

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

IN RE:           Hamlett Health Services, LLC  
                  d/b/a Hamlett Health Services, LLC  
                  91 Schraffts Drive, Suite #4  
                  Waterbury, CT 06705

**CONSENT ORDER**

WHEREAS, Hamlett Health Services, LLC (“Licensee”), has been issued License No. 0014 to operate a Home Health Care Agency (“Agency”) under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health (“Department”); and,

WHEREAS, the Facility Licensing and Investigations Section (“FLIS”) of the Department conducted unannounced inspections on various dates commencing on November 14, 2014 and concluding on December 11, 2014; and,

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated January 6, 2015 (Exhibit A – copy attached); and,

WHEREAS, an office conference regarding the January 6, 2015 violation letter was held between the Department and the Licensee on February 6, 2015, and,

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

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass its Section Chief, and the Licensee, acting herein and through Dorothy Boyles, its Sole Owner, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant ("INC") approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC and any other costs associated with compliance with this Consent Order.
2. Failure to pay the costs associated with the INC's duties may result in a fine not to exceed one thousand (\$1000.00) dollars per day until such time the costs are paid.
3. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
4. The INC shall provide consulting services for a minimum of three (3) months at the Agency unless the Department identifies through inspections or any other information that the Department deems relevant that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Agency twenty-four (24) hours per week and arrange his/her schedule in order to be present at the Agency at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the three (3) month period and may, in its sole and absolute discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
5. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
6. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order. During this initial assessment, if

- the INC identifies any issues requiring immediate attention, he/she shall immediately notify the Department and the Licensee for appropriate response.
7. The INC shall confer with the Licensee's Administrator, Supervisor of Clinical Services and other staff determined by the INC to be necessary for the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
  8. The INC shall make recommendations to the Licensee's Administrator and Supervisor of Clinical Services for improvement in the delivery of direct patient care in the Agency. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
  9. After the initial assessment is submitted, the INC shall submit written reports every two (2) weeks to the Department documenting:
    - a. The INC's assessment of the care and services provided to patients;
    - b. Whether the Licensee is in compliance with applicable federal and state statutes and regulations; and,
    - c. Any recommendations made by the INC and the Licensee's response and implementation of the recommendations.
  10. Copies of all INC reports shall be simultaneously provided to the Administrator, Supervisor of Clinical Services and the Department.
  11. The INC shall have the responsibility for:
    - a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, and home health aides, and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
    - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and,

- d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated January 6, 2015 (Exhibit A).
12. The INC, the Licensee's Administrator, and the Supervisor of Clinical Services shall meet with the Department every four (4) weeks throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.
13. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
14. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and any other information the Department deems relevant.
15. Within fourteen (14) days of the execution of this Consent Order the Administrator shall develop and/or review and revise, as necessary, policies and procedures related to staffing needs, administration of treatments, therapies, and medications, patient assessment, care planning, nutritional needs, hydration, physician notification, physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, accident and fall prevention, and abuse and neglect prevention and investigation.
16. Within four (4) weeks of the effect of the Consent Order all Agency nursing staff shall be in-serviced, to the policies and procedures identified in paragraph fifteen (15).
17. Effective immediately upon execution of this Consent Order, the Licensee shall ensure that all staff, including but not limited to, temporary or contracted staff, receive orientation prior to the start of their shift. Such orientation shall include, but not be limited to, emergency procedures and patient identification.
18. Within seven (7) days of receipt of the INC assessment, the Administrator shall provide to the Department a plan for remediation to address the issues identified in the INC initial assessment report.

19. The INC shall make recommendations to the Licensee's Administrator for improvement in the delivery of direct patient care in the facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
20. Copies of all INC reports shall be simultaneously provided to the Administrator and the Department.
21. The Agency will communicate to the Department, within two weeks of execution of this Consent Order, the agency's plan to ensure compliance with the Consent Order through redefining priorities, internal restructuring or strengthening and/or increasing clinical resources.
22. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
  - a. Inform patients and/or responsible party in advance of the discipline(s) that would furnish care and the frequency of the proposed visits;
  - b. Maintain proper infection control practices during home visits;
  - c. Provide in-service education of at least one hour per month for each employee involved in the care delivery of patients;
  - d. Adopt and review policies on medication management, medication reconciliation, administration and documentation in accordance with physician orders and acceptable standards of practice;
  - e. Ensure a safe process of medication administration in accordance with policies, procedures and acceptable standards of practice;
  - f. When using the medication profile, the agency nurses date and update the medication profile, and specify date of profile used when pre-pouring medications;
  - g. The medication profile reflects the current physician orders;
  - h. Review policies on medication management on an annual basis;
  - i. The agency staff shall follow physician orders and notify the physician of alterations of the physician orders; contact the physician to clarify unclear, contradicting and/or incomplete orders prior to providing care; parameters for reporting to the physician.

- The physician orders shall include, when applicable, but not be limited to, medications administration, frequency of visits, pressure sore interventions, and blood glucose monitoring;
- j. Provide the necessary assessments after a change in condition or abnormal findings;
  - k. Revise the plan of care to address the patient's needs;
  - l. Ensure home health aides carry a written plan of care and/or the written plan of care is available in the home for the aide and ensure the home health aides follow the plan of care;
  - m. Ensure the Registered Nurse supervises the home health aide every two weeks;
  - n. Maintain accurate and/or authenticated clinical record documentation;
  - o. The agency maintains adequate staffing ratios at all levels in accordance with federal laws and regulation;
  - p. The agency maintains coordination of care among disciplines to meet the patient's needs;
  - q. All agency staff accurately assess the patient and family's needs, promptly re-assess the patient's needs with each change in condition, hospitalization, new medications, and new treatment.
  - r. The agency aides report changes to the nurses promptly and Registered Nurses promptly assess the patients and report to the physician (s);
  - s. All patients are assessed for the risk of developing skin breakdown; patients determined to be at risk shall receive skin assessments according to the agency protocol;
  - t. Provide necessary interventions for pressure sore prevention and/or treatment shall be provided in accordance with the Agency policies and procedures; Clinical documentation is incorporated in the patient's record at least once a week; and
  - u. Quality assessment and performance improvement program activities shall include all required record reviews, completion of the program evaluation report, outcome process report, and 120-day reports.
23. Effectively immediately and upon execution of this Consent Agreement, the Licensee shall notify the Department immediately, if any of the following positions become vacant:

- a. Administrator; and
  - b. Supervisor of Clinical Services.
24. The Supervisor of Clinical Services shall within fourteen (14) days of the effective date of this Consent Order review and/or develop and/or revise all policies and procedures as necessary, which are pertinent to staffing, clinical record documentation, physician orders, assessments, changes in patient condition, physician notification, adherence to the plan of care, and revision of the plan of care.
  25. The Supervisor of Clinical Services shall within twenty-one (21) days of the effective date of this Consent Order, review and revise as necessary, each patient's plan of care based upon the patient's current and ongoing assessments.
  26. The Administrator shall within thirty (30) days of the effective date of this Consent Order and/or in accordance with the Agency's plan of correction, in-service all direct service staff on topics relevant to the provisions of paragraph twenty-five (25) of this document. The Licensee shall maintain an attendance roster of all in-service presentations pursuant to this provision and shall be retained and made available upon request to the Department for a period of five (5) years.
  27. The Administrator shall, institute in its evaluation of staff competency, a mechanism whereby the Supervisor of Clinical Services shall conduct quarterly joint home visits with each primary care nurse ("PCN"), as well as a clinical record audit of twenty (20) percent of the PCN's current caseload, to assess clinical competence and ensure care and services is provided in accordance with the plan of care. A report of the program's onsite competency evaluations and record audits shall be presented to the Professional Advisory Committee four (4) times per year. Said reports shall be retained and available upon request for review by the Department for a period of five (5) years. Upon identification of any variance with the plan of care or concerns with competency, prompt remediation should be provided and documented.
  28. Supervisors of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans and in accordance with standards of care. All Supervisors of Clinical Services shall be supervised and monitored by a representative of the Licensee's administrative/corporate clinical staff to ensure the Supervisors of Clinical Services are functioning in

accordance with this Consent Order and state and federal requirements. Records of such administrative visits and supervision shall be maintained for a period of five (5) years for the Department's review.

29. The Licensee, within seven (7) days of the execution of this Consent Order, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document once the INC reports have terminated.
30. The Licensee shall establish a Quality Assessment and Performance Improvement Program ("QAPI") to review patient care issues including those identified in the January 6, 2015 violation letter. The QAPI Committee shall consist of at least, the Licensee Administrator and Supervisor of Clinical Services. The Committee shall meet at least once every thirty (30) days to review all reports or complaints relating to patient care and compliance with federal state laws and regulations. The INC shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Quality Assurance Committee shall include, but not be limited to, assessing all patients of the Licensee to identify appropriateness of care and services, determination and adoption of new policies to be implemented by Licensee's staff to improve patient care practices, and routine assessing of care and response to treatment of patients affected with pressure sores. In addition, this Committee shall review and revise, as applicable infection control and medication policies and procedures and monitor their implementation. The Committee shall implement a QAPI program that will measure, track and report on compliance with the requirements of this Consent Order. The Committee shall measure and track the implementation of any changes in the Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of quality assurance meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Agency for a minimum period of five (5) years.

31. Within fourteen (14) days of the effective date of this Consent Order, the Licensee shall incorporate into its Quality Assessment and Performance Improvement Program (“QAPI”) a method to monitor implementation of the requirements of the Consent Order and those recommendations implemented as a result of the INC assessment. A report on such measures shall be presented every three months to Medical Staff.
32. At the time of signing this Consent Order, the Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars (\$5,000.00) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department. The money penalty and any reports required by this Consent Order shall be directed to:

Loan Nguyen, R.N., M.S.N., B.C.  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section  
Department of Public Health  
410 Capitol Avenue, P.O. Box 340308 MS #12 FLIS  
Hartford, CT 06134-0308

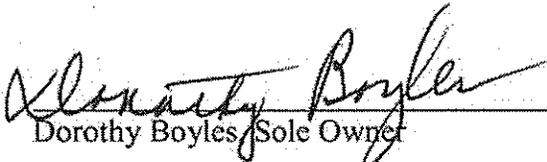
33. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department’s available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law. The allegations and findings contained in Exhibit A shall be deemed true in any subsequent proceeding in which the Licensee’s compliance with the Consent Order is at issue or the licensee’s compliance with Connecticut statutes and regulations and/or with Federal statutes and regulations are at issue.
34. The Licensee understands that this Consent Order will be reported consistent with federal and state law and regulations and consistent with Department policy. In

addition, the Licensee understands that this Consent Order will be posted on the Department's website.

35. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
36. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this Consent Order.
37. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
38. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the January 6, 2015 violation letter referenced in this Consent Order.
39. The Licensee has consulted with its attorney prior to the execution of this Consent Order.
40. The Licensee agrees that this Consent Order does not limit any other agency or entity in any manner including but not limited to any actions taken in response to the factual basis of this Consent Order.

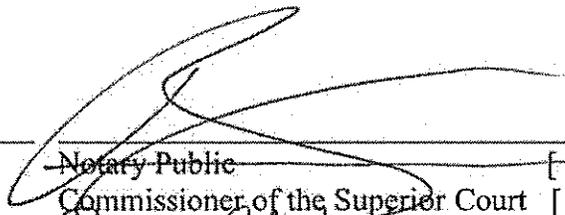
WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

HAMLETT HEALTH SERVICES, LLC - LICENSEE

By:   
Dorothy Boyles, Sole Owner

On this 16<sup>th</sup> day of June, 2015, before me, personally appeared Dorothy Boyles, who acknowledged herself to be the Sole Owner of Hamlett Health Services, LLC and that she, as such Sole Owner being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by herself as the Sole Owner.

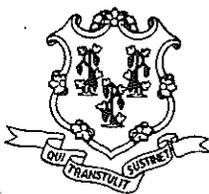
My Commission Expires:  
(If Notary Public)

  
~~Notary Public~~ [ ]  
Commissioner of the Superior Court [ ]  
Benjamin P. Michaelson, Csg.

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

June 17, 2015

By:   
Barbara Cass, R.N., Section Chief  
Facility Licensing and Investigations Section



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

January 6, 2015

Dorothy Boyles, Administrator  
Hamlett Health Services, LLC  
91 Schraffs Drive, Suite #4  
Waterbury, CT 06705

Dear Ms. Boyles:

Unannounced visits were made to Hamlett Health Service, LLC on November 14, 18, 19, 20, and December 11, 2014 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and a certification inspection.

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

An office conference has been scheduled for January 22, 2015 at 10:00AM 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 January 20, 2015 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, SNC  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

LN:mb



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

DATES OF VISIT: November 14, 18, 19, 20, and December 11, 2014

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D78 Patient's Bill of Rights and Responsibilities (d).

