

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

IN RE: Caring Choices Hospice, LLC of Rocky Hill, CT
d/b/a Caring Choices Hospice, LLC
1080 Elm Street
Rocky Hill, CT 06067

FEB 13 2008

CONSENT AGREEMENT

WHEREAS, Caring Choices Hospice, LLC (hereinafter the "Licensee"), has been issued License No. 0022 to operate a Home Health Care Agency known as Caring Choices Hospice, LLC, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on August 13, 2007 and concluding on October 23, 2007; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated October 24, 2007 (Exhibit A – copy attached); and

WHEREAS, without admitting to any wrongdoing, the Licensee is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Glen Cavallo, Member of the LLC, hereby stipulate and agree as follows:

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

Licensee: Caring Choices Hospice, LLC of Rocky Hill, CT.

2. Within twenty-one (21) days of the effective date of the Consent Agreement all Facility nursing and direct care staff shall be in-serviced pertinent to the policies and procedures identified in paragraph number 1.
3. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator/Supervisor of Clinical Services, Hospice Program Director and Supervisor of Clinical Services (Hospice), shall ensure substantial compliance with the following:
 - a. The hospice shall maintain professional management of the care plan for all patients residing in a nursing home and coordinate all care with the nursing home;
 - b. A complete clinical record shall be maintained by the hospice for all patients including those residing in a nursing home;
 - c. A primary care nurse and sufficient nursing services personnel shall be available to meet the needs of the patient/caregiver/family at all times;
 - d. Initial hospice plans of care shall be available within forty-eight (48) hours of admission to the hospice program;
 - e. All plans of care shall be individualized and shall include assessment of the patient's/caregiver's/family's individual needs including drug therapies, treatments prescribed by the physician, assessment of patient/caregiver/family needs as they relate to hospice services, plans for interventions and implementation including the management of discomfort and symptom relief and goals of management;
 - f. Hospice services shall be provided in accordance with each patient's comprehensive plan of care and integrated with the plan of care of the nursing home, if applicable;
 - g. The Interdisciplinary Group shall conduct ongoing assessments of the needs of each patient/caregiver/family then, in collaboration, review and revise each patient care plan to reflect appropriate interventions, supervise all services provided by the hospice to ensure implementation, coordination and continuity of the plan of care in accordance with applicable federal and state laws and regulations;
 - h. Volunteer services shall be made available to all patients, including those residing in a nursing home, in accordance with the needs of the patient and their family and the plan of care; and

Licensee: Caring Choices Hospice, LLC of Rocky Hill, CT.

- i. The hospice shall annually provide six (6) hours of in-service education to all direct service staff, including staff under contract with the nursing home and providing care to hospice patients.
4. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit reports every six (6) weeks to the Department regarding the provisions contained within this document.
5. The Licensee's Administrator, Supervisor of Clinical Services, Hospice Program Director, Supervisor of Clinical Services (Hospice) shall meet with the Department every eight (8) weeks after the effective date of this Consent Agreement for a period of six (6) months.
6. The Licensee shall include in the agency's Quality Assurance Program (QAP), in addition to the required quarterly clinical record reviews, a review of patient care issues including those identified in the October 24, 2007 violation letter. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients/families and, if applicable, implement remediation measures. Minutes of the monthly QAP meetings shall be kept for a minimum of two (2) years and made available for review upon request of the Department.
7. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand five hundred dollars (\$2,500.00) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

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

Licensee: Caring Choices Hospice, LLC of Rocky Hill, CT.

8. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
9. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
10. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
11. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
12. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

*

*

*

*

*

Licensee: Caring Choices Hospice, LLC of Rocky Hill. CT.

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

CARING CHOICES HOSPICE, LLC
OF ROCKY HILL, CT - Licensee

2/11/08
Date

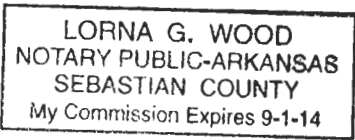
By: [Signature]
Glen Cavallo, Member of the LLC

STATE OF Arkansas)

County of Sebastian) ss 02-11- 2008

Personally appeared the above named GLEN R. CAVALLO and made oath to the truth of the statements contained herein.

My Commission Expires: 09-01-2014 / Lorna G. Wood
(If Notary Public) Notary Public []
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []



STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2/15/08
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 17

October 24, 2007

Mary Atkinson, RN, Administrator
Caring Choices Hospice
1080 Elm Street, Suite 201
Rocky Hill, CT 06067

Dear Ms. Atkinson:

Unannounced visits were made to Caring Choices Hospice on August 13, 14, 15, 16, 17, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation and licensing inspection with additional information received through October 23, 2007.

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

An office conference has been scheduled for November 8, 2007 at 1:00 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

Respectfully,

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

SNC:NC:

- c. Complaint #CT7331
Nurse Consultant



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b)(4) General requirements.

1. The governing body failed to assume responsibility for the services provided to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 by agency staff to ensure the safety and quality of care rendered to all patients and their families based on the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (e)(3)(A)(C) General requirements and 19-13-D72(b)(2)(G)(ii) Patient care policies.

2. Based on review of the agency's nursing schedule for the weeks of 08/06/07-08/12/07 and 08/13/07-08/19/07 and interviews with the senior administrator, the administrator/SCS and the hospice director/hospice SCS, it was determined that both the SCS and the hospice SCS failed to manage and coordinate all services rendered to the patients. The findings include:

a. The supervisor of clinical services for the hospice program failed to assume responsibility for the services provided to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 by agency staff to ensure the safety and quality of care rendered to all patients and their families based on the violations listed in this document.

b. When interviewed on 08/14/07, the administrator/SCS did not know if there was a nursing schedule. The surveyor's inquiry was deferred to the senior administrator, who submitted identical nursing schedules for the weeks of 08/06/07-08/12/07 and 08/13/07-08/19/07. These schedules listed 6/13 patients assigned to RN #1 (who is also the hospice director/SCS), 4/13 patients assigned to RN #2 and 3/13 patients assigned to RN #3. No visit dates were documented. The senior administrator did not know the frequency or days the patients were to be seen; the hospice director/hospice SCS would need to be contacted. Review of the schedule that included days patients were to be visited, identified numerous discrepancies and inconsistencies, but the senior administrator did at last obtain an accurate schedule.

