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

IN RE: The Waterbury Hospital of Waterbury, CT
The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

MODIFIED CONSENT ORDER

WHEREAS, The Waterbury Hospital of Waterbury, CT (hereinafter the "Licensee"), has been issued License No. 0060 to operate a General Hospital known as The Waterbury Hospital, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on August 9, 2010 and concluding on October 7, 2010; 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 November 3, 2010 (Exhibit A - copy attached); and

WHEREAS, the Department recognizes the measures taken by the Licensee to address certain violations identified in violation letter of November 3, 2010, as more fully set forth in the Licensee's revised corrective action plan dated November 19, 2010; and

WHEREAS, without admitting wrongdoing or fault, 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, Section Chief, and the Licensee, acting herein and through Darlene Stromstad, its President and CEO, hereby stipulate and agree as follows:

1. The Modified Consent Order executed with the Department on February 26, 2010 (Exhibit B - copy attached) shall be incorporated and made part of this Modified Consent Order.

2. Within thirty (30) days of the execution of this document, the Licensee shall submit to the Department for its approval one or more proposed contracts with Clinical Consulting Firm(s) (CCF), as required to fulfill the obligations under this Modified Consent Order. The Licensee shall provide to the Department a copy of the executed approved contract(s) within ten (10) days of receipt of the Department's approval.

3. The CCF shall, at a minimum, conduct onsite reviews of hospital systems as related to the care of the psychiatric patient and direct observations of the Facility staff's performance as further specified in Paragraph 4 of this Modified Consent Order. The CCF team shall consist of credentialed healthcare professionals necessary to address the issues identified in Exhibit A of this document. As used in this Paragraph 3, the term "credentialed" means, where applicable, possessing the appropriate license, certification and/or other qualifications in the relevant discipline or area of expertise (not limited solely to individuals licensed by the State of Connecticut).

4. The CCF review shall include, but not be limited to, the following professional and hospital services and systems and to make recommendations for improvements:
   a. Systems and mechanisms relative to care and safety of the psychiatric inpatient and outpatient, as appropriate, including but not limited to the implementation of the polices and procedures which relate to the care and safety of the psychiatric patient adopted pursuant to paragraph 12 of this Order and the tools adopted pursuant to paragraph 15 of this Order; and
   b. Review of the Facility's Patient Safety, Quality Assurance and Performance Improvement Programs as they relate to psychiatric patients and psychiatric units and/or departments inclusive of care and services provided in the emergency room with emphasis on their ability to detect and respond to system failures relating to said patients, units and/or departments.

5. The CCF and the Licensee shall enter into a written contract that includes the following requirements of this Modified Consent Order:
   a. Timeframes for the initial evaluation;
   b. The number of individuals with appropriate credentials for conducting the review; and
   c. The timeframes for the analysis and development of recommendations.

6. The initial onsite review shall be scheduled within forty-five (45) days of the execution of the contract with the CCF.

7. The CCF shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) and provide copies to the Licensee and the Department. Neither party shall be provided with the opportunity to review the report(s) prior to release and both parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. CCF recommendations shall include, as applicable, areas that need to be addressed by the Licensee, and, if applicable, continuing onsite hours per consulting staff per week. If the Licensee disagrees with any CCF findings or recommendations, the Licensee, the CCF and the Department shall meet to discuss issues. The Licensee shall have the right to present information related to the Licensee's areas of disagreement.

8. The Department shall have the final determination to accept or reject the CCF recommendations should the parties not be able to reach a mutual agreement.

9. Within twenty-one (21) days of either receipt of the report(s) from the CCF or final approval by the Department of the recommendations by the CCF, whichever is later, the Licensee shall provide the Department with a proposed timeframe for implementation of the CCF recommendations. The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented by the Licensee in accordance with the Departments approved timeframe. The Licensee may request that the Department modify the approved timeframe due to unforeseen circumstances. Such modification shall be in the sole discretion of the Department.

10. Any records maintained in accordance with any state or federal law or regulation or as required by this Modified Consent Order shall be made available to the Department upon request.

11. If the CCF initially determines onsite services by consultants are not necessary, the CCF shall re-evaluate the Licensee, at a minimum of six (6) months, following the completion of the initial facility evaluation. Should the CCF determine that onsite services are required, the Licensee shall meet at a minimum of four (4) months and at eight (8) months following the completion of the initial facility evaluation. The re-evaluation shall

determine the Licensee's ability to implement and maintain the professional and hospital services and systems delineated in Paragraph 4 of this Modified Consent Order and/or in the report(s) generated by the CCF. Upon conclusion of said reviews, the CCF shall provide the Department and the Licensee with comprehensive reports of said assessments.

12. Within fourteen (14) days of the execution of this Modified Consent Order, the facility shall develop and/or review and revise, as necessary, policies and procedures related to:

    a. Patient Assessments to include, where appropriate and relevant to the particular patient and patient setting, psychiatric/medical/social histories and medications, stressors and behavioral issues that may affect the patient's psychiatric condition;

    b. Patient assessments, where appropriate and relevant to the particular patient and patient setting to determine safety risks, including but not limited to suicidality;

    c. Master Treatment Plans (MTP) and/or multidisciplinary treatment plans of care ("MTPC") to include, but not be limited to, identification of individual psychiatric patient problems, goals, and approaches based upon the comprehensive assessment. All treatment modalities and professional disciplines involved with the patient during his/her hospitalizations shall specify the problems and the approaches they will utilize to attain stated goals;

    d. Each psychiatric patient shall have nursing assessment and treatment plan developed within twenty-four (24) hours of admission to inpatient service inclusive of care and services provided in the emergency room, and an MTP or MTPC developed within seventy-two (72) hours of admission to inpatient service. The MTP or MTPC shall be reviewed and revised, as necessary, to comply with applicable state and federal laws and regulations, at least seven (7) days thereafter or promptly upon a significant change in the patient's physical, mental or psychiatric condition(s) or behavior. The MTP or MTPC reviews shall be documented;

    e. Quality of care provided by the contracted service for hemodialysis and/or monitoring of the contracted service(s);

    f. Governing water testing including, but not limited to, utilization of water test strips in accordance with manufacturer's guidance and/or accurate accounting of

dialysis machine testing and/or Medical Director sign-off or water testing reports and/or dialysis orders are individualized based on current physician assessments;

g. Patient specific interventions to be implemented prior to the utilization of restraints on psychiatric patients and documentation of said interventions; and

h. Assessment for least restrictive restraint, physician orders for utilization of restraint and/or components of a patient assessment during the period a patient is in restraints.