1. Based on review of the clinical records and staff interview, for two of two patients (Patients #4 and #5) admitted to home care services in 2014, the agency failed to inform the patient and/or responsible party in advance of the discipline(s) that would furnish care and the frequency of the proposed visits. The findings include:
  - a. Patient #4 has a start of care date of 09/29/14 and diagnoses that included end-stage renal disease with hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic adenocarcinoma and chronic obstructive pulmonary disease. Physician ' s orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day to administer and pre-pour medications, assess vital signs daily and blood glucose twice a day.  
Interview and review of the nursing documentation for the period of 09/29/14 to 11/15/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified nursing visits twice a day, but failed to identify documentation of consent from the patient and/or responsible party for the nursing visits twice a day.
  - b. Patient #5 had a start of care date of 04/10/14 and diagnoses that included muscular dystrophy and anxiety. Physician ' s orders for the certification periods of 08/08/14 through 12/06/14 included skilled nursing visits twice a week to assess cardiopulmonary, skin and mental health/anxiety status and home health aide services Monday, Wednesday and Friday from 1 p.m. to 4 p.m.  
Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/20/14 identified nursing visits once to twice week, and home health aide service 2 to 4 times a week, but failed to identify consent from the patient and/or responsible party for the nursing visits and/or home health aide services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 Patient Care Policies (a) General Program Policies and/or 19-13-D71 Personnel Policies (a)(2).

2. Based on review of clinical record, observation and staff interview, for one of five patients (Patient # 3) who received home visits, the agency registered nurse (RN) failed to maintain acceptable infection control practice; for three of four personnel files (the files of RN #1, aide/NA #1, and NA #2) reviewed during the survey, the agency failed to provide the education required by the State regulations. The findings include:
  - a. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety.  
Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

DATES OF VISIT: November 14, 18, 19, 20, and December 11, 2014

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

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed using a single-compartment striped cloth bag as a nursing bag. The bag contained a bottle of hand sanitizer gel, paperwork, patient medications and the blood pressure equipment in a plastic bag.

The bottle of hand sanitizer was kept inside the only compartment of the bag, therefore the nurse contaminated the inside of the bag everytime the nurse reached inside the bag to reach the bottle of gel.

RN # 2 also dropped the plastic bag holding the sphygmomanometer on the floor, picked it up and put it back in the nursing bag, further contaminating the inside of the bag.

Interview and review of surveyor observation with the agency Administrator on 11/20/14 failed to identify an agency policy/guideline on hand hygiene.

In an interview on 11/20/14, the agency Administrator indicated that a single-compartment nursing bag was not acceptable, and the agency had multiple-compartment nursing bags available for home visits, and failed to identify an agency policy and/or guideline on bag technique.

Interview and review of the in-service education records and personnel files with the Administrator on 11/20/14 indicated that RN #1 was hired on 03/12/12 as a field nurse, and failed to identify documentation of twelve hours of in-service education for 2013 in accordance with the Regulations of Connecticut State Agencies 19-13-D71 Personnel policies (a)(2).

Interview and review of the in-service education records and personnel files with the Administrator on 11/20/14 indicated that NA #1 was hired on 09/24/12 as a home health aide, received five hours of in-service education in 2013, and failed to identify documentation of twelve hours of in-service education for 2013 in accordance with the Regulations of Connecticut State Agencies 19-13-D71 Personnel policies (a)(2).

Interview and review of the in-service education records and personnel files with the Administrator on 11/20/14 indicated that NA #2 was hired on 10/12/10 as a home health aide, received eight hours of in-service education in 2012, eight hours of in-service education in 2013, and failed to identify documentation of twelve hours of in-service education for 2012 and 2013 in accordance with the Regulations of Connecticut State Agencies 19-13-D71 Personnel policies (a)(2).

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D68 General Requirements (b) Governing Authority (4)(C).

3. Based on review of clinical records, agency documentation and interview with agency personnel, for six of six patients (Patients #1, 3, 4, 6, 8 and 9) who required medication administration by the agency nurses, the agency governing body failed to adequately adopt and review policies on medication management, which resulted in findings of Immediate Jeopardy. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma and diabetic neuropathy.

DATES OF VISIT: November 14, 18, 19, 20, and December 11, 2014

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

Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week for medication administration and pre-pour, assessment of blood glucose, blood pressure and heart rate.

The patient ' s medications included: Lisinopril, Metoprolol, Pantoprazole, Aspirin, Atorvastatin, Novolog insulin 60 units twice a day subcutaneously, Metformin and Singulair.

During a joint visit on 11/18/14 at 9:30 a.m. Registered Nurse (RN) #1 was observed pulling unidentified pills out of a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.

Interview and review of the nursing note dated 10/17/14 with the primary care nurse, (PCN) RN #1 and the SCS on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the Emergency Department and released on 10/16/14, however the nurses continued to sign off on 10/15/14 a.m. (while the patient was in the ED) for administering Lisinopril, Metoprolol, Pantoprazole, Aspirin, Novolog Insulin and Metformin and failed to identify accurate and authentic documentation of medication administration at the time the medications were actually administered to the patient.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to identify adequate policy to reflect the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- b. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg

DATES OF VISIT: November 14, 18, 19, 20, and December 11, 2014

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

weakness, depression and anxiety.

Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

The MAR identified medications scheduled for 6:30 a.m., 9:00 a.m., 12 noon, 4:00 p.m., 5 p.m., ) p.m. and many other medications to be taken on "as-needed" basis.

Although the surveyor observed that the nurse only administered the 9AM medications, the MAR identified the nurse's signature throughout all the medications listed, for all the doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

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weakness, depression and anxiety.

Physician's orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

The MAR identified medications scheduled for 6:30 a.m., 9:00 a.m., 12 noon, 4:00 p.m., 5 p.m., 6:30 p.m. and many other medications to be taken on "as-needed" basis.

Although the surveyor observed that the nurse only administered the 9AM medications, the MAR identified the nurse's signature throughout all the medications listed, for all the doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

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The medication profile rewritten on 11/05/14 included Tramadol 50 mgm every 12 hours as needed for pain.

The Medication Administration Records (MAR) for the months of September and October 2014 included Tramadol 50 mg 1 tablet every 12 hours as needed for pain. Nursing documentation indicated that the visiting nurse left 2 tablets of Tramadol 50 mg with the patient during thirteen of the twenty-eight daily nursing visits in September 2014, and each of the twenty-nine daily visits in October 2014, and failed to reflect that the nurse actually administered the Tramadol to the patient each day as signed off in the MAR;

Interview and review of the medication administration record for the month of November 2014 with the Administrator and Supervisor of Clinical Services on 11/18/14 indicated that the nurse signed off ahead of time for having administered Tramadol 50 mgm 1 tablet every 12 hours to the patient from 11/01/14 through 11/21/14, although the home visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14, and failed to identify accurate and authentic documentation of the medication administration process;

Interview and review of the surveyor observation of the joint home visit with RN # 2 on 11/18/14 indicated that the nurse had previously signed off for administering the Tramadol but did not administer the two tablets of Tramadol to the patient on 11/18/14 (left the two tablets in a compartment of the patient's medication box) and failed to identify accurate documentation of the medication administration process versus pre-pouring process;

The physician's orders for the certification period of 09/10/14 to 11/08/14 included Oxycodone 15 mg by mouth three times a day.

A subsequent physician's order dated 10/13/14 directed the administration of Oxycodone 15 mg 1 tablet by mouth twice a day as needed.

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime).

The medication administration record for the month of October 2014 listed Oxycodone 15 mg by mouth three times a day as needed for breakthrough pain from 10/04/14 through 10/12/14, and the agency nurse initialed the medication as administered three times a day until 10/15/14.

Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify documentation for administering or pre-pouring Oxycodone for two days (10/13/14 and 10/14/14) and failed to identify nursing documentation of the patient's pain management during those two days without Oxycodone;

The medication administration record for the month of October 2014 subsequently listed Oxycodone 15 mg by mouth twice a day as needed for breakthrough pain starting 10/16/14, and the agency nurse initialed the medication as administered twice a day. Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate implementation of the physician's order

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dated 10/13/14 for Oxycodone twice a day (instead of three times a day) until 10/16/14, three days later;

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime) and the agency nurse signed off on each dose as administered when in fact the nurse acknowledged on 11/18/14 visiting the patient only once a day, to administer one morning dose and leave the two remaining doses for the day in a compartment of the medication box, with no follow-up on the amount of tablets the patient needed after the nurse left, and/or documented outcome of the intake of the as-needed doses.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

The medication administration record (MAR) for the month of November 2014 included Oxycodone 15 mg by mouth twice a day and review of the November 2014 MAR indicated that the nurse signed off ahead of time for administering two Oxycodone tablets a day prior to the completion of the visits on 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Observation during a joint visit on 11/18/14 indicated that the nurse left two tablets of Oxycodone in a compartment of the patient's medication box, did not administer any Oxycodone, but had signed off ahead of time from the agency office for administering two doses of Oxycodone to the patient on 11/18/14.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

- c. Patient #4 had a start of care date of 09/29/14 and diagnoses that included end-stage renal disease, hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic adenocarcinoma, and chronic obstructive pulmonary disease. Physician 's orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day for medication administration and prepouring of noon medications, assessment of daily vital signs and blood glucose twice a day.

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals and Gabapentin 100 mg by mouth three times a day.

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Interview and review of the medication administration record (MAR) for the month of September 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurse pre-poured the noon dose of Renvela and Gabapentin, but signed off in the MAR as administering the Renvela and Gabapentin at noon although the nurse was not in the patient's home at noon, and failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Physician 's orders for the certification period of 09/29/14 to 11/26/14 included Albuterol inhaler 90 mcg 1 puff every 8 hours, and Symbicort 80 mcg/4.5 mcg actuation aerosol 2 puffs twice a day.

The patient was hospitalized on 10/17/14 with shortness of breath, hypoxia and oxygen saturation in the 70 's prior to completing a hemodialysis treatment. The patient was discharged from the hospital on 10/30/14 with diagnoses of acute hypoxic respiratory failure and pneumonia. The inter-agency referral (W10) form from the hospital included orders for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater than 90%, Simethicone chewable tablet 80 mg by mouth twice a day, and Renvela 2400 mg by mouth three times a day.

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed pulling unidentified pills from an envelope without the benefit of using the pharmacy bottles and MAR to verify the medications prior to administration. In addition, the nurse left an unidentified pill in the patient's medication box, called it "the noon dose of Renvela," but had previously signed off from the agency office for administering, not pre-pouring the noon dose of Renvela.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified that on 11/18/14 the agency nurses were allowed to sign off ahead of time as administering medications three times a day through 5 p.m. on 11/21/14 although the nursing visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14. The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the nursing documentation from 11/10/14 to 11/11/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the patient was hospitalized on 11/10/14 after the morning visit from the agency nurse, and remained hospitalized through 11/12/14, but the medication administration record

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(MAR) for the month of November 2014 indicated that the visiting nurse signed off for administering the 9:00 p.m. medications to the patient on 11/10/14 and 11/11/14, and failed to identify accurate and authentic nursing documentation for medication administration.

- d. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration.

Interview and review of the evening nursing visit note dated 11/06/14 P.M., the medication administration record (MAR) for the month of November 2014 and the "missed visit documentation" dated 11/06/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the patient was not at home for the evening nursing visit on 11/06/14, yet the agency nurse documented on the MAR that the nurse administered the medications to the patient at 5:00 p.m. on 11/06/14; Interview and review of the PM nursing visit note dated 11/09/14 P.M., the November medication administration record (MAR) and missed visit documentation dated 11/09/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 identified that the patient was not home for the p.m. medication administration visit on 11/09/14; however, the agency nurse documented on the MAR that the medications were administered at 5:00 p.m. on 11/09/14.

- e. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician's orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring. The patient's medications included Lantus insulin 43 units subcutaneously in the evening, a sliding scale for Insulin coverage, Lasix, Plavix, Lisinopril, Aspirin, Folic Acid, Advair, Lovastatin, Spiriva, Gabapentin, Colace, Metformin, Coreg, Tylenol and Dulcolax.

During a joint visit on 11/19/14 at 9:30 a.m., RN #1 was observed pulling out unidentified pills from a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days' worth of the patient's medications in manila envelopes, and took the manila envelopes out to the patient's home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as

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administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days' worth of the patient's medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered. Review of the MAR for the month of November 2014 with RN #1 on 11/18/14 indicated that RN # 1 signed off ahead of time for administering the medications Folic Acid, Aspirin and Furosemide for 11/20/14 and 11/21/14, when the visits had not been conducted and the medications had not been administered, and failed to identify accurate and authentic documentation of medication administration.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- f. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain, and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer the morning medications and prepour the noon and evening medications for the patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

On 06/21/14, the patient was treated in the Emergency Department (ED) for altered mental status and released on 06/22/14. The interagency referral form (W-10 form) dated 06/22/14 included an increase in the frequency of skilled nursing visits to twice a day for medication administration and prepour, an increase in the home health aide hours to 14 hours per week, and the need for an appointment with the primary care physician to address concerns of overmedication.

Further hospital documentation identified a subsequent transfer to the Emergency Department (ED) on 06/25/14 at 11:11 p.m. for mental status changes, and a release from the ED on 06/26/14 with a diagnosis of opiate overdose.

