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

IN RE: Life Choice Hospice of Connecticut, LLC d/b/a
Compassus – Greater Connecticut
109 Boston Post Road, Suites 202-203
Orange, CT 06477

CONSENT ORDER

WHEREAS, Life Choice Hospice of Connecticut, LLC ("Licensee"), has been issued License No. 9915726 to operate a Hospice known as Compassus – Greater Connecticut, ("Agency") pursuant to 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 August 19, 2015 and concluding on September 1, 2015; 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 September 14, 2015 and an amended violation letters dated December 15, 2015 (Exhibit A, and B– copies attached); and,

WHEREAS, an office conference regarding the September 14, 2015 violation letter was held between the Department and the Licensee on October 1, 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 Tony James, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant ("INC") pre-approved in writing 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. Failure to pay the INC in a timely basis and in accordance with the contract, as determined by the Department in its sole and absolute discretion, shall constitute a violation of this Consent Order. Failure to pay the costs associated with the INC's duties may result in a fine not to exceed one thousand ($1,000.00) dollars per day until such costs are paid.
2. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit C - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut and shall have experience in hospice care with a focus on pain management. 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. The INC shall provide consulting services for a minimum of six (6) 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 Facility sixteen (16) hours per week at various times. The Department shall evaluate the hours of the INC at the end of a 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, based upon any information it deems relevant, that 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.
3. 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.

4. 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 document. During the initial assessment, if the Independent Consultant identities any issues requiring immediate attention, she shall immediately notify the Department and the Licensee for appropriate response.

5. The INC shall confer with the Licensee's Administrator, Supervisor of Clinical Services, Hospice Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.

6. The INC shall make recommendations to the Licensee's Administrator, Supervisor of Clinical Services, Hospice Program Director, and Hospice Medical Director 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.

7. The INC shall submit written reports every other week 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.

8. Copies of all INC reports shall be simultaneously provided to the Supervisor of Clinical Services, Hospice Program Director, Administrator, Hospice Medical Director and the Department.

9. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care 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 letters dated September 14, 2015, amended on December 15, 2015 (Exhibits A and B).

10. The INC, the Licensee's Administrator, Hospice Program Director, and the Supervisor of Clinical Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals 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.

11. The Agency agrees that it will not use contracted staff for continuous care services.

12. 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.

13. The Department, in its absolute and sole discretion, 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.

14. Within fourteen (14) days of the execution of this Consent Order, the Hospice Program Director shall develop and/or review and revise, as necessary, policies and procedures related to filing of grievances, pain/symptom management, interdisciplinary care group ("IDG") coordination of care, complete medication orders, comprehensive plan of care, provision of core nursing services, orientation, education and performance evaluations of staff, education to contracted skilled nursing home staff on hospice, care plan revision,

social services, 10-day and 60-day summaries, RN supervision of LPN's, maintenance of personnel files for contracted staff, tracking federal requirements for staffing and subcontracting, documentation regarding wound care, and Quality Assurance and Performance Improvement ("QAPI") projects.

15. Within twenty-one (21) days of the effect of the Consent Order all Agency nursing staff shall be inserviced, to the policies and procedures identified above.

16. Effective upon the execution of this Consent Order, the Licensee, through its Governing Authority, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:

    a. Compliance with all state and federal regulations pertaining to home health and hospice;
    b. Plans of care revised accordingly;
    c. Wound care documentation will meet nursing standards;
    d. Coordination of care to meet the patient's needs, including but not limited to social services;
    e. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    f. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient. Patients with pain shall have ongoing symptoms managed. In the event the patient's pain is not relieved or worsens, the physician shall be notified and current pain management plan will be evaluated;
    g. Written concerns and/or grievance shall be addressed;
    h. Each patient shall have timely coordination of care by the interdisciplinary group ("IDG");
    i. Each patient care plan is certified by the physician and is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    j. Each patient shall have appropriate physician orders for medication services;
    k. Accurate documentation of 10-day and 60-day summaries;

l. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, unmanaged/uncontrolled pain, deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's pain management needs or if the patient requires immediate care, the Hospice Medical Director is notified;

m. Provision of core nursing services through direct employees;

n. Orientation of staff on Hospice philosophy;

o. Operation of a performance improvement program; and,

p. Operation of an effective Quality Assessment and Performance Improvement (QAPI) program;

17. The Licensee, within seven (7) days of the execution of this Consent Order, shall designate an individual within the Agency to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

18. The Licensee shall establish a Quality Assessment and Performance Improvement Program ("QAPI") to review patient care issues including those identified in the violation letter dated September 14, 2015 and amended violation letters dated December 15, 2015. The QAPI shall identify a Quality Assurance Performance Improvement Committee, consisting of, at least, the Administrator, Supervisor of Clinical Service, Hospice Program Director, and Hospice Medical Director. 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 Performance Improvement 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 and/or infections. The Committee shall implement a quality assurance 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.

19. At the time of signing this Consent Order, the Licensee agrees to pay a monetary settlement of two thousand five hundred dollars ($2,500.00) by money order or bank check payable to "Treasurer, State of Connecticut". The monetary settlement and all reports required by this document shall be directed to:

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

20. 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 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 Exhibits A and B 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 state and federal statutes and regulations is at issue.

21. The Licensee agrees that this Consent Order shall be reported consistent with federal and state law and regulations and consistent with Department policy. In addition, the Licensee agrees that this Consent Order will be posted on the Department's website.

22. 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.

23. 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.

24. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this Consent Order unless otherwise specified in this Consent Order.

25. The Licensee agrees 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 Consent Order 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.

26. 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 September 14, 2015and December 15, 2015 violation letters referenced in this Consent Order.

27. The Licensee has consulted with its attorney prior to the execution 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.

Tony James - President

On this 8th day of April, 2016, before me, personally appeared Tony James who acknowledged himself to be the President of Life Choice Hospice of Connecticut, LLC d/b/a Compassus – Greater Connecticut and that he, as such President being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by himself as President.

My Commission Expires: 7-8-19
(If Notary Public)

ASHLEY ALLEN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires 07-08-2019

Notary Public [X]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

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

Signed this 12th day of April, 2016.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A

September 14, 2015.

Ms. Karen Garlie, Administrator
Compassus - Greater Connecticut
109 Boston Post Road, Suite 202-203
Orange, CT 06477

Dear Ms. Garlie:

Unannounced visits were made to Compassus - Greater Connecticut concluding on September 1, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure inspection and a certification survey.

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

An office conference has been scheduled for **September 29, 2015** at **10:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish 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 September 28, 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 D. Nguyen, R.N., M.S.N., B.C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

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

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

LDN/JS:jpf

Complaints #18483 and #17647

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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

1. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with care concerns raised by the next-of-kin, the hospice agency failed to appropriately address the written concerns. The findings include:

    a. Patient #12 elected the Hospice benefits on 05/21/14. The patient ' s diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

    Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated. The patient received continuous care nursing from 05/23/14 until the patient expired on 05/28/14 at 3:15 a.m.

    Interview and review of the survey returns dated 10/06/14 with the Regional Clinical Director on 08/21/15 identified concerns from the deceased patient's next-of-kin regarding the lack of medical services involvement and/or availability, and medication as the only component of the hospice plan of care, but failed to identify an appropriate response to the concerns and/or comprehensive review of the plan of care following receipt of the written concerns.

    The agency policy on Complaint Process directed the Administrator to oversee the satisfactory resolution of the complaint/concern, maintenance of a complaint log and discussion of occurrences at Quality Assurance and Performance Improvement (QAPI) meetings for trend analysis and performance improvement purposes.

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

2. Based on review of the clinical record and staff interview, for two of four patients (Patients #12 and #13) who received continuous care, the hospice agency failed to ensure the patients received adequate pain and symptom management. The findings include:

    a. Patient #12 elected the Hospice benefits on 05/21/14.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

i. The documentation included in the record indicated that prior to the hospice care episode, the patient visited the primary care physician for an annual physical on 04/30/14. The physician documented about the patient ' s significant pain and a medication regimen of Oxycodone 30 mg every 6 hours by mouth as needed, and Oxycontin 40 mg three times a day by mouth.

The agency clinical record subsequently identified on 5/20/14 a referral for hospice care from the primary care physician.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient ' s self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

The hospice nurse contacted the on-call oncology physician to request changing the Oxycontin to 80 mg by mouth every 6 hours and the Oxycodone to 60 mg every 4 hours by mouth as needed, but prior to contacting the physician failed to document a comprehensive pain assessment that included the total and/or average daily amount of Oxycontin and Oxycodone self-administered by the patient;

ii. The primary care physician who saw the patient in an annual physical on 4/30/14 documented an allergy to Morphine.

The physician's orders for hospice care for the period of 05/21/14 to 08/14/14 were signed by the patient's oncologist and also identified an allergy to Morphine.

The nursing note for the visit of 05/22/15 from 11:15 a.m. to 1:45 p.m. indicated

that the patient was crying and reporting a pain level of 11 on scale of 1 to 10. The agency nurse documented a follow-up with the advance practice registered nurse (APRN).

On 05/22/14, the advance practice registered nurse (APRN) in the oncologist's office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

Interview and review of the physician's orders with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify communication from the hospice nurse to the APRN that the patient had an allergy to Morphine, clarification of the patient's specific adverse reaction to Morphine and failed to clarify whether the APRN ordered Benadryl "for hives" based on the APRN's assumption or knowledge that the patient's allergy to Morphine took the form of hives, prior to administering Morphine to the patient;

iii. Interview and review of the hospice nurse note for the visit of 05/22/14 from 4:30 pm to 5 pm with the Regional Clinical Director and RN #4 on 08/24/15 indicated that the nurse administered the first dose of morphine to the patient with no hives observed, but failed to identify previous clarification with the physician about the specific type of reaction to Morphine, prior to administering Morphine to the patient;

iv. Review and review of a typed nursing visit note dated 05/23/15 at 9:36 pm with RN #4 on 08/26/15 identified the availability of both Morphine and Ativan, that the patient received five doses, but failed to identify accurate nursing documentation of whether the patient received five doses of Morphine or five doses of Ativan, and how many mg of each;

v. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

vi. Interview and review of physician's orders dated 05/24/14 with the Regional

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified orders for Morphine to 20 mg sublingual every half hour as needed for respiratory rate over 21 and failed to identify nursing communication with the physician to clarify the respiratory rate parameter in the context of symptoms and/or lack of symptoms;

vii. The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurses (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am 05/24/14).

viii. However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient's pain and symptom management, and/or physician notification of the uncontrolled symptoms and consideration of alternate methods for symptom management;

Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care and/or methods to address the patient's symptoms;

Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient ' s symptoms through more effective methods of medication administration.

b. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician ' s orders for the recertification period of 05/25/15 to 07/23/15 included skilled nursing visits twice a week.

On 06/05/15, the physician ordered the initiation of continuous care and skilled nursing visits ten times for one week.

A nursing note dated 06/05/15 at 2:30 p.m. indicated that the patient received Morphine

5 mg sublingual at 1:30 p.m. with a respiratory rate of 30. The patient was lethargic, moaning with labored, gurgling respirations. The hospice nurse contacted the physician who ordered Morphine 5mg sublingually (20 mg/ml) every 2 hours around the clock, with Morphine 5mg sublingually (20 mg/5ml) every 1 hour as needed. The hospice nurse administered Morphine 5 mg sublingually.

Interview and review of the nursing notes from 06/05/15 at 3:00 p.m. through 06/07/15 at 6:00 p.m. with the Regional Vice President and the Regional Clinical Director on 09/01/15 indicated that the patient received 15 doses of Morphine 5 mg sublingually in a 24-hour period from 06/05/15 to 06/06/15, 16 doses of Morphine 5 mg sublingually in a 24-hour period from 06/06/15 to 06/07/15 at 6:00 pm with intermittent moaning, calling " help me " and copious secretions.

On 6/7/15 the nurse administered oral Atropine, and documented that the physician ordered Scopolamine patch, to be delivered by the pharmacy.

Interview and review of the Hospice registered nurse note dated 06/07/15 with the Regional Vice President and Regional Clinical Director on 09/01/15 identified RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN consultation with the Interdisciplinary Group (IDG) and/or communication with the physician regarding the need for a change in the plan of care and/or alternate methods to address the patient's symptoms.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D78 Patient's bill of rights and responsibilities (d).

3. Based on clinical record review, agency documentation and interview with agency personnel, for eight of thirteen patients (Patients #2, #3, #4, #5, #6, #7, #8 and #9) in the survey sample, the hospice agency failed to inform the patients of the disciplines providing the services, the frequency of the visits and/or the cost of the services. The findings include:

   a. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The physician's order for the period of 3/29/15 to 6/26/15 included skilled nursing services 2 times a week with 3 as-needed visits, hospice aide services 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed. Interview and review of the consent forms on 8/20/15 at 1:05 PM with the Director of Hospice failed to indicate that the patient was informed of the disciplines providing the services, the frequency of the visits and/or the cost for the services.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

b. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting. The physician's orders dated 7/31/2015 included skilled nursing services once a week for one week, then four times a week for one week, and three times a week for five weeks, medical social worker services one time week, hospice aide services five times a week for eleven weeks and chaplain services once every other week.