13. The Licensee shall employ sufficient personnel to meet the needs of its psychiatric patients and to provide adequate and appropriate delivery of health care services to those patients in accordance with the Licensee's staffing plans and applicable federal and state laws and regulations.

14. Prior to the assumption of duties, all appropriate facility staff shall be in-serviced to policies and procedures developed and/or revised in accordance with Paragraph 12 of the Modified Consent Order.

15. Within fourteen (14) days of the execution of this Modified Consent Order, the Licensee shall ensure the following:

a. An environment risk assessment tool for psychiatric units shall be developed which will be utilized to identify and/or eliminate environmental conditions that pose a potential risk to the patients' health and/or safety;

b. Said environmental assessment shall be completed whenever the physical environment is refurbished or new equipment is obtained. For purposes of this paragraph, refurbish does not include maintenance or repairs which result in a restoration of the physical environment as it existed before the cause of the repair occurred; and

c. The unit specific environmental risk assessment tool shall also be utilized for any renovation or related change to the physical environment and shall be adjusted after consultation with the facility's campus planning and construction staff to ensure its review of the current general standards for details and finishes for psychiatric hospitals as found in the 2006 Edition (or most recent, updated edition) of the "Guidelines for the Design and Construction of Health Care Facilities."

16. Any records maintained in accordance with any state or federal laws or regulation or as required by this Modified Consent Order shall be made available to the Department for review or copying, upon request.

17. The Department shall retain the authority to extend the period of the Modified Consent Order should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations said decision shall be based upon findings generated as the result of onsite inspections conducted by the Department.

18. The Licensee's Quality Assurance Program, shall within fourteen (14) days of the execution of this Modified Consent Order, be revised, as necessary, to include, but not limited to:

    a. Assessing serious events which have occurred in the Facility, identifying those situations with a potential risk of harm that is reasonably identifiable and determining what preventive measure(s) shall be implemented by staff to address the identifiable risk;

    b. Adoption or revising policies, as necessary, to be implemented by staff to ensure that patient care policies relating to the care and treatment of psychiatric patients are in compliance with applicable state and federal laws and regulations;

    c. Establishment or continuation of inservice education program for licensed and unlicensed personnel which shall reflect topics pertinent to those identified by the Quality Assessment Performance Improvement Committee (QAPI);

    d. Provision by the contracted service for Hemodialysis to the Hospital's QAPI of monthly audits, performed by qualified personnel to ensure operator's compliance with procedures as referenced in Paragraph 12(f) including random observations of water testing as part of the monthly audits and review of all such audits by the QAPI;

    e. Development and implementation of a mechanism to ensure compliance with restraint utilization as referenced in Paragraph 12 (g) and (h); and

    f. Assessing implementation and compliance with (i) recommendations of the CCF and (ii) the requirements set forth in paragraphs 12 and 15 of this Order for a period of two (2) year(s) from the effective date of this Modified Consent Order.

19. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Modified Consent Order. The name of the individual shall be provided to the Department within the said timeframe. Said individual assigned this responsibility shall submit a monthly summary report which addresses the components of this document to the Department.

20. The individual designated as responsible for the implementation and monitoring of this Agreement shall meet with the Department and the designated Department's representative every three (3) months for the duration of this Order.

21. The Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars ($5,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Modified Consent Order. The monetary penalty and any reports required by this document shall be directed to:

Maureen Klett, R.N., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12 FLIS
Hartford, CT 06134-0308

22. All parties agree that this Modified Consent Order is an agreement with 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 Modified Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Modified 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.

23. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

24. The terms of this Modified Consent Order shall remain in effect for a period of one (1) year from the effective date of this document unless otherwise specified in this document.

25. The Licensee understands that this Modified 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 exist at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

26. Should the Licensee not be able to maintain substantial compliance with the requirements of this Modified Consent Order, the Department retains the right to issue charges including those identified in the November 3, 2010 violation letter referenced in this document.

27. The Licensee had the opportunity to consult with an attorney prior to the execution of this Modified Consent Order.

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

THE WATERBURY HOSPITAL OF
WATERBURY, CT - LICENSEE

By: _____
Darlene Stromstad, President and CEO

January 3, 2012
Date

STATE OF Connecticut)

County of New Haven) ss 1/3/ 2012 KK

Personally appeared the above named Darlene Stromstad and made oath to the truth of the statements contained herein.

My Commission Expires: 8/31/2014
(If Notary Public)
Kelly L Keating

Notary Public	[✓]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

1-11-2012
Date

By: _____
Barbara Cass, Public Health Services Manager
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A

November 3, 2010

Mr. John Tobin, Administrator
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

Dear Mr. Tobin:

Unannounced visits were made to Waterbury Hospital on August 9, 10, 12, 17, October 4, 5, 6 and 7, 2010 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a revisit for the purpose of full federal 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. The state violations cannot be edited by the provider in any way.

An office conference has been scheduled for November 23, 2010 at 1:30 in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Elizabeth Andstrom, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ESA:lsl

CT #'s 10349, 10641, 11008
11272, 11327

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 9, 10, 12, 17, October 4, 5, 6 and 7, 2010

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

The following is a violation of the Connecticut General Statutes 17a-542 and/or Regulations of Connecticut State Agencies Section 19-13-D3 (h) Dietary service (2) and/or (i) General (6).

1. Based on a review of clinical records, interviews with staff, observation, and review of policies for 2 patients (Patients #7 and #17), the hospital failed to ensure that the patient's privacy was maintained and that care and services were provided in a dignified manner. The findings include:
    a. Patient #7 was admitted on 7/29/10 with a diagnosis of mood disorder and had recently attempted suicide, sustaining a gun shot wound. The treatment plan identified mood disorder, and suicidal ideations with an intervention to maintain a safe environment. An observation on 8/9/10 at 9:25 AM identified that an outside Clinical Social Worker was conducting an assessment of Patient #7 in the lounge area that was open to the milieu with other patients present. Patient #7 was over heard saying "wait, let me get closer to you." "I don't want anyone to hear." Upon surveyor inquiry, the patient and Social Worker were directed to a private area.
    b. Patient #17 was admitted on 8/10/10 with diagnoses of mood and borderline personality disorders and identified as clinically suicidal. The treatment plan identified a mood disorder, poor impulse control, and suicidal ideations with an intervention to maintain a safe environment by placing the patient on lounge restriction for safety. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10 who identified that Patient #17 was found with a knife hidden in his/her bedroom and was subsequently placed on 24 hour lounge restriction for safety. The patient's mattress was brought to the lounge each night to provide a place to sleep. The lounge was observed on 8/9/10 and noted to be an open area for the general population use and provided no privacy for a patient sleeping on a mattress in that area. The treatment plan failed to identify an appropriate environment that would be safe for Patient #17 while maintaining personal privacy and dignity.