Interview and review of the nursing documentation from 06/22/14 to 06/27/14 and the medication administration record (MAR) for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified the scheduling of nursing visits twice a day (morning and evening) for medication administration and prepour, but failed to identify documentation of nursing assessment during the evening nursing visits of 06/22/14, 06/23/14 and 06/24/14, although the evening medications were signed off as administered by the nurse on 06/22/14, 06/23/14

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and 06/24/14;

Although the nursing documentation indicated that the patient was hospitalized on 06/27/14 at 10:12 a.m., interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the visiting nurses signed off for administering the 5PM and 9PM doses of Morphine sulfate ER 100 mg and Hydromorphone 16 mg to the patient on 06/27/14 when the patient was not present at home;

Interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the nurses obtained several days worth of medications out of the agency office, and carried the medications in the car to administer to the patient each day, but once the patient was admitted to the hospital, some nurses returned the unidentified medications to the agency office while others continued to carry the medications in the car until the patient was discharged home from the hospital, and failed to identify an accurate, safe and secure system to store, sign off and administer the patient's medications on a daily basis;

- g. Patient # 9 was discharged from home care services on 06/27/14. Inspection of the agency medication cabinet on 12/11/14 with the Supervisor of Clinical Services (SCS) at 1:30PM indicated that Patient # 9's medications were still stored in the agency cabinet, and failed to identify disposal of the medications 30 days after the patient's discharge from service, in accordance with the agency policy;

Interview and review of the agency policy on Medication Disposal with the agency Administrator on 12/11/14 failed to identify instructions that reflected the guidelines established by the Connecticut Department of Energy and Environmental Protection on Disposal of Unwanted Medications [www.ct.gov/deep/medsdisposal](http://www.ct.gov/deep/medsdisposal) retrieved December 11, 2014;

Interview and review of the agency policy on Disposal of Controlled Drugs with the agency Administrator on 12/11/14 indicated that the staff would instruct the patient's family in proper disposal of the controlled substance, however inspection of the narcotic cabinet on 12/11/14 with the Supervisor of Clinical Services (SCS) identified the storage of narcotics of discharged patients in the narcotic cabinet located in the SCS office, and failed to identify disposal of the narcotics by the family in accordance with agency policies.

On 12/10/14, the Connecticut Department of Public Health requested an immediate action plan to address medication security and storage, controlled substance storage and reconciliation, accurate documentation of medication administration, disposal of medications and disposal of controlled substances.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D68 General Requirements (c) Professional Advisory Committee (2).

4. Based on review of clinical records, agency documentation and interview with agency personnel, for six of six patients (Patients #1, 3, 4, 6, 8 and 9) who required medication

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administration by the agency nurses, the Group of Professionals failed to adequately establish and review policies on medication management on an annual basis, which resulted in findings of Immediate Jeopardy. The findings include:

- a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week for medication administration and pre-pour, assessment of blood glucose, blood pressure and heart rate. The patient ' s medications included: Lisinopril, Metoprolol, Pantoprazole, Aspirin, Atorvastatin, Novolog insulin 60 units twice a day subcutaneously, Metformin and Singulair.

During a joint visit on 11/18/14 at 9:30 a.m. Registered Nurse (RN) #1 was observed pulling unidentified pills out of a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.

Interview and review of the nursing note dated 10/17/14 with the primary care nurse, (PCN) RN #1 and the SCS on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the Emergency Department and released on 10/16/14, however the nurses continued to sign off on 10/15/14 a.m. (while the patient was in the ED) for administering Lisinopril, Metoprolol, Pantoprazole, Aspirin, Novolog Insulin and Metformin and failed to identify accurate and authentic documentation of medication administration at the time the medications were actually administered to the patient.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken

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- out of the office in unlabeled containers) and failed to identify adequate policy to reflect the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.
- b. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety.

Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

The MAR identified medications scheduled for 6:30 a.m., 9:00 a.m., 12 noon, 4:00 p.m., 5 p.m., 6:30 p.m. and many other medications to be taken on "as-needed" basis. Although the surveyor observed that the nurse only administered the 9AM medications, the MAR identified the nurse's signature throughout all the medications listed, for all doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Interview and review of the Medication Administration Records (MAR) with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the

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right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

The medication profile rewritten on 11/05/14 included Tramadol 50 mgm every 12 hours as needed for pain.

The Medication Administration Records (MAR) for the months of September and October 2014 included Tramadol 50 mg 1 tablet every 12 hours as needed for pain.

Nursing documentation indicated that the visiting nurse left 2 tablets of Tramadol 50 mg with the patient during thirteen of the twenty-eight daily nursing visits in September 2014, and each of the twenty-nine daily visits in October 2014, and failed to reflect that the nurse actually administered the Tramadol to the patient each day as signed off in the MAR;

Interview and review of the medication administration record for the month of November 2014 with the Administrator and Supervisor of Clinical Services on 11/18/14 indicated that the nurse signed off ahead of time for having administered Tramadol 50 mgm 1 tablet every 12 hours to the patient from 11/01/14 through 11/21/14, although the home visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14, and failed to identify accurate and authentic documentation of the medication administration process;

Interview and review of the surveyor observation of the joint home visit with RN # 2 on 11/18/14 indicated that the nurse had previously signed off for administering the Tramadol but did not administer the two tablets of Tramadol to the patient on 11/18/14 (left the two tablets in a compartment of the patient's medication box) and failed to identify accurate documentation of the medication administration process versus pre-pouring process;

The physician's orders for the certification period of 09/10/14 to 11/08/14 included Oxycodone 15 mg by mouth three times a day.

A subsequent physician's order dated 10/13/14 directed the administration of Oxycodone 15 mg 1 tablet by mouth twice a day as needed.

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime).

The medication administration record for the month of October 2014 listed Oxycodone 15 mg by mouth three times a day as needed for breakthrough pain from 10/04/14 through 10/12/14, and the agency nurse initialed the medication as administered three times a day until 10/15/14.

Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify documentation for administering or pre-pouring Oxycodone for two days (10/13/14 and 10/14/14) and failed to identify nursing documentation of the patient's pain management during those

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two days without Oxycodone;

The medication administration record for the month of October 2014 subsequently listed Oxycodone 15 mg by mouth twice a day as needed for breakthrough pain starting 10/16/14, and the agency nurse initialed the medication as administered twice a day. Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate implementation of the physician's order dated 10/13/14 for Oxycodone twice a day (instead of three times a day) until 10/16/14, three days later;

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime) and the agency nurse signed off on each dose as administered when in fact the nurse acknowledged on 11/18/14 visiting the patient only once a day, to administer one morning dose and leave the two remaining doses for the day in a compartment of the medication box, with no follow-up on the amount of tablets the patient needed after the nurse left, and/or documented outcome of the intake of the as-needed doses.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

The medication administration record (MAR) for the month of November 2014 included Oxycodone 15 mg by mouth twice a day and review of the November 2014 MAR indicated that the nurse signed off ahead of time for administering two Oxycodone tablets a day prior to the completion of the visits on 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Observation during a joint visit on 11/18/14 indicated that the nurse left two tablets of Oxycodone in a compartment of the patient's medication box, did not administer any Oxycodone, but had signed off ahead of time from the agency office for administering two doses of Oxycodone to the patient on 11/18/14.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

- c. Patient #4 had a start of care date of 09/29/14 and diagnoses that included end-stage renal disease, hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic

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adenocarcinoma, and chronic obstructive pulmonary disease. Physician ' s orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day for medication administration and prepouring of noon medications, assessment of daily vital signs and blood glucose twice a day.

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals and Gabapentin 100 mg by mouth three times a day.

Interview and review of the medication administration record (MAR) for the month of September 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurse pre-poured the noon dose of Renvela and Gabapentin, but signed off in the MAR as administering the Renvela and Gabapentin at noon although the nurse was not in the patient's home at noon, and failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Physician ' s orders for the certification period of 09/29/14 to 11/26/14 included Albuterol inhaler 90 mcg 1 puff every 8 hours, and Symbicort 80 mcg/4.5 mcg actuation aerosol 2 puffs twice a day.

The patient was hospitalized on 10/17/14 with shortness of breath, hypoxia and oxygen saturation in the 70 ' s prior to completing a hemodialysis treatment. The patient was discharged from the hospital on 10/30/14 with diagnoses of acute hypoxic respiratory failure and pneumonia. The inter-agency referral (W10) form from the hospital included orders for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater than 90%, Simethicone chewable tablet 80 mg by mouth twice a day, and Renvela 2400 mg by mouth three times a day.

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed pulling unidentified pills from an envelope without the benefit of using the pharmacy bottles and MAR to verify the medications prior to administration. In addition, the nurse left an unidentified pill in the patient's medication box, called it "the noon dose of Renvela," but had previously signed off from the agency office for administering, not pre-pouring the noon dose of Renvela.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified that on 11/18/14 the agency nurses were allowed to sign off ahead of time as administering medications three times a day through 5 p.m. on 11/21/14 although the nursing visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14. The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov)

<<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right

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patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the nursing documentation from 11/10/14 to 11/11/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the patient was hospitalized on 11/10/14 after the morning visit from the agency nurse, and remained hospitalized through 11/12/14, but the medication administration record (MAR) for the month of November 2014 indicated that the visiting nurse signed off for administering the 9:00 p.m. medications to the patient on 11/10/14 and 11/11/14, and failed to identify accurate and authentic nursing documentation for medication administration.

- d. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration.

Interview and review of the evening nursing visit note dated 11/06/14 P.M., the medication administration record (MAR) for the month of November 2014 and the "missed visit documentation" dated 11/06/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the patient was not at home for the evening nursing visit on 11/06/14, yet the agency nurse documented on the MAR that the nurse administered the medications to the patient at 5:00 p.m. on 11/06/14; Interview and review of the PM nursing visit note dated 11/09/14 P.M., the November medication administration record (MAR) and missed visit documentation dated 11/09/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 identified that the patient was not home for the p.m. medication administration visit on 11/09/14; however, the agency nurse documented on the MAR that the medications were administered at 5:00 p.m. on 11/09/14.

- e. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician's orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring. The patient's medications included Lantus insulin 43 units subcutaneously in the evening, a sliding scale for Insulin coverage, Lasix, Plavix, Lisinopril, Aspirin, Folic Acid, Advair, Lovastatin, Spiriva, Gabapentin, Colace, Metformin, Coreg, Tylenol and Dulcolax.

During a joint visit on 11/19/14 at 9:30 a.m., RN #1 was observed pulling out unidentified pills from a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days' worth of the patient's medications in manila envelopes, and took the manila envelopes out to the patient's home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time

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of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days' worth of the patient's medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.

Review of the MAR for the month of November 2014 with RN #1 on 11/18/14 Folic Acid, Aspirin and Furosemide for 11/20/14 and 11/21/14, when the visits had not been conducted and the medications had not been administered, and failed to identify accurate and authentic documentation of medication administration.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- f. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain, and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer the morning medications and prepour the noon and evening medications for the patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

On 06/21/14, the patient was treated in the Emergency Department (ED) for altered mental status and released on 06/22/14. The interagency referral form (W-10 form) dated 06/22/14 included an increase in the frequency of skilled nursing visits to twice a day for medication administration and prepour, an increase in the home health aide hours to 14 hours per week, and the need for an appointment with the primary care physician to address concerns of overmedication.

Further hospital documentation identified a subsequent transfer to the Emergency Department (ED) on 06/25/14 at 11:11 p.m. for mental status changes, and a release from the ED on 06/26/14 with a diagnosis of opiate overdose.

Interview and review of the nursing documentation from 06/22/14 to 06/27/14 and the medication administration record (MAR) for the month of June 2014 with the

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Administrator and the Supervisor of Clinical Services on 11/20/14 identified the scheduling of nursing visits twice a day (morning and evening) for medication administration and prepour, but failed to identify documentation of nursing assessment during the evening nursing visits of 06/22/14, 06/23/14 and 06/24/14, although the evening medications were signed off as administered by the nurse on 06/22/14, 06/23/14 and 06/24/14;

Although the nursing documentation indicated that the patient was hospitalized on 06/27/14 at 10:12 a.m., interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the visiting nurses signed off for administering the 5PM and 9PM doses of Morphine sulfate ER 100 mg and Hydromorphone 16 mg to the patient on 06/27/14 when the patient was not present at home;

Interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the nurses obtained several days worth of medications out of the agency office, and carried the medications in the car to administer to the patient each day, but once the patient was admitted to the hospital, some nurses returned the unidentified medications to the agency office while others continued to carry the medications in the car until the patient was discharged home from the hospital, and failed to identify an accurate, safe and secure system to store, sign off and administer the patient's medications on a daily basis.

On 12/10/14, the Connecticut Department of Public Health requested an immediate action plan to address medication security and storage, controlled substance storage and reconciliation, accurate documentation of medication administration, disposal of medications and disposal of controlled substances.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D73 Patient Care Plan (b).

5. Based on review of clinical record and interview with agency personnel, for five of five patients (Patients #1, #2, #7, #8 and # 10) with specific orders for medication administration, blood pressure and blood glucose monitoring, the agency nurses failed to follow the physician ' s orders and/or failed to notify the physician of alterations of the physician ' s orders. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma, and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week, for medication administration and/or pre-pouring, assessment of blood glucose, blood pressure (BP) and heart rate at each visit. Interview and review of the nursing notes for the period of 09/18/14 to 11/15/14 with the Administrator on 11/20/14 at 3:20 p.m. failed to identify documentation of blood pressure and heart rate on 14 visits and/or notification to the physician of the omissions; Interview and review of the nursing notes for the period of 09/18/14 to 11/15/14 with the

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Administrator on 11/20/14 at 3:20 p.m. indicated that the patient declined blood glucose monitoring on 10/04/14 and 11/03/14, but failed to identify nursing notification to the physician of the patient's declination;

Interview with the Administrator on 11/20/14 at 3:20 p.m. failed to identify agency policies and/or guidelines to notify the physician of alterations in the plan of care.

- b. Patient #2 had a start of care date of 04/18/11 and diagnoses that included bipolar disorder and psychotic disorder. Physician's orders for the period of 09/29/14 to 11/27/14 included skilled nursing services five days a week for administration of the morning medications, pre-pouring of noontime, bedtime and weekend medications, and assessment of blood pressure and heart rate at each visit.

