registered nurse (RN) to reconcile the patient's medications at the time of admission and on an ongoing basis, with each new or changed medication. The RN was to create a list of medications including dose, route and frequency, and to reconcile all discrepancies (duplications, omissions, contraindications, and unclear information) with the patient's physician. The nurse was to review the patient's medication profile at each visit, and update the profile as changes occurred.

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

F. Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification period of 11/16/12 to 01/14/13 included skilled nursing visits once for one week, three times for two weeks, twice for two weeks and weekly for five weeks for assessments and pain management.

i. Physician's orders dated 12/10/12 included Prednisone 10 mg daily for 15 days, Tramadol 50 mg three times a day as needed for pain, with nursing instructions on medication actions, and nursing monitoring of side-effects. The nursing note dated 12/10/12 identified new medications ordered by the physician, and instructions on the action of each medication. Review of the medication profile dated 11/16/12 identified the addition of the medications Prednisone 10 mg daily for 15 days and Tramadol 50 mg three times a day as needed in accordance with the physician's orders dated 12/10/12, but failed to identify the signature of the nurse who revised the medication profile, and the date of the revision, as required in the agency pre-printed form for updating medication profiles;

ii. Interview and review of the nursing documentation dated 12/17/12 with Administrator #2 on 09/03/12 indicated that the patient was taking Prednisone 10 mg tapered dose and Tramadol 50 mg 1 to 2 tablets every 8 hours, but failed to identify reconciliation of the patient's medications and clarification of the tapering, and of the discrepancies with the patient's physician;

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iii. Interview and review of the LPN documentation dated 04/22/13 with Administrator #2 on 09/03/12 indicated that the patient had a new medication, Lidocaine patch 700 mg in aqueous base, and the agency was notified immediately, but failed to identify documentation of the name of the person notified of the medication change, the medication route and frequency, and failed to identify revision to the medication profile to include Lidocaine patch;

iv. Interview and review of the LPN documentation dated 05/06/13 with Administrator #2 on 09/03/12 identified the use of Lidocaine 1 patch to affected arm daily, on for 12 hours and off for 12 hours, but failed to identify notification to the registered nurse about the new medication, and failed to identify revision of the medication profile to include Lidocaine patch.

v. Interview and review of the nursing visit notes dated 12/17/12, 12/28/12, 12/31/12, 01/07/13, 04/15/13 and 05/06/13 with Administrator #2 on 09/03/13 identified nursing assessment of the patient's oxygen saturation (pulse oximetry), but failed to identify physician's orders for pulse oximetry assessment with parameters for physician notification;

vi. Review of the nursing documentation from 03/26/13 to 05/12/13 with Administrator #2 on 09/03/13 failed to identify nursing documentation of visits for the week of 04/29/13, and failed to identify physician notification of the missed visits.

G. Patient #11 had a start of care date of 04/11/2013 and diagnoses that included hypertensive heart

disease, chronic ischemic heart disease, and general osteoarthrosis. Physician's orders for the certification period of 04/11/13 through 06/09/13 included skilled nursing visits to prepare medications inside pills box once per week and follow-up on compliance. The patient's medications included Proair (8.5 gr) 2 puffs four times daily as needed for shortness of breath.

Interview and review of the medicine schedule (profile) with Administrator #2 on 09/16/13 identified Proair (8.5 gr) 2 puffs inhaled by mouth four times a day (at breakfast, lunch, dinner and bedtime) but failed to identify the listing of Proair (8.5 gr) 2 puffs by mouth four times a day as needed.

H. Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, urinary tract infection, multiple small bowel obstructions, status-post debulking surgeries, chemotherapy, status post cholecystomy tube, percutaneous endoscopic gastrostomy (PEG) tube, and suprapubic catheter. According to the hospital referral form, the patient received patient-controlled analgesia (PCA) of Dilaudid, total parenteral nutrition(TPN) via a triple lumen catheter (TLC) placed on 03/31/13, and intravenous Vancomycin from a home infusion company.

The hospital inter-agency referral form (W-10) dated 04/05/13 included Dulcolax 10 mg suppository daily as needed for constipation, Compazine 25 mg suppository every 12 hours as need for nausea, Vancomycin 750 mg in sodium chloride 0.9 % 250 ml every 12 hours, and included the discontinuation of Haldol 0.5 mg and Lidocaine 4%. The W-10 also included Dilaudid PCA continuous rate of 0.7 mg/hr with demand dose of Dilaudid 1 mg every 30 minutes with a 4 hour lock out 11 mg, and TPN infusion 24 hours/day at 110 cc/hr. The home infusion company managed the infusions.

The hospital record indicated that the patient presented at the clinic on 04/11/13 with

increased abdominal pain and inadequate pain relief, and the demand Dilaudid dose to 2 mg every hour. The patient was not admitted to home care services until on 04/20/13, fifteen days after the patient was discharged from the hospital, and the home care agency accepted the referral from the hospital.

i. Interview and review of the initial comprehensive assessment and medication profile dated 04/20/13 with Administrator #2 on 09/17/13 identified the listing of Hydromorphone (Dilaudid) 0.8 mg/hour continuous and Hydromorphone 2 mg/hr as needed for pain, and failed to reflect the correct continuous rate of 0.7mg/hr;

ii. Interview and review of the initial comprehensive assessment and medication profile dated 04/20/13 with Administrator #2 on 09/17/13 failed to identify the medications listed on the W-10 (Dulcolax 10mg suppository daily as needed for constipation, Compazine 25mg suppository every 12 hours as needed for nausea, and TPN infusion 24 hours/day at 110cc/hr.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13 D 71 Personnel policies (a) (5)

7. Based on review of personnel files and staff interview, for six of six direct care employees in the

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survey sample (Home Health Aides # 1, 2, 3 and Registered Nurses/RN # 1, 3 and 5), the agency failed to ensure the employee file contained a physician statement that the employee was free from communicable disease, prior to assigning the staff to patient care. The findings include:

A. Home Health Aide #1 had a hire date of 03/28/13; Home Health aide #2 had a hire date of 03/15/13; Home Health Aide #3 had a hire date of 09/13/12. Interview and review of the personnel files and the aide schedule with the Supervisor Clinical Services on 09/03/13 at 1pm indicated that Home Health Aide # 1 conducted home visits to the patients on the week of 04/02/13, Home Health Aide # 2 conducted home visits to the patients on the week of 03/19/13, and Home Health Aide # 3 conducted home visits to the patients on the week of 12/25/12, but failed to identify documentation by the physician that Home Health aides # 1, 2, and 3 were free from communicable disease prior to their patient assignments.

B. RN #1 had a date of hire of 12/14/12. Interview and review of the personnel file with Administrator #2 on 09/03/13 indicated that RN # 1 conducted home visits to the patient since 01/13/13, but failed to identify documentation by the physician that RN # 1 was free from communicable disease, prior to assignment to patient care activities.

C. RN #3 had a date of hire of 05/28/13. Interview and review of the personnel file with Administrator #2 on 09/03/13 indicated that RN # 3 conducted home visits to the patient since 09/09/13, but failed to identify documentation by the physician that RN # 3 was free from communicable disease, prior to assignment to patient care activities.