The following is a violation of the Connecticut General Statutes 17a-542 and/or Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (i) General (6).

2. Based on a review of clinical records, review of Hospital documentation, review of policies, and interviews with staff for 1 patient (Patient #1) who was admitted to the psychiatry unit with suicidal ideations, the Hospital failed to ensure that care was delivered in a safe setting when staff failed to assess/reassess the patient's environmental safety needs (presence of side rails on beds). In addition, for 19 of 19 patients (Patients #2 through 20) who were receiving treatment in the psychiatry unit, the Hospital failed to ensure that care was delivered in a safe setting when staff failed to assess/reassess each patient's environmental safety needs when the environment was identified as potentially unsafe (presence of side rails on beds on 8/4/10) The findings

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

include:

a. Patient #1 was admitted on 8/2/10 after an attempted suicide by cutting his/her wrists and consuming an overdose of opiates. The patient was assessed by MD #1 (Psychiatrist) on 8/3/10 and identified with diagnoses of severe major depressive disorder, opiate dependency, borderline personality disorder and was a suicide risk. The treatment plan identified suicidal ideations/gesture due to the patient's attempt to kill his/her self and mood disorder. Interventions included to maintain a safe environment and assess suicidality daily and as needed. The plan failed to identify the type of environment that would be safe for Patient #1, and failed to identify who would assess suicidality, when suicidality would be assessed, what would be done based on that assessment, and how it would be documented and communicated to others. The patient was assessed by a psychiatric APRN on 8/3/10, identified as experiencing opiate withdrawal, and had positive suicidal ideations. The APRN identified a plan to medicate for the opiate withdrawal symptoms and to offer emotional support. On 8/4/10 at 12 PM the APRN identified that the patient had vague suicidal ideations and continued to experience opiate withdrawal symptoms. The plan was to continue to medicate for the opiate withdrawal symptoms, offer emotional support, and start discharge planning. On 8/4/10 at 12:27 PM, RN #1 identified that Patient #1 had positive suicidal ideations, was isolative, depressed, felt that he/she had nothing, did not feel well, and reported that he/she would like to die. RN #1 identified to monitor the patient's mood and behavior. However, the clinical record failed to identify that RN #1 further assessed the patient's suicidality, and failed to ascertain if the patient would contract for safety and seek staff if he/she did not feel safe. Patient #1 was on 15-minute checks and was last observed at 5:30 PM. Approximately 10 minutes later, Patient #2 (Patient #1's room mate) identified that someone needed to check Patient #1. Patient #1 was found hanging from the side rail of his/her bed with a sheet around his/her neck. The patient was cut down and noted to be unresponsive and pulseless. CPR was administered, a pulse was reestablished, and the patient was intubated. Patient #1 was treated in the ICU, experienced seizures, and had pupils that were fixed and dilated. On 8/7/10 at 1:43 PM with family at the bedside, Patient #1 was extubated and expired at 1:59 PM.

b. Tour of the psychiatric unit on 8/9/10 identified 19 of 19 adult patients (Patients #2 through 20) currently under treatment and occupying beds with side rails. Interview with the Nurse Administrator on 8/9/10 at 9:15 AM identified that suicide risk assessments are conducted for all patients on admission and every shift. Prior to 8/4/10, the risk assessments did not include the risk posed by the presence of side rails on beds. However, once the side rails were known to pose a safety risk (8/4/10), staff failed to reassess patients for this risk. Following surveyor inquiry on 8/9/10, MD's #1 and #2 conducted side rail safety assessments on all patients.

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (e) Nursing service (1) and/or (i) General (6).

3. Based on a review of clinical records, review of policies, interview with staff, and review of Hospital documentation for 13 of 27 patients (Patients #3, #6, #7, #8, #9, #11, #12, #13, #14, #16, #18, #19 and #21) who resided on the psychiatric unit, the Hospital failed to immediately collect data in order to monitor the effectiveness and safety of care and services provided to patients in the presence of side rails once known that side rails posed a risk for hanging, necessitating an immediate action plan on 8/9/10. The findings include:
    a. Patient #1 was admitted on 8/2/10 after an attempted suicide by cutting his/her wrists and consuming an overdose of opiates and placed on 15-minute checks. On 8/4/10 Patient #1 was last observed at 5:30 PM. Approximately 10 minutes later, Patient #1 was found hanging from the side rail of his/her bed with a sheet around his/her neck. The patient was cut down and noted to be unresponsive and pulseless. CPR was administered, a pulse was reestablished, and the patient was intubated. Patient #1 was treated in the ICU, experienced seizures, and had pupils that were fixed and dilated. On 8/7/10 at 1:43 PM with family at the bedside, Patient #1 was extubated and expired at 1:59 PM. Subsequent to Patient #1's hanging on 8/4/10, the following was ascertained:
    b. Patient #3 was admitted on 8/4/10 with diagnoses of schizophrenia and psychosis, impaired judgment and a positive history of violence. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to evaluate the patient's safety in the presence of side rails, once known that side rails posed a risk for hanging.
    c. Patient #6 was admitted on 8/8/10 with diagnoses of depression and mood disorder and had recent suicidal and homicidal ideations. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/8/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
    d. Patient #7 was admitted on 7/29/10 with a diagnosis of mood disorder and had recently attempted suicide, sustaining a gun shot wound. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
    e. Patient #8 was admitted on 8/5/10 with a diagnosis of mood disorder and had recently intentionally cut self with a piece of glass in an attempt to harm his/her self. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/5/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
    f. Patient #9 was admitted on 8/4/10 with a diagnosis of mood disorder and had recently

attempted suicide by consuming an overdose of medication. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

g. Patient #11 was admitted on 7/27/10 with a diagnosis of schizophrenia. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

h. Patient #12 was admitted on 8/4/10 with diagnoses of schizoaffective disorder and dementia. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