When interviewed on 08/15/07, the senior administrator, hospice director/hospice SCS and RN #2 all stated that RN #s 2 and 3 worked per diem for the hospice, worked full-time at the skilled nursing facility and visited patients based on their personal schedule; as necessary (PRN) visits were made by RN #1; RN #1 was essentially the PCN for the total caseload of 13 patients as well as fulfilling the fulltime role of hospice program director/supervisor of clinical services for the hospice program.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (d)(4)(C) Services.

3. Based on interviews with the senior administrator and hospice director/hospice SCS (RN #1) it was

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

determined the agency failed to employ a full-time primary care nurse (PCN) from 09/20/06 through 05/28/07. The findings include:

a. On 05/29/07, the hospice director/hospice SCS assumed the role of the full-time PCN, as well as the RN with other responsibilities for the home health aide (H-HHA) program. When interviewed on 08/13/07, the hospice director/hospice SCS stated even though these two positions were full-time, it was necessary to assume the roles of full-time PCN and the RN responsible for the H-HHA program as the agency had been without them for several months. When interviewed on 08/13/07, the senior administrator stated despite recruitment efforts, the agency has been unable to hire a full-time PCN; from 09/20/06 through 07/31/07, the FTE for nursing was 0.50.

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

4. Based on clinical record review, staff interviews and agency policy review, it was determined that for five (5) of five (5) patients the agency failed to send a written summary report, containing a compilation of the patient's clinical notes and progress notes, to the attending physician at least every 60-days (Patient #s 6, 7, 9, 10 and 11). The findings include:

a. When interviewed on 08/27/07, the administrator/SCS stated the agency sends a copy of the most recent Interdisciplinary Group (IDG) summary along with the hospice recertification and plan of care to the physician; IDG summary is considered the 60-day summary report. When interviewed on 08/28/07, the senior administrator stated the agency did not have a policy concerning the written 60-day summary report to the physician; the agency considered the most recent IDG report as the 60-day report and sent a copy to the physician; only areas of concern were discussed at the IDG meeting, not a complete review of the status of the patient.

b. Patient #6 had a start of care of 11/09/06 with a principal diagnosis of end-stage Alzheimer's disease. For the recertification dated 05/09/07-07/06/07, the 05/01/07 IDG summary stated: open area to coccyx-shearing/maceration and appetite continues fair to good. For the recertification dated 07/07/07-09/04/07, the 07/03/07 IDG summary stated: new onset respiratory infection, bronchitis and breast, renew orders for 60-days, re-order times 60-days, family informed/business office aware.

c. Patient #7 had a start of care of 05/04/07 with a principal diagnosis of end stage Alzheimer's disease. For the recertification dated 07/03/07-08/31/07, the IDG summary dated 07/03/07 stated: incontinent of large amounts of urine, diet intake remains adequate, discussed purchasing a new doll baby as old one needs replacement, tactile activity keeps patient in a calm and joyous place.

d. Patient #9 had a start of care of 05/09/07 with a principal diagnosis of end stage Alzheimer's disease. For the recertification dated 07/08/07-09/05/07, the IDG summary dated 07/03/07 stated: new

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

skin tear on arm per staff, may try double portions breakfast, poor circulation to all extremities, to order geri-sleeves this week.

e. Patient #10 had a start of care of 03/08/07 with a principal diagnosis of end-stage stroke with hemiplegia. For the recertification dated 06/06/07-09/03/07, the IDG dated 06/05/07 stated: weight gain 2 pounds, remains on weekly weights for family, using O2 PRN, husband very supportive/visits daily, alert and aware, responds with short sentences, difficult to comprehend at times.

f. Patient #11 had a start of care of 04/04/07 with a principal diagnosis of end stage renal disease. For the recertification dated 06/03/07-08/17/07, the IDG dated 05/22/07 stated: discovered painful left great toe which patient kept covered with shoe to protect against sheets/blanket, podiatry consult, bed cradle recommended, Haldol for nausea.

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

5. Based on interviews with the senior administrator; the SNF physical, occupational and speech therapists; review of in-service education documentation and agency policy it was determined that the agency failed to ensure, as part of its coordination of patient care with the SNF, that all direct service staff received 6-hours of annual in-service education related to hospice care. The findings include:

- a. When interviewed on 08/14/07, the senior administrator stated no in-service education programs had been conducted with the SNF staff since 08/06. When interviewed on 08/17/07, PT #1, OT #1 and ST #1 all stated they have never had any hospice in-service training nor did they know they were required to have such training.
- b. Review of in-service education documentation showed in-services were last held in August 2006 with SNF staff.
- c. Agency policy concerning in-service education stated ongoing training is mandated for all members of the hospice team.

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

6. Based on clinical record review, staff interview and agency policy review, it was determined that for eleven (11) of eleven (11) patients, the IDG failed to document a complete review of the patient's hospice plan of care at the IDG meetings (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11). The findings include:

- a. Review of IDG meeting summaries for Patient #s 1-11 lacked complete documentation of the

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

patient's status, including physical, pain/symptom control, nutritional, emotional, psychosocial and spiritual. When interviewed on 08/15/07, the senior administrator stated most of the patients' attending physician, was also the hospice medical director; therefore, it was not necessary to write detailed IDG summaries. Agency policy stated the IDG sends the initial POC and any change to the attending physician.

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

7. Based on clinical record review, staff interview and agency policy review, it was determined that for nine (9) of eleven (11) hospice patients residing in and/or inpatients in a nursing home, the hospice failed to retain professional management/responsibility for those services and in accordance with the patient's plan of care (Patient #s 1, 2, 3, 4, 5, 6, 8, 10 and 11). The findings include:

a. Patient #1 had a start of care of 06/20/07 with a principal diagnosis of end stage COPD and secondary diagnoses of atrial fibrillation, pericardial disease, hypertension (HTN) and chronic kidney disease. The patient resided in a NH. The hospice certification and plan of care for the certification period 06/20/07-08/08/07 ordered skilled nursing 1-3x/week, hospice aide 2x/week, SW 1-3x/month, volunteer/spiritual PRN. The plan of care documented these disciplines were to support patient and family with end-of-life process, addressing issues and questions, ongoing education and anticipatory guidance for daughters who are primary caregivers and coordination with NH.