D. RN #5 had a date of hire of 04/10/13. Interview and review of the personnel file with Administrator #2 on 09/03/13 indicated that RN # 5 conducted home visits to the patient on the week of 04/11/13, but failed to identify documentation by the physician that RN # 5 was

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free from communicable disease, prior to assignment to patient care activities.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Services (3) (C) and/or (4)

8. Based on review of the clinical record and interview with agency personnel, for three of twelve patients (Patients # 1, 4 and 10) in the survey sample, the agency failed to ensure documentation of case coordination. The findings include:

A. Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy.

The nursing documentation identified a total of 63 nursing visits from 11/09/12 through 08/06/13, with 8 skilled nursing visits completed by either LPN #1 or LPN #2, and the remaining 5 visits completed by RN #4 on 11/09/13, RN #1 on 01/07/13 and 05/03/13 and RN #3 on 07/03/13. Interview and review of the nursing documentation from 11/09/12 through 08/06/13 with Administrator # 2 on 09/11/13 identified one (1) documented "care coordination" written by LPN #2 on 01/25/13, with no RN identified, and failed to identify consistent documentation of care coordination among the RNs and LPNs for nine months.

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

B. Patient #4 had a start of care date of 10/18/12 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis.

Interview and review of the nurse's notes with Administrator #2 on 09/11/13 identified a total of sixteen (16) skilled nursing visits from 05/09/13 through 08/05/13, with fourteen (14) of the skilled nursing visits completed by either LPN #3 or LPN #4, and failed to identify documentation of case coordination between the LPN and the registered nurse/Primary Care Nurse from 05/09/13 through 08/05/13.

The agency policy on "Coordination of Patient Care" directed the staff to regularly communicate to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care.

C. Patient #10 had a start of care date of 11/01/12 and diagnoses that included Bell's Palsy, prostate cancer, hypertension, and hypothyroidism. Physician's orders for the certification periods of 11/01/12 through 04/07/13 included 3 nursing visits per week for assessments and teaching on disease process and management.

Interview and review of the nurse's notes with Administrator # 2 on 09/11/13 indicated that all the nursing visits were made by Licensed Practical Nurse (LPN) #1 and LPN #2 from 11/01/12 through discharge from home care services on 04/07/13, and failed to identify documentation of case coordination between the registered nurse and the LPNs who provided care to Patient #10.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (C) and/or (F) and/or (4) (C)

9. Based on review of the personnel file and staff interviews, the agency failed to appoint a

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qualifying Supervisor for the Homemaker-Home Health aide program and/or failed to ensure the completion of an adequate homemaker-home health aide competency evaluation. The findings include:

A. i. NA #2's date of hire was 03/15/13. Interview and review of the personnel file with Administrator #2 on 09/03/13 indicated that NA # 2's competency evaluation was completed by Administrator # 1 on 03/17/13, that evaluation was completed by Administrator #1 on 03/17/13, that Administrator # 1 functioned as Administrator, Supervisor of Clinical Services and Supervisor of the Homemaker-Home health Aide program from 11/03/2011 through 08/18/13, and failed to identify the appointment of a qualifying Supervisor for the Homemaker-Home Health Aide program;

i. Interview and review with Administrator #2 on 09/03/13 of NA #2's Homemaker-home health aide competency evaluation dated 03/17/13 identified areas lacking documentation of evaluation, such as bathing (bed, sponge and tub baths), shampoo (at the sink, bed bath and shampoo), use of assistive devices (crutches, walker and wheelchair), normal range of motion of the upper and lower extremities, occupied-bed making and laundry, and failed to identify an adequately completed competency evaluation form for NA # 2.

B. Registered nurse (RN) #3's date of hire was 05/28/13. RN # 3 was appointed as full-time primary care nurse and Supervisor of the Homemaker-Home Health Aide

program on 08/14/13. Interview with the Administrator/SCS #2 and RN #3 on 09/03/13 indicated that RN #3 was employed at 30 hours per week, and RN # 3 would complete the home health aide competency evaluations.

i. Interview and review of the Regulations of Connecticut State Agencies at Section19-13-D66 Definitions (n) identified the definition of full-time as employed and on duty a minimum of thirty-five (35) hours per workweek on a regular basis,

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and failed to indicate that RN # 3 qualified as a full-time registered nurse with other responsibilities, in order to be appointed as the Supervisor for the Homemaker-Home Health aide program;

ii. Interview and review of RN #3's personnel file with Administrator #2 on 09/11/13 failed to indicate that RN # 3 possessed a minimum of two years of nursing experience, one of which would be in the provision of home care, prior to completing homemaker-home health aide competency evaluations.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (1) (G).

10. Based on review of the personnel folders and staff interviews for seven of seven personnel files reviewed (the files of Home Health Aides #1, 2, 3, and 4, Administrator # 2, and Registered Nurses/RN # 3 and 5) the agency failed to document the orientation dates, with the name and title of the person providing the orientation. The findings include:

A. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that Administrator # 2 was hired on 08/19/13, and failed to identify the documentation of the dates of orientation, with the name and title of the agency staff person providing the orientation to

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Administrator # 2.

B. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that NA # 1 was hired on 04/02/13, and failed to identify the documentation of the dates of orientation, with the name and title of the agency staff person providing the orientation to NA #1.

C. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that NA #2 was hired on 03/15/13, and failed to identify the documentation of the dates of orientation, with the name and title of the agency staff person providing the orientation to NA # 2. Instead, NA #2 initialed and dated the orientation content on 03/15/13.

D. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that NA # 3 was hired on 09/13/12, and failed to identify the documentation of the dates of orientation, with the name and title of the agency staff person providing the orientation to NA # 3.

E. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that NA # 4 was hired on 12/07/12, and failed to identify the documentation of the dates of orientation, with the name and title of the agency staff person providing the orientation to NA # 4.

F. Interview and review of the personnel files with Administrator # 2 on 09/03/13 indicated that RN #3 was hired on 05/28/13. Interview and review of the personnel folder with the Adm/SCS #2 on 09/03/13 identified the agency failed to document the dates of orientation and the name and title of the person providing the orientation; rather, RN #3 initialed and dated the provision

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of orientation content on 05/28/13.

G. RN #5's date of hire was 04/10/13. Interview and review of the personnel folder with the Adm/SCS #2 on 09/03/13 identified the agency failed to document the dates of orientation and the name and title of the agency staff person providing the orientation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (1) (D) and/or (F).

11. Based on review of the personnel files and staff interviews, for seven of seven personnel files reviewed (the files of Home Health Aides # 1, 2, 3, 4, Administrator # 2, Registered Nurses # 3 and 5), the agency failed to document an adequate orientation to the employees. The findings include:

Interview and review of the personnel files of Home Health Aides # 1, 2, 3, 4, Administrator # 2, Registered Nurses # 3 and 5 with Administrator #2 on 09/03/13 and 09/11/13 identified the provision of orientation to the new employees, but failed to identify the inclusion of a description of client population and geographic area served, and the applicable state and federal regulations governing the delivery of home health care services, during the agency orientation to the new employees, in accordance with the Regulations of Connecticut State Agencies.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76

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Quality assurance program (f).