Interview and review of the consent forms dated 7/30/15 with Corporate Nurse # 1 on 8/27/15 at 11:30 AM identified documentation of the patient's understanding of the services provided, but failed to identify notification to the patient of the disciplines providing the services and the frequency of the services.

c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, 2 times a week for 8 weeks, hospice aide services 2 times a week for 1 week then 5 times a week for 12 weeks and 1 time a week for 1 week, social work (SW) services 1 time a week for 1 week then 1 time every 2 weeks for 12 weeks, and spiritual services 1 time a week for 1 week then 1 time every 2 weeks for 12 weeks. Interview and review of the consent forms on 8/20/15 at 1:05 PM with the Director of Hospice failed to indicate that the patient was informed of the disciplines providing the services, the frequency of the visits and/or the cost for these services.

d. Patient #5 had a start of care date of 3/23/15 and diagnoses that included paralysis agitans and dysphagia. The physician's order for the period of 3/23/15 to 6/20/15 included skilled nursing services 2 times a week with 3 as needed visits, hospice aide services 4 times a week for 1 week then 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed. Interview and review of the consent forms on 8/20/15 at 1:05 PM with the Director of Hospice failed to indicate that the patient was informed of the disciplines providing the services, the frequency of the visits and/or the cost for these services.

e. Patient #6 had a start of care date of 2/13/15 and diagnoses that included end-stage renal disease. The physician's orders dated 2/13/15 included skilled nursing services two times a week, medical social work evaluation, home health aide five times a week for 12 weeks and chaplain evaluation. Interview and review of the consent for care, election of hospice benefit and the assignment of benefits forms dated 2/13/15 with Corporate Nurse #1 on 8/27/15 at 11:30 AM identified documentation of the patients

understanding of the services provided, but failed to identify notification to the patient of the disciplines providing the services and the frequency of the services.

f. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's disease. The physicians order dated 9/10/14 directed for skilled nursing services two times a week for the certification period, hospice aide services two times a week for one week, then three times a week, medical social work services evaluation and chaplain services evaluation.

Interview and review of the consent forms dated 9/10/14 with Corporate Nurse # 1 on 8/27/15 at 11:30 AM identified documentation of the patient's understanding of the services provided, but failed to identify notification to the patient of the disciplines providing the services and the frequency of the services.

g. Patient #8 had a start of care date of 9/27/13 and diagnoses that included Alzheimer's dementia and septicemia. The physician's order dated 9/27/13 included skilled nursing services three times a week for one week, then two times a week for 12 weeks and one time a week, home health aide services five times a week for three weeks, then three times a week for nine weeks, and two times a week for one week. Interview and review of the consent forms dated 9/27/13 with Corporate Nurse #1 on 8/27/15 at 11:30 AM identified documentation of the patient's understanding of the services provided, but failed to identify notification to the patient of the disciplines providing the services and the frequency of the services.

h. Patient #9 had a start of care date of 7/6/15 and diagnoses that included cerebrovascular disease, cerebral arterial occlusion and atrial fibrillation. The physician's orders dated 7/6/2015 included skilled nursing services three times a week for one week then two times a week for twelve weeks, medical social work services one time a week for one week, home health aide three times a week for thirteen weeks and chaplain services one time a week for one week.

Interview and review of the consent forms dated 7/6/15 with Corporate Nurse #1 on 8/27/15 at 11:30 AM identified documentation of the patient's understanding of the services provided, but failed to identify notification to the patient of the disciplines providing the services and the frequency of the services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74 Administration of medicines.

4. Based on review of the clinical record and interview with agency personnel, for two of thirteen

patients (Patients #1 and #13) with a new medication and/or treatment order, the hospice nurse failed to reconcile the patient ' s medications and/or update the plan of care. The findings include:

a. Patient #1 elected the hospice benefit on 10/31/13.

The patient's diagnoses included chronic airway obstruction. Physician's orders for the certification period of 06/23/15 to 08/21/15 included skilled nursing visits three times a week with 5 additional visits as needed (prn) for symptom management.

i. The patient's medications included continuous oxygen 3 to 4 liters per minute.

The medication profile reviewed on 07/29/15, 08/03/15 and 08/12/15, included continuous oxygen 3 to 4 liters per minute.

A physician note (certificate of terminal illness) dated 06/10/15 indicated that the patient was breathless in spite of receiving oxygen 5 liters per minute via nasal cannula.

Interview and review of the clinical notes dated 07/02/15 through 08/17/15 with the Regional Clinical Director on 08/24/15 failed to identify a physician's order for the use of continuous oxygen at 5 liters/m and failed to identify revision of the medication profile to reflect the patient ' s oxygen use at 5 liters/m;

ii. Interview and review of the physician's orders and the medication profile with the Regional Clinical Director on 08/24/15 identified three concurrent orders for Lorazepam: Lorazepam intensol oral 0.5mg sublingually (2 mg/ml) every 12 hours for anxiety, Lorazepam intensol oral 0.25mg sublingually (2 mg/ml) every 1 hour as needed for mild anxiety and sleep, and Lorazepam intensol orally 0.5mg (2 mg/ml) every 2 hour as needed for anxiety, nausea and vomiting, and failed to identify nursing attempts to clarify the orders with the physician;

iii. Interview and review of the physician's orders and the medication profile with the Regional Clinical Director on 08/24/15 identified two concurrent orders of Morphine: Morphine concentrate 5mg orally (20 mg/ml) three times a day as needed for shortness of breath, and Morphine concentrate 5mg sublingually (20 mg/ml) every hour as needed for pain and shortness of breath, and failed to identify nursing attempts to clarify the orders with the physician.

b. Patient #13 elected the Hospice benefit on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician's order for the recertification period of

05/25/15 to 07/23/15 included skilled nursing visits twice a week. The physician's orders included Bacitracin twice a day to wound (of unspecified location), Duoderm CGF dressing to skin tear every 3 days and Silvadene topical daily to wound.

Interview and review of the Interdisciplinary Group (IDG) notes dated 04/01/15 with the Regional Clinical Director on 09/01/15 indicated that the right heel pressure ulcer and the right buttock pressure ulcers were healed, the nursing documentation dated 04/01/15 to 06/09/15 did not reflect wound care, and failed to identify nursing attempts to clarify the orders with the physician (location of the wounds, types of wounds, etc.)

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(m)(iii)(lll).

5. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with issues in symptom management and family coping, the hospice registered nurse (RN) failed to ensure timely coordination of care by the IDG. The findings include:

   a. Patient #12 elected the Hospice benefits on 05/21/14.
   The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.
   Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

   Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient's self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

   On 05/22/14, the advance practice registered nurse (APRN) in the oncologist ' s office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

i. Interview and review of the hospice nursing assessment dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was alert, oriented, depressed, withdrawn and the patient was lying in bed in almost a fetal position complaining of severe pain, but failed to identify nursing assessments of the patient's nutrition and/or risk for falls;

ii. Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient rolled out of bed at 3 AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6 AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40 AM, but failed to identify the initiation of safety measures and fall prevention interventions;

iii. The hospice social worker initial assessment dated 05/23/14 indicated that the next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient's decline in status but failed to identify the hospice agency's further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process;

iv. The nursing visit note dated 5/24/14 indicated that the patient was asleep in bed, minimally responsive to external stimuli. The patient's sibling visited, the patient moaned when the sibling touched the patient's head, then the sibling began shaking the patient, calling the patient by name, saying, "Wake up (name), open your eyes."

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The nurse documented trying to educate the family, but most family members had "unreasonable ideas of the patient's status."

Another nursing note dated 5/24/14 indicated that the sibling objected to the administration of Morphine for comfort, as the sibling wanted the patient "aware" instead of "sedated."

On 5/25/14, the Hospice RN documented that the patient's symptoms were poorly controlled, the patient exhibited a rapid deterioration in condition, was at risk for inpatient care, the family support system collapsed, the family was suffering and having a difficult time handling the patient's acute decline, and the family needed extensive education in pain and symptom management.

On 5/26/14 the Hospice RN documented that the patient's pain was out of control.

Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care;

v. Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(L).

6. Based on clinical record review, agency documentation and interview with hospice personnel, for one of thirteen patient s (Patient #4) in the survey sample, the hospice agency failed to obtain a physician's order prior to pre-filling the patient's medication syringes. The findings

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

include:

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week and 2 times a week for 8 for assessments and administration of pain medications.

Interview and review of the nurse's note dated 6/24/15 with Registered Nurse (RN) #1 on 8/24/15 at 10:00 AM indicated that RN #1 pre-filled oral syringes with Morphine 5 milligrams (mg) in syringes, and failed to identify a physician ' s order directing the nursing practice of pre-filling of oral syringes of Morphine.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(G).

7. Based on clinical record review, agency documentation and interview with hospice personnel, for six of thirteen patients (Patients #1, #2, #4, #5, #10 and #13) in the survey sample, the hospice agency failed to develop a plan of care that addressed the patient ' s needs. The findings include:

a. Patient #1 elected the hospice benefit on 10/31/13.

The patient's diagnoses included chronic airway obstruction.

Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up the medications due to tremors.

Subsequent physician's orders for the recertification period of 06/23/15 to 08/21/15 included skilled nursing visits three times a week with 5 additional visits as needed (prn) for symptom management, hospice aide services 5 times a week and social work services every other week.

Interview and review of the latter orders with the Regional Clinical Director on 08/24/15 failed to identify the listing of interventions and goals for nursing services, social work services and hospice aide services.

b. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The patient resided in a skilled nursing facility. The physician's

orders for the period of 3/29/15 to 6/26/15 included skilled nursing services 2 times a week with 3 as-needed visits, hospice aide services 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed.

The Interdisciplinary Group (IDG) note dated 5/13/15 identified a non-healing wound on the coccyx showing no signs of infection, with pain medication required prior to wound care, and the use of an air mattress on a hospital-type bed. Interview and review of the hospice plan of care on 8/21/15 at 12:05 PM with the Director of Hospice failed to identify orders wound treatment, frequency of measurements and/or vital signs.

c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation, oxygen dependence and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week and 2 times a week for 8 weeks, hospice aide services 2 times a week for 1 week then 5 times a week for 12 weeks and 1 time a week for 1 week.

i. Interview and review of the hospice plan of care on 8/20/15 at 1:05 PM with the Director of Hospice failed to identify documentation of the purpose for hospice aide services;

ii. The Hospice plan of care identified "dyspnea with minimal exertion" as a functional limitation, the need for oxygen supplies, and the goal for the patient to verbalize safe and effective use of oxygen, but failed to included physician's orders for oxygen with the specific amount of liters per minute, and orders for pulse oximetry monitoring and vital signs;

iii. The IDG note dated 7/15/15 identified the need for decubitus wound care (with no site specified), but the hospice plan of care and the physician's orders failed to include orders for wound care.

d. Patient #5 had a start of care date of 3/23/15 and diagnoses that included paralysis agitans and dysphagia. The physician's order for the period of 3/23/15 to 6/20/15 included skilled nursing services 2 times a week with 3 as needed visits, hospice aide services 4 times a week for 1 week then 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed.

The hospice IDG notes dated 4/15/15 indicated that the patient was using oxygen for shortness of breath and oxygen saturation below 88%.

However, interview and review of the physician ' s orders and the plan of care on 8/21/15 at 12:05 PM with the Director of Hospice failed to identify orders for oxygen

saturation monitoring, vital signs, and respiratory assessments.

e. Patient #10 elected the hospice benefit on 09/28/14.

The patient's diagnoses included end-stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice.

Interview and review of the physician's orders with the Regional Clinical Director on 08/24/15 failed to identify specific interventions and goals for continuous care hospice services.

f. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician's orders for the recertification period of 05/25/15 to 07/23/15 included skilled nursing visits twice a week.

Interview and review of the physician's orders for the period of 05/25/15 to 07/23/15 with the Regional Clinical Director on 09/01/15 failed to identify specific interventions, treatments and goals for nursing services.

On 06/05/15, the physician ordered the initiation of continuous care.

Interview and review of the physician's orders with the Regional Clinical Director on 08/24/15 failed to identify interventions and goals for continuous care hospice services.

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D73 Patient care plan (a) and/or 19-13-D72 Patient care policies (b) Patient care standards (2)(G)(iii).

8. Based on clinical record review and interview with hospice personnel, for two of thirteen patients (Patients #7 and #8) in the survey sample, the hospice agency failed to ensure the physician-certified plan of care was comprehensive and addressed the patient ' s needs. The findings include:

a. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's dementia. Interview and review of the hospice recertification orders for the period of 7/7/15 through 9/4/15 with Corporate Nurse #1 on 8/27/15 at 11:30 AM failed to identify physician's orders for services that included the disciplines providing the services, the frequency of visits, purpose of the services (wound care, medication administration, etc.), and the goals of care.