The hospice nursing notes between 06/20/07-08/15/07, NH nursing notes from 06/21/07-08/16/07, IDG summaries from 06/20/07-08/14/07 and the physician assistant (PA) notes for 07/18/07 and 08/15/07 identified the patient's clinical status was stable, nutrition improved as the family brought food from home; use of continuous oxygen changed to times when the patient could go without it. When interviewed on 08/17/07, the patient talked with the surveyor for 20 minutes without using oxygen; later that same day the patient was observed with the hospice aide in the courtyard for approximately 1 hour without using oxygen.

Review of the hospice aide care plan identified the patient was to have a bath every week; maximum assist with dressing daily; mouth, skin and hand care every visit; weekly foot soak. From 06/26/07-08/15/07 there was no hospice aide documentation that these activities were performed. When interviewed on 08/17/07, the patient stated the nurse aide from the nursing home gave the shower once a week; no assistance was needed to dress, perform mouth, skin and hand care; assistance with a foot soak would be appreciated; all the hospice aide had to do was carry the tub of water after the patient filled it with water; the patient could soak and wash own feet. The patient stated conversation and wheelchair rides both inside and outside were what the hospice aide did; no one seemed to have time to help with a foot soak; did not know a volunteer could visit; a volunteer would be nice; daughters brought delicious food from home; NH food was not too tasty.

When interviewed on 08/17/07, Hospice Aide #1 stated the patient refused any personal care assistance; the PCN had not been told. When interviewed on 08/17/07, PCN #1 (also the hospice director/SCS)

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through
October 23, 2007

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

stated the patient has been doing so well since the start of care, perhaps the patient should not be on hospice care. Subsequent to surveyor inquiry, RN #1 stated it would be discussed at the next IDG; RN #3 had recently conveyed the questionable hospice care to RN #1. RN #1 was not aware the hospice aide was not performing the assigned tasks.

Review of the agency's medication sheet dated 06/20/07 and the nursing home's Medication Administration Record (MAR) indicated the agency's medication list did not correspond with the NH's list. Since 06/12/07, the NH had been administering Remeron 30mg at night for the patient's newly diagnosed depression, due to the patient learning the NH had become a permanent home for the patient. Remeron was not listed on the hospice medication sheet. The patient's depression was not discussed in the IDG summaries.

RN #s 1 and 3 failed to re-evaluate the patient's plan of care for continued hospice care.

b. Patient #2 had a start of care date of 8/7/07. Review of the hospice patient referral/admission form stated that the patient was in an acute care hospital from 7/12/07 to 8/7/07 with diagnoses of a history of lymphatic malignancy, anasarca, anemia, GI bleed, renal failure, a stage 4 coccyx decubitus ulcer and a recent 25 lb. weight loss. The referral/admission form noted that the patient was alert/confused at times, bed bound, had a Foley catheter, needed a low air mattress and skilled nursing would visit daily, aide 3 x a week, MSW 1-4 x a month and a spiritual evaluation was declined.

The nursing assessment of 8/7/07 noted that the patient denied pain, resided in a NH, had unlabored respirations, poor nutrition and a sacral decubitus.

The hospice clinical record lacked an interagency referral form from the hospital and lacked a hospice physician's plan of care for the patient. The clinical record lacked wound description/measurement/drainage and/or that the nurse assessed the wound on admission and/or orders for wound care. The coordination of service form between the hospice agency and the NH indicated that the hospice would be responsible for family teaching, pain management/education, wound care management with instruction/supervision of staff. The NH was responsible for medication administration, wound care, 24-hour monitoring, nursing care of the patient and communication to hospice. The clinical record lacked documentation of who assumed responsibility for the Foley catheter reinsertion.

The patient's hospice clinical record from 8/7/07 to 8/15/07 lacked documentation that the hospice nurse assessed the patient's stage 4 decubitus on admission to hospice and/or on subsequent visits and/or provided any wound care management.

RN #1 stated on 8/13/07 that he had not as yet observed the patient's decubitus but had spoken to the treatment nurse at the NH regarding the patient's decubitus. RN #1 stated that the treatment nurse provided the wound care during the 11-7 shift and/or early in the AM and he didn't visit at that time so he couldn't observe the wound and that the NH was responsible for wound care. He thought that RN #2 had observed the wound during one of the nursing visits. Subsequent to surveyor's inquiry RN #1 observed the patient's wound care procedure on 8/15/07. RN #1 noted the sacral wound to be stage 3-4 and measured 12 cm x 9 cm., 1-2 layers deep and oozing serous drainage. The decubitus had "eschar like islands" in the middle. RN #1 noted for the first time that the patient had a right ankle pressure area and bilateral blisters which were soft, spongy with fluid inside. RN #1 noted that the patient refused

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

pain medication but non-verbal clues indicated significant discomfort with turning.

Review of the hospice record prior to the note of 8/15/07 identified documentation was lacking regarding the patient's heel and/or ankle wounds and/or description/measurements/treatment and/or staging and/or coordination with the NH staff and/or IDG regarding the patient's skin integrity/status and care.

The NH's clinical record noted on 8/7/07 and 8/14/07 that the patient's coccyx was unstageable with slough and eschar and measured 13 x 15 cm. The record also noted that on 8/7 and 8/14/07 the patient had areas on the right and left ankles identified as stage 1 decubiti and as of 8/14/07 the patient had areas on the right and left heels identified as stage 1 decubiti. The patient's hospice record, including IDG notes of 8/14/07 lacked documentation to support that the IDG was aware of the patient's deteriorating skin integrity and/or that the hospice nurse was assessing/monitoring/managing the patient's plan of care including alteration in skin integrity.

During a visit to the patient by the surveyor on 8/16/07 it was noted that the patient had numerous decubiti and excoriation on coccyx and buttocks with eschar in center, stage 2 decubiti on both heels, a stage 2 decubitus on the patient's left outer ankle, a right hip abrasion and a stage 1 decubitus on right inner knee. The patient was alert/oriented but at times confused and stated that he/she was not experiencing any pain. The patient was to have the feet elevated off of the mattress.