12. Based on review of the personnel files and staff interviews, for one of eight personnel files reviewed during the survey (the file of Registered Nurse/RN #1), the agency failed to ensure the required performance evaluation was conducted and/or documented. The findings include:

RN #1's date of hire was 12/14/12. Interview and review of the personnel file with Administrator #2 on 09/03/13 failed to identify the completion and/or documentation of a 6-month performance evaluation (due June 2013), in accordance with Regulations of Connecticut State Agencies.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (A) Nursing Service (3) (D) and/or (E) and/or (4)

13. Based on review of the clinical record and staff interview, for four of four patient (Patients #1, 4, 7, and 9) who exhibited a change in condition and/or required additional services, the registered nurse failed to re-assess the patient and identify the need for other services, and/or the licensed practical nurse failed to report the patient's change in condition to the registered nurse. The findings include:

A. Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy. Physician's orders dated 11/09/12 through 07/07/13 included skilled nursing services to pre-pour medications one (1) or two (2) times a week, perform assessments and

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evaluation of all body systems, and notify physician of significant findings.

i. Interview and review of OASIS Assessments with Administrator #2 on 09/11/13 identified a fall risk assessment score of 45 on 11/09/12 (the January 2010 OASIS assessment tool used by the agency directed the implementation of fall precautions for a total score of 15 or greater, including a referral to physical therapy and/or occupational therapy), a fall risk assessment score of 35 on 01/07/13, a fall risk assessment score of 15 on 03/06/13, and failed to identify nursing notification to the physician of the need for referrals to physical therapy and/or occupational therapy.

Instead, RN # 4 documented on the 11/09/12 Certification Assessment that the patient was instructed to "use furniture and walls for balance;"

ii. Interview and review of OASIS Assessments with Administrator #2 on 09/11/13 identified a fall risk assessment score of 5, using the 2007 OASIS tool (the 2007 OASIS assessment tool indicated that a score of 4 or more was considered at risk for falling), but failed to identify the documentation of measures to prevent falls.

B. Patient #4 had a start of care date of 10/18/12 and 05/15/13 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders dated 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications one (1) to two (2) times a week, perform complete assessment of all body systems, and teach life-style modification including diet.

Interview and review of the OASIS Assessments with Administrator #2 on 09/11/13 identified a

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fall risk assessments score of 30 on 10/18/12, 02/14/13, 04/11/13 and 07/05/13 (the January 2010 OASIS assessment tool used by the agency directed the implementation of fall precautions for a total score of 15 or greater, including a referral to physical therapy and/or occupational therapy), but failed to identify nursing notification to the physician of the need for referrals to physical therapy and/or occupational therapy.

Instead, Administrator # 1 documented on 12/15/12 that the patient was instructed to "use furniture and walls for balance."

C. Patient #7 had a start of care date of 11/08/12 and diagnoses that included acute myeloid leukemia, cholecystostomy (11/01/12), general anxiety disorder, hypertension, morbid obesity and immunosuppressed therapy. Physician's orders dated 11/08/12 included skilled nursing services two (2) times a week for assessments, teaching on new medications, home safety and fall precaution measures.

Interview and review of the OASIS Assessments with Administrator #2 on 09/11/13 identified a fall risk assessment score of 15 (the January 2010 OASIS assessment tool used by the agency directed the implementation of fall precautions for a total score of 15 or greater, including a referral to physical therapy and/or occupational therapy), but failed to identify nursing notification to the physician of the need for referrals to physical therapy and/or occupational therapy.

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

D. Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification period of 01/15/13 to 03/15/13 included skilled nursing visits weekly to assess all body systems with special attention to cardio-respiratory and musculoskeletal systems, pain, nutrition, hydration, depression, signs and symptoms of infection.

i. The initial comprehensive assessment dated 11/16/12 indicated that the patient lived alone and ate alone. A nutritional status assessment identified fair appetite, and poor food and fluid intake. Measurement of the patient's blood pressure while sitting was 138/88 mmHg. The patient had difficulty with ambulation, range of motion and balance, had episodes of dizziness for 10 to 15 minutes in the morning on 1 to 2 days a week, shortness of breath with moderate exertion and with walking distance of less than 20 feet, weakness in bilateral upper and lower extremities, required supervision or assistance to negotiate stairs, steps or uneven surfaces, and had a fall risk assessment score of 20 indicating the patient was at risk for falls (a score of 15 or higher was considered a risk for falls, and would require implementation of fall precautions). The agency nurse documented that the nurse educated the patient to use the wall and furniture for balance and when dizzy, to remain in sitting or lying position until the patient felt better before standing up or walking; if the patient fell, the patient was to remain on the floor and not immediately stand up, but take deep breaths then call family or call 911 if the patient suspected an injury. The agency nurse also recommended that the patient obtained a walker to use outside of the house, and the patient declined.

Interview and review of the clinical record with Administrator #2 on 09/11/13 indicated that the visiting nurse should not have instructed the patient to lean on the wall or furniture for ambulation, and failed to indicate that the visiting nurse initiated a referral for physical therapy evaluation;

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

ii. Interview and review of the nursing documentation from 11/16/12 through 05/12/13 with Administrator #2 on 09/11/13 identified nursing documentation regarding the patient's dizziness, balance, unsteady gait, weakness, and poor fluid intake on 11/19/12, 11/21/12, 11/23/12, 11/26/12, 11/28/12, 11/30/12, 12/03/12, 12/06/12, 12/10/12, 12/13/12, 01/07/13, 01/21/13, 01/28/13 and 05/06/13 but failed to identify the documentation of assessments of orthostatic blood pressure (BP) until over five months later on 05/06/13 when the licensed practical nurse (LPN) identified inadequate fluid intake, unsteady gait and syncope, a lying BP of 122/80 mmHg, a sitting BP of 120/72 mmHg, and a standing BP of 98/58 mmHg;

iii. Interview and review of the nursing documentation with Administrator #2 on 09/11/13 failed to locate documentation that the licensed practical nurse notified the registered nurse and/or physician of the variations in the patient's blood pressure. Administrator #2 indicated on 09/11/13 that Patient # 9 should have received blood pressure assessments/monitoring since November 2012, and that LPN should have reported the variations in the patient's blood pressure to the registered nurse on 05/06/13;

iv. The home health aide documentation dated 01/31/13 identified a pain level of 5 on a scale of 1 to 10 over the left shoulder and under the left arm, and the patient took pain medications. A "patient status update memorandum" dated 01/31/13 by Administrator #1 indicated that the aide reported a pain level of 5 on a scale of 1 to 10 (left shoulder, left arm and stomach pain), the primary care physician was notified and an appointment was scheduled for 02/01/13. A "patient status update" dated 02/01/13 by Administrator #1 indicated that the patient was seen at the cancer center on 01/31/13 and the pain medications were changed. Physician's orders dated 01/31/13 included Omeprazole 20 mg daily at bedtime and Tramadol 50 mg every 4 hours as needed for pain, instructions on the medication actions, and monitoring for side-effects. Interview and review of the nursing documentation with Administrator # 2 on 09/11/13 identified a subsequent nursing visit note dated 02/04/13 by a licensed practical nurse, but failed to identify documentation of nursing instructions to the patient, evaluation of the pain medication change, effectiveness and use,

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

and failed to identify patient assessment by a registered nurse after an episode of increased pain and subsequent medication changes;

v. The LPN documentation dated 02/14/13, 02/25/13, and 03/04/13 indicated that the patient was taking Ibuprofen 800 mg and Tylenol 1000 mg to control the pain, the pain caused the patient to vomit, the patient had occasional bloody sputum with coughing, and the patient experienced restlessness and anxiety from the pain; however, interview and review of the nursing documentation with Administrator # 2 on 09/11/13 failed to identify notification by the licensed practical nurse to the registered nurse and/or the physician of the patient's change in status;

vi. Interview and review of the licensed practical nurse documentation dated 05/06/13 with Administrator #2 on 09/03/13 identified the development of a blister on the patient's left lower buttock, red in color and with no drainage, but failed to identify measurements of the blister and description of the surrounding skin, and failed to identify notification by the licensed practical nurse to the registered nurse and/or the physician of the patient's change in condition;

vii. Interview and review of the discharge assessment dated 05/12/13 with Administrator #2 on 09/03/13 indicated that RN #1 applied a barrier cream to a blister on the patient's left buttock, but failed to identify documentation of an assessment by the registered nurse of the blister and surrounding tissue, and failed to identify nursing notification to the physician and obtention of treatment orders from the physician.