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

b. Patient #8 had a start of care date of 9/27/13 and diagnoses that included Alzheimer's dementia and septicemia.

Interview and review of the hospice recertification orders for the period of 3/26/14 through 5/24/14 with Corporate Nurse #1 on 8/27/15 at 11:30 AM identified orders for aide services, social work services and chaplain services, but failed to identify the purpose of the visits and the goals of care.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(G)(iii).

9. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with issues in symptom management and family coping, the hospice team failed to ensure timely coordination of care by the IDG. The findings include:

a. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient's self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

On 05/22/14, the advance practice registered nurse (APRN) in the oncologist ' s office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

i. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

b. Interview and review of the hospice nursing assessment dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was alert, oriented, depressed, withdrawn and the patient was lying in bed in almost a fetal position complaining of severe pain, but failed to identify nursing assessments of the patient ' s nutrition and/or risk for falls;

Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient rolled out of bed at 3AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40AM, but failed to identify the initiation of safety measures and fall prevention interventions;

The hospice social worker initial assessment dated 05/23/14 indicated that the next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process;

c. The nursing visit note dated 5/24/14 indicated that the patient was asleep in bed, minimally responsive to external stimuli. The patient ' s sibling visited, the patient moaned when the sibling touched the patient ' s head, then the sibling began shaking the patient, calling the patient by name, saying, "Wake up (name), open your eyes." The nurse documented trying to educate the family,

but most family members had "unreasonable ideas of the patient's status."

Another nursing note dated 5/24/14 indicated that the sibling objected to the administration of Morphine for comfort, as the sibling wanted the patient "aware" instead of "sedated."

On 5/25/14, the Hospice RN documented that the patient's symptoms were poorly controlled, the patient exhibited a rapid deterioration in condition, was at risk for inpatient care, the family support system collapsed, the family was suffering and having a difficult time handling the patient ' s acute decline, and the family needed extensive education in pain and symptom management.

On 5/26/14 the Hospice RN documented that the patient's pain was out of control.

Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care;

d. Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient ' s symptoms through more effective methods of medication administration.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D76 Quality assurance program (a).

10. Based on review of the agency documentation and interview with agency personnel, the hospice agency failed to adequately demonstrate the operation of the performance improvement program. The findings include:

a. Interview and review of the hospice agency Quality Assurance and Performance

Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 indicated that the chosen performance improvement project was to ensure the 60-day plan of care included all required elements such as orders, interventions, and goals, but failed to identify the availability of documentation to support the ongoing operation of the QAPI project, from data gathering, administration and coordination of the project, to methodology for monitoring and evaluating, priorities for problem resolution and oversight responsibility;

b. Interview and review of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 failed to identify documentation of QAPI projects for 2014.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D76 Quality assurance program and/or 19-13-D77 Administrative organization and records (a).

11. Based on review of the agency documentation and interviews with agency personnel, the hospice agency failed to adhere to specific tracking requirements for adverse events and other aspects of performance during the data collection of QAPI projects. The findings include:

a. Interview and review of the of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 indicated that the chosen performance improvement project was to ensure the 60-day plan of care included all required elements such as orders, interventions, and goals, but failed to identify the availability of documentation to support the ongoing operation of the QAPI project, and further indicated that the hospice agency failed to adhere to specific requirements to track adverse events and other aspects of performance, and show through quantitative data that the hospice agency was able to improve quality.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D77 Administrative organization and records (a).

12. Based on review of the agency documentation and interviews with agency personnel, the hospice agency failed to define adverse events, analyze causes and implement preventive actions during data collection of QAPI projects. The findings include:

a. Interview and review of the of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 failed to identify the availability of documentation to support the ongoing operation for the QAPI project for 2015, failed to identify QAPI projects for 2014, and further indicated that the hospice agency failed to define adverse events, develop a system for root cause analysis, with interventions to reduce their occurrence, and indicators or measures to improve quality.

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS 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 Section19-13-D72 Patient care policies (b) Patient care standards (2)(M).

13. Based on review of clinical record, agency documentation and staff interviews for four of four patients (Patients # 4, 10, 12 and 13) who required continuous care, the agency failed to provide the core nursing services through direct employees. The findings include:

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks.

The nurse's notes from 7/19/15 to 7/21/15 indicated that continuous care was initiated for Patient #4 on 7/19/15 at 8:00 PM for unmanaged symptoms of pain, respiratory distress and caregiver teaching.

Continuous care was discontinued on 7/20/15 at 4:00 PM.

Interview and review of the continuous care log on 8/21/15 at 12:05 PM with the Director of Hospice indicated that the continuous care hours were provided through licensed practical nurses (LPN) subcontracted from a staffing agency, and failed to identify the provision of nursing (a hospice core service) through nurses directly employed by the hospice agency.

b. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end- stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14 and failed to identify the provision of nursing (a

hospice core service) through nurses directly employed by the hospice agency.

c. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

On 05/23/14, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on 05/24/14, 05/25/14, 05/26/14 and 05/27/14 and failed to identify provision of core nursing service through the hospice agency's employees.

d. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.

On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient ' s increasing symptoms.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m. and failed to identify the provision of nursing (a hospice core service) through nurses directly employed by the hospice agency.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(B)(vi).

14. Based on review of clinical record, agency documentation and staff interviews for three of three patients (Patients #10, #12 and #13) who required continuous care services, the hospice agency failed to apply for qualification for "extraordinary circumstances" through the State Agency

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

prior to contracting out for core nursing services. The findings include:

a. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end- stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.

While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency ." extraordinary circumstance " as supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14 but failed to identify prior notification to the Connecticut Department of Public Health of the hospice agency request for qualification of " extraordinary circumstance " exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

b. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency " extraordinary circumstance " as supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on 05/24/14, 05/25/14, 05/26/14 and 05/27/14 but failed to identify prior notification to the Connecticut Department of Public Health of the hospice agency request for qualification of " extraordinary circumstance " exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

c. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.

On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency " extraordinary circumstance " as supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m. but failed to identify prior notification to the Connecticut Department of Public Health of the hospice agency request for qualification of " extraordinary circumstance " exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

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

15. Based on review of the clinical record and staff interviews, for three of thirteen patients (Patients #1, #4 and #12) in the survey sample, the hospice registered nurse failed to coordinate the care and meet the patient ' s needs. The findings include:

a. Patient #1 elected the hospice benefit on 10/31/13.
The patient's diagnoses included chronic airway obstruction.
Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up medications due to tremors.

i. However, interview and review of the physician ' s orders for recertification periods of 06/23/15 through 08/21/15 with the Regional Clinical Director 08/24/15 failed to identify physician ' s orders for the hospice nurse to prefill oral syringes of Morphine and Lorazepam, and failed to identify a physician ' s order for the use of the locked medication box.
During a joint home visit on 08/19/15, RN #4 indicated that the bottles of Morphine and Ativan were stored in a locked box in the home, the hospice nurse prefilled 6 oral syringes of morphine concentrate with 5mg (20 mg/ml) and placed the syringes in a cup in the refrigerator.

ii. On 07/24/15 the hospice nurse documented that the patient had 11 oral syringes filled with Morphine and 16 syringes filled with Lorazepam in a cup in the refrigerator, and that the patient rarely used more than 4 oral syringes of Morphine per day.
Interview and review of the nursing visit notes dated 07/02/15 through 08/17/15

with the Regional Clinical Director and RN #4 on 08/24/15 failed to accurate documentation of the amount of Morphine pre-filled in each oral syringe, the amount of Lorazepam pre-filled in each oral syringe and the number of oral syringes pre-filled at each nursing visit, the time frame for the medication pre-fill, and the reference used for pre-filling.

iii. In an interview on 08/24/154 with the Regional Clinical Director present, RN #4 indicated that the pharmacy usually delivered prefilled oral syringes of Morphine, but another nurse ordered the Morphine from the pharmacy and forgot to request prefilled oral syringes.

However, the pharmacist indicated on 9/3/15 that the pharmacist only prefilled Morphine oral syringes for Patient #1 once in May or June 2015, that the pharmacy delivered bottles of liquid Morphine sulfate of 30ml (100 mg/ 5 ml = 600mg per bottle) on 05/30/15, 06/18/15, 07/05/15, 07/20/15, 07/30/15 and 08/13/15 and bottles of Lorazepam of 30ml (2 mg per ml = 60 mg per bottle) on 05/14/15, 06/18/15, 07/10/15, 07/30/15 and 08/13/15.

Interview and review of the nursing notes dated 07/02/15 through 08/17/15 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify documentation of the daily amount of Morphine and Ativan in ml or mg) self-administered by the patient from the pre-filled syringes.

The agency policy on Medication Pre-fill directed the nurse to obtain physician's orders for all medications pre-fills, document the date medications were prefilled, any teaching, special instructions, communication with the physician or pharmacist, and the anticipated date of the next pre-fill.

iv. Interview and review of the nursing documentation with the Regional Clinical Director on 08/21/15 and RN #4 on 08/24/15 failed to identify documentation of narcotic accountability at each nursing visit.

The agency policy on Nursing Oversight of controlled substance directed the hospice nurses to maintain an accountability form for controlled substance record, and a medication tracking sheet for as-needed (prn) doses that included the initials of the nurses administering the narcotics.

b. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician ' s orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks to administer pain medications, provide assessments and minimize uncomfortable symptoms.

i. Interview and review of the nursing documentation on 8/20/15 at 1:05 PM with the Director of Hospice failed to identify a respiratory assessment and an assessment of

the patient ' s risk for skin breakdown upon admission, with the development of necessary preventive measures for skin breakdown;

ii. Interview and review of the nurse's notes from 7/27/15 to 8/20/15 with the Director of Hospice on 8/20/15 at 1:05 PM identified a stage II pressure ulcer on Patient #4's coccyx measuring 4 centimeters (cm) x 2 cm but failed to identify comprehensive weekly wound assessments from 7/27/15 to 8/11/15.

The agency policy on Wound care directed the assessment of wounds and documentation of the assessment on a weekly basis.

c. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

i. The documentation included in the record indicated that prior to the hospice care episode, the patient visited the primary care physician for an annual physical on 04/30/14. The physician documented about the patient ' s significant pain and a medication regimen of Oxycodone 30 mg every 6 hours by mouth as needed, and Oxycontin 40 mg three times a day by mouth.

The agency clinical record subsequently identified on 5/20/14 a referral for hospice care from the primary care physician.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient ' s self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

The hospice nurse contacted the on-call oncology physician to request changing the Oxycontin to 80 mg by mouth every 6 hours and the Oxycodone to 60 mg every 4 hours by mouth as needed, but prior to contacting the physician failed to document a comprehensive pain assessment that included the total and/or average daily amount of Oxycontin and Oxycodone self-administered by the patient;

ii. The primary care physician who saw the patient in an annual physical on 4/30/14 documented an allergy to Morphine.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The physician's orders for hospice care for the period of 05/21/14 to 08/14/14 were signed by the patient ' s oncologist and also identified an allergy to Morphine.
The nursing note for the visit of 05/22/14 from 11:15 a.m. to 1:45 p.m. indicated that the patient was crying and reporting a pain level of 11 on scale of 1 to 10. The agency nurse documented a follow-up with the advance practice registered nurse (APRN).
On 05/22/14, the advance practice registered nurse (APRN) in the oncologist's office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.
Interview and review of the physician's orders with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify communication from the hospice nurse to the APRN that the patient had an allergy to Morphine, clarification of the patient's specific adverse reaction to Morphine and failed to clarify whether the APRN ordered Benadryl "for hives" based on the APRN ' s assumption or knowledge that the patient ' s allergy to Morphine took the form of hives, prior to administering Morphine to the patient;

iii. Interview and review of the hospice nurse note for the visit of 05/22/14 from 4:30 p.m. to 5 p.m. with the Regional Clinical Director and RN #4 on 08/24/15 indicated that the nurse administered the first dose of morphine to the patient with no hives observed, but failed to identify previous clarification with the physician about the specific type of reaction to Morphine, prior to administering Morphine to the patient;

iv. Interview and review of a typed nursing visit note dated 05/23/14 at 9:36 p.m with RN #4 on 08/26/15 identified the availability of both Morphine and Ativan, that the patient received five doses, but failed to identify accurate nursing documentation of whether the patient received five doses of Morphine or five doses of Ativan, and how many mg of each;

v. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

vi. Interview and review of the admission comprehensive assessment and nursing note dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered Nurse (RN) #3 on 08/26/15 identified the documentation of bilateral nephrostomy

tubes, clean sites and amber urine is amber but failed to identify the documentation of a plan for nephrostomy tube management ;

vii. Interview and review of the hospice nursing assessment dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was alert, oriented, depressed, withdrawn and the patient was lying in bed in almost a fetal position complaining of severe pain, but failed to identify nursing assessments of the patient's nutrition and/or risk for falls;

viii. Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient rolled out of bed at 3AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40AM, but failed to identify the initiation of safety measures and fall prevention interventions;

ix. Interview and review of physician's orders dated 05/24/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified orders for Morphine to 20 mg sublingual every half hour as needed for respiratory rate over 21 and failed to identify nursing communication with the physician to clarify the respiratory rate parameter in the context of symptoms and/or lack of symptoms;

x. The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurses (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am on 05/24/14).