Documentation of the patient's deterioration in skin integrity from 8/7/07 to 8/15/07 and/or preventive measures to be implemented were not noted in the hospice record and/or the IDG meetings and/or the patient's plan of care.

The 8/7/07 hospice medication record had not been updated and differed from the NH medication record and/or orders. The NH physician orders of 8/7/07 discontinued the patient's Lasix, Lomitol, Lisinopril and Acidophilus and added Antivert for vertigo. On 8/14/07 the physician in the NH ordered morphine sulfate (MSO4) and Ativan. The hospice medication record did not include the 8/7/07 discontinuation of medications but listed them as active medications and failed to list the new medications the physician ordered. The hospice agency was to monitor the patient's medications. The hospice clinical record from 8/7/067 to 8/12/07 noted that the patient denied pain to the hospice nurse. The patient had Tylenol and oxycodone ordered for pain relief. On 8/14/07 the patient's physician ordered MSO4 for pain relief and SOB. The IDG meeting of 8/14/07 failed to identify that the patient's pain status and/or SOB had changed. The NH nursing notes and the hospice clinical record failed to identify the patient's change in status and/or communication between the hospice nurse and the NH staff.

The patient was bed bound on admission to hospice on 8/7/07 through 8/15/07. The hospice clinical record failed to include continued assessment of the patient's functional status by the hospice nurse with the possible need to get the patient out of bed for short periods of time. RN #1 stated on 8/20/07 that the physician wanted the patient in bed but he would look into the possibility of getting the patient out of bed in the future.

RN #1 stated on 8/13/07 that the NH was responsible for the patient's wound care treatment and since the wound care was done early in the AM he did not observe the patient's decubitus. RN #1 stated on 8/20/07 that he visited daily to encourage the patient to take pain medication since he/she refused medication and denied pain.

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

The hospice agency failed to provide professional management of the patient's plan of care in order to meet the patient's needs.

c. Patient #3 had a start of care of 07/05/07 with a principal diagnosis of adult onset failure to thrive and secondary diagnoses of progressive dementia, HTN, thoracic aortic aneurysm and weight loss. The hospice certification and plan of care for the certification period 07/05/07-09/02/07 ordered skilled nursing 1-3 x/week with 4 PRN visits, SW 1-4x/month with 4 PRN visits, hospice aide 2-3x/week as accepted/tends to resist help; declined volunteer; spiritual evaluation pending; no interventions were specified. The patient resided in a NH.

Review of the 07/05/07 initial nursing assessment identified the patient was Catholic; importance uncertain. The spiritual assessment dated 07/05/07 was made by the SW. The patient's conservator told the SW the patient was Catholic; degree of importance was low. When interviewed on 08/17/07, the SW stated since the patient was confused, the conservator had stated religion was of low importance to the patient and since the agency was without a spiritual counselor, spiritual counseling had not been pursued.

Review of the six IDG meeting summaries held since the SOC identified spiritual involvement was not discussed.

A joint home visit was made with RN #2 on 08/16/07. The patient was observed lying in bed, covered with a hand made afghan. RN #2 attempted to take the patient's blood pressure; the patient stated that's cold, leave me alone; the patient spontaneously reached out and tightly took hold of the surveyor's hand, saying, "You're warm". The patient would not let go and made constant eye contact with the surveyor. The patient smiled and nodded affirmatively when asked if the patient made the afghan. The surveyor asked if the patient wanted to say a prayer, the patient said yes and proceeded to say the Lord's Prayer, asking the surveyor to join in; the patient then squeezed the surveyor's hand tighter. Only at the conclusion of the prayer did the patient release his/her hand.

On 08/17/06, Patient #3 was observed outdoors, in a wheelchair with a NH aide. The patient beckoned to the surveyor; Patient #3 took the surveyor's hand and began saying the Lord's Prayer; at the conclusion of the prayer, Patient #3 let go of the surveyor's hand, smiled, said thank you and goodbye. RN #s 2 and 3 failed to discuss with the IDG and implement spiritual interventions for the patient. Hospice Aides #s 1 and 2 were never given direct supervision while rendering care to the patient.

d. Patient #4 had a start of care of 08/03/07 with a principal diagnosis of advanced Alzheimer's disease with behavioral disturbance/hallucination and secondary diagnoses of adult onset failure to thrive, anorexia, urinary and bowel incontinence. The hospice certification and plan of care for the certification period 08/03/07-10/31/07 ordered skilled nursing 1-3x/week with 4 PRN visits; hospice aide 1-3x/ a week; SW 1-4x/week; no interventions were specified for any service. Physical therapy was ordered to evaluate for potential reuse of a cushion wheelchair. The patient resided in a NH.

An initial nursing assessment was made by RN #3 on 08/04/07; the patient was non-communicative, alert, confused, disoriented, incontinent of bowel/bladder, jaundiced, poor appetite with <25% BID pureed food consumed. On 08/03/07 RN #1, the PCN/hospice director/SCS documented on the narrative summary of prognosis: unintentional, progressive weight loss; rapid loss of cognitive and

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

functional capacity; chronic UTI; severe anorexia, weight <80 pounds from 93 pounds in April 2006. When interviewed on 08/28/07, the senior administrator stated RN #1 did not see the patient on 08/03/07; the SOC should have been 08/04/07; RN #1 based the summary of prognosis documentation on NH information, not on an actual hospice nursing assessment.

Review of the agency's medication sheet dated 08/03/07 and the NH's MAR indicated the agency's medication list did not correspond to the NH's. On 08/08/07, the NH MAR was amended to include Ativan 0.25mg every 6 hours PRN for restlessness/anxiety. The agency's most current medication sheet dated 08/03/07, failed to include this revision.

When interviewed on 08/27/07, RN #3 stated RN #1 was the PCN though RN #1 made no home visits to the patient; most patients were seen 1 time a week depending on the agency's schedule; saw patient on 08/04/07 at dinnertime; wasn't eating; fetal position; skin and bones; incoherent; visited the patient 1 time a week as condition was already so poor, for so long; hard to ascertain when to increase nursing visits; still evaluating the visit frequency at second visit of 08/08/07; RN #1 (hospice director/SCS) did not increase nursing visits.