DATE(S) OF VISIT: August 8, 9, 19 and September 3, 2013

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 Services (a) Nursing Service (3) (G) and/or (d) Homemaker home health aide services (3) and/or (4)(B)

14. Based on review of the clinical record and staff interviews, for one of three patients (Patient #9) who received both skilled nursing services and home health aide services, the agency nurse failed to provide orientation to the plan of care to the home health aide. The findings include:

Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification period of 011/16/12 to 01/14/13 included home health aide services twice a week to assist with bathing, dressing, ambulation if needed, light meal preparation, light housekeeping. The aide assignment sheet dated 11/16/12 indicated that the patient was prone to falls, experienced difficulty with ambulation and balance, dizziness, and partial weight bearing. The tasks listed on the aide assignment sheet included assistance with shower or bath, grooming, light meal preparation, light housekeeping and monitoring of temperature, pulse and respirations.

i. Interview and review of the aide assignment sheet with Administrator # 2 on 09/11/13 identified documentation of "not applicable" next to the task of ambulation, and failed to reflect the physician's orders for ambulation by the aide as needed;

ii. The home health aide services started on 11/20/12 from 9:00 am to 10:00 am. Interview and review of the home health aide weekly visit record, aide assignment sheet and field supervisory report with Administrator #2 on 09/11/13 failed to identify documentation of orientation by the registered nurse to the aide on the home health aide plan of care.

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 Services (a) Nursing service (3)(G)(H).

15. Based on review of the clinical record and staff interviews for one of three patients (Patient #9) who received both skilled nursing services and home health aide services, the agency nurse failed to develop adequate written instructions for the aide and/or failed to clarify physician's orders for the aide. The findings include:

Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification period of 011/16/12 to 01/14/13 included home health aide services twice a week to assist with bathing, dressing, ambulation if needed, light meal preparation, light housekeeping, parameters for physician notification (heart rate below 60 or above 100, respiratory rate below 12 or above 22, temperature below 95.1F and above 101.5F). The aide assignment sheet dated 11/16/12 indicated that the patient was prone to falls, experienced difficulty with ambulation and balance, dizziness, and partial weight bearing. The tasks listed on the aide assignment sheet included assistance with shower or bath, grooming, light meal preparation, light housekeeping, notification to the case manager of heart rate below 60 or above 100, respiratory rate below 12 or above 22, temperature below 95.1F and above 101.5F, cloudy or bloody urine, and pain level greater than 6 on a scale of 0 to 10.

The home health aide services started on 11/20/12 from 9:00 am to 10:00 am.

The home health aide weekly documentation from 11/20/12 through 01/12/13 identified the recording of the temperature, pulse and respiratory rate at each visit, and the completion of a

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

weekly pain assessment on a scale of 0 to10 using face diagrams.

Interview and review of the home health aide weekly visit record, aide assignment sheet and physician orders with Administrator #2 on 09/11/13 failed to identify specific physician orders for the aide to perform vital signs and to assess pain, failed to identify attempts by the nurse to clarify the physician's orders regarding the parameters for reporting vital signs, and failed to identify determination by the registered nurse of all aspects of care for delegation to the nurse's aide.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D78 (d) Patient bill of rights and responsibilities (d).

16. Based on observation and staff interviews for three of three patients (Patients #1, 4 and 7) with a documented emergency disaster plan, the agency staff failed to provide the appropriate emergency contact information to the patient. The findings include:

A. Patient #1 had start of care date of 11/09/12 and diagnoses that included dementia, hypertensive heart disease, gouty arthropathy and past history of non-adherence. Physician's orders for the certification period of 07/06/13 to 09/03/13 included weekly skilled nursing visits to prefill medications, evaluate medication adherence and monitor side effects. During a joint home visit on 09/03/13 with RN #1, Patient #1 verbalized that the patient was instructed to call LPN # 2 in emergency situations, and Patient # 1 exhibited a yellow post-it note with the name and cellular telephone number of LPN # 2. In response, RN #1 instructed the patient during the join visit to call RN # 1 instead, and gave the patient another yellow post-it note with RN # 1's name and cellular telephone number.

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

Interview and review of the home visit observation with Administrator #2 on 09/03/13 indicated that the nurses should have provided the patient with the agency's main telephone number, failed to identify provision of the correct telephone number for emergency contact to the patient, and failed to identify the correct format for providing emergency contact information to the patient (in permanent and formal admission paperwork) by LPN # 2 and RN # 1.

B. Interview and review of the Emergency/Disaster Plan dated 02/14/13 for Patient # 4 with Administrator # 2 on 09/11/13 identified the cellular telephone number of LPN # 5 as an emergency contact for nursing-related problems, and failed to identify provision of the correct telephone number for emergency contact to the patient (the main number for the agency).

C. Interview and review of the Emergency/Disaster Plan dated 11/08/12 for Patient # 7 with Administrator # 2 on 09/11/13 identified the cellular telephone number of LPN # 1 as an emergency contact for nursing-related problems, and failed to identify provision of the correct telephone number for emergency contact to the patient (the main number for the agency).

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-D73 Patient Care Plan (b)

17. Based on record review, staff interview and agency documentation, for one of one patient with a change in condition (Patient # 1), the registered nurse failed to notify the physician of the change in condition and the need to revise the plan of care. The findings include:

Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy. Physician's orders for the periods of 11/09/12 through 07/07/13 included skilled nursing services to pre-pour medications once or twice a week, assess the patient, teach the patient about diet, and notify the physician of significant finding.

i. Interview and review of the LPN note dated 04/11/13 with Administrator #2 on 09/11/13 identified patient's report of left heel gout pain, followed by LPN # 1's advice to take the as-needed Advil as ordered, but failed to identify documentation of the LPN's notification to the registered nurse and/or physician about the onset of left heel pain;

ii. Interview and review of the physician's orders dated 03/09/13 and the medication profile dated 03/06/13 with Administrator #2 on 09/11/13 failed to identify the medication Advil;

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

iii. Interview and review of a subsequent note written on 07/15/13 (by LPN #2) with Administrator #2 on 09/11/13 identified patient's report of pain in the right knee, occurring during episodes of ambulation or sitting still, but failed to identify documentation of the LPN's notification to the registered nurse and/or physician about the onset of right knee pain;

iv. Further documentation indicated that LPN # 2 advised the patient to apply Icy Hot Rub to relieve the pain on the right knee. Interview and review of the physician's orders dated 07/06/13 and the medication profile dated 07/03/13 with Administrator #2 on 09/11/13 failed to identify the listing of Icy Hot Rub as a treatment for pain.