Interview and review of the nursing notes from 09/29/14 to 11/27/14 with the Supervisor of Clinical Services (SCS) on 11/20/14 at 3:00 pm failed to identify documentation of blood pressure monitoring on 13 nursing visits, failed to identify documentation of heart rate monitoring on 25 nursing visits, and/or failed to identify nursing notification to the physician of the omissions.

- c. Patient #7 had a start of care date was 08/06/12 and diagnoses included cerebral palsy and incontinence. Physician's orders for the certification periods of 07/27/14 through 11/21/14 included skilled nursing visits once for the 60 day recertification and twice a month for home health aide supervision and patient assessments.

Interview and review of the nursing documentation for the period of 09/23/14 to 11/15/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify a nursing visit since 09/23/14 and/or nursing notification to the physician of the alteration in the plan of care.

- d. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of right great toe, below-the-knee amputation of the left leg, and hypertension. Physician's orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose monitoring, blood pressure (BP) and heart rate monitoring. The sliding scale for Insulin coverage included 12 units of Humalog Insulin for a blood glucose value greater than 400mmHg and nursing notification to the physician.

Interview and review of the nursing notes for the period of 09/16/14 to 11/14/14 with the Supervisor of Clinical Services (SCS) and the agency Administrator on 11/20/14 at 9:30 a.m. failed to identify a morning nursing visit for medication administration on 09/16/14, 09/17/14, 09/18/14, 09/19/14, 10/06/14, 10/13/14, 10/15/14, failed to identify an evening visit for medication administration on 09/21/14 and 10/08/14 and/or nursing notification to the physician of the missed nursing visits;

Interview and review of the nursing notes for the period of 09/16/14 to 11/14/14 with the Supervisor of Clinical Services (SCS) and the Administrator on 11/20/14 at 9:30 a.m. failed to identify documentation of blood glucose monitoring on 10/05/14, 10/13/14, 10/16/14, 10/17/14, 10/23/14, 10/30/14, 11/01/14, 11/08/14, 11/12/14 and/or nursing notification to the physician of the omission.

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- e. Patient #10 had a start of care date of 03/12/12 and diagnoses that included chronic pain syndrome, recurrent depression with psychosis, borderline personality disorder, fibromyalgia and hemarthrosis. Physician ' s orders for the period of 10/28/14 to 12/26/14 included weekly skilled nursing services for medication management and assessment of blood pressure and heart rate at each visit.  
Interview and review of the nursing notes with the Supervisor of Clinical Services (SCS) on 11/20/14 at 3:00 p.m. failed to identify documentation of blood pressure or heart rate on 11/06/14 and/or nursing notification to the physician of the omission.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D73 Patient Care Plan (a).

6. Based on review of clinical record and interview with agency personnel, for two of three patients (Patients #1 and # 2) who required cardiopulmonary and/or blood glucose monitoring, the agency nurses failed to ensure the physician ' s orders included parameters for reporting. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma, and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week, for medication administration and/or pre-pouring, assessment of blood glucose, blood pressure (BP) and heart rate at each visit.  
Interview and review of the physician ' s orders for the period of 09/18/14 to 11/15/14 with the Administrator on 11/20/14 at 3:20 p.m. failed to identify parameters in blood pressure, heart rate and/or blood glucose for physician notification.
  - b. Patient #2 had a start of care date of 04/18/11 and diagnoses that included bipolar disorder and psychotic disorder. Physician ' s orders for the period of 09/29/14 to 11/27/14 included skilled nursing services five days a week for medication administration and assessment of blood pressure (BP) and heart rate at each visit.  
Interview and review of the physician ' s orders with the Administrator on 11/20/14 at 3:20 p.m. failed to identify parameters in blood pressure and heart rate for physician notification.  
As a result, the nursing visit notes identified elevated blood pressures on 10/20/14 (BP = 158/98), on 10/21/14 (BP = 143/92), on 10/22/14 (BP = 147/101), on 10/24/14 (BP = 161/98), on 10/29/14 (BP = 159/96), on 10/30/14 (BP = 146/98) and on 10/31/14 (BP = 142/98) but no nursing notification was made to the physician. According to the American Heart Association [www.heart.org](http://www.heart.org) <<http://www.heart.org>> retrieved on 12/01/14, normal systolic blood pressure should be less than 120mmHg (millimeters of mercury) and normal diastolic blood pressure should be less than 80mmHg.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (1).

7. Based on review of clinical records, agency documentation and interview with agency personnel, for six of six patients (Patients #1, 3, 4, 6, 8 and 9) who required daily medication administration by the agency nurses, the nurses failed to demonstrate a safe process of medication administration each day, which resulted in findings of Immediate Jeopardy. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week for medication administration and pre-pour of Sunday medications, assessment of blood glucose, blood pressure and heart rate. The patient ' s medications included: Lisinopril, Metoprolol, Pantoprazole, Aspirin, Atorvastatin, Novolog insulin 60 units twice a day subcutaneously, Metformin and Singulair.  
During a joint visit on 11/18/14 at 9:30 a.m. Registered Nurse (RN) #1 was observed pulling unidentified pills out of a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.  
The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;  
Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.  
Interview and review of the nursing note dated 10/17/14 with the primary care nurse, (PCN) RN #1 and the SCS on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the Emergency Department and released on 10/16/14, however the nurses continued to sign off on 10/15/14 a.m.

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(while the patient was in the ED) for administering Lisinopril, Metoprolol, Pantoprazole, Aspirin, Novolog Insulin and Metformin and failed to identify accurate and authentic documentation of medication administration at the time the medications were actually administered to the patient.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to identify adequate policy to reflect the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration; Interview and review of the nursing note dated 09/18/14 with the agency Administrator on 12/11/14 identified nursing documentation of the patient's forgetfulness with medication taking, nursing observation that medications pre-poured for Sunday were taken by the patient, and failed to identify further plan to expand the patient's practice of taking pre-poured medications when the patient was successful in self-administration of pre-poured medications, versus continuing to administer medications to the patient six times a week.

- b. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety.

Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included daily nursing administration of the morning medications and prepouring of noon, 4 p.m., 9 p.m. and 6 a.m. medications for the patient to self-administer.

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

The MAR identified medications scheduled for 6:30 a.m., 9:00 a.m., 12 noon, 4:00 p.m., 5 p.m., 6:30 p.m. and many other medications to be taken on "as-needed" basis.

Although the surveyor observed that the nurse only administered the 9AM medications, the MAR identified the nurse's signature throughout all the medications listed, for all the doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Interview and review of the Medication Administration Records (MAR) with the

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Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

The medication profile rewritten on 11/05/14 included Tramadol 50 mgm every 12 hours as needed for pain.

The Medication Administration Records (MAR) for the months of September and October 2014 included Tramadol 50 mg 1 tablet every 12 hours as needed for pain.

Nursing documentation indicated that the visiting nurse left 2 tablets of Tramadol 50 mg with patient during thirteen of the twenty-eight daily nursing visits in September 2014, and each of the twenty-nine daily visits in October 2014, and failed to reflect that the nurse actually administered the Tramadol to the patient each day as signed off in the MAR;

Interview and review of the medication administration record for the month of November 2014 with the Administrator and Supervisor of Clinical Services on 11/18/14 indicated that the nurse signed off ahead of time for having administered Tramadol 50 mgm 1 tablet every 12 hours to the patient from 11/01/14 through 11/21/14, although the home visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14, and failed to identify accurate and authentic documentation of the medication administration process;

Interview and review of the surveyor observation of the joint home visit with RN # 2 on 11/18/14 indicated that the nurse had previously signed off for administering the Tramadol but did not administer the two tablets of Tramadol to the patient on 11/18/14 (left the two tablets in a compartment of the patient's medication box) and failed to identify accurate documentation of the medication administration process versus pre-pouring process;

The physician's orders for the certification period of 09/10/14 to 11/08/14 included

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Oxycodone 15 mg by mouth three times a day.

A subsequent physician's order dated 10/13/14 directed the administration of Oxycodone 15 mg 1 tablet by mouth twice a day as needed.

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime).

The medication administration record for the month of October 2014 listed Oxycodone 15 mg by mouth three times a day as needed for breakthrough pain from 10/04/14 through 10/12/14, and the agency nurse initialed the medication as administered three times a day until 10/15/14.

Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify documentation for administering or pre-pouring Oxycodone for two days (10/13/14 and 10/14/14) and failed to identify nursing documentation of the patient's pain management during those two days without Oxycodone;

The medication administration record for the month of October 2014 subsequently listed Oxycodone 15 mg by mouth twice a day as needed for breakthrough pain starting 10/16/14, and the agency nurse initialed the medication as administered twice a day.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate implementation of the physician's order dated 10/13/14 for Oxycodone twice a day (instead of three times a day) until 10/16/14, three days later;

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime) and the agency nurse signed off on each dose as administered when in fact the nurse acknowledged on 11/18/14 visiting the patient only once a day, to administer one morning dose and leave the two remaining doses for the day in a compartment of the medication box, with no follow-up on the amount of tablets the patient needed after the nurse left, and/or documented outcome of the intake of the as-needed doses.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

The medication administration record (MAR) for the month of November 2014 included Oxycodone 15 mg by mouth twice a day and review of the November 2014 MAR indicated that the nurse signed off ahead of time for administering two Oxycodone tablets a day prior to the completion of the visits on 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

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The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Observation during a joint visit on 11/18/14 indicated that the nurse left two tablets of Oxycodone in a compartment of the patient's medication box, did not administer any Oxycodone, but had signed off ahead of time from the agency office for administering two doses of Oxycodone to the patient on 11/18/14.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Interview and review of the physician's orders and nursing notes dated 09/10/14 with the agency Administrator on 12/11/14 identified nursing documentation that the nurse was to hold the patient's medications, specifically narcotics and benzodiazepines to ensure safety of medications, that in the past the patient's family members had stolen medications, leaving the patient under medicated, yet the nurse visited each morning to administer the morning medications, and left behind the doses for 4PM, 9PM and 6AM for the patient to self-administer, and failed to identify a safe system to secure medications and ensure proper administration of all doses to the patient.

- c. Patient #4 had a start of care date of 09/29/14 and diagnoses that included end-stage renal disease, hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic adenocarcinoma, and chronic obstructive pulmonary disease. Physician 's orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day for medication administration and prepouring of noon medications, assessment of daily vital signs and blood glucose twice a day.

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals and Gabapentin 100 mg by mouth three times a day.

Interview and review of the medication administration record (MAR) for the month of September 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurse pre-poured the noon dose of Renvela and Gabapentin, but signed off in the MAR as administering the Renvela and Gabapentin at noon although the nurse was not in the patient's home at noon, and failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Physician 's orders for the certification period of 09/29/14 to 11/26/14 included Albuterol inhaler 90 mcg 1 puff every 8 hours, and Symbicort 80 mcg/4.5 mcg actuation aerosol 2 puffs twice a day.

The patient was hospitalized on 10/17/14 with shortness of breath, hypoxia and oxygen saturation in the 70 's prior to completing a hemodialysis treatment. The patient was discharged from the hospital on 10/30/14 with diagnoses of acute hypoxic respiratory failure and pneumonia. The inter-agency referral (W10) form from the hospital included orders for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater

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than 90%, Simethicone chewable tablet 80 mg by mouth twice a day, and Renvela 2400 mg by mouth three times a day.

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed pulling unidentified pills from an envelope without the benefit of using the pharmacy bottles and MAR to verify the medications prior to administration. In addition, the nurse left an unidentified pill in the patient's medication box, called it "the noon dose of Renvela," but had previously signed off from the agency office for administering, not pre-pouring the noon dose of Renvela.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified that on 11/18/14 the agency nurses were allowed to sign off ahead of time as administering medications three times a day through 5 p.m. on 11/21/14 although the nursing visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14. The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the nursing documentation from 11/10/14 to 11/11/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the patient was hospitalized on 11/10/14 after the morning visit from the agency nurse, and remained hospitalized through 11/12/14, but the medication administration record (MAR) for the month of November 2014 indicated that the visiting nurse signed off for administering the 9:00 p.m. medications to the patient on 11/10/14 and 11/11/14, and failed to identify accurate and authentic nursing documentation for medication administration;

Interview and review of the nursing documentation dated 09/29/14 indicated that the patient was "totally unable" to self-administer medications, that the nurse was to monitor and assess for use of illicit drugs and misuse of prescription medications, that the visiting nurse saw the patient in the morning, pre-poured the noon doses of medication and left those behind for the patient to self-administer, and failed to identify safe administration, storage and/or pre-pouring of medications.

- d. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration. A nursing summary dated 10/23/14 identified the inability to manage medications.

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Interview and review of the evening nursing visit note dated 11/06/14 P.M., the medication administration record (MAR) for the month of November 2014 and the "missed visit documentation" dated 11/06/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the patient was not at home for the evening nursing visit on 11/06/14, yet the agency nurse documented on the MAR that the nurse administered the medications to the patient at 5:00 p.m. on 11/06/14; Interview and review of the PM nursing visit note dated 11/09/14 P.M., the November medication administration record (MAR) and missed visit documentation dated 11/09/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 identified that the patient was not home for the p.m. medication administration visit on 11/09/14; however, the agency nurse documented on the MAR that the medications were administered at 5:00 p.m. on 11/09/14.

- e. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring. The patient ' s medications included Lantus insulin 43 units subcutaneously in the evening, a sliding scale for Insulin coverage, Lasix, Plavix, Lisinopril, Aspirin, Folic Acid, Advair, Lovastatin, Spiriva, Gabapentin, Colace, Metformin, Coreg, Tylenol and Dulcolax.