However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient ' s pain and symptom management, and/or notification to the physician for consideration of an alternate method of symptom management;

xi. Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care and/or methods to address the patient's symptoms;

Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms through more effective methods of medication administration;

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care.

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

16. Based on review of the clinical record and staff interview, for two of thirteen patients (Patients #3 and #12) in the survey sample, the hospice agency failed to ensure the provision of social work services to meet the patient's and family's needs. The findings include:

a. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting. The physician's orders dated 7/31/2015 included medical social work (MSW) services evaluation.

Subsequent physician's orders dated 8/13/15 included medical social work services one time a week for twelve weeks.

Interview and review of the clinical notes with Corporate Nurse #1 on 8/27/15 at 11:30 AM identified a social work visit on 8/13/15, and failed to identify subsequent weekly visits from the social worker in accordance with the physician's orders.

b. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

The hospice social worker initial assessment dated 05/23/14 indicated that the

next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(P).

17. Based on clinical record review, agency documentation and interview with agency personnel, for six of thirteen patient s (Patients #2, 3, 4, 5, 7 and 10) in the survey sample, the agency failed to ensure the availability of volunteer services. The findings include:

a. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The physician ' s order for the period of 6/27/15 to 9/24/15 included skilled nursing services, hospice aide services, social work services, spiritual services and volunteer services.

Interview and review of the social work note dated 3/31/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified an assessment by the social worker, during which Patient #2 was agreeable to occasional volunteer visits, but failed to identify a volunteer visit until 8/1/15 for lack of available volunteers.

b. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting.

The Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 8/5/2015 indicated that Patient #3 was a baseball fanatic, and the Volunteer Coordinator was looking for memorabilia for the patient to enjoy.
Interview and review of the Client Coordination note dated 8/13/15 with the Volunteer Coordinator on 8/27/15 at1:50 PM indicated that Patient #3 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.

c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage

congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services, hospice aide services social work services and spiritual services.

Interview and review of the social work note dated 6/26/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified an assessment from the social worker during which Patient #4 was agreeable to occasional volunteer visits, but failed to identify the provision of volunteer services for lack of available volunteers.

d. Patient #5 had a start of care date of 3/23/15 and diagnoses that included paralysis agitans and dysphagia. The physician's order for the period of 6/21/15 to 9/18/15 included skilled nursing services, hospice aide services 5 times a week for 13 weeks, social work services, spiritual services and volunteer services evaluation.

Interview and review of the social work note dated 3/27/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified a volunteer assessment completed by the social worker during which Patient #5 was agreeable to occasional volunteer visits, but failed to identify the provision of volunteer services for lack of available volunteers.

e. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's dementia.

Interview and review of the Client Coordination Note dated 9/11/14 with the Volunteer Coordinator on 8/27/15 at 1:50 PM indicated that Patient #7 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.

f. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnoses included end-stage Alzheimer's dementia, Down's syndrome, autism, a history of deep vein thrombosis and pulmonary embolism in April 2013. Physician's orders for the recertification period of 09/28/14 to 12/26/14 included volunteer services as needed and as indicated. The patient resided in a group home.

Interview and review of the Interdisciplinary Group (IDG) meeting minutes dated 10/8/14 with the Regional Clinical Director on 08/24/15 indicated that the hospice agency had no volunteer available, and failed to identify the provision of volunteer services in accordance with the physician ' s orders and/or in response to the patient ' s needs.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(P) and/or 19-13-D77 Administrative organization and records (a).

18. Based on review of the hospice staffing pattern, agency documentation and interview with hospice staff, the hospice agency failed to provide day-to day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care

hours of all paid hospice employees and contract staff. The findings include:

a. Interview and review of the 2014 hospice volunteer reports with the Volunteer Coordinator and the Regional Clinical Director on 09/01/15 indicated that in 2014 the hospice agency provided volunteer service hours that averaged 3.89 % of the direct patient care hours of all paid hospice employees and contracted staff, and failed to identify the provision of volunteer hours that averaged at a minimum 5% of the direct patient care hours of all paid hospice employees and contracted staff.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(M)(iii)(lll).

19. Based on review of clinical record, agency documentation and staff interviews for four of four patients (Patients #4, #10, #12 and #13) who required continuous care, the hospice agency failed to retain administrative management over the contracted staff. The findings include:

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician ' s orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks.

The nurse's notes from 7/19/15 to 7/21/15 indicated that continuous care was initiated for Patient #4 on 7/19/15 at 8:00 PM for unmanaged symptoms of pain, respiratory distress and caregiver teaching.

Continuous care was discontinued on 7/20/15 at 4:00 PM.

Interview and review of the continuous care log on 8/21/15 at 12:05 PM with the Director of Hospice indicated that the continuous care hours were provided through licensed practical nurses (LPN) subcontracted from a staffing agency, and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

b. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end-stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by

utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m. on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14 and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

c. Patient #12 elected the Hospice benefits on 05/21/14.
The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes, hypertension, depression and liver cirrhosis.
On 05/23/14, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.
Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on 05/24/14, 05/25/14, 05/26/14 and 05/27/14 but failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.
Interview and review of the nursing documentation with the Regional Clinical Director on 08/21/15 and RN #4 on 08/24/15 failed to identify documentation of narcotic accountability and failed to identify the initials of the nurses (including the contracted LPN) who administered each dose of narcotic.
The agency policy for Nursing Oversight of controlled substance directed the agency staff to maintain an accountability form for controlled substance record, and a medication tracking sheet for as-needed (prn) doses that included the initials of the nurses administering the narcotics.

The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurse (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am 05/24/14).

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient ' s pain and symptom management;

Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care and/or methods to address the patient's symptoms;

Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification by the hospice agency RN and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms through more effective methods of medication administration.

d. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.

On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m. and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D74 Administration of medicines (b).

20. Based on clinical record review, agency documentation and interview with hospice personnel, for two of thirteen patients (Patients #4 and #12) who required the use of narcotics, the hospice

agency failed to ensure the reconciliation of the narcotics. The findings include:

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician ' s orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week and 2 times a week for 8 weeks.

Interview and review of the nurse ' s notes from 7/19/15 to 7/21/15 indicated that continuous care was initiated for Patient #4 on 7/19/15 at 8:00 PM for unmanaged symptoms of pain, respiratory distress and caregiver teaching.

Interview and review of the continuous care Medication Administration Record (MAR) identified 3 administrations of Morphine 5 mg and two administrations of Ativan 0.5 mg from the Comfort Kit, but failed to identify documentation of reconciliation of the remaining narcotics from the Comfort Kit.

b. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurses (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am on 05/24/14).

Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired.

Interview and review of the nursing documentation with the Regional Clinical Director on 08/21/15 and RN #4 on 08/24/15 failed to identify documentation of narcotic accountability and failed to identify the initials of the nurses who administered each dose of narcotic.

The agency policy for Nursing Oversight of controlled substance directed the agency staff to maintain an accountability form for controlled substance record, and a medication tracking sheet for as-needed (prn) doses that included the initials of the

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

nurses administering the narcotics.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(vii).

21. Based on review of the hospice documentation and interview with hospice staff, the hospice agency failed to provide orientation on hospice philosophy and policies to the staff at the skilled nursing facilities contracted with the hospice. The findings include:

a. Interview with the Regional Vice President on 08/24/15 and 09/01/15 indicated that the hospice agency entered contracts with thirteen skilled nursing facilities (SNF) to provide hospice care, that the hospice agency provided orientation on hospice philosophy and policies to the staff at seven SNF, and failed to identify hospice education provided to the staff at the remaining six SNF.

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (a) General program policies (2) Delivery of services (c) and/or 19-13-D77 Administrative organization and records (g)(2) and/or 19-13-D72 Patient care policies (b) Patient care standards (2)(B(vii) and/or (m)(i) and/or (J) and/or 19-13-D68 General requirements (d) Administrator (2)(I) and/or (e) Supervisor of clinical services (5) and/or (b) Governing's authority (5)(D) and/or 19-13-D69 Services (d) Homemaker Home Health aide service (2)(S) and/or 19-13-D71 Personnel Policies (a)(1) and/or 19-13-D76 Quality assurance program (f) and/or 19-13-D71 Personnel policies (a)(5) and/or 19-13-D67 Personnel (a)(4).

22. Based on review of the hospice documentation and interview with hospice staff, the hospice agency failed to follow the State regulations. The findings include:

a. Patient #3 had a start of care date of 7/31/15 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting. Physician ' s orders dated 7/31/15 included skilled nursing services, social work services, home health aide services and chaplain services.

Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

b. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician ' s orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks, hospice aide services 2 times a week for 1 week then 5 times a week for 12 weeks and 1 time a week for 1 week, social work services 1 time a week for 1 week then 1 time every 2 weeks for 12 weeks, and spiritual services 1 time a week

for 1 week then 1 time every 2 weeks for 12 weeks.

The patient resided in assisted living facility (ALF).

Interview and review of the hospice record on 8/24/15 with the Director of Hospice failed to identify the development of a written Memorandum of Understanding between the ALF and the hospice agency to delineate responsibilities and coordinate the care of the patient through communication of information to ensure safe and effective delivery of care, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D77 Administrative organization and records (g) (2).

c. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's disease. The physician ' s orders dated 9/10/14 included skilled nursing services, home health aide services, social work services and chaplain services.

Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

d. Patient #8 had a start of care date of 9/27/13 and diagnoses that included Alzheimer's dementia and septicemia. The physician's orders dated 9/27/13 included skilled nursing services and home health aide services.

Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

e. Patient #9 had a start of care date of 7/6/15 and diagnoses that included cerebrovascular disease, cerebral arterial occlusion and atrial fibrillation. The physician's orders dated 7/6/15 included skilled nursing services, social work services, home health aide services and chaplain services.

Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

f. Interview with the Regional Vice President on 08/24/15 and 09/01/15 indicated that the hospice agency entered contracts with thirteen skilled nursing facilities (SNF) to provide hospice care, that the hospice agency provided two hours of orientation on hospice philosophy and policies to the staff at seven SNF, and failed to identify hospice education provided to the staff at the remaining six SNF in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care

policies (b) Patient Care Standards (2)(B)(vii).

g. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to identify the appointment of a Supervisor of Clinical Services for the Hospice program in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2)(M)(i).

h. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to identify the appointment of a full-time Hospice Program Director in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2)(J).

i. Review of the personnel files for RN #5 indicated that RN #5 resigned from the position of Administrator and departed the agency on 06/25/15.

Interview and review of the agency documentation with the Regional Clinical Director on 09/02/15 failed to identify a written plan for the delegation of administrative responsibilities and functions in the absence of the Administrator in accordance with the Regulations of Connecticut State Agencies section 19-13-D68 General requirements (d) Administrator (2) (I). As a result, after the departure of the former Administrator, the Supervisor of Clinical Services for the Hospice Program assumed the functions of Administrator and the functions of Hospice Program Director.

j. An Interim Administrator was appointed on 07/06/15. At the time of the appointment on 07/06/15, the Interim Administrator did not meet the requirements of the Regulations of Connecticut State Agencies at 19-13-D67 Personnel (a) (4) (two years of supervisory experience) as the Interim Administrator had twenty-one months of supervisory experience.

k. The Interim Administrator was also appointed as and carrying the full-time duties of Hospice Program Director and full-time duties of a hospice Supervisor of Clinical Services, which were required as two separate full-time positions per the Regulations of Connecticut State Agencies at 19-13-D72 Patient care policies (b) Patient Care Standards (2) (J) and/or (M) (i).

l. Review of the personnel files of Registered Nurse (RN) #5 with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 indicated that RN #5 resigned from the position of Administrator on 06/25/15, and failed to identify notification to the Connecticut Department of Public Health within forty-eight hours of RN #5's departure, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (b) Governing Authority (5) (D).

m. Review of the personnel files of the Interim Administrator with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 indicated that an Interim Administrator was appointed on 07/06/15 but failed to identify notification of the appointment to the Connecticut Department of Public Health within three (3) days of the appointment in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (b) Governing

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Authority (5) (D).

n. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 09/02/15 failed to identify the appointment in writing of a registered nurse to act in the absence of the Supervisor of Clinical Services in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (e) Supervisor of Clinical Services (5).

i. Interview and review of the agency personnel files with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to indicate that the Governing Body and/or the Interim Administrator were aware of staff qualifying education, as the staff providing care for Patient # 12 (RN # 3, RN # 4, LPN # 1, LPN #2 and the social worker) lacked the twelve hours of education per year, with six hours of topics related to hospice care, as required by the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

Patient #1 elected the hospice benefit on 10/31/13. The patient ' s diagnoses included chronic airway obstruction. Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up medications due to tremors. The patient resided in an assisted living facility.