The agency's policy on "Coordination of Patient Care" directed the agency staff to provide the physician with patient information on an ongoing basis regarding changes in condition.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D 19-13-D69 Services (a) Nursing Service (2) and/or (3) and/or of the General statutes of Connecticut Chapter 368v Health Care Institutions Section 19a-490 (d)

18. Based on surveyor observation, review of clinical records, agency documentation and staff interview, the agency failed to employ a primary care nurse. The findings include:

A. Interview with Administrator # 1 on 09/16/13 indicated that the Administrator also

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

functioned as Supervisor of Clinical Services, Supervisor of Home Health Aide Services, and Primary care Nurse, and failed to identify the active employment of a registered nurse as a primary care nurse from 11/03/11 to 08/08/13.

B. Interview on 08/08/13 with the agency Office Manager/Assistant Administrator indicated that the only employed registered nurse (RN #1) was on a leave of absence with an unknown return date, that LPN #1 and LPN #2 provided care to the patients, and failed to identify supervision provided to the LPNs by a registered nurse/primary care nurse.

C. In an interview on 08/08/13, the agency Office Manager/Assistant Administrator indicated that the registered nurse would visit the patient every 60 days for the recertification assessment. Surveyor observation on 08/08/13 and 08/09/13 indicated that the agency Office Manager/Assistant Administrator was the only staff present, and failed to identify the presence of the registered nurse or the LPNs during the survey.

D. Interview and review of the agency contracts with Administrator # 2 on 09/11/13 identified "Independent Contractor Agreements" signed by RN # 1 on 12/14/12 and RN # 3 on 05/28/13 on an as-needed basis to provide service to the agency patients, and failed to identify the direct employment of registered nurses in accordance with the General Statutes of Connecticut.

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-D75 Clinical Record System (a) (4)

19. Based on review of clinical records, observation and staff interview, for two of twelve patients (Patients # 1 and # 4) in the survey sample, the agency failed to maintain the clinical records on the agency's premises. The findings include:

Interview and query of the clinical records of Patients # 1 and 4 with the Office Manager/Assistant Administrator on 08/08/13 indicated that LPN # 2 and LPN # 3 maintained the patient's records in the nurse's homes (Patient #1's clinical record, including physician orders and skilled nursing notes, from 05/07/13 thru 08/06/13, and Patient #4's clinical record, including physician orders and skilled nursing notes, from 05/15/13 thru 08/05/13), and failed to identify maintenance of the records on the agency's premises in lockable areas, in accordance with the Regulations of Connecticut State Agencies.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-19-D72 Patient care policies (a) general Program Policies

20. Based on review of clinical records, agency policies and staff interviews, for three of three patients (Patients # 1, 4 and 5) who required medication pre-pouring, the agency failed to develop policies and/or guidelines to direct the documentation of pre-pouring. The findings include:

A. Patient #1 had a start of care date of 11/09/12 and diagnoses that included senile

dementia, non-insulin dependent diabetes mellitus, iron deficiency anemia, hypertensive heart disease and gouty arthropathy. Physician's orders dated 11/09/12 through 07/07/13 included skilled nursing services to pre-pour medications one (1) or two (2) times a week, perform complete assessment and evaluation of all body systems, notify physician of significant findings and teach diet.

Interview and review of the nursing notes from 11/09/12 through 08/06/13with Administrator #2 on 09/11/13 identified only one documentation (on 10/22/12) of medication pre-pouring in nine months, and failed to identify accurate documentation of the medications pre-poured, the reference used for pre-pouring, and the time frame for the medications pre-poured.

B. Patient #4 had a start of care date of 10/18/12 and 05/15/13 and diagnoses that included unspecified cardiac arrhythmia, pre-senile dementia with depressive features, morbid obesity, hypertensive heart disease, coronary artery disease and osteoarthritis. Physician's orders dated 10/18/12 through 07/14/13 included skilled nursing services to pre-pour medications one (1) to two (2) times a week, assess all body systems, teach life-style modification including diet and exercise.

Interview and review of the nursing notes from 10/18/12 through 08/05/13with Administrator #2 on 09/11/13 either failed to identify accurate documentation of the medications pre-poured, the reference used for pre-pouring, and the time frame for the medications pre-poured.

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

C. Patient #5 had a start of care date of 09/22/12 and diagnoses that included lung cancer, bladder cancer, iron deficiency anemia, rheumatoid arthritis, chronic bacterial endocarditis, above-the-knee amputation of the left leg, and benign prostatic hypertrophy. Physician's orders dated 09/22/12 through 11/20/12 included skilled nursing services to provide medication set-up and management, perform assessments and evaluate the patient's status two (2) times a week.

Interview and review of the nursing notes from 09/22/12 through 10/01/12 with Administrator #2 on 09/11/13 identified documentation on 09/24/12 and 09/27/12 of "SN filling pillbox as ordered," but failed to identify accurate documentation of the medications pre-poured, the reference used for pre-pouring, and the time frame for the medications pre-poured.

D. Interview and review of the agency policies with the Office manager/Assistant Administrator on 08/09/13 failed to identify a policy on medication pre-pouring and documentation.

DATE(S) OF VISIT: August 8, 9, 19 and September 3, 2013

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 19-13-19 D76 Quality assurance program (e)(1)

21. Based on review of agency documentation and staff interviews, the agency failed to conduct clinical record reviews at a minimum every quarter. The findings include:

Interview and review of the quarterly clinical record reviews with Administrator #2 on 09/11/13 failed to identify distinct clinical record reviews for the fourth quarter of 2012 and the first quarter of 2013. Instead, the agency combined the fourth quarter of 2012 and the first quarter of 2013 into one single review.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-19-D68 General requirements (c) Professional Advisory Committee (1)

22. Based on review of agency documentation and staff interviews, the agency failed to include the minimum required members on the professional advisory committee. The findings include:

Interview and review of the professional advisory committee (PAC) meeting minutes dated 10/26/12, 01/14/13 and 04/04/13 and the agency PAC organizational chart with Administrator # 2 on 09/11/13 failed to identify the appointment and/or participation of at least one (1) therapist representing the skilled therapy services offered by the agency (according to the agency's current license, the agency offered physical therapy and occupational therapy).

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-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C)

23. Based on review of clinical records, agency policy and staff interview, for nine of twelve patients (Patients # 1, 2, 3, 4, 5, 6, 7, 9 and 10) in the survey sample, the nursing staff failed to identify a summary of the skilled services provided to the patient in the ten-day report forwarded to the physician. The findings include:

Interview and review of the 10-day summary reports with Administrator #2 on 09/11/13 failed to identify a summary of the skilled services provided to Patient #s 1, 2, 3, 4, 5, 6, 7, 9 and 10. Instead, Administrator #1 recopied the physician's orders in the summary report, without including the professional staff assessments and/or interventions.