Review of the NH nursing notes for 08/08/07 documented Patient #4 was found lying on the floor next to bed at 9:45am; no apparent injury; daughter and PA notified; PT and OT evaluations for transfer and wheelchair positioning ordered. Review of the initial IDG meeting summary for 08/08/07 stated PT consult for re-used custom chair; low air loss mattress; Ativan and morphine sulfate (MSO4). There was no hospice clinical record documentation of PT involvement or coordination. Review of NH PT notes, identified the NH instituted PT after the patient fell out of bed, not the hospice. There was no documentation in the patient's initial IDG summary of physical, nutritional and emotional/psychosocial status. The IDG summary for 08/14/07 stated diet <10%, takes po fluids/aspiration risk; Ativan and MSO4; CNA took patient outside; daughter has been visiting since return; RN 1-2x/ week; CNA 3x/week for 1.5 hours. When interviewed on 08/28/07, the senior administrator was not sure if PT was provided under the hospice benefit, but would find out and ensure proper payment.

RN#3 visited the patient only 2 times, 08/04/07 and 08/08/07. On 08/15/07 the patient passed away alone in bed per the NH nursing notes. RN #s1 and 3 failed to increase the nursing visits and/or other nursing interventions to meet the patient's need as the condition deteriorated.

e. Patient #5 had a start of care date of 7/25/07 with a diagnosis of bronchiogenic cancer. The plan of care dated 7/25/07 included skilled nursing 1-3x a week to provide the patient and family with anticipatory guidance for advancing disease process and pain and symptom control, home health aide 2-3 x a week, MSW 1-3 x a month and spiritual evaluation as needed.

Review of the hospice clinical record noted that the patient had recently been to the emergency room (ER) with a gastrointestinal (GI) bleed. The patient was admitted to the NH on 7/20/07 and to the hospice program on 7/25/07 with metastatic disease, a recent 4 lb. weight loss and decreased endurance.

Initial review of the hospice clinical record lacked IDG minutes and lacked nursing notes after 7/31/07. The patient's plan of care did not include therapy services.

Review of the MSW notes from 7/25/07 to 8/1/07 noted that the patient was very unhappy being admitted to a NH and wanted to go home. The MSW note of 8/1/07 and 8/10/07 stated that the patient

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

had awareness that physical therapy "tires her out". Subsequent to surveyor request and receiving additional hospice nursing notes and IDG notes from the hospice record at the NH, additional information was noted regarding therapy services. The nursing visit note of 8/7/07 stated that the patient received ST for memory loss and "PT had slow progress" as safety was a concern. The nursing visit note of 8/14/07 indicated that PT was working on safety training with slow progress due to the patient's short-term memory loss.

Review of the IDG minutes of 8/8/07 stated "continues with PT" and in the IDG minutes of 8/14/07 it was noted that ST wanted orders for 2 x week for memory training and that PT would be discontinued if memory training failed.

On 8/15/07, the senior administrator stated that he was not sure if PT was being provided under the hospice benefit or by the NH and informed the surveyor that ST was also visiting the patient.

On interview with the OT and PT at the NH on 8/17/07, they stated that they both provide services to the patient but they had never communicated/collaborated with any hospice staff. The therapy supervisor stated on 8/17/07 that she was not sure of payment responsibility for therapy services but did find out that ST, OT and PT services were being provided to the patient under the hospice benefit. The hospice clinical record lacked therapy orders.

Review of the IDG minutes of 8/8 and 8/14/07 for Patient #5 lacked documentation that any therapy services were represented at the meeting to discuss the patient's progress/goals.

The patient's hospice clinical record lacked documentation to support that the nurse/IDG ensured that the therapy services rendered were in accordance with the hospice plan of care and/or that the hospice communicated with therapy services and/or was aware that OT was providing services to the patient.

Review of the hospice's medication record and plan of care dated 7/25/07 indicated that the patient's medications did not correspond with the NH's medication record. The hospice's medication record included Oxycodone and Zantac, which were not on the NH's medication list, and the hospice's medication list did not include Lexapro, APAP and Nexium, which were on the NH's medication list. The discrepancy in medications was not identified/clarified in the hospice clinical record and/or documented as having been discussed at the IDG meetings.

f. Patient #6 had a start of care date of 11/9/06 with a principle diagnosis of end stage Alzheimer's disease. Review of the hospice record identified the patient as nonverbal, totally dependent for all ADLs, incontinent of bowel and bladder, up with a Hoyer lift to a custom wheelchair, disoriented, agitated and resisted care, and was on a regular pureed diet with supervised feeding. The visit schedule included nursing 1-3 visits per week and 3 PRN; social work (MSW) 1-4 times per week and 3 PRN; aide 1-3 times per week and 3 PRN. The certification and plan of care dated 3/7/07, decreased the SW visits to 1-3 visits per month and the PRN visits for all disciplines were increased to 4. Review of the hospice care plan dated 11/9/06 identified that the patient had a history of a stage II decubitus on the right heel and needed weekly skin checks, cream was to be applied to the heels and a barrier cream to the buttocks and that an air mattress was on the bed. It was also identified that the patient was to be transferred with the assist of two, via mechanical lift to a CWC. Review of hospice nursing notes identified that on 4/7/07 the patient had an open area on the coccyx, which healed on 5/8/07. Review of

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

the NH nursing notes identified that on 8/1/07 while an aide was attempting to dress the patient, the patient slipped to the floor sustaining a 7.5 x 3 cm hematoma. Review of the IDG notes and plan of care updates from 4/7/07 through 8/8/07 failed to identify that the pressure sore and/or the fall were discussed at the IDG meetings and/or that they were ever added to the hospice plan of care and/or that appropriate interventions were developed and implemented to treat, and/or to prevent the worsening or reoccurrence of the pressure sore and/or that the pressure sore was identified on the recertification which the hospice also used as it's 60-day summary to the physician.

Additionally, review of the patient's hospice medication list dated 11/9/06 identified that it was never updated and did not correspond with the NH MAR regarding Solosite ordered for decubitus care on 11/16/06 and intermittently stopped and reordered, and Zyrtec discontinued on 6/26/07.