Interview and review of the memorandum of understanding dated 10/31/13 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify revisions to the memorandum of understanding to indicate that the hospice nurse would pre-filling oral syringes of Morphine and Lorazepam for patient self- administration, in accordance with the Regulations of Connecticut State Agencies section 19-13-D77 Administrative organization and records (g)(2);

The physician's orders for the recertification period of 06/23/15 to 08/21/15 included hospice aide services and social work services. Interview and review of the memorandum of understanding dated 10/31/13 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify revisions to the memorandum of understanding to indicate that the patient received hospice aide services and hospice social work services, in accordance with the Regulations of Connecticut State Agencies section 19-13-D77 Administrative organization and records (g)(2).

o. Hospice Aide (HA) #1's date of hire was 10/06/14.

i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2)(S) and/or 19-13-D71 Personnel policies (a)(1) prior to the assignment to patient care;

ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f).

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

p. HA #2's date of hire was 01/21/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care;
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f).
   iii. Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

q. HA #3's date of hire was 09/16/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f);
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care; Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

r. HA #4's date of hire was 01/21/13 and was assigned to patient care beginning 04/22/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a statement from a physician ' s or designee that the employee was free from communicable disease, prior to patient care activities in accordance with the Regulations of Connecticut State Agencies Section

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

19-13-D71 Personnel policies (a) (5);

ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f);

iii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care;

iv. Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2)(B)(vii).

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH EXHIBIT B

December 15, 2015

Ms. Bridget Perun Administrator
Compassus - Greater Connecticut
109 Boston Post Road, Suite 202-203
Orange, CT 06477

Dear Ms. Perun:

This letter is an amended version of the letter dated September 14, 2015

Unannounced visits were made to Compassus - Greater Connecticut concluding on September 1, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure inspection and a certification survey.

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

An office conference has been scheduled for **September 29, 2015** at **10:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish 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 September 28, 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,

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:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Loan D Nguyen

Loan D. Nguyen, R.N., C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LDN/JS:jpf

Complaints #18483 and #17647

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

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

1. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with care concerns raised by the next-of-kin, the hospice agency failed to appropriately address the written concerns. The findings include:

    a. Patient #12 elected the Hospice benefits on 05/21/14. The patient ' s diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

    Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated. The patient received continuous care nursing from 05/23/14 until the patient expired on 05/28/14 at 3:15 a.m.

    Interview and review of the survey returns dated 10/06/14 with the Regional Clinical Director on 08/21/15 identified concerns from the deceased patient's next-of-kin regarding the lack of medical services involvement and/or availability, and medication as the only component of the hospice plan of care, but failed to identify an appropriate response to the concerns and/or comprehensive review of the plan of care following receipt of the written concerns.

    The agency policy on Complaint Process directed the Administrator to oversee the satisfactory resolution of the complaint/concern, maintenance of a complaint log and discussion of occurrences at Quality Assurance and Performance Improvement (QAPI) meetings for trend analysis and performance improvement purposes.

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

2. Based on review of the clinical record and staff interview, for two of four patients (Patients #12 and #13) who received continuous care, the hospice agency failed to ensure the patients received adequate pain and symptom management. The findings include:

    a. Patient #12 elected the Hospice benefits on 05/21/14.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

i. The documentation included in the record indicated that prior to the hospice care episode, the patient visited the primary care physician for an annual physical on 04/30/14. The physician documented about the patient ' s significant pain and a medication regimen of Oxycodone 30 mg every 6 hours by mouth as needed, and Oxycontin 40 mg three times a day by mouth.

The agency clinical record subsequently identified on 5/20/14 a referral for hospice care from the primary care physician.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient ' s self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

The hospice nurse contacted the on-call oncology physician to request changing the Oxycontin to 80 mg by mouth every 6 hours and the Oxycodone to 60 mg every 4 hours by mouth as needed, but prior to contacting the physician failed to document a comprehensive pain assessment that included the total and/or average daily amount of Oxycontin and Oxycodone self-administered by the patient;

ii. The primary care physician who saw the patient in an annual physical on 4/30/14 documented an allergy to Morphine.

The physician's orders for hospice care for the period of 05/21/14 to 08/14/14 were signed by the patient's oncologist and also identified an allergy to Morphine.

The nursing note for the visit of 05/22/15 from 11:15 a.m. to 1:45 p.m. indicated

that the patient was crying and reporting a pain level of 11 on scale of 1 to 10. The agency nurse documented a follow-up with the advance practice registered nurse (APRN).

On 05/22/14, the advance practice registered nurse (APRN) in the oncologist's office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

Interview and review of the physician's orders with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify communication from the hospice nurse to the APRN that the patient had an allergy to Morphine, clarification of the patient's specific adverse reaction to Morphine and failed to clarify whether the APRN ordered Benadryl "for hives" based on the APRN's assumption or knowledge that the patient's allergy to Morphine took the form of hives, prior to administering Morphine to the patient;

iii. Interview and review of the hospice nurse note for the visit of 05/22/14 from 4:30 pm to 5 pm with the Regional Clinical Director and RN #4 on 08/24/15 indicated that the nurse administered the first dose of morphine to the patient with no hives observed, but failed to identify previous clarification with the physician about the specific type of reaction to Morphine, prior to administering Morphine to the patient;

iv. Review and review of a typed nursing visit note dated 05/23/15 at 9:36 pm with RN #4 on 08/26/15 identified the availability of both Morphine and Ativan, that the patient received five doses, but failed to identify accurate nursing documentation of whether the patient received five doses of Morphine or five doses of Ativan, and how many mg of each;

v. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

vi. Interview and review of physician's orders dated 05/24/14 with the Regional

Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified orders for Morphine to 20 mg sublingual every half hour as needed for respiratory rate over 21 and failed to identify nursing communication with the physician to clarify the respiratory rate parameter in the context of symptoms and/or lack of symptoms;

vii. The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurses (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am 05/24/14).

viii. However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient's pain and symptom management, and/or physician notification of the uncontrolled symptoms and consideration of alternate methods for symptom management;

Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care and/or methods to address the patient's symptoms;

Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient ' s symptoms through more effective methods of medication administration.

b. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician ' s orders for the recertification period of 05/25/15 to 07/23/15 included skilled nursing visits twice a week.

On 06/05/15, the physician ordered the initiation of continuous care and skilled nursing visits ten times for one week.

A nursing note dated 06/05/15 at 2:30 p.m. indicated that the patient received Morphine

5 mg sublingual at 1:30 p.m. with a respiratory rate of 30. The patient was lethargic, moaning with labored, gurgling respirations. The hospice nurse contacted the physician who ordered Morphine 5mg sublingually (20 mg/ml) every 2 hours around the clock, with Morphine 5mg sublingually (20 mg/5ml) every 1 hour as needed. The hospice nurse administered Morphine 5 mg sublingually.

Interview and review of the nursing notes from 06/05/15 at 3:00 p.m. through 06/07/15 at 6:00 p.m. with the Regional Vice President and the Regional Clinical Director on 09/01/15 indicated that the patient received 15 doses of Morphine 5 mg sublingually in a 24-hour period from 06/05/15 to 06/06/15, 16 doses of Morphine 5 mg sublingually in a 24-hour period from 06/06/15 to 06/07/15 at 6:00 pm with intermittent moaning, calling " help me " and copious secretions.

On 6/7/15 the nurse administered oral Atropine, and documented that the physician ordered Scopolamine patch, to be delivered by the pharmacy.

Interview and review of the Hospice registered nurse note dated 06/07/15 with the Regional Vice President and Regional Clinical Director on 09/01/15 identified RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN consultation with the Interdisciplinary Group (IDG) and/or communication with the physician regarding the need for a change in the plan of care and/or alternate methods to address the patient's symptoms.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74 Administration of medicines.

3. Based on review of the clinical record and interview with agency personnel, for two of thirteen patients (Patients #1 and #13) with a new medication and/or treatment order, the hospice nurse failed to reconcile the patient ' s medications and/or update the plan of care. The findings include:
   a. Patient #1 elected the hospice benefit on 10/31/13.
      The patient's diagnoses included chronic airway obstruction. Physician's orders for the certification period of 06/23/15 to 08/21/15 included skilled nursing visits three times a week with 5 additional visits as needed (prn) for symptom management.
      i. The patient's medications included continuous oxygen 3 to 4 liters per minute.

         The medication profile reviewed on 07/29/15, 08/03/15 and 08/12/15, included continuous oxygen 3 to 4 liters per minute.

         A physician note (certificate of terminal illness) dated 06/10/15 indicated that the patient was breathless in spite of receiving oxygen 5 liters per minute via nasal

cannula.

Interview and review of the clinical notes dated 07/02/15 through 08/17/15 with the Regional Clinical Director on 08/24/15 failed to identify a physician's order for the use of continuous oxygen at 5 liters/m and failed to identify revision of the medication profile to reflect the patient ' s oxygen use at 5 liters/m;

i. Interview and review of the physician's orders and the medication profile with the Regional Clinical Director on 08/24/15 identified three concurrent orders for Lorazepam: Lorazepam intensol oral 0.5mg sublingually (2 mg/ml) every 12 hours for anxiety, Lorazepam intensol oral 0.25mg sublingually (2 mg/ml) every 1 hour as needed for mild anxiety and sleep, and Lorazepam intensol orally 0.5mg (2 mg/ml) every 2 hour as needed for anxiety, nausea and vomiting, and failed to identify nursing attempts to clarify the orders with the physician;

ii. Interview and review of the physician's orders and the medication profile with the Regional Clinical Director on 08/24/15 identified two concurrent orders of Morphine: Morphine concentrate 5mg orally (20 mg/ml) three times a day as needed for shortness of breath, and Morphine concentrate 5mg sublingually (20 mg/ml) every hour as needed for pain and shortness of breath, and failed to identify nursing attempts to clarify the orders with the physician.

b. Patient #13 elected the Hospice benefit on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician's order for the recertification period of 05/25/15 to 07/23/15 included skilled nursing visits twice a week. The physician's orders included Bacitracin twice a day to wound (of unspecified location), Duoderm CGF dressing to skin tear every 3 days and Silvadene topical daily to wound.

Interview and review of the Interdisciplinary Group (IDG) notes dated 04/01/15 with the Regional Clinical Director on 09/01/15 indicated that the right heel pressure ulcer and the right buttock pressure ulcers were healed, the nursing documentation dated 04/01/15 to 06/09/15 did not reflect wound care, and failed to identify nursing attempts to clarify the orders with the physician (location of the wounds, types of wounds, etc.)

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(m)(iii)(lll).

4. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with issues in symptom management and family coping, the hospice registered nurse (RN) failed to ensure timely coordination of care by the

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

IDG. The findings include:

a. Patient #12 elected the Hospice benefits on 05/21/14.
The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.
Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient's self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

On 05/22/14, the advance practice registered nurse (APRN) in the oncologist ' s office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

i. Interview and review of the hospice nursing assessment dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was alert, oriented, depressed, withdrawn and the patient was lying in bed in almost a fetal position complaining of severe pain, but failed to identify nursing assessments of the patient's nutrition and/or risk for falls;

ii. Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15

indicated that the patient rolled out of bed at 3 AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6 AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40 AM, but failed to identify the initiation of safety measures and fall prevention interventions;

iii. The hospice social worker initial assessment dated 05/23/14 indicated that the next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient's decline in status but failed to identify the hospice agency's further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process;

iv. The nursing visit note dated 5/24/14 indicated that the patient was asleep in bed, minimally responsive to external stimuli. The patient's sibling visited, the patient moaned when the sibling touched the patient's head, then the sibling began shaking the patient, calling the patient by name, saying, "Wake up (name), open your eyes." The nurse documented trying to educate the family, but most family members had "unreasonable ideas of the patient's status."

Another nursing note dated 5/24/14 indicated that the sibling objected to the administration of Morphine for comfort, as the sibling wanted the patient "aware" instead of "sedated."

On 5/25/14, the Hospice RN documented that the patient's symptoms were poorly controlled, the patient exhibited a rapid deterioration in condition, was at risk for inpatient care, the family support system collapsed, the family was suffering and having a difficult time handling the patient's acute decline, and the family needed extensive education in pain and symptom management.

On 5/26/14 the Hospice RN documented that the patient's pain was out of control.

Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on

08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care;

v. Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(L).

5. Based on clinical record review, agency documentation and interview with hospice personnel, for one of thirteen patient s (Patient #4) in the survey sample, the hospice agency failed to obtain a physician's order prior to pre-filling the patient's medication syringes. The findings include:
   a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week and 2 times a week for 8 for assessments and administration of pain medications.
   Interview and review of the nurse's note dated 6/24/15 with Registered Nurse (RN) #1 on 8/24/15 at 10:00 AM indicated that RN #1 pre-filled oral syringes with Morphine 5 milligrams (mg) in syringes, and failed to identify a physician ' s order directing the nursing practice of pre-filling of oral syringes of Morphine.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(G).