The agency policy on "Coordination of Patient Care" directed the completion of summary reports to the physician regarding skilled services provided to the patient, within ten days of admission.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D77 Administrative organization and records (a)

24. Based on review of the clinical records, agency documentation and staff interview, for one of three patients (Patient #9) who received both skilled nursing services and home health aide

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

services, the

agency failed to maintain compliance with federal requirements to provide registered nurse supervision to the home health aide every fourteen days. The findings include:

Patient #9 had a start of care date of 11/16/12 and diagnoses that included malignant lung neoplasm, debility, general muscle weakness and chronic obstructive pulmonary disease. Physician's orders for the certification periods of 11/16/12 to 05/14/13 included home health aide services twice a week for assistance with personal care, light meal preparation and housekeeping. The home health aide services were initiated on 11/20/12.

The "field supervisory report for home health aides" identified the documentation of home health aide supervision on 12/04/12, 12/18/12, 12/28/12, 01/10/13, 01/23/13, 02/05/13, 02/25/13, 03/05/13, 03/19/13, and 04/02/13.

Interview and review of the nursing documentation with Administrator #1 on 09/16/13 indicated that the home health aide supervision was conducted either on site or "over the telephone" and failed to identify compliance with Medicare State Operations Manual Appendix B at CFR 484.36 (d) (2) which requires the registered nurse or another professional to conduct an on-site visit to the patient's home at a minimum every fourteen days to provide supervision.

DATE(S) OF VISIT: August 8, 9, 19 and September 3, 2013

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-D78 Patient's bill of rights and responsibilities (a) and/or (d)

25. Based on clinical record review and staff interview, for two of twelve patients (Patients #11 and #13) in the survey sample, the agency nurse failed to inform the patient in writing of the charges, the disciplines that would furnish care, and the frequency of the visits proposed. The findings include:

1. Patient #11 had a start of care date of 04/11/13 and diagnoses that included hypertensive heart disease, chronic ischemic heart disease, and general osteoarthrosis. Physician's orders for the certification period of 04/11/13 through 06/09/13 included skilled nursing visits twice a week for one week, three a week for two weeks and twice a week for six weeks for assessments.

   Interview and review of the admission consent forms dated 04/11/13 with Administrator #2 on 09/16/13 failed to identify documentation of the disciplines providing care, the frequency of visits proposed, and the absence of costs to the patient for the home care services.

2. Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, multiple small bowel obstructions, debulking surgeries, chemotherapy, status-post cholecystomy tube and PEG tube. The patient received Dilaudid via a patient-controlled analgesia (PCA) pump and total parenteral nutrition (TPN) via a triple lumen catheter (TLC) at home.

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

Interview and review of the admission consent forms with Administrator #2 on 09/17/13 failed to identify documentation of the disciplines providing care, the frequency of visits proposed, and the absence of costs to the patient for the home care services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D75 Clinical record system (a) (2) and (b) Administrative organization and records (a) and/or 19-13-D77 Administrative organization and records (h)

26. Based on review of the clinical records, agency documentation and staff interview, the agency failed to ensure accountability, provide full disclosure of the patient census, and/or accessibility of the clinical records. The findings include:

A. On 08/08/13, the surveyor team inquired about the number of unduplicated admissions from 11/01/12 to 08/08/13, and was told by the Office Manager/Assistant Administrator that there were 12 unduplicated admissions from 11/01/12 to 08/08/13. From 08/08/13 through 08/19/13, the surveyors reviewed ten clinical records.

However, on 09/03/13, the surveyor team requested the two remaining clinical records, and was told by the Office Manager/Assistant Administrator that there were only ten patients admitted.

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

B. Also on 09/03/13, a list of active and inactive patients was provided to the surveyors. Interview and review of the list with Administrator # 2 on 09/17/13 identified two new patients (Patients #14 and 15) but failed to identify the availability of the clinical records and/or full disclosure of the records to the surveyor upon request.

C. A review of the field staff time sheets on 09/12/13 indicated that Patient #12 received home health aide services for 2 hours on 03/26/13 and 03/27/13, and NA #5 was paid by the agency for the services rendered.

In interviews on 09/12/13, the Office Manager/Assistant Administrator suggested that the agency did not provide services for Patient # 12, that NA #5 worked for another agency at that time, and NA # 5 submitted the time sheet incorrectly.

In an interview on 09/16/13, NA # 5 indicated that NA # 5 worked only for this agency on 03/26/13 and 03/27/13, was assigned to Patient #12 by the Office Manager/Assistant Administrator, and recalled accessing the agency folder in the patient's home to review the aide plan of care.

Interview with Administrator #2 on 09/17/13 indicated that Patient #12 did in fact receive home care services from the agency on 03/26/13 and 03/27/13, but failed to identify a clinical record maintained for the patient and/or provided upon surveyor's request.

D. Review of field staff time sheets on 09/12/13 indicated that RN #5 provided home visits to Patient #11 on 04/22/13, 04/24/13, 04/26/13, 04/30/13, 05/03/13, 05/10/13, 05/13/13, and

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

05/16/13 and was paid for all visits. Interview and review of the agency documentation with Administrator # 2 on 09/17/13 indicated that the agency staff excluded Patient # 11 from the agency's total census, and failed to identify full disclosure of information to the surveyor upon request.

E. Review of the field staff time sheets on 09/16/13 indicated that RN #1 admitted Patient #13 on 04/20/13. Interview and review of the agency documentation with Administrator # 2 on 09/17/13 indicated that the agency staff excluded Patient # 13 from the agency's total census, and failed to identify full disclosure of information to the surveyor upon request.

F. In an interview with the Office Manager/Assistant Administrator on 09/18/13 in the presence of Administrator # 2, the Office Manager/Assistant Administrator acknowledged that Administrator # 1 directed the Office Manager/Assistant Administrator to exclude five patients (Patients # 11, 12, 13, 14 and 15) from the census to avoid disclosure during the inspection by the accrediting organization (JCAHO).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73 Patient care plan (b) and/or (c)(1)(2) and/or 19-13-D69 Services (a) Nursing (3)(D) and/or 19-13-D77 Administrative organization and records (a)

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

27. Based on review of the clinical record and staff interviews, for two of two patients (Patients # 11 and #13) with complex needs, the agency nurse failed to accurately assess the patient's needs, failed to develop and implement a plan of care based on a comprehensive assessment of the patient's needs, failed to notify the physician of changes in the patient's condition, and failed to demonstrate compliance with the federal regulations. The findings include:

A. Patient #11 had a start of care date of 04/11/13 and diagnoses that included hypertensive heart disease, chronic ischemic heart disease, and general osteoarthrosis.

i. Interview and review of the start-of-care comprehensive assessment dated 04/11/13 with Administrator # 2 on 09/16/13 indicated that the patient lived alone, and that the home had unsafe floor coverings, but failed to identify the documentation of details on the floor type or condition to explain the safety issues identified;

ii. Interview and review of the initial comprehensive assessment with Administrator # 2 on 09/16/13 identified documentation by the admitting nurse of "medication problems" during the drug regimen review, but failed to identify documentation of details of the medication issues and/or notification to the physician for clarification of medication orders. Instead, the nursing documentation indicated that the patient independently self-administered proper dosages of the medications at the correct times.