i. Patient #13 was admitted on 8/6/10 with diagnoses of bipolar and oppositional defiant disorders, and behavioral dyscontrol. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/6/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

j. Patient #14 was admitted on 8/7/10 with a diagnosis of bipolar disorder, and manic with psychotic features. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/7/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

k. Patient #16 was admitted on 8/3/10 with diagnoses of schizoaffective disorder, borderline personality, with recent self inflicted lacerations requiring 15 staples and 8 sutures. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

l. Patient #18 was admitted on 7/14/10 with diagnoses of schizoaffective and borderline personality disorders, with multiple serious overdose attempts. The Clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

m. Patient #19 was admitted on 8/3/10 with a diagnosis of major depression, severe with psychotic features, with a recent attempt to cut self with a knife. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

n. Patient #21 was admitted on 8/3/10 with diagnoses of psychosis and personality disorder of the criminal type, with recent suicidal thoughts. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (4)(A) and/or (i) General (6).

4. Based on clinical record review, review of Hospital documentation, review of policies, and interviews with staff for 1 patient (Patient #1) who was admitted to the psychiatry unit with positive suicidal ideations, the Hospital failed to ensure that care was delivered in a safe setting when staff failed to assess/reassess the patient's environmental safety needs (presence of side rails on beds). The findings include:
    a. Patient #1 was admitted on 8/2/10 after an attempted suicide by cutting his/her wrists and consuming an overdose of opiates. The patient was assessed by MD #1 (Psychiatrist) on 8/3/10 and identified with diagnoses of severe major depressive disorder, opiate dependency, borderline personality disorder and was a suicide risk. The treatment plan identified suicidal ideations/gesture due to the patient's attempt to kill his/her self and mood disorder. Interventions included to maintain a safe environment and assess suicidality daily and as needed. The plan failed to identify the type of environment that would be safe for Patient #1, and failed to identify who would assess suicidality, when suicidality would be assessed, what would be done based on that assessment, and how it would be documented and communicate to others. The patient was assessed by a psychiatric APRN on 8/3/10, identified as experiencing opiate withdrawal, and had positive suicidal ideations. The APRN identified a plan to medicate for the opiate withdrawal symptoms and to offer emotional support. On 8/4/10 at 12 PM the APRN identified that the patient had vague suicidal ideations and continued to experience opiate withdrawal symptoms. The plan was to continue to medicate for the opiate withdrawal symptoms, offer emotional support, and start discharge planning. However, the patient's continued suicidal ideations were not addressed at that time. On 8/4/10 at 12:27 PM, RN #1 identified that Patient #1 had positive suicidal ideations, was isolative, depressed, felt that he/she had nothing, did not feel well, and reported that he/she would like to die. RN #1 identified to monitor the patient's mood and behavior. However, the clinical record failed to identify that RN #1 further assessed the patient's suicidality, and failed to ascertain if the patient would contract for safety and seek staff if he/she did not feel safe. Patient #1 was placed on 15-minute checks and was last observed at 5:30 PM. Approximately 10 minutes later, Patient #2 (Patient #1's room mate) identified that someone needed to check Patient #1. Patient #1 was found hanging from the side rail of his/her bed with a sheet around his/her neck. The patient was cut down and noted to be unresponsive and pulseless. CPR was administered, a pulse was reestablished, and the patient was intubated. Patient #1 was treated in the ICU, experienced seizures, and had pupils that were fixed and dilated. On 8/7/10 at 1:43 PM with family at the bedside, Patient #1 was extubated and expired at 1:59 PM.
    Following surveyor inquiry on 8/9/10, MD's #1 and #2 conducted side rail safety assessments on all patients.

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (3) and/or (c) Medical staff (4)(A) and/or (e) Nursing service (1) and/or (i) General (6).

5. Based on review of Hospital documentation, review of staffing, and interviews with staff, the Hospital failed to ensure that there were sufficient numbers of staff on the psychiatric unit, based on the Hospital's staffing guide. The findings include:
    a. Review of the staffing guidelines for the psychiatric unit identified that staffing was based on an average census of 19, despite the unit capacity of 30 patients. The staffing pattern for 19 patients identified the need for 4 RN's, 2 Psychiatric Technicians, and 1 Patient Care Assistant. Interview with the Director of Acute Care Behavioral Health Services on 8/17/10 at 3 PM identified that the unit's staffing guidelines did not reflect staffing requirements or guidelines if the patient census rose above 19, but that if the census or acuity was high, the staffing level would increase. The Director of Acute Care Behavioral Health Services identified that there was no system in place to measure patient acuity. Review of staffing and patient census from 7/18/10 to 8/4/10 identified that the patient census rose above 19 on 10 days, and that staffing was not increased accordingly on 8 of the 10 days, and/or lacked rationale for not adding additional staff.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

6. Based on a review of clinical records, review of Hospital documentation, review of policies, and interviews with staff for one patient (Patient #1) who was admitted to the psychiatric unit with positive suicidal ideations, nursing staff failed to ensure that care was delivered in a safe setting when staff failed to assess/reassess the patient's environmental safety needs (presence of side rails on beds). In addition, for 13 of 27 patients (Patients #3, #6, #7, #8, #9, #11, #12, #13, #14, #16, #18, #19 and #21) nursing staff failed to perform an assessment of each patients safety in the presence of side rails once known that side rails posed a risk for hanging. In addition, for 10 patients (Patients #2, #4, #9, #10, #11, #17, #18, #19, #24 and #27), nursing staff failed to include an assessment for side rails in the environmental risk assessment conducted each shift, as identified in an immediate action plan developed on 8/9/10. The findings include:

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a. Patient #1 was admitted on 8/2/10 after an attempted suicide by cutting his/her wrists and consuming an overdose of opiates. The patient was assessed by MD #1 (Psychiatrist) on 8/3/10 and identified with diagnoses of severe major depressive disorder, opiate dependency, borderline personality disorder and was a suicide risk. The treatment plan identified suicidal ideations/gesture due to the patient's attempt to kill his/her self and mood disorder. Interventions included to maintain a safe environment and assess suicidality daily and as needed. The plan failed to identify the type of environment that would be safe for Patient #1, and failed to identify who would assess suicidality, when suicidality would be assessed, what would be done based on that assessment, and how it would be documented and communicate to others. The patient was assessed by a psychiatric APRN on 8/3/10, identified as experiencing opiate withdrawal, and had positive suicidal ideations. The APRN identified a plan to medicate for the opiate withdrawal symptoms and to offer emotional support. On 8/4/10 at 12 PM the APRN identified that the patient had vague suicidal ideations and continued to experience opiate withdrawal symptoms. The plan was to continue to medicate for the opiate withdrawal symptoms, offer emotional support, and start discharge planning. On 8/4/10 at 12:27 PM, RN #1 identified that Patient #1 had positive suicidal ideations, was isolative, depressed, felt that he/she had nothing, did not feel well, and reported that he/she would like to die. RN #1 identified to monitor the patient's mood and behavior. However, the clinical record failed to identify that RN #1 further assessed the patient's suicidality, and failed to ascertain if the patient would contract for safety and seek staff if he/she did not feel safe. Patient #1 was placed on 15-minute checks and was last observed at 5:30 PM. Approximately 10 minutes later, Patient #2 (Patient #1's room mate) identified that someone needed to check Patient #1. Patient #1 was found hanging from the side rail of his/her bed with a sheet around his/her neck. The patient was cut down and noted to be unresponsive and pulseless. CPR was administered, a pulse was reestablished, and the patient was intubated. Patient #1 was treated in the ICU, experienced seizures, and had pupils that were fixed and dilated. On 8/7/10 at 1:43 PM with family at the bedside, Patient #1 was extubated and expired at 1:59 PM.

b. Patient #3 was admitted on 8/4/10 with diagnoses of schizophrenia and psychosis, impaired judgment and a positive history of violence. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to evaluate the patient's safety in the presence of side rails, once known that side rails posed a risk for hanging.

c. Patient #6 was admitted on 8/8/10 with diagnoses of depression and mood disorder and had recent suicidal and homicidal ideations. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/8/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

d. Patient #7 was admitted on 7/29/10 with a diagnosis of mood disorder and had recently attempted suicide, sustaining a gunshot wound. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6

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PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

e. Patient #8 was admitted on 8/5/10 with a diagnosis of mood disorder and had recently intentionally cut self with a piece of glass in an attempt to harm his/her self. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/5/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
f. Patient #9 was admitted on 8/4/10 with a diagnosis of mood disorder and had recently attempted suicide by consuming an overdose of medication. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
g. Patient #11 was admitted on 7/27/10 with a diagnosis of schizophrenia. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
h. Patient #12 was admitted on 8/4/10 with diagnoses of schizoaffective disorder and dementia. The clinical record was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
i. Patient #13 was admitted on 8/6/10 with diagnoses of bipolar and oppositional defiant disorders, and behavioral dyscontrol. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/6/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
j. Patient #14 was admitted on 8/7/10 with a diagnosis of bipolar disorder, and manic with psychotic features. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/7/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
k. Patient #16 was admitted on 8/3/10 with diagnoses of schizoaffective disorder, borderline personality, with recent self inflicted lacerations requiring 15 staples and 8 sutures. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
l. Patient #18 was admitted on 7/14/10 with diagnoses of schizoaffective and borderline personality disorders, with multiple serious overdose attempts. The Clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.
m. Patient #19 was admitted on 8/3/10 with a diagnosis of major depression, severe with psychotic features, with a recent attempt to cut self with a knife. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence

of side rails.

n. Patient #21 was admitted on 8/3/10 with diagnoses of psychosis and personality disorder of the criminal type, with recent suicidal thoughts. The clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

o. On 8/9/10 the Hospital developed an immediate action plan to address safety issues on the psychiatric unit. The plan identified that nursing staff would include side rails in their environmental risk assessment and document this each shift in a progress note. The clinical records of Patients #2, #4, #9, #10, #11, #17, #18, #19, #24 and #27 were reviewed with the Assistant Nursing Director on 8/12/10. Nursing staff failed to perform an assessment for side rails in the environmental risk assessment conducted each shift (as identified in an immediate action plan developed on 8/9/10) on one or more shifts between 8/9/10 and 8/12/10.

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7. Based on a review of clinical records, review of Hospital documentation, review of policies, and interviews with staff for 22 of 27 patients (Patients #1, #3, #4, #6, #7, #8, #9, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, and #26) who were admitted to the psychiatry unit, nursing staff failed to develop care plans (multidisciplinary treatment plans) that were specific to each patients safety needs related to the environment and to the level of observation required to maintain safety. In addition, for 27 of 27 patients, the hospital failed to ensure that group therapies were identified for each patient, specific to his/her needs. The findings include:

   a. Patient #1 was admitted on 8/2/10 after an attempted suicide by cutting his/her wrists and consuming an overdose of opiates. The patient was assessed by MD #1 (Psychiatrist) on 8/3/10 and identified with diagnoses of severe major depressive disorder, opiate dependency, borderline personality disorder and was a suicide risk. The treatment plan identified suicidal ideations/gesture due to the patient's attempt to kill his/her self and mood disorder. Interventions included to maintain a safe environment and assess suicidality daily and as needed. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #1, and failed to identify who would assess suicidality, when suicidality would be assessed, what would be done based on that assessment, and how it would be documented and communicate to others. Review of the policy for a clinical psychiatric record identified that the treatment plan would define prescribed treatment interventions. Patient #1 was placed on routine 15-minute checks and was last observed at 5:30 PM. Approximately 10 minutes later, Patient #1 was found hanging from the side rail of his/her bed with a sheet around his/her neck. Patient

#1 expired on 8/7/10 at 1:59 PM. In addition, Patient #1's clinical record identified that between 8/3/10 and 8/4/10, he/she failed to attend/participate in any group therapies including orientation and goals, post acute withdrawal, walk and talk, first step, skill building, and wrap-up.