6. Based on clinical record review, agency documentation and interview with hospice personnel, for six of thirteen patients (Patients #1, #2, #4, #5, #10 and #13) in the survey sample, the

hospice agency failed to develop a plan of care that addressed the patient's needs. The findings include:

a. Patient #1 elected the hospice benefit on 10/31/13.
The patient's diagnoses included chronic airway obstruction.

Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up the medications due to tremors.

Subsequent physician's orders for the recertification period of 06/23/15 to 08/21/15 included skilled nursing visits three times a week with 5 additional visits as needed (prn) for symptom management, hospice aide services 5 times a week and social work services every other week.

Interview and review of the latter orders with the Regional Clinical Director on 08/24/15 failed to identify the listing of interventions and goals for nursing services, social work services and hospice aide services.

b. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The patient resided in a skilled nursing facility. The physician's orders for the period of 3/29/15 to 6/26/15 included skilled nursing services 2 times a week with 3 as-needed visits, hospice aide services 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed.
The Interdisciplinary Group (IDG) note dated 5/13/15 identified a non-healing wound on the coccyx showing no signs of infection, with pain medication required prior to wound care, and the use of an air mattress on a hospital-type bed. Interview and review of the hospice plan of care on 8/21/15 at 12:05 PM with the Director of Hospice failed to identify orders wound treatment, frequency of measurements and/or vital signs.

c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation, oxygen dependence and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week and 2 times a week for 8 weeks, hospice aide services 2 times a week for 1 week then 5 times a week for 12 weeks and 1 time a week for 1 week.
   i. Interview and review of the hospice plan of care on 8/20/15 at 1:05 PM with the Director of Hospice failed to identify documentation of the purpose for hospice aide services;

   ii. The Hospice plan of care identified "dyspnea with minimal exertion" as a functional

limitation, the need for oxygen supplies, and the goal for the patient to verbalize safe and effective use of oxygen, but failed to included physician's orders for oxygen with the specific amount of liters per minute, and orders for pulse oximetry monitoring and vital signs;

iii. The IDG note dated 7/15/15 identified the need for decubitus wound care (with no site specified), but the hospice plan of care and the physician's orders failed to include orders for wound care.

d. Patient #5 had a start of care date of 3/23/15 and diagnoses that included paralysis agitans and dysphagia. The physician's order for the period of 3/23/15 to 6/20/15 included skilled nursing services 2 times a week with 3 as needed visits, hospice aide services 4 times a week for 1 week then 5 times a week, social work (SW) services evaluation, spiritual services evaluation and volunteer services as needed.

The hospice IDG notes dated 4/15/15 indicated that the patient was using oxygen for shortness of breath and oxygen saturation below 88%.

However, interview and review of the physician ' s orders and the plan of care on 8/21/15 at 12:05 PM with the Director of Hospice failed to identify orders for oxygen saturation monitoring, vital signs, and respiratory assessments.

e. Patient #10 elected the hospice benefit on 09/28/14.

The patient's diagnoses included end-stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice.

Interview and review of the physician's orders with the Regional Clinical Director on 08/24/15 failed to identify specific interventions and goals for continuous care hospice services.

f. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia. Physician's orders for the recertification period of 05/25/15 to 07/23/15 included skilled nursing visits twice a week.

Interview and review of the physician's orders for the period of 05/25/15 to 07/23/15 with the Regional Clinical Director on 09/01/15 failed to identify specific interventions, treatments and goals for nursing services.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 06/05/15, the physician ordered the initiation of continuous care.

Interview and review of the physician's orders with the Regional Clinical Director on 08/24/15 failed to identify interventions and goals for continuous care hospice services.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(G)(iii).

7. Based on review of clinical record, agency documentation and interview with hospice personnel, for one of one patient (Patient #12) with issues in symptom management and family coping, the hospice team failed to ensure timely coordination of care by the IDG. The findings include:
   a. Patient #12 elected the Hospice benefits on 05/21/14.
      The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

      Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

      Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient's self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

      On 05/22/14, the advance practice registered nurse (APRN) in the oncologist ' s office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.
      i. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the

Interdisciplinary Group (IDG) to discuss and revise the plan of care;

b. Interview and review of the hospice nursing assessment dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was alert, oriented, depressed, withdrawn and the patient was lying in bed in almost a fetal position complaining of severe pain, but failed to identify nursing assessments of the patient ' s nutrition and/or risk for falls;

Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient rolled out of bed at 3AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40AM, but failed to identify the initiation of safety measures and fall prevention interventions;

The hospice social worker initial assessment dated 05/23/14 indicated that the next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process;

c. The nursing visit note dated 5/24/14 indicated that the patient was asleep in bed, minimally responsive to external stimuli. The patient ' s sibling visited, the patient moaned when the sibling touched the patient ' s head, then the sibling began shaking the patient, calling the patient by name, saying, "Wake up (name), open your eyes." The nurse documented trying to educate the family, but most family members had "unreasonable ideas of the patient's status."

Another nursing note dated 5/24/14 indicated that the sibling objected to the administration of Morphine for comfort, as the sibling wanted the patient "aware" instead of "sedated."

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 5/25/14, the Hospice RN documented that the patient's symptoms were poorly controlled, the patient exhibited a rapid deterioration in condition, was at risk for inpatient care, the family support system collapsed, the family was suffering and having a difficult time handling the patient ' s acute decline, and the family needed extensive education in pain and symptom management.

On 5/26/14 the Hospice RN documented that the patient's pain was out of control.

Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care;

d. Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient ' s symptoms through more effective methods of medication administration.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D76 Quality assurance program (a).

8. Based on review of the agency documentation and interview with agency personnel, the hospice agency failed to adequately demonstrate the operation of the performance improvement program. The findings include:
   a. Interview and review of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 indicated that the chosen performance improvement project was to ensure the 60-day plan of care included all required elements such as orders, interventions, and goals, but failed to identify the availability of documentation to support the ongoing operation of the QAPI project, from data gathering, administration and coordination of the project, to methodology for monitoring and evaluating, priorities for problem resolution and oversight responsibility;

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

b. Interview and review of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 failed to identify documentation of QAPI projects for 2014.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D76 Quality assurance program and/or 19-13-D77 Administrative organization and records (a).

9. Based on review of the agency documentation and interviews with agency personnel, the hospice agency failed to adhere to specific tracking requirements for adverse events and other aspects of performance during the data collection of QAPI projects. The findings include:
   a. Interview and review of the of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 indicated that the chosen performance improvement project was to ensure the 60-day plan of care included all required elements such as orders, interventions, and goals, but failed to identify the availability of documentation to support the ongoing operation of the QAPI project, and further indicated that the hospice agency failed to adhere to specific requirements to track adverse events and other aspects of performance, and show through quantitative data that the hospice agency was able to improve quality.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D77 Administrative organization and records (a).

10. Based on review of the agency documentation and interviews with agency personnel, the hospice agency failed to define adverse events, analyze causes and implement preventive actions during data collection of QAPI projects. The findings include:
    a. Interview and review of the of the hospice agency Quality Assurance and Performance Improvement (QAPI) with the Regional Vice President of Operations on 09/01/15 failed to identify the availability of documentation to support the ongoing operation for the QAPI project for 2015, failed to identify QAPI projects for 2014, and further indicated that the hospice agency failed to define adverse events, develop a system for root cause analysis, with interventions to reduce their occurrence, and indicators or measures to improve quality.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(M).

11. Based on review of clinical record, agency documentation and staff interviews for four of four patients (Patients #4, #10, #12 and #13) who required continuous care, the agency failed to provide the core nursing services through direct employees. The findings include:

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks.
The nurse's notes from 7/19/15 to 7/21/15 indicated that continuous care was initiated for Patient #4 on 7/19/15 at 8:00 PM for unmanaged symptoms of pain, respiratory distress and caregiver teaching.

Continuous care was discontinued on 7/20/15 at 4:00 PM.

Interview and review of the continuous care log on 8/21/15 at 12:05 PM with the Director of Hospice indicated that the continuous care hours were provided through licensed practical nurses (LPN) subcontracted from a staffing agency, and failed to identify the provision of nursing (a hospice core service) through nurses directly employed by the hospice agency.

b. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end- stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.
On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.
Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14 and failed to identify the provision of nursing (a hospice core service) through nurses directly employed by the hospice agency.

c. Patient #12 elected the Hospice benefits on 05/21/14.
The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.
On 05/23/14, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on 05/24/14, 05/25/14, 05/26/14 and 05/27/14 and failed to identify provision of core nursing service through the hospice agency's employees.

d. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.

On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m. and failed to identify the provision of nursing (a hospice core service) through nurses directly employed by the hospice agency.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D77 Administrative organization and records (a)

12. Based on review of clinical record, agency documentation and staff interviews for three of three patients (Patients #10, #12 and #13) who required continuous care services, the hospice agency failed to apply for qualification for "extraordinary circumstances" through the State Agency prior to contracting out for core nursing services. The findings include:
    a. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end- stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.
    On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.

    While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency " extraordinary circumstance " as

supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14, but failed to identify a prior request from the hospice agency to the Connecticut Department of Public Health to qualify for the "extraordinary circumstance" exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

b. Patient #12 elected the Hospice benefits on 05/21/14.
The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency " extraordinary circumstance " as supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on

05/24/14, 05/25/14, 05/26/14 and 05/27/14, but failed to identify a prior request from the hospice agency to the Connecticut Department of Public Health to qualify for the "extraordinary circumstance" exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

c. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.
On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

While the federal regulations identified nursing service as a core service to be provided directly by the hospice agency staff, the Survey and Certification (S&C) 12-43 letter dated 09/14/12 authorized hospice agencies to supplement existing staff through the use of contracted staff if qualified by the State Agency (Connecticut Department of Public Health) after a review of the hospice agency " extraordinary circumstance " as supported by evidence that the hospice agency was unable to hire (copies of advertisement, telephone contacts, competitive salary offerings, other recruiting activities and ongoing analyses of the hospice ' s trends in hiring and retaining qualified staff).

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m., but failed to identify a prior request from the hospice agency to the Connecticut Department of Public Health to qualify for the "extraordinary circumstance" exemption.

Further interview with the Interim Administrator and the Regional Clinical Director on 08/20/15 failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, in accordance with the S&C 12-43 letter.

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

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

13. Based on review of the clinical record and staff interviews, for three of thirteen patients (Patients #1, #4 and #12) in the survey sample, the hospice registered nurse failed to coordinate the care and meet the patient's needs. The findings include:
    a. Patient #1 elected the hospice benefit on 10/31/13.
    The patient's diagnoses included chronic airway obstruction.
    Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up medications due to tremors.
        i. However, interview and review of the physician's orders for recertification periods of 06/23/15 through 08/21/15 with the Regional Clinical Director 08/24/15 failed to identify physician's orders for the hospice nurse to prefill oral syringes of Morphine and Lorazepam, and failed to identify a physician's order for the use of the locked medication box.
        During a joint home visit on 08/19/15, RN #4 indicated that the bottles of Morphine and Ativan were stored in a locked box in the home, the hospice nurse prefilled 6 oral syringes of morphine concentrate with 5mg (20 mg/ml) and placed the syringes in a cup in the refrigerator.
        ii. On 07/24/15 the hospice nurse documented that the patient had 11 oral syringes filled with Morphine and 16 syringes filled with Lorazepam in a cup in the refrigerator, and that the patient rarely used more than 4 oral syringes of Morphine per day.
        Interview and review of the nursing visit notes dated 07/02/15 through 08/17/15 with the Regional Clinical Director and RN #4 on 08/24/15 failed to accurate documentation of the amount of Morphine pre-filled in each oral syringe, the amount of Lorazepam pre-filled in each oral syringe and the number of oral syringes pre-filled at each nursing visit, the time frame for the medication pre-fill, and the reference used for pre-filling.
        iii. In an interview on 08/24/154 with the Regional Clinical Director present, RN #4 indicated that the pharmacy usually delivered prefilled oral syringes of Morphine, but another nurse ordered the Morphine from the pharmacy and forgot to request prefilled oral syringes.
        However, the pharmacist indicated on 9/3/15 that the pharmacist only prefilled Morphine oral syringes for Patient #1 once in May or June 2015, that the pharmacy delivered bottles of liquid Morphine sulfate of 30ml (100 mg/ 5 ml = 600mg per bottle) on 05/30/15, 06/18/15, 07/05/15, 07/20/15, 07/30/15 and 08/13/15 and bottles of Lorazepam of 30ml (2 mg per ml = 60 mg per bottle) on 05/14/15, 06/18/15, 07/10/15, 07/30/15 and 08/13/15.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Interview and review of the nursing notes dated 07/02/15 through 08/17/15 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify documentation of the daily amount of Morphine and Ativan in ml or mg) self-administered by the patient from the pre-filled syringes.
The agency policy on Medication Pre-fill directed the nurse to obtain physician's orders for all medications pre-fills, document the date medications were prefilled, any teaching, special instructions, communication with the physician or pharmacist, and the anticipated date of the next pre-fill.

b. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for 8 weeks to administer pain medications, provide assessments and minimize uncomfortable symptoms.
    i. Interview and review of the nursing documentation on 8/20/15 at 1:05 PM with the Director of Hospice failed to identify a respiratory assessment and an assessment of the patient ' s risk for skin breakdown upon admission, with the development of necessary preventive measures for skin breakdown;
    ii. Interview and review of the nurse's notes from 7/27/15 to 8/20/15 with the Director of Hospice on 8/20/15 at 1:05 PM identified a stage II pressure ulcer on Patient #4's coccyx measuring 4 centimeters (cm) x 2 cm but failed to identify comprehensive weekly wound assessments from 7/27/15 to 8/11/15. The agency policy on Wound care directed the assessment of wounds and documentation of the assessment on a weekly basis.
c. Patient #12 elected the Hospice benefits on 05/21/14.
The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.
Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.
d. The documentation included in the record indicated that prior to the hospice care episode, the patient visited the primary care physician for an annual physical on 04/30/14. The physician documented about the patient's significant pain and a medication regimen of Oxycodone 30 mg every 6 hours by mouth as needed, and Oxycontin 40 mg three times a day by mouth.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The agency clinical record subsequently identified on 5/20/14 a referral for hospice care from the primary care physician.