During a joint visit on 11/19/14 at 9:30 a.m., RN #1 was observed pulling out unidentified pills from a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered; Review of the MAR for the month of November 2014 with RN #1 on 11/18/14 indicated

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that RN # 1 signed off ahead of time for administering the medications Folic Acid, Aspirin and Furosemide for 11/20/14 and 11/21/14, when the visits had not been conducted and the medications had not been administered, and failed to identify accurate and authentic documentation of medication administration;

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration;

Interview and review of the nursing documentation with the agency Administrator on 12/11/14 failed to identify documentation of reasons to support holding the patient's medications in the agency office;

Interview and review of the nursing documentation with the agency Administrator on 12/11/14 failed to identify documentation of an assessment of the patient's ability to self-medicate and/or self-administer pre-poured medications, and/or documentation of reasons to support the need to administer medications to the patient twice a day.

- f. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain, and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer the morning medications and prepour the noon and evening medications for the patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

On 06/21/14, the patient was treated in the Emergency Department (ED) for altered mental status and released on 06/22/14. The interagency referral form (W-10 form) dated 06/22/14 included an increase in the frequency of skilled nursing visits to twice a day for medication administration and prepour, an increase in the home health aide hours to 14 hours per week, and the need for an appointment with the primary care physician to address concerns of overmedication.

Further hospital documentation identified a subsequent transfer to the Emergency Department (ED) on 06/25/14 at 11:11 p.m. for mental status changes, and a release from the ED on 06/26/14 with a diagnosis of opiate overdose.

Interview and review of the nursing documentation from 06/22/14 to 06/27/14 and the medication administration record (MAR) for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified the scheduling of nursing visits twice a day (morning and evening) for medication administration and prepour, but failed to identify documentation of nursing assessment during the evening nursing visits of 06/22/14, 06/23/14 and 06/24/14, although the evening medications were signed off as administered by the nurse on 06/22/14, 06/23/14 and 06/24/14;

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Although the nursing documentation indicated that the patient was hospitalized on 06/27/14 at 10:12 a.m., interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the visiting nurses signed off for administering the 5PM and 9PM doses of Morphine sulfate ER 100 mg and Hydromorphone 16 mg to the patient on 06/27/14 when the patient was not present at home;

Interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the nurses obtained several days worth of medications out of the agency office, and carried the medications in the car to administer to the patient each day, but once the patient was admitted to the hospital, some nurses returned the unidentified medications to the agency office while others continued to carry the medications in the car until the patient was discharged home from the hospital, and failed to identify an accurate, safe and secure system to store, sign off and administer the patient's medications on a daily basis, and/or an agency policy on the tracking and reconciliation of narcotics, disposal of medications and disposal of narcotics;

Interview and review of a nursing note dated 02/17/13 with the agency Administrator on 12/11/14 identified nursing documentation that Patient # 9 was capable of storing medications properly, yet the agency held the patient's medications in the agency office with no documented reasons.

On 12/10/14, the Connecticut Department of Public Health requested an immediate action plan to address medication security and storage, controlled substance storage and reconciliation, accurate documentation of medication administration, disposal of medications and disposal of controlled substances.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (D).

8. Based on review of clinical record and interview with agency personnel, for two of three patients (Patients # 1 and 9) with a change in condition, the agency registered nurses (RN) failed to provide the necessary assessments. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma, and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day six days a week for medication administration and/or pre-pouring, assessment of blood glucose, blood pressure and heart rate at each visit. Interview and review of the nursing note dated 10/17/14 with the Primary Care Nurse (PCN) RN #1 on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the ED where the patient remained in observation for two days, but failed to identify an RN assessment of the patient upon return to the home on 10/16/14, after a significant change in condition. Instead, the patient received a home visit from the Licensed Practical Nurse (LPN) on 10/16/14;

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Interview and review of the nursing note dated 11/05/14 with RN #1 on 11/19/14 at 2:00 p.m. indicated that the patient reported to RN having had a pacemaker implanted on 11/04/14, and failed to identify a nursing assessment by RN # 1 of the patient after the pacemaker implant;

Interview and review of the agency policies and procedures with the Administrator on 11/20/14 at 3:20 p.m. failed to identify policies and procedures on RN assessment.

- b. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer morning medication administration and to prepour the noon and evening medications for patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

The nurse's notes dated 06/21/14 and 06/22/14 indicated that the patient was transferred to the hospital for altered mental status on 06/21/14 during the morning home visit.

The ambulance service report dated 06/21/14 indicated that the ambulance personnel arrived to the patient's home at 10:33 a.m., and noticed an "apartment very unkept."

The Emergency Department (ED) documentation dated 06/21/14 included assessment of a "patient unkept, feet caked with dried stool and dried stool on buttocks, a red wound with white discharge on abdominal skin fold and two red scabs on back".

An Emergency Department (ED) progress note dated 06/22/14 at 1:30 p.m. indicated that the ED staff contacted RN # 3 at the home care agency to request an increase in skilled nursing visits to twice a day for medication prepour, and to increase home health aide hours to 14 hours per week.

The hospital inter-agency referral form (W10) dated 06/22/14 included orders to increase skilled nursing visits to twice a day for medication prepour, to increase home health aide hours to 14 hours per week, and included the need for an appointment with the primary care provider to address concerns of overmedication.

Interview and review of the nursing visit note dated 06/22/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that home care services were resumed by Licensed Practical Nurse (LPN) # 1 between 5:45PM and 6PM for medication administration, that LPN # 1 documented "visible skin intact," failed to identify an RN assessment upon the patient's return from the hospital with a change in condition, failed to identify a comprehensive assessment of the patient's skin condition to include body hygiene and open areas on abdomen and back, and failed to indicate that the RN initiated a social work referral to address the patient's housing condition.

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

9. Based on review of clinical record and interview with agency personnel, for one of three

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patients (Patient # 9) with a change in condition, the agency registered nurse (RN) failed to revise the plan of care to address the patient's needs. The findings include:

- a. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer morning medication administration and to prepour the noon and evening medications for patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

The nurse's notes dated 06/21/14 and 06/22/14 indicated that the patient was transferred to the hospital for altered mental status on 06/21/14 during the morning home visit.

The ambulance service report dated 06/21/14 indicated that the ambulance personnel arrived to the patient's home at 10:33 a.m., and noticed an "apartment very unkept." The Emergency Department (ED) documentation dated 06/21/14 included assessment of a "patient unkept, feet caked with dried stool and dried stool on buttocks, a red wound with white discharge on abdominal skin fold and two red scabs on back".

An Emergency Department (ED) progress note dated 06/22/14 at 1:30 p.m. indicated that the ED staff contacted RN # 3 at the home care agency to request an increase in skilled nursing visits to twice a day for medication prepour, and to increase home health aide hours to 14 hours per week.

The hospital inter-agency referral form (W10) dated 06/22/14 included orders to increase skilled nursing visits to twice a day for medication prepour, to increase home health aide hours to 14 hours per week, and included the need for an appointment with the primary care provider to address concerns of overmedication.

Interview and review of the nursing visit note dated 06/22/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that home care services were resumed by Licensed Practical Nurse (LPN) # 1 between 5:45PM and 6PM for medication administration, that LPN # 1 documented "visible skin intact," failed to identify an RN assessment upon the patient's return from the hospital with a change in condition, failed to identify a comprehensive assessment of the patient's skin condition to include body hygiene and open areas on abdomen and back, and failed to indicate that the RN initiated a social work referral to address the patient's housing condition.

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

10. Based on review of clinical record and interview with agency personnel, for one of one patient (Patient # 9) who required a comprehensive skin assessment after discharge from the Emergency Department (ED), the agency Registered Nurse (RN) failed to provide the necessary assessments. The findings include:
  - a. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex

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sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer morning medication administration and to prepour the noon and evening medications for patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

The nurse's notes dated 06/21/14 and 06/22/14 indicated that the patient was transferred to the hospital for altered mental status on 06/21/14 during the morning home visit.

The ambulance service report dated 06/21/14 indicated that the ambulance personnel arrived to the patient's home at 10:33 a.m., and noticed an "apartment very unkept." The Emergency Department (ED) documentation dated 06/21/14 included assessment of a "patient unkept, feet caked with dried stool and dried stool on buttocks, a red wound with white discharge on abdominal skin fold and two red scabs on back".

An Emergency Department (ED) progress note dated 06/22/14 at 1:30 p.m. indicated that the ED staff contacted RN # 3 at the home care agency to request an increase in skilled nursing visits to twice a day for medication prepour, and to increase home health aide hours to 14 hours per week.

The hospital inter-agency referral form (W10) dated 06/22/14 included orders to increase skilled nursing visits to twice a day for medication prepour, to increase home health aide hours to 14 hours per week, and included the need for an appointment with the primary care provider to address concerns of overmedication.

Interview and review of the nursing visit note dated 06/22/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that home care services were resumed by Licensed Practical Nurse (LPN) # 1 between 5:45PM and 6PM for medication administration, that LPN # 1 documented "visible skin intact," failed to identify an RN assessment upon the patient's return from the hospital with a change in condition, and failed to identify a comprehensive assessment of the patient's skin condition to include body hygiene and open areas on abdomen and back.

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

11. Based on review of clinical record and interview with agency personnel, for one of three patients at risk for skin breakdown (Patient # 3), the agency Registered Nurse (RN) failed to implement the necessary preventive interventions. The findings include:
  - a. Patient # 3 had a start of care date of 07/17/2013 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety. Physician ' s orders for the certification period of 09/10/14 to 11/08/14 included skilled nursing services to administer morning medications and prepour noon, 4 p.m., and 9 p.m. and medication. A comprehensive assessment dated 11/05 14 identified total dependence to dress upper

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and lower body, inability to use shower or tub, ability to participate in bed bath or sink sponge bath with the assistance or supervision of another person, total dependence in toileting, bladder and bowel incontinence, ability to bear weight and pivot during transfer, inability to transfer self, ability to walk only with the supervision or assistance of another person at all times.

Interview and review of the nursing documentation with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified a Braden scale scoring of 17 (at risk for skin breakdown) dated 07/17/13 but failed to identify interpretation of the score and/or associated interventions;

Interview and review of the nursing documentation with the Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify subsequent Braden scale re-assessments since 07/17/13;

A joint visit on 11/18/14 with Registered Nurse (RN) #2 identified the use of an electric wheelchair with a pressure-relieving device in the home, and a hospital bed, but failed to identify the use of a pressure-relieving device on the hospital bed;

Interview and review of the agency policies and/or guidelines with the Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify policies and/or guidelines on skin assessment and/or interventions associated with Braden scale scoring.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (C) and/or 19-13-D72 Patient Care Plan (b).

12. Based on review of clinical record and interview with agency personnel, for three of three patients (Patients #1, 2 and 8) who required blood glucose monitoring and/or blood pressure monitoring, the Registered Nurse (RN) failed to notify the physician of abnormal findings, which resulted in findings of Immediate Jeopardy. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included Insulin dependent diabetes mellitus, hypertension, asthma, diabetic retinopathy and diabetic neuropathy. Physician 's orders for the period of 09/18/14 to 11/15/14 included skilled nursing twice a day six days a week for medication administration, pre-pour for one day, assessment of blood glucose, blood pressure and heart rate.  
Interview and review of the nursing visit notes with RN # 1 on 11/19/14 identified elevated blood glucose values on 10/06/14 (= 557 mg/dl), 11/07/14 (= 506 mg/dl), 11/08/14 (= 567 mg/dl), 11/12/14 (= 503 mg/dl) and 11/14/14 (= 523 mg/dl) and failed to identify nursing notification to the physician. According to the American Diabetes Association [www.diabetes.org](http://www.diabetes.org) <<http://www.diabetes.org>> retrieved on 12/01/14, normal pre-prandial plasma glucose (before meals) should be from 70 to 130mg/dl, and normal post-prandial plasma glucose should not exceed 180mg/dl;  
Interview and review of a nursing visit note dated 10/17/14 with the primary care nurse, (PCN) RN #1 on 11/19/14 at 2:00 p.m. indicated that the patient passed out at an office visit on 10/14/14, was transferred to the Emergency Department (ED) and discharged home from the ED after two days of observation on 10/16/14, but failed to identify

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nursing notification to the physician of the patient ' s change in condition and/or any necessary changes to the plan of care;

Interview and review of the nursing note dated 11/05/14 with RN #1 on 11/19/14 at 2:00 p.m. indicated that the patient reported having a pacemaker implanted on 11/04/14, but failed to identify nursing notification to the physician of the patient ' s change in condition and/or any necessary changes to the plan of care until the following visit five days later on 11/10/14.

- b. Patient #2 had a start of care date of 04/18/11 and diagnoses that included bipolar disorder and psychotic disorder. Physician ' s orders for the period of 09/29/14 to 11/27/14 included skilled nursing services five days a week for medication administration and assessment of blood pressure and heart rate at each visit. Interview and review of the nursing visit notes with RN #1 on 11/18/14 identified elevated blood pressures on 10/20/14 (= 158/98), on 10/21/14 (= 143/92), on 10/22/14 (= 147/101), on 10/24/14 (= 161/98), on 10/29/14 (= 159/96), on 10/30/14 (= 146/98) and on 10/31/14 (= 142/98) and failed to identify documentation of nursing notification to the physician. According to the American Heart Association [www.heart.org](http://www.heart.org) <<http://www.heart.org>> retrieved on 12/01/14, normal systolic blood pressure should be less than 120mmHg (millimeters of mercury) and normal diastolic blood pressure should be less than 80mmHg;

Interview and review of the agency policies and/or procedures with the Administrator on 11/20/14 at 3:20 p.m. failed to identify agency policies and/or procedures regarding nursing notification to the physician of changes in the patient ' s condition.