During an interview with the PCN/RN #1 on 8/16/07, he stated that because there is frequent verbal interaction between all disciplines, the staff sometimes forgets to update the written forms.

g. Patient #8 had a start of care date of 6/25/07 with diagnoses of end stage COPD and dementia. The plan of care dated 6/25/07 included skilled nursing 1-3 x a week, MSW 1-4 x a month, aide 2 x a wk. in order to provide comfort and supportive care, anticipatory grief for the family, proper nutrition, maintain skin integrity, pain control and relief of anxiety.

The hospice medication list did not correspond with the medication record at the NH. Medications that were discontinued were still included in the hospice list and medications that should have been listed such as Aricept, Oxycodone and Lidoderm patch for pain were not included in the hospice list.

Trazadone for agitation was listed as 50mg. in the hospice medication list but Trazadone 25mg. was listed in the NH medication record.

The hospice clinical record lacked documentation to support that the discrepancies were clarified with the physician, IDG and/or the NH.

The hospice nursing notes from 6/25/07 to 8/8/07 (1x a week frequency) indicated that the patient stated that pain was not an issue and that the patient agreed with pain management. On 7/5/07 the narrative hospice note stated that the patient's right shoulder discomfort was being treated with a Lidoderm patch but the nurse failed to complete an accurate pain assessment and/or to provide pain management. The patient fell on 7/9/07 and complained of left shoulder discomfort however the hospice nurse failed to complete an accurate pain assessment and/or to provide management. The IDG minutes of 7/10/07 noted that Percocet was discontinued and Oxycodone was to be tried. The subsequent IDG minutes noted that the patient had increased pain but failed to provide any pain management which included the intensity of the pain, frequency of the medication and effect of the medication/duration of relief and/or other modalities used for pain relief, but only noted an increase in prn medications. The 8/1/07 nursing note narrative noted that the patient was receiving Trazadone prn which was effective for agitation and prn Oxycodone which was effective for discomfort. Review of the NH medication record indicated that the patient received Oxycodone on 7/6, 7/9, 7/10, 7/12, 7/13, 7/16, 7/23, 7/24, 7/30, 8/2, 8/3 and 8/13/07. The clinical record lacked documentation that the nurse and/or the IDG accurately assessed the patient's pain and/or the effectiveness of the pain medications and/or provided ongoing pain management and/or communicated/collaborated with the NH regarding the use of pain medications. The NH physician's orders of 7/11/07 changed the Lidoderm patch to be

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

applied to bilateral shoulders however the hospice record including IDG minutes failed to include any communication with the NH and/or physician regarding the change in the medication.

The hospice nursing note of 7/9/07 stated that the patient was found lying on the floor at the side of the bed without any recollection of what he/she was attempting to do. The patient complained of left shoulder discomfort and was to be assessed by the physician. The IDG minutes of 7/10/07 noted that the patient fell out of bed on 7/9/07 and a low bed with mats on the floor was recommended. The subsequent visit to the patient was not conducted until 7/16/07 a week following the fall to assess the effectiveness of the change in the plan of care, further changes needed for safety and/or the patient's level of discomfort. The senior administrator stated on 8/17/07 that his expectation would be that the nurse would have changed her plan of care and increased the visits after the fall.

The patient had been taking Prednisone prior to the hospice admission date of 6/25/07. Review of the NH physician orders of 6/25/07 noted that the patient had open "purporas" on the inner and outer aspects of the left lower extremity (LLE), which were to be cleansed with normal saline followed by triple antibiotic ointment and a dry clean dressing daily until healed.

The hospice patient referral/admission form and nursing assessment form of 6/25/07 indicated that the patient was prone to skin tears and had bruising and edema. The hospice certification and plan of care dated 6/25/07 stated under patient goals that the hospice would maintain skin integrity. The clinical record lacked documentation of a plan including modalities to maintain the patient's skin integrity and/or failed to document an assessment of the patient's skin, which would have included the areas being treated on the LLE. The IDG minutes of 6/26/07 failed to identify impaired skin integrity as a current and/or potential problem.

On 8/13/07 the NH called the physician for orders to cleanse the patient's open area on her forearm with normal saline (NS) and antibiotic ointment/dry clean dressing daily until healed. The IDG minutes of 8/14/07 failed to include discussion of the patient's recent impaired skin integrity. The hospice clinical record and the NH clinical record lacked documentation to support that the NH and the hospice communicated regarding the patient's skin integrity and/or supervised the implementation of a plan of care related to the patient's skin integrity.

h. Patient #10 had a start of care date of 3/8/07 with diagnoses of end stage stroke with hemeplegia and expressive aphasia, as well as COPD. At the time of admission the patient was a resident of a nursing home (NH) and continued through the current survey. The certification and plans of care dated 3/8/07-5/6/07, 5/7/07-7/5/07, and 7/6/07-9/3/07 identified that the patient was severely cognitively impaired with intermittent agitation, incontinent of bowel and bladder, totally dependent in all activities of daily living (ADLs), up in a custom wheelchair (CWC) with the transfer assist of two, had an alternating pressure mattress on the hospital bed, and was on a pureed regular diet and thickened liquids with aspiration precautions. The hospice visit plan remained consistent on the certifications from 3/8/07 through 9/3/07 and was for skilled nursing visits 1-3 times per week and 3 visits as needed (PRN), social worker 1-4 times per month and 3 PRN visits, and aide 1-3 times a week and 3 PRN visits. There was no hospice medication record in the patient's chart and it was unable to be located by the hospice administrator. Narrative notes dated 3/17/07 identified that while a family member was feeding the patient; the patient choked and experienced severe respiratory distress. The NH staff was able to treat

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

with suctioning, oxygen and positioning. Thereafter, the family would not feed the patient. IDG notes dated 6/12/07 identified that the patient was continuing to have dysphagia episodes requiring high suctioning and on 6/19/07 it was noted that the dysphagia was improved but the patient required slow and careful feeding. IDG notes dated 7/3/07 through 8/14/07 identified that the spouse hired a private duty CNA for extra care and feeding lunch. The hospice visit plan was not changed to accommodate the patient's feeding needs. During a visit to the patient at the NH on 8/16/07, it was identified that the patient was very thin, sitting in a slightly reclined CWC, chewing on fingers. The spouse was visiting and stated that the patient had lost significant weight and he/she had hired a private aide to feed the patient lunch 3 days a week because that was the big meal of the day and the patient had been gaining some weight. The spouse stated that hospice provided an aide 3 days per week for feeding but there was no consistent assistance at a specified meal because sometimes the aides would work in the morning and sometimes in the evening. The spouse then stated that the patient's lunch had been sitting at the nurse's station for an hour. The tray was at the nurse's station and a nurse sitting near it said that she hadn't noticed it and the NH staff never knew when the private aide was to feed and/or when they were responsible.