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

iii. The assessment identified a risk for fall, with a score of 25 (a score of 15 or greater required the implementation of fall precautions). Interview and review of the fall risk assessment with Administrator # 2 on 09/16/13 indicated that a correct score for Patient # 11 would be 10 (no significant risk for falls), not 25, and failed to identify an accurate assessment of fall risk by the agency nurse;

iv. Interview and review of the initial comprehensive assessment and plan of care with Administrator #2 on 09/16/13 indicated that Patient # 11 independently self-administered proper dosages of the medications at the correct times, yet identified physician's orders to pre-pour medications on a weekly basis, and failed to identify nursing communication with the physician to clarify the orders for pre-pouring;

v. The initial assessment dated 04/11/13 identified slight swelling of both feet. Interview and review of the skilled nursing visit notes dated 04/15/13, 04/17/13, 04/19/13, 04/22/13, 04/24/13, 04/26/13, 04/30/13, 05/03/13, 05/10/13 and a discharge skilled nursing visit on 05/14/13 with Administrator #2 on 09/16/13 failed to identify continued assessment of the patient's pedal edema;

vi. The initial assessment dated 04/11/13 identified dyspnea with ambulation. Interview and review of the skilled nursing visit notes dated 04/15/13, 04/17/13, 04/19/13, 04/22/13, 04/24/13, 04/26/13, 04/30/13, 05/03/13, 05/10/13 and a discharge skilled

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nursing visit on 05/14/13 with Administrator #2 on 09/16/13 failed to identify documentation of an assessment of the patient's dyspnea with ambulation;

vii. Physician's orders for the periods of 04/11/13 through 06/09/13 included skilled nursing services to evaluate pain location, intensity, frequency and relief measures.

Interview and review of the skilled nursing visit notes dated 04/15/13, 04/17/13, 04/19/13, and 04/22/13 with Administrator #2 on 09/16/13 failed to identify documentation of assessment of the patient's pain location, intensity, frequency and relief measures as directed by the physician;

viii. Physician's orders for the periods of 04/11/13 through 06/09/13 included skilled nursing services to evaluate the patient for signs and symptoms of infection. Interview and review of the skilled nursing visit notes dated 04/15/13, 04/17/13, 04/19/13, 04/22/13, 04/24/13, 04/26/13, 04/30/13, 05/03/13, 05/10/13 and a discharge skilled nursing visit on 05/14/13 with Administrator #2 on 09/16/13 failed to identify documentation of nursing assessment of signs and symptoms of infection as directed by the physician;

ix. Physician's orders for the periods of 04/11/13 through 06/09/13 included Warfarin 1.5mg by mouth on Monday, Tuesday, Thursday, Friday and Sunday, and Warfarin 3mg by mouth on Wednesday and Saturday. Interview and review of the skilled nursing visit notes dated 04/15/13, 04/17/13, 04/19/13, 04/22/13, 04/24/13, 04/26/13, 04/30/13, 05/03/13, 05/10/13 and a discharge skilled nursing visit on 05/14/13 with Administrator #2 on 09/16/13 failed to identify nursing documentation and monitoring of blood values for coagulation while on anticoagulation therapy;

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x. The nursing notes did not indicate that the patient was self-monitoring own blood pressure and/or whether the patient possessed own equipment and/or the type of equipment used. However, interview and review of the patient discharge instructions dated 05/14/13 with Administrator #2 on 09/16/13 identified nursing documentation that the patient to "continued with daily blood pressure checks" and failed to identify consistency in the nursing assessment of the patient's needs and/or abilities.

B. Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, urinary tract infection, multiple small bowel obstructions, status-post debulking surgeries, chemotherapy, status post cholecystomy tube, percutaneous endoscopic gastrostomy (PEG) tube, and suprapubic catheter. According to the hospital referral form, the patient received patient-controlled analgesia (PCA) of Dilaudid, total parenteral nutrition(TPN) via a triple lumen catheter (TLC) placed on 03/31/13, and intravenous Vancomycin from a home infusion company.

i. Interview and review of the clinical record with Administrator #2 on 09/17/13 indicated that the agency provided skilled nursing home visits on 04/20/13, 05/08/13, 05/10/13 and 05/29/13, but failed to identify the documentation of physician's orders for the provision of home care services;

ii. An inter-agency communication from the hospital to the agency on 04/05/13 at11:41 a.m. notified the agency that the patient would be discharged around 4 p.m. and to watch for the referral fax and if not received contact the hospital. The hospital discharge medications and

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

orders (W-10 referral) dated 04/05/13 included current the current medication Vancomycin 750 mgm in sodium chloride 0.9 % 250 ml every 12 hours, Dilaudid PCA continuous rate of 0.7 mgm/hr and demand dose of Dilaudid 1 mgm every 30 minutes with a 4 hour lock out 11 mgm and to manage the TPN infusion 24 hours at 110 cc/hr, Review of the hospital record indicated the patient presented at the clinic on 04/11/13 with increased abdominal pain and inadequate pain relief and the Dilaudid infusion rate was adjusted to continue 0.7 mgm continuously and increase the demand Dilaudid dose to 2 mgm every hour. The patient was not admitted to home care services until 04/20/13, fifteen days after the patient was discharged home and the agency accepted the referral from the hospital.

Interview and review of the nursing documentation with Administrator #2 on 09/17/13 Agency failed to identify by name the entity providing intravenous therapy and a written agreement with the infusion therapy company to delineate responsibilities (the home care agency is not licensed to provide infusion therapy);

iii. Interview and review of the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 indicated that the patient was dependent with grooming, dressing and bathing and that home health aide services were indicated, but failed to identify documentation of notification to the physician for the need to initiate home health aide services;

iv. Interview and review of the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 identified three surgical wounds (a right upper quadrant drain, a suprapubic drain and a gastrostomy tube) but failed to identify documentation of nursing assessment of the wounds sites for appearance, drainage, treatment and management and/or assessment of the patient's or caregiver's knowledge, skill and competency in managing the

sites and instructions provided to the patient/caregiver regarding care and management of the sites;

v. Interview and review of the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 identified documentation of issues with patient compliance during the drug regimen review (item M2000 of the OASIS assessment form), but failed to identify documentation of physician notification within one calendar day at OASIS item M2002;

vi. Interview and review of referrals and the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 identified referrals for physical therapy for safety and fall prevention, transfer and gait training, following an assessment of the patient's needs, but failed to identify notification to the physician for a therapy referral, and/or the documentation of a physical therapy evaluation;

vii. Interview and review of the nursing visit notes by LPN #2 dated 05/08/13, 05/10/13 and 05/29/13 with Administrator #2 on 09/17/13 failed to identify nursing assessments of the patient's respiratory status, pain location, frequency, triggers, alleviating factors, treatment, and coping pattern of patient/family;

viii. Interview and review of the hospital referral note and the nursing visit notes by LPN #2 dated 05/08/13 and 05/10/13 with the Administrator #2 on 09/17/13 identified discontinuation of the Lidocaine cream on the hospital referral dated 04/05/13, indicated that LPN #2 changed the gastrostomy tube dressing, cleansed the site with sterile water, applied lidocaine and gauze to absorb drainage on 05/08/13 and on 05/10/13, but failed to identify physician's orders directing the care of the gastrostomy tube and ostomy site;

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

ix. Interview and review of the nursing visit notes by LPN #2 dated 05/08/13, 05/10/13 and 05/29/13 with Administrator #2 on 09/17/13 identified documentation on 05/08/13 of constant daily abdominal pain self-rated at 6 on a scale of 1 to 10, and on 05/10/13 of constant daily pain self-rated at 7 on a scale of 1 to 10, but failed to identify nursing notification to the physician of the patient's pain. Review of the hospital record indicated that the patient was admitted to the hospital on 05/12/13 for pain control and was discharged on 05/21/13;

x. Interview and review of the nursing visit note by LPN #2 dated 05/29/13 with Administrator #2 on 09/17/13 indicated that the last nursing visit note was dated 05/29/13, and failed to identify further nursing documentation regarding the patient's status and/or disposition.