- c. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose monitoring with physician notification of blood glucose value exceeding 400mg/dl, blood pressure monitoring and heart rate monitoring. Interview and review of nursing notes with RN #1 on 11/18/14 at 2:00 p.m. failed to identify nursing notification to the physician of elevated blood glucose values on 10/06/14 (= 557 mg/dl), 11/07/14 (= 506 mg/dl), 11/08/14 (= 567 mg/dl), 11/12/14 (= 503 mg/dl), and 11/14/14 (= 523 mg/dl).

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (3)(H).

13. Based on review of clinical record and interview with agency personnel, for two of four patients (Patients #8 and #9) who required home health aide services, the agency registered nurses (RN) failed to ensure the home health aide carried a written plan of care and/or the written plan of care was available in the home for the aide. The findings include:
- a. Patient #8 had a start of care date of 07/24/13 and diagnoses that included

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insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring and home health aide services five times a week to assist with personal care.

During a joint home visit on 11/19/14 with the home health aide and RN #1, the aide was unable to produce a written plan of care upon surveyor ' s request, and the RN failed to identify a written plan of care for the home health aide in the patient ' s home.

- b. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification periods of 04/13/14 through 08/10/14 included daily skilled nursing visits to administer morning medications and to prepour the noon and evening medications for the patient to self-administer.

Subsequent physician's orders dated 04/22/14 included home health aide services 2 hours a day for personal care.

Interview and review of the nursing documentation and the aide documentation for the period of 05/05/14 to 06/27/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified home health aide services provided for 2 hours each day, four to five days a week from 05/12/14 to 06/27/14, but failed to identify a written plan of care for the home health aide.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (3)(F) and/or (H) and/or (J) and/or (d) Homemaker-Home Health Aide Services (3).

14. Based on review of clinical record and interview with agency personnel, for one of four patients (Patient #8) who required home health aide services, the home health aide failed to follow the plan of care. The findings include
- a. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring and home health aide services five times a week to assist with personal care.
- During a joint home visit on 11/19/14 with the home health aide and RN #1, the aide was unable to produce a written plan of care upon surveyor ' s request, and explained that the aide knew how to care for the patient, for having taken care of the patient for a long time. Interview and review of the aide documentation from 09/16/14 to 11/14/14 with RN #1 on 11/19/14 indicated that the aide provided baths, showers and light housekeeping, and failed to identify adherence to the home health aide plan of care (found in the patient ' s record in the agency) which did not include baths, showers and light housekeeping.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (a) Nursing Service (3)(G) and/or (H).

15. Based on clinical record review and staff interviews, for four of five patients (Patients #6, #7, #8 and #9) who required home health aide services, the agency registered nurse (RN) failed to supervise the home health aide every two weeks. The findings include:
  - a. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration and daily home health aide services for personal hygiene. Interview and review of the nursing documentation for the period of 09/27/14 to 11/15/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify RN supervision of the home health aide every two weeks.
  - b. Patient #7 had a start of care date of 08/06/12 and diagnoses that included cerebral palsy and incontinence. Physician's orders for the certification periods of 07/27/14 through 11/21/14 included home health aide services twice a day (to a total of 38.5 hours per week), physical therapy (PT) services, occupational therapy (OT) services and skilled nursing services once for the 60-day recertification and twice a month for home health aide supervision. Interview and review of the nursing documentation for the period 09/24/14 to 11/15/14, and the occupational therapy (OT) notes from 09/05/14 to 11/10/14 and the physical therapy (PT) notes from 09/02/14 to 10/25/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify RN, PT or OT supervision of the home health aide every two weeks.
  - c. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician's orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring and home health aide services five times a week to assist with personal care. Interview and review of the nursing documentation for the period of 09/16/14 to 11/14/14 with RN #1 on 11/19/14 failed to identify RN supervision of the home health aide every two weeks.
  - d. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification periods of 04/13/14 through 08/10/14 included daily skilled nursing visits to administer the morning medications and to prepour the noon and evening medications for patient to self administer. Physician's interim order dated 04/22/14 included home health aide services 2 hours a day for personal care. The nursing 60-day summary for both certification periods indicated that the patient continued to refuse a home health aide.

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Interview and review of the home health aide documentation and the nursing documentation for the period of 05/05/14 through 06/27/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the home health aides serviced the patient for 2 hours, four to five days a week from 05/12/14 to 06/27/14, that the RN failed to review the aide documentation thus was unaware of home health aide services being delivered, and the RN failed to provide supervision of the home health aide every two weeks.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D75 Clinical Record System (b)(6).

16. Based on review of clinical record and interview with agency personnel, for seven of ten patients in the survey sample (Patients #1, #2, # 3, # 4, # 6, # 8 and # 9) who required skilled nursing services, the agency staff failed to maintain accurate and/or authentic documentation. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week for medication administration and pre-pour, assessment of blood glucose, blood pressure and heart rate. The patient ' s medications included: Lisinopril, Metoprolol, Pantoprazole, Aspirin, Atorvastatin, Novolog insulin 60 units twice a day subcutaneously, Metformin and Singulair. During a joint visit on 11/18/14 at 9:30 a.m. Registered Nurse (RN) #1 was observed pulling unidentified pills out of a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration. The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prir to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several

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days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.

Interview and review of the nursing note dated 10/17/14 with the primary care nurse, (PCN) RN #1 and the SCS on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the Emergency Department and released on 10/16/14, however the nurses continued to sign off on 10/15/14 a.m. (while the patient was in the ED) for administering Lisinopril, Metoprolol, Pantoprazole, Aspirin, Novolog Insulin and Metformin and failed to identify accurate and authentic documentation of medication administration at the time the medications were actually administered to the patient.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to identify adequate policy to reflect the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- b. Patient #2 had a start of care date of 04/18/11 and diagnoses that included bipolar disorder and psychotic disorder. Physician 's orders for the period of 09/29/14 to 11/27/14 included skilled nursing services five days a week for medication administration and assessment of blood pressure and heart rate at each visit. The findings include:

Interview and review of the nursing notes dated 09/30/14, 10/01/14, 10/02/14 and 10/03/14 with Registered Nurse (RN) #1 on 11/19/14 at 2:30 p.m. identified the RN signature crossed out with an " X " , followed by RN # 1 ' s verbal explanation to the surveyor that RN # 1 did not visit the patient on those dates, had written nursing notes " in advance " (meaning prior to the day of the visit, except for the vital signs section which were left blank) then crossed out the signature to indicate that the visits were not made, and failed to identify accurate and authentic documentation of nursing visits at the actual time of the visits.

- c. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety.

Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

The MAR identified medications scheduled for 6:30 a.m., 9:00 a.m., 12 noon, 4:00 p.m., 5 p.m., 6:30 p.m. and many other medications to be taken on "as-needed" basis.

Although the surveyor observed that the nurse only administered the 9AM medications,

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the MAR identified the nurse's signature throughout all the medications listed, for all the doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Interview and review of the Medication Administration Records (MAR) with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

The medication profile rewritten on 11/05/14 included Tramadol 50 mgm every 12 hours as needed for pain.

The Medication Administration Records (MAR) for the months of September and October 2014 included Tramadol 50 mg 1 tablet every 12 hours as needed for pain.

Nursing documentation indicated that the visiting nurse left 2 tablets of Tramadol 50 mg with the patient during thirteen of the twenty-eight daily nursing visits in September 2014, and each of the twenty-nine daily visits in October 2014, and failed to reflect that the nurse actually administered the Tramadol to the patient each day as signed off in the MAR;

Interview and review of the medication administration record for the month of November 2014 with the Administrator and Supervisor of Clinical Services on 11/18/14 indicated that the nurse signed off ahead of time for having administered Tramadol 50 mgm 1 tablet every 12 hours to the patient from 11/01/14 through 11/21/14, although the home visits had not

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taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14, and failed to identify accurate and authentic documentation of the medication administration process;

Interview and review of the surveyor observation of the joint home visit with RN # 2 on 11/18/14 indicated that the nurse had previously signed off for administering the Tramadol but did not administer the two tablets of Tramadol to the patient on 11/18/14 (left the two tablets in a compartment of the patient's medication box) and failed to identify accurate documentation of the medication administration process versus pre-pouring process;

The physician's orders for the certification period of 09/10/14 to 11/08/14 included Oxycodone 15 mg by mouth three times a day.

A subsequent physician's order dated 10/13/14 directed the administration of Oxycodone 15 mg 1 tablet by mouth twice a day as needed.

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime).

The medication administration record for the month of October 2014 listed Oxycodone 15 mg by mouth three times a day as needed for breakthrough pain from 10/04/14 through 10/12/14, and the agency nurse initialed the medication as administered three times a day until 10/15/14.

Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify documentation for administering or pre-pouring Oxycodone for two days (10/13/14 and 10/14/14) and failed to identify nursing documentation of the patient's pain management during those two days without Oxycodone;

The medication administration record for the month of October 2014 subsequently listed Oxycodone 15 mg by mouth twice a day as needed for breakthrough pain starting 10/16/14, and the agency nurse initialed the medication as administered twice a day.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate implementation of the physician's order dated 10/13/14 for Oxycodone twice a day (instead of three times a day) until 10/16/14, three days later;

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime) and the agency nurse signed off on each dose as administered when in fact the nurse acknowledged on 11/18/14 visiting the patient only once a day, to administer one morning dose and leave the two remaining doses for the day in a compartment of the medication box, with no follow-up on the amount of tablets the patient needed after the nurse left, and/or documented outcome of the intake of the as-needed doses.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

The medication administration record (MAR) for the month of November 2014 included Oxycodone 15 mg by mouth twice a day and review of the November 2014 MAR indicated that the nurse signed off ahead of time for administering two Oxycodone tablets a day prior to the completion of the visits on 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

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The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Observation during a joint visit on 11/18/14 indicated that the nurse left two tablets of Oxycodone in a compartment of the patient's medication box, did not administer any Oxycodone, but had signed off ahead of time from the agency office for administering two doses of Oxycodone to the patient on 11/18/14.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

- d. Patient #4 had a start of care date of 09/29/14 and diagnoses that included end-stage renal disease, hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic adenocarcinoma, and chronic obstructive pulmonary disease. Physician 's orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day for medication administration and prepouring of noon medications, assessment of daily vital signs and blood glucose twice a day.

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals and Gabapentin 100 mg by mouth three times a day.

Interview and review of the medication administration record (MAR) for the month of September 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurse pre-poured the noon dose of Renvela and Gabapentin, but signed off in the MAR as administering the Renvela and Gabapentin at noon although the nurse was not in the patient's home at noon, and failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Physician 's orders for the certification period of 09/29/14 to 11/26/14 included Albuterol inhaler 90 mcg 1 puff every 8 hours, and Symbicort 80 mcg/4.5 mcg actuation aerosol 2 puffs twice a day.

The patient was hospitalized on 10/17/14 with shortness of breath, hypoxia and oxygen saturation in the 70 's prior to completing a hemodialysis treatment. The patient was discharged from the hospital on 10/30/14 with diagnoses of acute hypoxic respiratory failure and pneumonia. The inter-agency referral (W10) form from the hospital included orders for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater than 90%, Simethicone chewable tablet 80 mg by mouth twice a day, and Renvela 2400 mg by mouth three times a day.

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed pulling unidentified pills from an envelope without the benefit of using the pharmacy bottles and

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MAR to verify the medications prior to administration. In addition, the nurse left an unidentified pill in the patient's medication box, called it "the noon dose of Renvela," but had previously signed off from the agency office for administering, not pre-pouring the noon dose of Renvela.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified that on 11/18/14 the agency nurses were allowed to sign off ahead of time as administering medications three times a day through 5 p.m. on 11/21/14 although the nursing visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the nursing documentation from 11/10/14 to 11/11/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the patient was hospitalized on 11/10/14 after the morning visit from the agency nurse, and remained hospitalized through 11/12/14, but the medication administration record (MAR) for the month of November 2014 indicated that the visiting nurse signed off for administering the 9:00 p.m. medications to the patient on 11/10/14 and 11/11/14, and failed to identify accurate and authentic nursing documentation for medication administration.

- e. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration.

Interview and review of the evening nursing visit note dated 11/06/14 P.M., the "missed visit documentation" dated 11/06/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the patient was not at home for the evening nursing visit on 11/06/14, yet the agency nurse documented on the MAR that the nurse administered the medications to the patient at 5:00 p.m. on 11/06/14;

Interview and review of the PM nursing visit note dated 11/09/14 P.M., the November medication administration record (MAR) and missed visit documentation dated 11/09/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 identified that the patient was not home for the p.m. medication administration visit on 11/09/14; however, the agency nurse documented on the MAR that the medications were administered at 5:00 p.m. on 11/09/14.

- f. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe,

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below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring.

The patient ' s medications included Lantus insulin 43 units subcutaneously in the evening, a sliding scale for Insulin coverage, Lasix, Plavix, Lisinopril, Aspirin, Folic Acid, Advair, Lovastatin, Spiriva, Gabapentin, Colace, Metformin, Coreg, Tylenol and Dulcolax.