During an interview with RN #1 on 8/16/07, he stated that the hospice aides worked full time for the NH and part-time for the hospice and felt that if the family wished to hire private duty aides that was their prerogative, and he had not thought to arrange for hospice aides to feed the patient daily and/or to coordinate the feeding schedule with the NH staff.

i. Patient #11 had a start of care date of 4/4/07 with a principle diagnosis of end stage renal disease. Review of the hospice medication sheet dated 4/4/07 identified that it did not correspond with the NH MAR regarding: Bactroban and Allyvan dressings to the left heel ordered on 3/7/07, order for PRN Haldol on 5/15/07, Keflex 250 mg ordered for 10 days on 5/22/07, Lidoderm patches to be applied every morning starting 6/4/07 that were discontinued on 6/12/07, Prednisone 20 mg for one day 6/7/07 and 7/17/07, Prednisone 10 mg for 3 days starting 6/8/07 and Prednisone 20 mg from 7/18 to 7/20/07, Morphine Concentrate 5mg every 8 hours, discontinued on 6/28/07 and PRN Morphine discontinued on 7/30/07, Solsite to a stage II decubitus on 6/29/07 and Ativan 0.5 mg PRN ordered on 6/30/07. Review of the patient's NH record identified that on 6/28/07 at 7:00 AM, the patient was found on the floor next to the bed, was very confused and complaining of right leg pain, and exhibiting extreme lethargy (Morphine q8 hr. D/C on 6/28/07). On 6/29/07 nursing notes identified that a 1 x 1.5 cm open area was identified on the buttocks. Review of patient #11's hospice record failed to identify that the care plan dated 4/4/07 was updated to identify and/or to develop interventions for the treatment of the open areas on the heels (started 3/7/07) or buttocks (6/29/07) and/or the fall, and/or the increased pain and/or lethargy from the Morphine. Although the patient had developed the open area of the heel on 3/7/07 and the buttocks on 6/29/07, a low air loss mattress was not ordered until 7/2/07. Additionally, there was no documentation in the hospice record that the pressure sore had been visualized and assessed by the hospice PCN/RN #1, and/or that alternative pressure reduction methods had been implemented.

During an interview with the PCN/RN#1 on 8/16/07, he stated that because there was so much cross over with the NH, some issues and medications did not always make it to the hospice care plan and/or

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

medication record and was not able to address the reason for not developing and/or implementing other pressure reduction alternatives.

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

8. Based on clinical record review, staff interviews, agency policy review and patient observations it was determined that for five (5) of eleven (11) patients, the hospice nurse failed to coordinate services and implementation of the hospice plan of care with the IDG and/or NH staff and/or the IDG failed to supervise the care and services offered by the hospice (Patient #s 1, 2, 3, 4 and 5). The findings include:

a. Patient #1 had a start of care of 06/20/07, resided in a NH and had a principal diagnosis of end-stage COPD. RN #1 (PCN) failed to coordinate with the IDG as to whether the patient should be continued on hospice due to stability in the patient's physical and mental status.

b. Patient #2 had a start of care date of 8/7/07. The patient resided in a NH, had a decubitus ulcer on the coccyx and buttocks which required daily wound care, was bed bound and had a 25 lb. weight loss in 30 days while hospitalized from 7/12/07 to 8/7/07.

The initial plan of care dated 8/7/07 indicated that the nurse would visit daily as Patient #2 was on inpatient level of care in the NH. The nurse was to visit daily for daily monitoring and assessment of symptom control and management since the patient's condition was poor. The patient's wound was to be assessed with the treatment nurse at the NH. The plan of care lacked nursing interventions specific to the patient's needs and/or lacked description of the patient's wounds/treatments. The nurse noted that the patient was on inpatient level of care due to decrease urine output, anasarca, ascites and liver dysfunction, anticipate pharmacological interventions for pain and work with NH to prevent wound enlargement.

Review of the hospice and NH clinical record from 8/7/07 to 8/15/07 indicated the patient's output had increased from 175cc to 900cc in 24 hours, the patient denied pain and was not given any pain medication, the patient was noted by the NH to eat 50 to 75 % of the meals, remained alert, verbally responsive with occasional confusion. A hospice nurse visited daily but did not assess the patient's decubitus ulcer until 8/12/07 when she observed the wound care procedure by the NH nurse and the primary care nurse did not observe the patient's decubitus ulcer until 8/15/07. Review of the NH record indicated that the patient developed heel blisters and an ankle wound, which the hospice nurses did not assess. The hospice record and the NH record had discrepancies in wound measurements and staging and the hospice record did not include the patient's accurate medications. Review of the IDT notes of 8/8 and 8/14/07 lacked documentation regarding the discussion of the patients needs with appropriate interventions and/or lacked documentation regarding the appropriateness of the patient being on inpatient level of care since the patient assessment and the documented nursing modalities and/or interventions did not substantiate that level of care.

On a patient visit of 8/16/08 the surveyor noted the patient to be pale, alert, occasionally confused,

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

verbally responsive, denied any pain, in good spirits and had multiple decubiti/skin abrasions.

RN #1 stated on 8/20/07 that the NH was responsible for the patient's wound care and he was visiting daily to "stay ahead of the curve" and to try to encourage the patient to take the pain medication since he felt that he/she was experiencing pain but would not take medication.