Interview and review of the admission comprehensive assessment and nursing note dated 05/21/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified patient's self-rating pain at 11 on a scale of 0 to 10, with 10 being the worse pain. According to the nursing documentation, the patient experienced little or no effect from Oxycodone and Oxycontin, taking "more often than prescribed."

The hospice nurse contacted the on-call oncology physician to request changing the Oxycontin to 80 mg by mouth every 6 hours and the Oxycodone to 60 mg every 4 hours by mouth as needed, but prior to contacting the physician failed to document a comprehensive pain assessment that included the total and/or average daily amount of Oxycontin and Oxycodone self-administered by the patient;

e. The primary care physician who saw the patient in an annual physical on 4/30/14 documented an allergy to Morphine.

The physician's orders for hospice care for the period of 05/21/14 to 08/14/14 were signed by the patient's oncologist and also identified an allergy to Morphine.

The nursing note for the visit of 05/22/14 from 11:15 a.m. to 1:45 p.m. indicated that the patient was crying and reporting a pain level of 11 on scale of 1 to 10. The agency nurse documented a follow-up with the advance practice registered nurse (APRN).

On 05/22/14, the advance practice registered nurse (APRN) in the oncologist's office ordered Morphine sulfate concentrate 20 mg every 2 hours as needed for pain and shortness of breath, Ativan Intensol 2 mg every 2 hours as needed for anxiety and restlessness, and Benadryl 50 mg every 6 hours by mouth for hives.

Interview and review of the physician's orders with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify communication from the hospice nurse to the APRN that the patient had an allergy to Morphine, clarification of the patient's specific adverse reaction to Morphine and failed to clarify whether the APRN ordered Benadryl "for hives" based on the APRN ' s assumption or knowledge that the patient's allergy to Morphine took the form of hives, prior to administering Morphine to the patient;

f. Interview and review of the hospice nurse note for the visit of 05/22/14 from 4:30 p.m. to 5 p.m. with the Regional Clinical Director and RN #4 on 08/24/15 indicated that the nurse administered the first dose of morphine to the patient with no hives observed, but failed to identify previous clarification with the physician about the specific type of reaction to Morphine, prior to administering Morphine to the patient;

g. Interview and review of a typed nursing visit note dated 05/23/14 at 9:36 p.m with RN #4 on 08/26/15 identified the availability of both Morphine and Ativan, that the patient

received five doses, but failed to identify accurate nursing documentation of whether the patient received five doses of Morphine or five doses of Ativan, and how many mg of each;

h. Interview and review of further documentation in the typed nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient was lethargic, with slightly furrowed brow, occasional moan, increased respiratory rate with the use of accessory muscles, and the nursing assessment identified an acute decline noted in the last twenty-four hours, but failed to identify physician notification and care coordination with the Interdisciplinary Group (IDG) to discuss and revise the plan of care;

i. Interview and review of the admission comprehensive assessment and nursing note dated 05/21/15 with the Regional Clinical Director on 08/21/15 and Registered Nurse (RN) #3 on 08/26/15 identified the documentation of bilateral nephrostomy tubes, clean sites and amber urine is amber but failed to identify the documentation of a plan for nephrostomy tube management ;

j. Interview and review of the subsequent nursing note dated 05/23/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 indicated that the patient rolled out of bed at 3 AM, the next-of-kin was unable to lift he patient back to bed and called the nurse at 6 AM, and the nurse helped the next-of-kin get the patient back to bed at 7:40 AM, but failed to identify the initiation of safety measures and fall prevention interventions;

k. Interview and review of physician's orders dated 05/24/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #3 on 08/26/15 identified orders for Morphine to 20 mg sublingual every half hour as needed for respiratory rate over 21 and failed to identify nursing communication with the physician to clarify the respiratory rate parameter in the context of symptoms and/or lack of symptoms;

l. The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurses (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am on 05/24/14).

However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient ' s pain and symptom management, and/or notification to the physician for consideration of an alternate method of symptom management;

m. Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care

and/or methods to address the patient's symptoms;
Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms through more effective methods of medication administration;
Interview and review of the nursing note dated 05/25/14, 5/26/14 and 5/27/14 with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the family was suffering and having a difficult time handling the patient's acute decline, the next-of-kin was having a very difficult time understanding and coping with the disease process, disease progression and end-of-life care, the education on end of life was repeated many times, but failed to identify nursing referrals to the hospice social worker, bereavement counselor and the necessity to meet with the IDG to develop interventions to address the family's needs and revise the plan of care.

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

14. Based on review of the clinical record and staff interview, for one of thirteen patients (Patient #12) in the survey sample, the hospice agency failed to ensure the provision of social work services to meet the patient's and family's needs. The findings include:
    a. Patient #12 elected the Hospice benefits on 05/21/14.
    The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes mellitus, hypertension, depression and liver cirrhosis.

    Physician's orders for the period of 05/21/14 to 08/14/14 included skilled nursing visits 3 times a week for one week then 2 to 3 times a week for assessments and report of changes to the physician, hospice aide services 3 to 5 times a week to assist with personal care needs, social work and chaplain evaluation, and volunteer services as indicated.

    The hospice social worker initial assessment dated 05/23/14 indicated that the next-of-kin's emotional status was assessed with no problems identified and the next-of-kin appeared to be grieving appropriately.

    A nursing visit note dated 05/23/14 indicated that the patient had an acute decline in

status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(P).

15. Based on clinical record review, agency documentation and interview with agency personnel, for six of thirteen patient s (Patients #2, 3, 4, 5, 7 and 10) in the survey sample, the agency failed to ensure the availability of volunteer services. The findings include:
    a. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The physician's order for the period of 6/27/15 to 9/24/15 included skilled nursing services, hospice aide services, social work services, spiritual services and volunteer services.
    Interview and review of the social work note dated 3/31/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified an assessment by the social worker, during which Patient #2 was agreeable to occasional volunteer visits, but failed to identify a volunteer visit until 8/1/15 for lack of available volunteers.
    b. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting.
    The Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 8/5/2015 indicated that Patient #3 was a baseball fanatic, and the Volunteer Coordinator was looking for memorabilia for the patient to enjoy.
    Interview and review of the Client Coordination note dated 8/13/15 with the Volunteer Coordinator on 8/27/15 at1:50 PM indicated that Patient #3 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.
    c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services, hospice aide services social work services and spiritual services.
    Interview and review of the social work note dated 6/26/15 with the Volunteer

status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(P).

15. Based on clinical record review, agency documentation and interview with agency personnel, for six of thirteen patient s (Patients #2, 3, 4, 5, 7 and 10) in the survey sample, the agency failed to ensure the availability of volunteer services. The findings include:
    a. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The physician's order for the period of 6/27/15 to 9/24/15 included skilled nursing services, hospice aide services, social work services, spiritual services and volunteer services.
    Interview and review of the social work note dated 3/31/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified an assessment by the social worker, during which Patient #2 was agreeable to occasional volunteer visits, but failed to identify a volunteer visit until 8/1/15 for lack of available volunteers.
    b. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting.
    The Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 8/5/2015 indicated that Patient #3 was a baseball fanatic, and the Volunteer Coordinator was looking for memorabilia for the patient to enjoy.
    Interview and review of the Client Coordination note dated 8/13/15 with the Volunteer Coordinator on 8/27/15 at1:50 PM indicated that Patient #3 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.
    c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services, hospice aide services social work services and spiritual services.
    Interview and review of the social work note dated 6/26/15 with the Volunteer

status in the past 24 hours, the next-of-kin was unable to cope and continuous care was initiated.

Interview and review of the subsequent nursing visits notes dated 05/25/14, 05/26/14 and 05/27/14 with the regional Clinical Director on 05/21/15 and the Medical Social Worker (MSW) on 8/26/15 indicated that the family was having difficulty coping with the patient ' s decline in status but failed to identify the hospice agency ' s further offering of social work services to assess the family ' s coping pattern and assist the family in the coping process.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(P).

15. Based on clinical record review, agency documentation and interview with agency personnel, for six of thirteen patient s (Patients #2, 3, 4, 5, 7 and 10) in the survey sample, the agency failed to ensure the availability of volunteer services. The findings include:
    a. Patient #2 had a start of care date of 3/29/15 and diagnoses that included paralysis agitans (from Parkinson's disease). The physician's order for the period of 6/27/15 to 9/24/15 included skilled nursing services, hospice aide services, social work services, spiritual services and volunteer services.
    Interview and review of the social work note dated 3/31/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified an assessment by the social worker, during which Patient #2 was agreeable to occasional volunteer visits, but failed to identify a volunteer visit until 8/1/15 for lack of available volunteers.
    b. Patient #3 had a start of care date of 7/31/2015 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting.
    The Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 8/5/2015 indicated that Patient #3 was a baseball fanatic, and the Volunteer Coordinator was looking for memorabilia for the patient to enjoy.
    Interview and review of the Client Coordination note dated 8/13/15 with the Volunteer Coordinator on 8/27/15 at1:50 PM indicated that Patient #3 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.
    c. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician's orders for the period of 6/24/15 to 9/21/15 included skilled nursing services, hospice aide services social work services and spiritual services.
    Interview and review of the social work note dated 6/26/15 with the Volunteer

Coordinator on 8/21/15 at 11:30 AM identified an assessment from the social worker during which Patient #4 was agreeable to occasional volunteer visits, but failed to identify the provision of volunteer services for lack of available volunteers.

d. Patient #5 had a start of care date of 3/23/15 and diagnoses that included paralysis agitans and dysphagia. The physician's order for the period of 6/21/15 to 9/18/15 included skilled nursing services, hospice aide services 5 times a week for 13 weeks, social work services, spiritual services and volunteer services evaluation.
Interview and review of the social work note dated 3/27/15 with the Volunteer Coordinator on 8/21/15 at 11:30 AM identified a volunteer assessment completed by the social worker during which Patient #5 was agreeable to occasional volunteer visits, but failed to identify the provision of volunteer services for lack of available volunteers.

e. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's dementia.
Interview and review of the Client Coordination Note dated 9/11/14 with the Volunteer Coordinator on 8/27/15 at 1:50 PM indicated that Patient #7 agreed to occasional volunteer visits, but failed to identify the provision of volunteer services, for lack of available volunteers.

f. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnoses included end-stage Alzheimer's dementia, Down's syndrome, autism, a history of deep vein thrombosis and pulmonary embolism in April 2013. Physician's orders for the recertification period of 09/28/14 to 12/26/14 included volunteer services as needed and as indicated. The patient resided in a group home.
Interview and review of the Interdisciplinary Group (IDG) meeting minutes dated 10/8/14 with the Regional Clinical Director on 08/24/15 indicated that the hospice agency had no volunteer available, and failed to identify the provision of volunteer services in accordance with the physician's orders and/or in response to the patient's needs.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(M)(iii)(lll).

16. Based on review of clinical record, agency documentation and staff interviews for four of four patients (Patients #4, #10, #12 and #13) who required continuous care, the hospice agency failed to retain administrative management over the contracted staff. The findings include:

a. Patient #4 had a start of care date of 6/24/15 and diagnoses that included end-stage congestive heart failure, atrial fibrillation and hypertension. The physician ' s orders for the period of 6/24/15 to 9/21/15 included skilled nursing services 3 times a week for 1 week then 2 times a week for 1 week, 3 times a week for 1 week, and 2 times a week for

8 weeks.

The nurse's notes from 7/19/15 to 7/21/15 indicated that continuous care was initiated for Patient #4 on 7/19/15 at 8:00 PM for unmanaged symptoms of pain, respiratory distress and caregiver teaching.