During a joint visit on 11/19/14 at 9:30 a.m., RN #1 was observed pulling out unidentified pills from a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration.

RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.

Review of the MAR for the month of November 2014 with RN #1 on 11/18/14 indicated that RN # 1 signed off ahead of time for administering the medications Folic Acid, Aspirin and Furosemide for 11/20/14 and 11/21/14, when the visits had not been conducted and the medications had not been administered, and failed to identify accurate and authentic documentation of medication administration.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- g. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer morning medication administration and to prepour the noon and evening medications for patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day,

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Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisprodol 350 mg by mouth four times a day.

The nurse's notes dated 06/21/14 and 06/22/14 indicated that the patient was transferred to the hospital for altered mental status on 06/21/14 during the morning home visit.

The hospital inter-agency referral form (W-10) dated 06/22/14 indicated that the patient was discharged home with an increase in the frequency of nursing services (from once a day to twice a day) to administer and prepour medications.

Although the Medication Administration Record (MAR) indicated that the nurses administered the morning medications and the evening medications on 06/22/14, 06/23/14 and 06/26/14, interview and review of the nursing notes with the agency Administrator and the Supervisor of Clinical Services on 11/20/14 failed to identify documentation of nursing assessments for the evening visits occurring on 06/22/14, 06/23/14 and 06/26/14 to support the implementation of nursing visits twice a day in accordance with the W-10 orders;

The hospital record indicated that the patient was hospitalized on 06/27/14 at 10:12AM, yet interview and review of the MAR with the agency Administrator and the Supervisor of Clinical Services on 11/20/14 identified documentation that Licensed Practical Nurse (LPN) # 1 administered medications to the patient on 06/27/14 at 5PM, when the patient was hospitalized and absent from the home, and failed to identify accurate and authentic documentation of nursing visits and medication administration;

Interview and review of the nursing notes from 06/16/14/through 06/20/14 with the agency Administrator and the Supervisor of Clinical Services on 11/20/14 identified nursing documentation on the front side of the page of nursing visits occurring from 06/16/14/through 06/20/14 from 9:00AM to 9:15AM, but the back side of the page (where nursing assessments corresponding to the visit dates should be documented) identified assessments made on 06/21/14 instead, and failed to identify accurate documentation of the nursing visits dates;

The ambulance report dated 06/27/14 indicated that the ambulance personnel responded to a call on 9:48AM, arrived to the patient's home at 9:53AM and found the patient unresponsive on a bench outside the home, surrounded by bystanders, and the patient acknowledged having taken morphine that morning.

However, interview and review of the nursing note dated 06/27/14 with the agency Administrator and the Supervisor of Clinical Services on 11/20/14 identified documentation by the nurse on 06/27/14 between 9:00AM and 9:15AM, that the nurse administered Dilaudid and Lorazepam to the patient, that the patient was hospitalized after being found outside the apartment with a fresh needle mark in the patient's arm, and failed to identify accuracy of timing and/or facts from the nurse's notes and/or signing off in the MAR; Interview and review of the aide documentation with the agency Administrator and the Supervisor of Clinical Services on 11/20/14 identified documentation that the aide provided services to the patient from 9:40AM to 11:40AM on 06/27/14, although the ambulance report indicated that the patient was found unresponsive outside the apartment on 06/27/14 at 9:53AM and transported to the hospital with an arrival time of 10:05AM on 06/27/14, and failed to identify accuracy and authenticity of the aide's documentation purporting to

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provide home care to a patient absent from the home and being admitted to the hospital.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D74 Administration of Medicines.

17. Based on review of clinical records, agency documentation and interview with agency personnel, for seven of seven patients (Patients #1, 3, 4, 5, 6, 8 and 9) who required medication management, the agency nurses failed to ensure accurate administration of medications, accurate and authentic documentation of medication administration, and the agency failed to ensure the development of adequate policies for medication reconciliation, administration and documentation. The findings include:
  - a. Patient #1 had a start of care date of 11/28/12 and diagnoses that included insulin-dependent diabetes mellitus, hypertension, asthma and diabetic neuropathy. Physician ' s orders for the period of 09/18/14 to 11/15/14 included skilled nursing services twice a day, six days a week for medication administration and pre-pour, assessment of blood glucose, blood pressure and heart rate. The patient ' s medications included: Lisinopril, Metoprolol, Pantoprazole, Aspirin, Atorvastatin, Novolog insulin 60 units twice a day subcutaneously, Metformin and Singulair. During a joint visit on 11/18/14 at 9:30 a.m. Registered Nurse (RN) #1 was observed pulling unidentified pills out of a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration. RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration. The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered. A nursing note dated 09/22/14 by a licensed practical nurse (LPN) indicated that Patient # 1 ' s next-of-kin presented the LPN with pre-colonoscopy instructions from the

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gastro-intestinal (GI) physician group for Patient # 1, including " no insulin/no Metformin on 09/24/14, hold Metformin on 09/23/14 at bedtime and only one half dose of Insulin of 30 units, resume orders once colonoscopy completed by 09/25/14, orders will be sent to the physician and primary care nurse notified. "

Interview and review of the LPN note with RN #1 on 11/19/14 at 2:30PM failed to identify awareness from RN # 1 of the orders, and/or failed to indicate that the LPN sought clarification of the orders with the patient ' s primary care physician (PCP).

As a result, review of the medication administration record (MAR) with RN #1 and the SCS indicated that Patient # 1 received Novolog Insulin 60 units on 09/23/14 and 09/24/14 in the evening, and 1000mg of on the evening of 09/23/14;

Interview and review of the medication profile for September 2014 with RN #1 and the SCS on 11/19/14 at 2:30PM failed to identify documentation of the pre-colonoscopy orders to hold the patient ' s medications;

Interview and review of the nursing note dated 10/17/14 with the primary care nurse, (PCN) RN #1 and the SCS on 11/19/14 at 2:00 p.m. indicated that the patient passed out during an office appointment on 10/14/14, was transferred to the Emergency Department and released on 10/16/14, however the nurses continued to sign off on 10/15/14 a.m. (while the patient was in the ED) for administering Lisinopril, Metoprolol, Pantoprazole, Aspirin, Novolog Insulin and Metformin and failed to identify accurate and authentic documentation of medication administration at the time the medications were actually administered to the patient.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to identify adequate policy to reflect the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- b. Patient # 3 had a start of care date of 07/17/13 and diagnoses that included traumatic brain injury, epilepsy, cerebrovascular accident with left arm paralysis and left leg weakness, depression and anxiety.

Physician ' s orders for the certification period from 09/10/14 to 11/08/14 included nursing administration of the morning medications and prepouring of noon, 4 p.m., and 9 p.m. medications.

The 60-day nursing summary indicated that the patient previously had orders for Lactulose twice a day, was seen in the Emergency Department (ED) for constipation during the previous recertification period (the previous 60 days), and as a result the frequency of Lactulose was increased to four times a day.

The patient's medications for the certification period from 09/10/14 to 11/08/14 therefore included Lactulose 15 to 30 milliliters (ml) four times a day as needed for constipation. However, interview and review of the medication profiles with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the medication profile was rewritten on 09/11/14 and 11/05/14 with Lactulose one to two times a day, and failed to identify nursing revision to the medication profiles to reflect the correct frequency of

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Lactulose as four times a day as needed;

The certified plan of care for the subsequent period of 11/08/14 to 01/06/15 included Lactulose, now listed as 15 to 30ml by mouth one to two times a day, with the nursing 60-day summary mentioning that the patient was taking Amitiza daily (a medication used to relieve abdominal pain, bloating and constipation). However, review of the physician's orders with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified a prescription dated 11/08/14 to refill Lactulose elixir and continue with dose as directed, and failed to identify accurate nursing reconciliation of the patient's medication frequency and status (as-needed versus standing or around-the-clock dose);

Interview and review of Medication Administration Record (MAR) for the months of September, October and November 2014 the Administrator and the Supervisor of Clinical Services on 11/20/14 identified nursing transcription of Lactinex "tabs" (tablets) 15 to 30ml (instead of Lactulose 15 to 30ml), indicated that Lactinex was a probiotic supplement, available only in the form of tablets or granules, not liquid, and failed to identify accurate transcription for three months of a liquid medication for constipation, transcribed instead as a probiotic supplement in a solid form, with no nursing reconciliation and/or oversight of the documentation of the patient's medication to identify errors;

During a joint home visit on 11/18/14, the surveyor observed Registered Nurse (RN) #2 administer the morning medications to the patient by pulling from a small envelope, unidentified pills, without the benefit of identifying those pills from the pharmacy bottle, and/or matching the pills to the physician's order or the Medication Administration Record (MAR);

p.m., 5 p.m., 6:30 p.m. and many other medications to be taken on "as-needed" basis. Although the surveyor observed that the nurse only administered the 9AM medications, the MAR identified the nurse's signature throughout all the medications listed, for all the doses and times listed, without the nurse witnessing the patient's intake of the medications, and/or knowing whether the patient would forget or decline to take the medications later on, or whether the patient might drop one pill on the floor or miss some of the pills left in the envelope.

The nurse was also observed leaving unidentified pills for the evening doses in medication planner, with unidentified tablets of narcotics in a separate container, and two tablets of each "as-needed" medication, without checking whether the patient took all the pre-poured medications from the day before, and/or checking how many of the "as-needed" medications the patient took the day before, and the outcome of the "as-needed" medications taken by the patient;

Interview and review of the Medication Administration Records (MAR) with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that on 11/18/14 the agency nurse had already signed off for administering all the medications to the patient, for all the medications due for 11/18/14, 11/19/14, 11/20/14, 11/21/14 and 11/22/14, including the 6:30 a.m. dose of Morphine Sulfate extended-release 15 mg for 11/22/14 (four and a half days ahead);

The agency policy on Medication Administration directed the holding of all medications in

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the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Physician's orders for the certification period of 09/10/14 to 11/08/14 included Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain and fever.

A physician prescription dated 11/08/14 directed the administration of Tramadol 50 mg 1 tablet by mouth every 8 to 12 hours as needed.

The medication profile rewritten on 11/05/14 included Tramadol 50 mgm every 12 hours as needed for pain.

The Medication Administration Records (MAR) for the months of September and October 2014 included Tramadol 50 mg 1 tablet every 12 hours as needed for pain. Nursing documentation indicated that the visiting nurse left 2 tablets of Tramadol 50 mg with the patient during thirteen of the twenty-eight daily nursing visits in September 2014, and each of the twenty-nine daily visits in October 2014.

Interview and review of the of the physician's orders, medication administration records, and medication profile with the Administrator and Supervisor of Clinical Services on 11/20/14 failed to identify nursing reconciliation of the physician's orders and/or nursing attempts to seek clarification of the frequency of the Tramadol with the physician prior to administering and/or pre-pouring;

November 2014 with the Administrator and Supervisor of Clinical Services on 11/18/14 indicated that the nurse signed off ahead of time for having administered Tramadol 50 mgm 1 tablet every 12 hours to the patient from 11/01/14 through 11/21/14, although the home visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14, and failed to identify accurate and authentic documentation of the medication administration process;

Interview and review of the surveyor observation of the joint home visit with RN # 2 on 11/18/14 indicated that the nurse had previously signed off for administering the Tramadol but did not administer the two tablets of Tramadol to the patient on 11/18/14 (left the two tablets in a compartment of the patient's medication box) and failed to identify accurate documentation of the medication administration process versus pre-pouring process;

The physician's orders for the certification period of 09/10/14 to 11/08/14 included Oxycodone 15 mg by mouth three times a day.

A subsequent physician's order dated 10/13/14 directed the administration of Oxycodone 15 mg 1 tablet by mouth twice a day as needed.

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime).

The medication administration record for the month of October 2014 listed Oxycodone 15 mg by mouth three times a day as needed for breakthrough pain from 10/04/14 through

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10/12/14, and the agency nurse initialed the medication as administered three times a day until 10/15/14.

Interview and review of the nursing documentation with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify documentation for administering or pre-pouring Oxycodone for two days (10/13/14 and 10/14/14) and failed to identify nursing documentation of the patient's pain management during those two days without Oxycodone; The medication administration record for the month of October 2014 subsequently listed Oxycodone 15 mg by mouth twice a day as needed for breakthrough pain starting 10/16/14, and the agency nurse initialed the medication as administered twice a day.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate implementation of the physician's order dated 10/13/14 for Oxycodone twice a day (instead of three times a day) until 10/16/14, three days later;

The medication administration record for the month of September 2014 included Oxycodone 15 mg by mouth three times a day (at 6:30 a.m., 9 a.m. and bedtime) and the agency nurse signed off on each dose as administered when in fact the nurse acknowledged on 11/18/14 visiting the patient only once a day, to administer one morning dose and leave the two remaining doses for the day in a compartment of the medication box, with no follow-up on the amount of tablets the patient needed after the nurse left, and/or documented outcome of the intake of the as-needed doses.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

The medication administration record (MAR) for the month of November 2014 included Oxycodone 15 mg by mouth twice a day and review of the November 2014 MAR indicated that the nurse signed off ahead of time for administering two Oxycodone tablets a day prior to the completion of the visits on 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;

Observation during a joint visit on 11/18/14 indicated that the nurse left two tablets of Oxycodone in a compartment of the patient's medication box, did not administer any Oxycodone, but had signed off ahead of time from the agency office for administering two doses of Oxycodone to the patient on 11/18/14.