The hospice clinical record lacked documentation by the hospice primary care nurse that coordination occurred with the NH staff /IDG and/or patient/family regarding the patient's deterioration in skin integrity, pain management, medications, nutritional status, functional status as evidenced by discrepancy in medications, lack of wound observation by the hospice nurse and lack of substantial information in the IDG meeting minutes.

c. Patient #3 had a start of care of 07/05/07, resided in a NH and had a principal diagnosis of adult onset failure to thrive. RN #1 (PCN) and RN #2 failed to coordinate with the IDG to further evaluate for the need to implement a spiritual plan of care.

d. Patient #4 had a start of care of 08/03/07, resided in a NH and had a principal diagnosis of advanced Alzheimer's disease. When the patient was admitted to hospice, RN #s 1 and 3 failed to coordinate with the NH regarding the necessity to implement PT; failed to communicate/coordinate with the NH regarding indicators of the level of care that should be provided as the patient's condition deteriorated.

e. Patient #5 had a start of care date of 7/25/07. The plan of care dated 7/25/07 included skilled nursing, aide services and MSW. Review of the hospice clinical record from 7/25/07 to 8/15/07 documented that the patient was receiving PT and ST services. The clinical record lacked documentation that the hospice nurse communicated with and/or coordinated with the therapy services. On 8/17/07, PT #1 and OT #1 stated that they had never spoken to any hospice nurse/staff. The patient's clinical record did not mention that the patient was receiving OT services. The hospice nurse failed to coordinate the implementation of the patient's plan of care.

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

9. Based on clinical record review, staff interviews and agency policy review, it was determined that for nine (9) of eleven (11) patients the agency failed to establish, within 48-hours, an initial hospice plan of care for each patient admitted to the hospice program which was individualized to meet the specific needs of the patient, including specific treatments/interventions for each discipline (Patients #s 1, 2, 3, 4, 5, 6, 8, 10 and 11). The findings include:

a. Review of hospice certifications and plans of care for Patient #s 1, 3, 4, 5, 6, 8, 10 and 11 failed to identify patient specific treatments and interventions for each discipline for each patient. All plans of care included only generic information such as provide patient and family with anticipatory guidance, provide comfort and support. When interviewed on 08/13/07 RN #1 stated it took several days to

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through October 23, 2007

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

complete the hospice certification and plan of care; and was not aware the plans of care were incomplete

Review of the agency admissions policy stated the plan of care would address the scope of each service and development of the initial plan of care would be accomplished within 48 hours of admission.

b. Patient #2 had a start of care date of 8/7/07. The hospice patient referral/admission form stated that the patient was in an acute hospital from 7/12/07 to 8/7/07 with diagnoses of a history of lymphatic malignancy, anasarca, anemia, GI bleed, renal failure and a stage 4 coccyx decubitus ulcer. The patient was recently hospitalized for a 25 lb. weight loss. The referral/admission form noted that the patient was alert/confused at times, bed bound, had a Foley catheter, needed a low air mattress and skilled nursing would visit daily, aide 3x a week, MSW 1-4x a month and a spiritual evaluation was declined. The nursing assessment of 8/7/07 noted that the patient denied pain, was bed bound, resided in a NH, had unlabored respirations, poor nutrition and a sacral decubitus. Review of the hospice clinical record on 8/13/07 lacked documentation of an interagency referral form from the hospital (W-10), and/or a hospice certification and plan of care for the patient and/or an assessment of the wound by hospice staff including wound description/measurement/drainage.

RN #1 stated on 8/13/07 that the patient's plan of care was not as yet completed as it often took many days to complete. RN #1 stated that the hospice did not receive a W-10 from the hospital and that the NH usually received the W-10 but the NH had not forwarded a W-10 to hospice.

The referral/admission form and the nursing assessment lacked documentation that the nurse conferred/collaborated with the IDG prior to providing services to the patient. Initial review of the clinical record on 8/13/07 identified that the IDG notes were not in the hospice record but were subsequently faxed from the inpatient facility where the patient resided. The IDG met on 8/8/07 and noted only that the patient had severe edema, slight dementia, ascites, and a stage 3-4 sacral decubitus and had a supportive son. The IDG meeting minutes lacked documentation of collaboration by the IDG regarding care planning.

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

10. Based on interviews with the senior administrator and the social worker, it was determined the agency failed to have a volunteer coordinator to manage the volunteer program from 07/13/07 through 08/19/07 and/or failed to have any volunteers assigned to the hospice program since May 2007. The findings include:

a. When interviewed on 08/15/07, the senior administrator stated the agency has been unable to find any volunteers to provide services at the skilled nursing facility (NH) where their current patients reside and the agency has been without a volunteer coordinator since 07/13/07. When interviewed on 08/16/07, the social worker stated the agency has no volunteers; as it is difficult to find volunteers.

DATE(S) OF VISIT: August 13, 14, 15, 16, 17, 2007 with additional information received through
October 23, 2007

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D75
(a)(b)(c) Clinical record system. _

11. Based on clinical record review, observation, interviews with the senior administrator and hospice director/hospice SCS and agency policy review, it was determined that for eleven (11) of eleven (11) patients the agency failed to maintain a complete, accurately documented and readily accessible clinical record (Patient #s 1-11). The findings include:

a. Review of the clinical records of Patient #s 1-11 identified that there were numerous missing required documents and/or copies of professional progress notes in the record. When interviewed on 08/13/07, the senior administrator stated professional staff had inadvertently filed original notes in the hospice section of the NH record. When interviewed on 08/13/07, the hospice director/hospice SCS stated it takes several days to formulate a plan of care, therefore, new patient records were missing hospice plans of care. Agency policy stated the original file in its entirety should be retained in the hospice office.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76(f)
Quality assurance program. _

12. Based on interviews with the senior administrator and hospice director/hospice SCS and review of personnel files, it was determined that the agency failed to prepare written six (6) month and/or twelve (12) month evaluations for two (2) RNs and three (3) hospice aides. The findings include:

a. Hospice Aide #1 had a date of hire of 05/19/06; Hospice Aide #s 2 and 3 had a date of hire of 06/27/06. Documentation was lacking of both 6- and 12-month evaluations for Hospice Aide #s 1, 2 and 3.

b. Per diem RN #s 2 and 3 were both hired on 05/24/06. Documentation was lacking of both 6- and 12-month written evaluations.

c. When interviewed on 08/16/07, the hospice director/hospice SCS stated there had not been an opportunity, since 05/29/07, to evaluate RN #s 2, 3 and Hospice Aide #s 1, 2, 3. The previous administrator/supervisor did not evaluate these employees. When interviewed on 08/17/07, the senior administrator stated 3-month evaluations were done for RN #s 2, 3; 6- and 12-month evaluations had not been conducted for RN #s 2, 3 and Hospice Aide #s 1, 2, 3.