Continuous care was discontinued on 7/20/15 at 4:00 PM.

Interview and review of the continuous care log on 8/21/15 at 12:05 PM with the Director of Hospice indicated that the continuous care hours were provided through licensed practical nurses (LPN) subcontracted from a staffing agency, and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

b. Patient #10 elected the hospice benefit on 09/28/14. The patient's diagnosis included end-stage Alzheimer's dementia, Down's syndrome, autism, history of deep vein thrombosis and pulmonary embolism in April 2013.

On 10/09/14, the physician ordered the initiation of continuous care hospice services for symptom management.

Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #4 from 7:00 p.m. to 8:00 a.m. on 10/09/14, 10/10/14, 10/11/14; from 8:00 p.m. to 11:45 a.m. on 10/12/14 and 8:00 p.m. to 10:35 p.m. on 10/13/14; LPN #5 from 8:00 a.m. to 7:30 p.m. on 10/10/14; LPN #6 from 8:00 a.m. to 7:00 p.m. on 10/11/14 and LPN #7 from 8:00 a.m. to 8:00 p.m. on 10/12/14 and 11:45 a.m. to 8:00 p.m. on 10/13/14 and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

c. Patient #12 elected the Hospice benefits on 05/21/14.

The patient's diagnoses included metastatic prostate cancer with metastases to bone, kidney and bladder, status-post bilateral nephrostomy tubes placement, non-insulin dependent diabetes, hypertension, depression and liver cirrhosis.

On 05/23/14, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.

Interview and review of the agency documentation with the Interim Administrator and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #3 from 12:00 p.m. to 4:00 p.m. on 05/24/14, 05/25/14, 05/26/14 and 05/27/14 but failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.
Interview and review of the nursing documentation with the Regional Clinical Director on 08/21/15 and RN #4 on 08/24/15 failed to identify documentation of narcotic accountability and failed to identify the initials of the nurses (including the contracted LPN) who administered each dose of narcotic.
The agency policy for Nursing Oversight of controlled substance directed the agency staff to maintain an accountability form for controlled substance record, and a medication tracking sheet for as-needed (prn) doses that included the initials of the nurses administering the narcotics.

The continuous care notes written from 05/23/14 to 05/24/14 by the Licensed Practical Nurse (LPN) identified discomfort and increased respiratory rate, requiring twelve doses of sublingual Morphine 20mg in an eleven-hour period (from 10 pm 05/23/14 to 9 am 05/24/14).
However interview and review of the Hospice registered nurse note dated 05/24/14 with the Regional Clinical Director on 08/21/15 failed to identify knowledge and/or oversight of the patient ' s pain and symptom management;

Interview and review of the Hospice registered nurse note dated 05/25/14 with the Regional Clinical Director on 08/21/15 identified the RN documentation that the patient required frequent assessment and medication changes, but failed to identify RN communication to the physician regarding the need for a change in the plan of care and/or methods to address the patient's symptoms;
Interview and review of the nursing documentation (LPN continuous care notes, Hospice RN note and medication administration log) with the Regional Clinical Director on 08/21/15 and Registered nurse (RN) #4 on 08/24/15 indicated that the patient received fifty doses of Morphine 20 mg sublingually from 05/25/14 until 05/28/14 at 3:15 a.m. when the patient expired, and failed to identify timely physician notification by the hospice agency RN and/or consultation with the IDG for the development of appropriate measures to control the patient's symptoms through more effective methods of medication administration.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

d. Patient #13 elected the Hospice benefits on 01/30/14. The patient's diagnoses included Parkinson's disease and Alzheimer's dementia.
On 06/05/15, the physician ordered the implementation of continuous hospice care in response to the patient's increasing symptoms.
Interview and review of the agency documentation with the Interim Administrator and the Regional Clinical Director on 08/20/15 indicated that the agency contracted with a staffing agency for supplemental staffing and provided continuous hospice care by utilizing contracted Licensed Practical Nurse (LPN) #8 from 4:15 p.m. to 11:15 p.m. on 06//05/15; 7:00 a.m. to 4:15 p.m. on 06/06/15; 8:00 a.m. to 4:15 p.m. on 06/08/15; 8:00 a.m. to 4:15 p.m. on 06/09/15; and 8:00 a.m. to 12:00 p.m. on 06/10/15 p.m. and failed to identify the provision of training to the contracted staff in the hospice philosophy and provision of palliative care prior to patient contact, the maintenance of personnel files of the contracted staff to ensure credentialing and qualifications, and the clinical monitoring and oversight by the hospice agency registered nurses of the care delivered by contracted staff.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (b) Patient care standards (2)(vii).

17. Based on review of the hospice documentation and interview with hospice staff, the hospice agency failed to provide orientation on hospice philosophy and policies to the staff at the skilled nursing facilities contracted with the hospice. The findings include:
    a. Interview with the Regional Vice President on 08/24/15 and 09/01/15 indicated that the hospice agency entered contracts with thirteen skilled nursing facilities (SNF) to provide hospice care, that the hospice agency provided orientation on hospice philosophy and policies to the staff at seven SNF, and failed to identify hospice education provided to the staff at the remaining six SNF.

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D72 Patient care policies (a) General program policies (2) Delivery of services (c) and/or 19-13-D77 Administrative organization and records (g)(2) and/or 19-13-D72 Patient care policies (b) Patient care standards (2)(B(vii) and/or (m)(i) and/or (J) and/or 19-13-D68 General requirements (d) Administrator (2)(I) and/or (e) Supervisor of clinical services (5) and/or (b) Governing's authority (5)(D) and/or 19-13-D69 Services (d) Homemaker Home Health aide service (2)(S) and/or 19-13-D71 Personnel Policies (a)(1) and/or 19-13-D76 Quality assurance program (f) and/or 19-13-D71 Personnel policies (a)(5) and/or 19-13-D67 Personnel (a)(4).

18. Based on review of the hospice documentation and interview with hospice staff, the hospice

agency failed to follow the State regulations. The findings include:

a. Patient #3 had a start of care date of 7/31/15 and diagnoses that included malignant neoplasm of the brain, nausea and vomiting. Physician ' s orders dated 7/31/15 included skilled nursing services, social work services, home health aide services and chaplain services.
Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

b. Patient #7 had a start of care date of 9/10/14 and diagnoses that included Alzheimer's disease. The physician ' s orders dated 9/10/14 included skilled nursing services, home health aide services, social work services and chaplain services.
Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

c. Patient #8 had a start of care date of 9/27/13 and diagnoses that included Alzheimer's dementia and septicemia. The physician's orders dated 9/27/13 included skilled nursing services and home health aide services. The patient was discharged from hospice services 05/05/14.
Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries and/or the 60-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

d. Patient #9 had a start of care date of 7/6/15 and diagnoses that included cerebrovascular disease, cerebral arterial occlusion and atrial fibrillation. The physician's orders dated 7/6/15 included skilled nursing services, social work services, home health aide services and chaplain services.
Interview and review of the clinical notes with Corporate Nurse # 1 on 8/28/15 at 10:45 AM failed to indicate that the hospice professionals completed and forwarded to the physician the 10-day summaries in accordance with the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (a) General Program Policies (2) Delivery of Services (C).

e. Interview with the Regional Vice President on 08/24/15 and 09/01/15 indicated that the

hospice agency entered contracts with thirteen skilled nursing facilities (SNF) to provide hospice care, that the hospice agency provided two hours of orientation on hospice philosophy and policies to the staff at seven SNF, and failed to identify hospice education provided to the staff at the remaining six SNF in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2)(B)(vii).

f. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to identify the appointment of a Supervisor of Clinical Services for the Hospice program in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2)(M)(i).

g. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to identify the appointment of a full-time Hospice Program Director in accordance with the Regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2)(J).

h. Review of the personnel files for RN #5 indicated that RN #5 resigned from the position of Administrator and departed the agency on 06/25/15.
Interview and review of the agency documentation with the Regional Clinical Director on 09/02/15 failed to identify a written plan for the delegation of administrative responsibilities and functions in the absence of the Administrator in accordance with the Regulations of Connecticut State Agencies section 19-13-D68 General requirements (d) Administrator (2) (I). As a result, after the departure of the former Administrator, the Supervisor of Clinical Services for the Hospice Program assumed the functions of Administrator and the functions of Hospice Program Director.

i. An Interim Administrator was appointed on 07/06/15. At the time of the appointment on 07/06/15, the Interim Administrator did not meet the requirements of the Regulations of Connecticut State Agencies at 19-13-D67 Personnel (a) (4) (two years of supervisory experience) as the Interim Administrator had twenty-one months of supervisory experience.

j. The Interim Administrator was also appointed as and carrying the full-time duties of Hospice Program Director and full-time duties of a hospice Supervisor of Clinical Services, which were required as two separate full-time positions per the Regulations of Connecticut State Agencies at 19-13-D72 Patient care policies (b) Patient Care Standards (2) (J) and/or (M) (i).

k. Review of the personnel files of Registered Nurse (RN) #5 with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 indicated that

RN #5 resigned from the position of Administrator on 06/25/15, and failed to identify notification to the Connecticut Department of Public Health within forty-eight hours of RN #5's departure, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (b) Governing Authority (5) (D).

l. Review of the personnel files of the Interim Administrator with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 indicated that an Interim Administrator was appointed on 07/06/15 but failed to identify notification of the appointment to the Connecticut Department of Public Health within three (3) days of the appointment in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (b) Governing Authority (5) (D).

m. Review of the agency staffing pattern with the Regional Vice President and the Regional Clinical Director on 09/02/15 failed to identify the appointment in writing of a registered nurse to act in the absence of the Supervisor of Clinical Services in accordance with the Regulations of Connecticut State Agencies Section 19-13-D68 General requirements (e) Supervisor of Clinical Services (5).

i. Interview and review of the agency personnel files with the Regional Vice President and the Regional Clinical Director on 08/20/15 and 08/21/15 failed to indicate that the Governing Body and/or the Interim Administrator were aware of staff qualifying education, as the staff providing care for Patient # 12 (RN # 3, RN # 4, LPN # 1, LPN #2 and the social worker) lacked the twelve hours of education per year, with six hours of topics related to hospice care, as required by the regulations of Connecticut State Agencies Section 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

Patient #1 elected the hospice benefit on 10/31/13. The patient's diagnoses included chronic airway obstruction. Physician's orders dated 01/26/15 included directions for the hospice nurse to prefill oral syringes with Morphine sulfate concentrate and Lorazepam intensol as the patient was unable to draw up medications due to tremors. The patient resided in an assisted living facility.

Interview and review of the memorandum of understanding dated 10/31/13 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify revisions to the memorandum of understanding to indicate that the hospice nurse would pre-fill oral syringes of Morphine and Lorazepam for patient self- administration, in accordance with the Regulations of Connecticut State Agencies section 19-13-D77 Administrative organization and records (g)(2);

The physician's orders for the recertification period of 06/23/15 to 08/21/15 included hospice aide services and social work services. Interview and review of the memorandum of understanding dated 10/31/13 with the Regional Clinical Director and RN #4 on 08/24/15 failed to identify revisions to the memorandum of understanding to indicate that the patient received hospice aide services and hospice social work services, in accordance with the Regulations of Connecticut State Agencies section 19-13-D77 Administrative organization and records (g)(2).

DATES OF VISIT:August 19, 20, 21, 24, 26, 27, and September 1, 2015

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

n. Hospice Aide (HA) #1's date of hire was 10/06/14.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2)(S) and/or 19-13-D71 Personnel policies (a)(1) prior to the assignment to patient care;
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f).

o. HA #2's date of hire was 01/21/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care;
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f).
   iii. Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

p. HA #3's date of hire was 09/16/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f);
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide

Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care;

Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2) (B) (vii).

q. HA #4's date of hire was 01/21/13 and was assigned to patient care beginning 04/22/13.
   i. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a statement from a physician ' s or designee that the employee was free from communicable disease, prior to patient care activities in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (5);
   ii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify a 6-month performance evaluation in accordance with the Regulations of Connecticut State Agencies Section 19-13-D76 Quality assurance program (f);
   iii. Interview and review of the personnel file with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of 10 hours of orientation on specific topics as required by the Regulations of Connecticut State Agencies Section 19-13-D69 Services (d) Homemaker-Home Health Aide Service (2) (S) and/or 19-13-D71 Personnel policies (a) (1) prior to the assignment to patient care;
   iv. Interview and review of the in-service education attendance records for 2013 and 2014 with the Regional Vice President of Operations on 09/01/15 failed to identify the provision of one (1) hour of in-service per month including six hours per year of topics related to hospice care in 2013 and 2014, in accordance with the Regulations of Connecticut State Agencies Section 19-13-D71 Personnel policies (a) (2) and/or 19-13-D72 Patient care policies (b) Patient Care Standards (2)(B)(vii).

EXHIBIT C

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Reports in accordance with the Consent Agreement/Order to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.