Review of the hospital record indicated that the patient was hospitalized on 05/02/13 for nausea and vomiting, gastrostomy tube malfunction. The gastrostomy tube was replaced with a #22 MIC gastrostomy tube, the patient was treated with Zofran 4 mg by mouth every 8 hours as needed, and the patient was discharged to home on 05/04/13;

xi. The patient was re- hospitalized on 05/12/13 for pain control, left upper quadrant (LUQ)

percutaneous drainage of abdominal fluid collection, Dilaudid patient-controlled analgesia (PCA) infusion dose increase, Zofran dose adjustment to 8 mg by mouth every 8 hours and code status changed to DNR/DNI. The patient was discharged home on 05/21/13.

The patient was re-hospitalized on 05/30/13 with fever and hypotension. The cholecystomy tube and LUQ percutaneous drainage catheter were removed, new medications Lidocaine 5% and Nystatin 100,000 U/ml 5 ml four times a day were initated, and the patient was discharged home to 06/12/13.

The patient was re-hospitalized on 06/15/13 with fever and sepsis of unclear source, and transferred to facility hospice on 06/25/13.

Interview and review of the multiple hospitalization dates with Administrator #2 on 09/19/13 failed to identify documentation of home visits by the registered nurse for resumption-of-care assessments, revisions of the plan of care, resumption-of-care orders from the physician, and review of medication profiles upon discharges from the hospital.

The following is a violation of the Regulations of Connecticut State Agencies Section 9-13-D69 Services (a) Nursing Service (3) (E)

28. Based on review of the clinical record, hospital documentation and staff interviews, for one of one patient (Patient #13) who required therapy services and social work services, the agency failed to provide the needed services and/or coordinate services. The findings include:

Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, urinary tract infection, multiple small bowel obstructions, status-post debulking surgeries, chemotherapy, status post cholecystomy tube, percutaneous endoscopic gastrostomy (PEG) tube, and suprapubic catheter. According to the hospital referral form, the patient received

patient-controlled analgesia (PCA) of Dilaudid, total parenteral nutrition(TPN) via a triple lumen catheter (TLC) placed on 03/31/13, and intravenous Vancomycin from a home infusion company.

An inter-agency communication note from the discharging hospital to the home care agency dated 04/05/13 at11:41 a.m. indicated that the patient would be discharged around 4 p.m. The physical therapy discharge summary from the hospital identified the need for1 person assistance to change position from supine to sitting and a contact guard for position change of sit to stand and ambulation. Impairments identified were aerobic capacity, endurance, gait, locomotion and balance. Physical therapy at home 3 times per week was recommended.

i. Interview and review of the referral and the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 identified referrals from the hospital for physical therapy for safety, fall prevention, transfer and gait training, but failed to identify the provision of physical therapy by the home health agency;

ii. The patient was uninsured and financially burdened by the cost of care associated with the diagnoses. Interview and review of the initial comprehensive assessment dated 04/20/13 with Administrator #2 on 09/17/13 failed to identify a referral for social work evaluation to assist the patient and/or family with coping strategies.

The following is a violation of the Regulations of Connecticut State Agencies Section 9-13-D72 Patient care policies (a) (1) Conditions of Admission (F) and/or 19-13-D77 Administrative organization and records (a)

DATE(S) OF VISIT: August 8, 9, 19 and September 3, 2013

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

29. Based on review of the clinical record and staff interviews for one of twelve patients (Patient #13) in the survey sample, the agency failed to admit the patient to home care services within acceptable time frames. The findings include:

Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, urinary tract infection, multiple small bowel obstructions, status-post debulking surgeries, chemotherapy, status post cholecystomy tube, percutaneous endoscopic gastrostomy (PEG) tube, and suprapubic catheter. According to the hospital referral form, the patient received patient-controlled analgesia (PCA) of Dilaudid, total parenteral nutrition (TPN) via a triple lumen catheter (TLC) placed on 03/31/13, and intravenous Vancomycin from a home infusion company.

Review of the clinical record and an email from the hospital dated 04/02/13 at 2:40 p.m. indicated that the Office Manager/Assistant Administrator of the home care agency had accepted the referral. The hospital provided the agency with patient contact information, and information regarding the home infusion company managing the PCA, TPN and Vancomycin infusion. The discharge date was communicated from the hospital as Friday 04/05/13.

Interview and review of the clinical record with Administrator #2 on 09/17/13 indicated that the agency accepted the hospital referral on 04/02/13, received a hospital discharge confirmation on 04/05/13, for a discharge date and time of 04/05/13 around 4 pm, but failed to identify documentation of admission to home care services until 04/20/13, fifteen days later, and failed to identify nursing notification to the physician of the delay in patient admission.

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 9-13- D72 Patient care policies (a) (2) Delivery of Services (C) and/or (D)

30. Based on clinical record review and staff interview, for one of six patients (Patient #13) who received skilled nursing services, the agency failed to provide a ten-day summary report of the skilled services provided to the physician. The findings include:

Patient #13 had a start of care date of 04/20/13 and diagnoses that included mucinous adenocarcinoma of the appendix, urinary tract infection, multiple small bowel obstructions, status-post debulking surgeries, chemotherapy, status post cholecystomy tube, percutaneous endoscopic gastrostomy (PEG) tube, and suprapubic catheter. According to the hospital referral form, the patient received patient-controlled analgesia (PCA) of Dilaudid, total parenteral nutrition(TPN) via a triple lumen catheter (TLC) placed on 03/31/13, and intravenous Vancomycin from a home infusion company.

Interview and review of the clinical record with Administrator #2 on 09/17/13 indicated that the patient was admitted to home care services on 04/20/13, but failed to identify the completion of a summary report to the patient's physician of the skilled services provided to the patient within ten days of admission.

DATE(S) OF VISIT: August 8, 9, 19 and September 3, 2013

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- D67 personnel (a) and/or 19-13-D77 Administrative organization and records (a)

31. Based on on-site observation, review of agency documentation, personnel file and interview with agency personnel, the agency failed to appoint a qualifying person to act in the absence of the Administrator. The findings include:

On-site observation, interview and review of the personnel file of the Office Manager/Assistant Administrator on 09/03/13 indicated that Administrator # 1 was not present in the agency on 09/03/13, and that the Office manager was appointed as Assistant Administrator to act in the absence of the Administrator, but failed to indicate that the Office Manager possessed the qualifications required at Section 19-13- D67 personnel (a) and/or in accordance with the State Operations Manual Appendix B at CFR 484.14 (c) to act in the absence of the Administrator .