b. Patient #3 was admitted on 8/4/10 with diagnoses of schizophrenia and psychosis, impaired judgment and a positive history of violence. The treatment plan identified psychosis as evidenced by auditory and visual hallucinations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #3 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails, once known that side rails posed a risk for hanging. On 8/9/10 the Hospital developed an immediate action plan to address safety issues on the psychiatric unit. The plan identified that nursing staff would include side rails in their environmental risk assessment and document this each shift in a progress note

c. Patient #4 was admitted on 8/9/10 with a diagnosis of severe depression and had recently overdosed with aspirin in a suicide attempt. The treatment plan identified mood disorder, poor impulse control and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #4 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

d. Patient #6 was admitted on 8/8/10 with diagnoses of depression and mood disorder and had recent suicidal and homicidal ideations. The treatment plan identified mood disorder, and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #6 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/8/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

e. Patient #7 was admitted on 7/29/10 with a diagnosis of mood disorder and had recently attempted suicide, sustaining a gunshot wound. The treatment plan identified mood disorder, and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #7 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

f. Patient #8 was admitted on 8/5/10 with a diagnosis of mood disorder and had recently intentionally cut self with a piece of glass in an attempt to harm his/her self. The treatment plan identified mood disorder with an intervention to maintain a safe

environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #8 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/5/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

g. Patient #9 was admitted on 8/4/10 with a diagnosis of mood disorder and had recently attempted suicide by consuming an overdose of medication. The treatment plan identified mood disorder and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #9 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

h. Patient #11 was admitted on 7/27/10 with a diagnosis of schizophrenia. The treatment plan identified psychosis with delusions and paranoia with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #11 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

i. Patient #12 was admitted on 8/4/10 with diagnoses of schizoaffective disorder and dementia. The treatment plan identified psychosis with delusions and paranoia with an intervention to maintain a safe environment. The plan was reviewed with the nursing Director and Assistant Director of psychiatry on 8/9/10. The plan failed to identify the type of environment that would be safe for Patient #12 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

j. Patient #13 was admitted on 8/6/10 with diagnoses of bipolar and oppositional defiant disorders, and behavioral dyscontrol. The treatment plan identified mood disorder, poor impulse control, homicidal and suicidal ideations involving a knife, with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #13 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/6/10 and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

k. Patient #14 was admitted on 8/7/10 with a diagnosis of bipolar disorder, and manic with psychotic features. The treatment plan identified psychosis with delusions and paranoia with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #14 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/7/10 and 8/9/10 at 7

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AM, staff failed to reevaluate the patient's safety in the presence of side rails.

l. Patient #15 was admitted on 8/10/10 with a diagnosis of major depression that was severe with psychotic features. The patient was identified as suicidal after cutting his/her neck with a broken glass bottle. The treatment plan identified a mood disorder, poor impulse control, and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #15 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

m. Patient #16 was admitted on 8/3/10 with diagnoses of schizoaffective disorder, borderline personality, with recent self inflicted lacerations requiring 15 staples and 8 sutures. The treatment plan identified suicidal ideations and psychosis with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #16 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

n. Patient #17 was admitted on 8/10/10 with diagnoses of mood and borderline personality disorders and identified as clinically suicidal. The treatment plan identified a mood disorder, poor impulse control, and suicidal ideations with an intervention to maintain a safe environment by placing the patient on lounge restriction for safety. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10 who identified that Patient #17 was found with a knife hidden in his/her bedroom and placed on 24-hour lounge restriction for safety. The patient's mattress was brought to the lounge each night to provide a place to sleep. The lounge was observed on 8/9/10 and noted to be an open area for the general populations use and provided no privacy for a patient sleeping on a mattress in that area. The treatment plan failed to identify an appropriate environment that would be safe for Patient #17 while maintaining personal privacy and dignity.

o. Patient #18 was admitted on 7/14/10 with diagnoses of schizoaffective and borderline personality disorders, with multiple serious overdose attempts. The treatment plan identified suicidal ideations and psychosis with auditory hallucinations and delusions, with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #18 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

p. Patient #19 was admitted on 8/3/10 with a diagnosis of major depression, severe with psychotic features, with a recent attempt to cut self with a knife. The treatment plan identified suicidal ideations and psychosis with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry

on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #19 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

q. Patient #20 was admitted on 8/9/10 with a diagnosis of major depression, with a recent attempt to overdose on medications, and suffocation with a plastic bag. The treatment plan identified mood disorder and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #20 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

r. Patient #21 was admitted on 8/3/10 with diagnoses of psychosis and personality disorder of the criminal type, with recent suicidal thoughts. The treatment plan identified suicidal ideations, mood disorder, and psychosis with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #21 and failed to include any precautions that staff should take to maintain the patient's safety. Between 8/4/10 at 6 PM and 8/9/10 at 7 AM, staff failed to reevaluate the patient's safety in the presence of side rails.

s. Patient #22 was admitted on 8/11/10 with diagnoses of bipolar disorder and depression with psychosis, with recent suicidal thoughts. Patient #22's clinical record was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. Although the patient had been newly admitted and the treatment team had not yet met, the patient was placed on routine 15-minute checks. However, the record failed to reflect that an environmental assessment was conducted on admission, to identify the type of environment that would be safe for Patient #22 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

t. Patient #23 was admitted on 8/11/10 with a diagnosis of severe major depression, and had recently cut his/her wrists and throat. The treatment plan identified suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #19 and failed to include any precautions that staff should take to maintain the patient's safety, in the presence of side rails.

u. Patient #24 was admitted on 8/10/10 with a diagnosis of severe major depression with psychosis, with a recent attempt to overdose on medications, and suffocation with a plastic bag. The treatment plan identified mood disorder and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #20 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

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v. Patient #26 was admitted on 8/9/10 with a diagnosis of major depression, with current thoughts of suicidal ideations. The treatment plan identified mood disorder and suicidal ideations with an intervention to maintain a safe environment. The plan was reviewed with the nursing Assistant Director of psychiatry on 8/12/10. The plan failed to identify the type of environment that would be safe for Patient #20 and failed to include any precautions that staff should take to maintain the patient's safety, including the presence of side rails.

w. For 27 of 27 patients residing on the psychiatric unit, the hospital failed to ensure that treatment plans identified specific group therapies that were appropriate to each patients needs. Review of the policy for a clinical psychiatric record identified that the treatment plan would define prescribed treatment interventions including specific group or individual therapy.