Interview and review of the MAR with the Administrator and Supervisor of Clinical Services on 11/18/14 failed to identify accurate nursing documentation of the medication

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administration process versus pre-pouring;

The patient's medications included Topiramate 50mg half a tablet twice a day, originally ordered on 05/22/14. Review of the physician's orders for the period of 11/08/14 to 01/06/15 indicated that the order for Topiramate was reworded as Topiramate 25mg by mouth twice a day.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and Supervisor of Clinical Services on 11/20/14 identified changes made to the transcription of Topiramate by crossing out and handwriting over the original order, and failed to identify proper documentation for discontinuation of the old order, and transcription of the new order in another blank space;

Interview and review of the medication administration records for the months of October and November 2014, and the nursing notes from 10/04/14 through 11/14/14 with RN #2 on 11/18/14, the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurses documented the patient's pain using a rating scale, but failed to identify nursing documentation of the patient's pain site, character, triggering or alleviating factors, times of occurrence, and/or documentation of the amount of Tramadol and/or Oxycodone used in a 24 hour-period and resulting effects.

- c. Patient #4 had a start of care date of 09/29/14 and diagnoses that included end-stage renal disease, hemodialysis treatment, diabetes mellitus Type II on insulin, metastatic adenocarcinoma, and chronic obstructive pulmonary disease. Physician's orders for the certification period of 09/29/14 to 11/26/14 included skilled nursing visits twice a day for medication administration and prepouring of noon medications, assessment of daily vital signs and blood glucose twice a day.

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals and Gabapentin 100 mg by mouth three times a day.

Interview and review of the medication administration record (MAR) for the month of September 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the agency nurse pre-poured the noon dose of Renvela and Gabapentin, but signed off in the MAR as administering the Renvela and Gabapentin at noon although the nurse was not in the patient's home at noon, and failed to identify accurate nursing documentation of the medication administration process versus pre-pouring;

Physician's orders for the certification period of 09/29/14 to 11/26/14 included Albuterol inhaler 90 mcg 1 puff every 8 hours, and Symbicort 80 mcg/4.5 mcg actuation aerosol 2 puffs twice a day.

The patient was hospitalized on 10/17/14 with shortness of breath, hypoxia and oxygen saturation in the 70's prior to completing a hemodialysis treatment. The patient was discharged from the hospital on 10/30/14 with diagnoses of acute hypoxic respiratory failure and pneumonia. The inter-agency referral (W10) form from the hospital included orders for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater than 90%, Simethicone chewable tablet 80 mg by mouth twice a day, and Renvela 2400 mg by mouth three times a day.

The home care agency resumed services on 11/01/14, with the visiting nurse administering

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medications twice a day.

Interview and review of the nursing documentation and November 2014 medication administration record with RN #2 on 11/19/14 indicated that the patient had not obtained Simethicone chewable tablets since the order date of 10/30/14 (twenty days), and failed to identify nursing notification to the physician of the patient's inability to purchase over-the-counter medication, in order to request a substitute medication via prescription for the patient;

Interview and review of the medication administration record for the month of November 2014 with RN #2 on 11/19/14 indicated that the nurse marked the medications Albuterol inhaler, Symbicort 80 mcg-4.5 mcg actuation aerosol and Gabapentin 100 mg as discontinued in the medication administration record on 11/01/14 based on their absence from the W-10 orders, but failed to identify nursing attempts to seek clarification with the attending physician of the discrepancies between the attending physician's orders and the hospital W-10, prior to discontinuing for 20 days, inhalers and nerve pain medication from a patient with known metastatic adenocarcinoma and chronic obstructive pulmonary disease;

The patient's medications included Renvela 800 mg 1 tablet by mouth three times a day with meals, originally ordered on 06/21/14. On 10/30/14, the hospital W-10 form included an increase in the dose of Renvela to 2400 mg by mouth three times a day.

Interview and review of the medication administration record (MAR) for the month of November 2014 with RN #2 on 11/19/14 identified nursing transcription of the new order of Renvela from the hospital by crossing out and handwriting over the original order in the MAR, and failed to identify proper discontinuation of the existing order, and transcription of the new order into a blank space in the MAR;

Interview and review of the medication administration record (MAR) for the month of November 2014 and the medication profile dated 11/17/18 with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the MAR included Lexapro 20 mg 1 tablet daily, but failed to identify the listing of Lexapro 20 mg 1 tablet daily in the medication profile, and failed to identify nursing reconciliation of the patient's medication discrepancies;

During a joint home visit on 11/18/14, Registered Nurse (RN) #2 was observed pulling unidentified pills from an envelope without the benefit of using the pharmacy bottles and MAR to verify the medications prior to administration. In addition, the nurse left an unidentified pill in the patient's medication box, called it "the noon dose of Renvela," but had previously signed off from the agency office for administering, not pre-pouring the noon dose of Renvela.

Interview and review of the medication administration record for the month of November 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified that on 11/18/14 the agency nurses were allowed to sign off ahead of time as administering medications three times a day through 5 p.m. on 11/21/14 although the nursing visits had not taken place yet for 11/18/14, 11/19/14, 11/20/14 and 11/21/14.

The agency policy on Medication Administration directed the holding of all medications in

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the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration. The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) <<http://www.guideline.gov>> retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration; Interview and review of the nursing documentation from 11/10/14 to 11/11/14 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the patient was hospitalized on 11/10/14 after the morning visit from the agency nurse, and remained hospitalized through 11/12/14, but the medication administration record (MAR) for the month of November 2014 indicated that the visiting nurse signed off for administering the 9:00 p.m. medications to the patient on 11/10/14 and 11/11/14, and failed to identify accurate and authentic nursing documentation for medication administration.

- b. Patient #5 had a start of care date of 04/10/14 and diagnoses that included muscular dystrophy and anxiety. A physician's order for the certification periods of 08/08/14 through 12/06/14 included skilled nursing visits twice a week to assess cardiopulmonary, skin and mental health/anxiety status. The patient's medications included Claritin 5 mg by mouth daily as needed for allergies, Nexium 20 mg by mouth as needed for reflux and Miralax 1 capful as needed for constipation. However, the 60-day summary dated 08/04/14 indicated that the patient used glycerine suppository as needed for constipation. Interview and review of the physician's orders and the medication profile with the Administrator and Supervisor of Clinical Services on 11/20/14 identified a medication profile bearing no creation or revision date, and failed to identify nursing reconciliation of the patient's medications.
- c. Patient #6 had a start of care date of 05/09/11 and diagnoses that included diabetes mellitus Type II, asthma, cognitive deficit and depression. Physician's orders for the certification periods of 08/24/14 through 12/21/14 included skilled nursing visits twice a day for medication administration. Interview and review of the evening nursing visit note dated 11/06/14 P.M., the medication administration record (MAR) for the month of November 2014 and the "missed visit documentation" dated 11/06/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that the patient was not at home for the evening nursing visit on 11/06/14, yet the agency nurse documented on the MAR that the nurse administered the medications to the patient at 5:00 p.m. on 11/06/14; Interview and review of the PM nursing visit note dated 11/09/14 P.M., the November medication administration record (MAR) and missed visit documentation dated 11/09/14 p.m. with the Administrator and Supervisor of Clinical Services on 11/20/14 identified that the patient was not home for the p.m. medication administration visit on 11/09/14; however, the agency nurse documented on the MAR that the medications were administered at 5:00 p.m. on 11/09/14.

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- d. Patient #8 had a start of care date of 07/24/13 and diagnoses that included insulin-dependent diabetes mellitus, diabetic neuropathy, amputation of the right great toe, below-the-knee amputation of the left leg and hypertension. Physician ' s orders for the period of 09/16/14 to 11/14/14 included skilled nursing services twice a day for medication administration, blood glucose, blood pressure and heart rate monitoring.
- The patient ' s medications included Lantus insulin 43 units subcutaneously in the evening, a sliding scale for Insulin coverage, Lasix, Plavix, Lisinopril, Aspirin, Folic Acid, Advair, Lovastatin, Spiriva, Gabapentin, Colace, Metformin, Coreg, Tylenol and Dulcolax.
- During a joint visit on 11/19/14 at 9:30 a.m., RN #1 was observed pulling out unidentified pills from a small manila envelope bearing only the initials of the patient, and failed to identify verification of each medication prior to administration.
- RN # 1 subsequently explained that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications in manila envelopes, and took the manila envelopes out to the patient ' s home each day to administer the medications to the patient, without the benefit of verifying each medication for accuracy at the time of administration.
- The National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov) retrieved 12/01/14 directed the verification of the right patient, the right medication, the right dose, the right route, the right time and the right documentation at the time of medication administration;
- Interview and review of the surveyor observation with RN # 1 on 11/18/14 indicated that the medications that RN # 1 administered to the patient on 11/18/14 were signed off as administered since 11/13/14 (five days prior to the visit) in the Medication Administration Record (MAR), and failed to indicate that the nurse signed off for the medications administered in the home at the time of the administration. RN # 1 indicated that from the agency office, RN # 1 poured out ahead of time several days ' worth of the patient ' s medications, signed off for administering the medications several days ahead of time, and failed to identify accurate and authentic signature for administering the medications at the time the medications were administered.
- Interview and review of the medication profile on 11/19/14 at 2:00 p.m. with RN #1 and the SCS failed to identify any update of the medication profile since 12/28/13.
- As a result, the physician increased Lantus insulin to 50 units subcutaneously in the evening on 01/210/14, but was still listed on the medication profile as Lantus insulin 62 units in the evening, while the Medication Administration record (MAR) indicated that Lantus insulin 43 units was administered in September, October and November 2014;
- The physician ' s orders for the period of 09/16/14 to 11/14/14 included Lisinopril 2.5 mg and did not include oxygen and/or Percocet, while the medication profile listed Lisinopril 5 mg (instead of 2.5mg), Percocet and oxygen. At the same time, the MAR for the month of November 2014 indicated that Lisinopril was discontinued.
- Review of the MAR for the month of November 2014 with RN #1 on 11/18/14 indicated that RN # 1 signed off ahead of time for administering the medications Folic Acid, Aspirin and Furosemide for 11/20/14 and 11/21/14, when the visits had not been conducted and the medications had not been administered, and failed to identify accurate and authentic

DATES OF VISIT: November 14, 18, 19, 20, and December 11, 2014

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documentation of medication administration.

The agency policy on Medication Administration directed the holding of all medications in the agency office, signing off of medications as the medications are "poured" (taken out of the office in unlabeled containers) and failed to reflect an adequate policy that included the need to bring pharmacy-labeled containers to the patient's home to identify each pill at the time of administration, and sign off for medications at the time of administration.

- e. Patient #9 had a start of care date of 02/17/13 and diagnoses that included reflex sympathetic dystrophy, chronic pain, and depression. Physician's orders for the certification period of 06/12/14 to 08/10/14 included daily skilled nursing visits to administer the morning medications and prepour the noon and evening medications for the patient to self administer.

The patient's medications included Morphine sulfate 100 mg by mouth three times a day, Hydromorphone 16 mg by mouth four times a day, Lorazepam 2 mg by mouth four times a day and Carisoprodol 350 mg by mouth four times a day.

On 06/21/14, the patient was treated in the Emergency Department (ED) for altered mental status and released on 06/22/14. The interagency referral form (W-10 form) dated 06/22/14 included an increase in the frequency of skilled nursing visits to twice a day for medication administration and prepour, an increase in the home health aide hours to 14 hours per week, and the need for an appointment with the primary care physician to address concerns of overmedication.

Further hospital documentation identified a subsequent transfer to the Emergency Department (ED) on 06/25/14 at 11:11 p.m. for mental status changes, and a release from the ED on 06/26/14 with a diagnosis of opiate overdose.

Interview and review of the nursing documentation dated 06/26/14 and the medication administration record (MAR) for the month of June 2014 with the Administrator and Supervisor of Clinical Services on 11/20/14 indicated that LPN #1 completed a visit on 06/26/14 from 5:45 p.m. to 6:00 p.m, but failed to identify documentation of medication administration and/or prepour;

Interview and review of the nursing documentation from 06/22/14 to 06/27/14 and the medication administration record (MAR) for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 identified the scheduling of nursing visits twice a day (morning and evening) for medication administration and prepour, but failed to identify documentation of nursing assessment during the evening nursing visits of 06/22/14, 06/23/14 and 06/24/14, although the evening medications were signed off as administered by the nurse on 06/22/14, 06/23/14 and 06/24/14;

Although the nursing documentation indicated that the patient was hospitalized on 06/27/14 at 10:12 a.m., interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the visiting nurses signed off for administering the 5PM and 9PM doses of Morphine sulfate ER 100 mg and Hydromorphone 16 mg to the patient on 06/27/14

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when the patient was not present at home;  
Interview and review of the MAR for the month of June 2014 with the Administrator and the Supervisor of Clinical Services on 11/20/14 indicated that the nurses obtained several days worth of medications out of the agency office, and carried the medications in the car to administer to the patient each day, but once the patient was admitted to the hospital, some nurses returned the unidentified medications to the agency office while others continued to carry the medications in the car until the patient was discharged home from the hospital, and failed to identify an accurate, safe and secure system to store, sign off and administer the patient's medications on a daily basis.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2)(H).

18. This will serve as notification that, per 42 CFR, 484.36 (a)(2) (i) (C) and based on the determination of substandard care at the time of the December 11, 2014 survey, Hamlett Health Services LLC, located at 91 Schraffs Drive Suite # 4, Waterbury CT 06705 may not operate a home health aide training and/or evaluation program from January 31, 2015, to January 31, 2017.