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8. Based on a tour of the Behavioral Health unit located on the 8th floor and the Behavioral Health holding area in the Emergency department, review of hospital documentation, review of policies, and staff interviews, the hospital failed to ensure a safe environment. The following are a list of findings based on the above:
   a. The facility installed non-breakaway clothes hanging hooks on the interior of patient wardrobe closets;
   b. The facility installed doors on patient wardrobe closets which had hinges that pose a risk for strangulation, these hinges were identified as a risk on April 30, 2010 by the facility Environment of Care Committee annual risk assessment of the Behavioral Health Unit and to date have not been further addressed;
   c. The facility installed door knobs on patient bathrooms within the patient rooms which pose a risk for strangulation, these door knobs were identified on April 30, 2010 by the facility Environment of Care Committee annual risk assessment of the Behavioral Health Unit and to date have not been further addressed;
   d. The facility installed surface mounted hand towel dispensers in all double patient rooms which pose a safety hazard as these dispensers can be used as a weapon;
   e. The facility installed locks on all patient bedrooms with thumb style turn knobs on the interior of the patients door, these knobs pose a risk for strangulation as they were mounted in the upright position;
   f. The door to the patient area washer/dryer room was unlocked. An interview with the Assistant Director of the Behavioral Health unit at the time of this finding identified that this door is always kept unlocked. The washer/dryer room is considered a hazardous area due to it having an automatic closing device on the interior of the door, two (2) hoses connected to water pipes, a ventilation pipe connected to the dryer which was very hot at the time, and high voltage receptacle within the room;
   g. An interview with the Director of Engineering / Chairperson of the Environment of Care

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Committee identified that on May 19, 2010 an EOC committee meeting was held and the Annual Environment Risk Assessment of the Behavioral Health unit was reviewed, the risks/issues which were identified were deemed not feasible for correction and the item was closed. The Chairperson failed to report these issues to the Quality and Safety Committee as required by the facility's Environment of Care Safety Program Policy section IV item #5.

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9. The facility did not ensure that the common wall of the non-conforming building was a fire barrier having at least a two-hour fire resistance rating as required by the referenced LSC.

   On 10/05/10 at 2:00 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the 2-hour barrier between the Pomeroy Building and the Main Building contained voids and penetrations that were not patched and sealed with materials having a 2-hour fire resistance rating; i.e. large pieces of masonry block removed in storage area for empty, rigid metal conduit installation.

10. The facility did not ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch sold-bonded core wood, capable of resisting the passage of smoke.

    a. On 10/04/10 at 09:45 AM, the surveyor while accompanied by the Operating Room Staff observedthat the Anesthesia Work Room door had holes on the workroom side of the door that damaged the core of the door.

    b. On 10/04/10 at 11:15 AM, the surveyor while accompanied by the Operating Room Staff and the Engineering Technician observed that the door to Reed Operating Room #5 was binding at the frame and failed to close & latch.

    c. On 10/04/10 at 11:05 AM, the surveyor while accompanied by the Operating Room Staff and the Engineering Technician observed that the door to Equipment Storage Room # 1634 in the Reed Operating corridor was binding at the frame and failed to close & latch.

11. The facility did not ensure that smoke barriers were constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.

    a. On 10/04/10 at 10:30 AM, the surveyor while accompanied by the Assistant Director of Engineering and the Engineering Technician observed that the smoke barriers located on

floors 1, 5 & 9 were not being inspected and maintained; i.e. surveyors not allowed to inspect smoke barriers above the ceilings because of the presence of asbestos, although during previous inspections there was no such restriction.

b. On 10/04/10 at 11:03 AM, the surveyor while accompanied by the Assistant Director of Engineering and the Engineering Technician observed that the smoke barrier located on floor 7 and 8 of the Pomeroy Building contained gaps and voids around penetrations that were not sealed with materials having a 30-minute fire resistance rating; i.e. large holes in drywall above ceiling in patient rooms 7012 & 7029 & 8039.

c. On 10/05/10 at 09:50 AM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the smoke barrier located on floor 3 of the Pomeroy Building contained gaps and voids around penetrations that were not sealed with materials having a 30-minute fire resistance rating; i.e. the cable raceway passing through smoke barrier above the corridor ceiling outside room #3029 has voids around the cables that are not sealed with fire rated materials. The square metallic electrical raceway was sealed with RTV silicone type materials and not the appropriate fire/smoke resistant materials required.

d. On 10/04/10 at 1:30 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the smoke barriers located in the Emergency Department (Pomeroy Ground) contained voids around penetrations, above the ceiling that were not properly protected with materials having a 30-minute fire resistance rating.

e. On 10/04/10 at 1:15 PM, the surveyor while accompanied by the Engineering Technician observed multiple penetrations in the smoke barrier wall, near patient room #8103 & room # 8139 located within Behavioral Health that were not sealed with materials having a 30-minute fire resistance rating.

f. On 10/05/10 at 1:45 PM, the surveyor while accompanied by the Engineering Technician observed the gaps between the double-fire rated door assembly separating the Dietary Department Kitchen and the Dietary Department Storeroom was greater than the 1/8 " allowed by the LSC.

g. On 10/05/10 at 1:35 PM, the surveyor while accompanied by the Engineering Technician observed the fire barrier marked and identified as M206 (Pomeroy 2) had multiple voids around penetrations that were not sealed with materials having a 30-minute fire rating.

12. The facility did not ensure that hazardous areas were either separated by construction providing at least a one hour fire resistance rating or protected by an automatic extinguishing system,

where the sprinkler option is used the areas shall be separated by smoke resisting partitions and self closing doors as required by 19.3.2.1

a. On 10/04/10 at 1:56 PM, the surveyor while accompanied by the Assistant Director of Engineering and the Engineering Technician observed that cables were routed through the wall of the electrical closets 4062 & 8103 in a cable tray -into the exit access corridor, were not protected with materials that were fire rated or could resist the passage of smoke; i.e. existing fire rated materials cleared away to allow new cables to be installed and not resealed with proper materials.

b. On 10/05/10 at 10:20 AM and at other times throughout the survey, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that cables were routed through the wall of the electrical closets 3044 and 3062 in a cable tray -into the exit access corridor, and not protected with materials that were fire rated or could resist the passage of smoke; i.e. existing fire rated materials cleared away to allow new cables to be installed and not resealed with proper materials.

c. On 10/04/10 at 09:50 AM, the surveyor while accompanied by the Operating Room Staff observed that the fire rated door to the Pathology Laboratory was not equipped with a self-closing device.

d. On 10/05/10 at 10:30 AM, the surveyor while accompanied by the Engineering Technician observed that the walls and ceiling in the Carbon Dioxide Storage Room in the Main Laboratory (floor 2); have large holes in fire-rated barrier.

13. The facility did not ensure that exit components such as stairways were enclosed with construction having a fire resistance rating of at least two hours and were arranged to provide both a continuous path of escape and protection against fire or smoke from other parts of the building as required by the referenced LSC.

    a. On 10/04/10 at 1:30 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed penetrations around voids in the wall above the ceiling in stair enclosure by the Emergency Department Ambulance Exit (Pomeroy Ground).

14. The facility did not ensure that emergency lighting is provided in accordance with LSC 7.9 & 19.2.9.1.

    a. On 10/06/10 at 1:45 PM, the surveyor were not provided with documentation that the emergency light fixtures are being tested & inspected monthly; i.e. No documentation that monthly (30 second) testing of the battery, emergency lights has occurred since July 2010.

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

15. The facility did not ensure that means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

    a. On 10/05/10 at 1:30 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the path from the base of exit stair #1 and the exit door at the loading dock in Pomeroy Building was not maintained free of obstructions that have the potential to impede egress; i.e. boxes, storage, pallets and other stored materials in the exit passageway.

    b. On 10/04/10 at 1:00 PM, the surveyor while accompanied by the Engineering Department Volunteer observed that the exit-access corridor throughout the Emergency Department (Pomeroy Ground) was cluttered with items that impede egress; i.e. equipment, patient beds, photo copier, a desk with chair and hard wired computer.

16. The facility did not ensure that draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of NFPA 13, Standards for the Installation of Sprinkler Systems and NFPA 701.

    a. On 10/04/10 at 11:02 AM, the surveyor while accompanied by the Assistant Director of Engineering and the Engineering Technician observed that the window curtains in all the patient rooms were equipped with no markings or tags that indicated a flame-resistance rating; nor was documentation provided by the Assistant Director of Engineering to indicate a rating.

    b. On 10/04/10 at 1:15 PM, the surveyor while accompanied by the Assistant Director of Engineering and the Engineering Technician observed that the cubicle curtains in all the patient rooms were equipped with no markings or tags that indicated a flame-resistance rating; nor was documentation provided by the Assistant Director of Engineering to indicate a rating.

17. The facility did not ensure that solid linen or trash collection receptacles do not exceed 32 gal in capacity and mobile soiled linen or trash collection receptacles with capacities greater than 32 gal are located in a room protected as a hazardous area when not attended as required by the referenced LSC.

    On 10/04/10 at 10:55 AM and at different dates & times throughout the survey, the surveyor while accompanied by the Assistant Director of Engineering, the Engineering Department Volunteer and the Engineering Technician observed that the mobile soiled linen or trash collection receptacles with capacities greater than 32 gal were not located in a room protected

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as a hazardous area when not attended as required by the referenced LSC; i.e. open-top, soiled linen carts observed throughout the exit-access corridors on floors 3, 4, 5, 7, 9 and in the Cardiac Wing on Ground and outside Dietary on floor 1.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (3) and/or (b) Administration (2) and/or (i) General (6).

18. The facility did not ensure that nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes was in compliance with NFPA 99: Heath Care Facilities.

    On 10/05/10 at 1:40 & 1:43 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the steel, high-pressure cylinders located in the outside, loading dock storage area and the inside, Gas Vault (P007A) were not restrained or secure; i.e. most tanks not secured by chains-left un hooked and laying on floor.

    On 10/05/10 at 1:43 PM, the surveyor while accompanied by the Engineering Department Volunteer and the Engineering Technician observed that the access door to the emergency oxygen supply connection was not locked or secured; i.e. the system can be tampered with, also appears as deficiency on August 2010 Environmental Technology Associates Inspection Report.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (b) Administration (2) and/or (i) General (6).

19. The facility did not ensure that patient care electrical devices in-patient areas were being inspected as required in NFPA 99 " Health Care Facilities " .

    On 10/06/10 at 1:30 PM, the surveyors were not provided with documentation from the Director of Engineering that indicated that all electrical devices in patient areas are inspected as required in NFPA 99, Section 7-5.1.3,7-5.2.2.1 and 7-6.2.1.2 and as part of the facilities preventive maintenance program; i.e. patient beds located in patient rooms 9017 (due 08/15/10), 5005 (due 08/13/10) & wheeled, Newborn Photography Unit (no label at all) located in Storage Room # 3058.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1) and/or (2) and/or (i) General (6).

20. Based on review of facility documentation, review of the facility policy and interviews, the facility failed to ensure that quality care was provided by the contracted dialysis service. The findings include the following:
    a. On 10/05/10 at 10:15 AM the surveyor observed that the test strips utilized to monitor

water were not dated upon opening in accordance with the dialysis policy.

b. On 10/5/10, a dialysis nurse was observed to test water for chlorine/chloramines. The nurse was observed to expose the test strip to the sampled water for approximately five (5) seconds although review of the manufactures directions directed the sample be exposed for thirty seconds (30) seconds. Subsequent to this observation the facility provided the department with an immediate action plan that included all staff were reeducated in the proper testing procedures.

c. Review of the documentation for maintenance for six dialysis machines and six portable reverse osmosis units on 10/5/10, inclusive of all water and machine culture testing, identified that testing documentation for specific machines failed to be precise, rendering an inability to understand what test was done on what machine. During interview on 10/6/10, the Facility Administrator (FA) stated that the hospital dialysis unit had replaced three new RO's in September 2009 and that although the unit utilized serial numbers for recognition of each machine identity, that identity was not conveyed throughout the testing documentation.

d. Review of water testing documentation for July, August and September 2010 reflected that the Facility Administrator and Medical Director failed to sign off recognition of the water values per facility policy. During interview on 10/6/10, the Facility Administrator stated that secondary to conflicted meeting times she was unable to meet with the Medical Director to review and sign off testing documentation for the hospital unit during the above referenced months.

e. Review of Patient #70's medical record on 10/5/10, identified that the patient, known to receive outpatient (chronic) hemodialysis, had fractured the right hip and required surgery on 10/4/10. Review of physician's orders (MD #5) identified a telephone order dated 10/4/10 at 8:00 AM to RN #4 (dialysis nurse) directing a hemodialysis treatment using the "chronic orders except change the bath to 2K 2CA and hemodialysis time to 2 hours". A second order, which failed to be dated and timed, directed the patient to have no heparin and no sodium modeling. During interview on 10/5/10, RN #5 stated she initiated the patient's treatment at approximately 8:30 AM according to the physician's order and that MD #5 evaluated the patient at approximately 9:30 AM. MD #5 directed the heparin to be stopped, which occurred. Physician #5 failed to direct complete acute hemodialysis orders (rather than chronic) at the start of hemodialysis treatment and failed to date and time further orders for hemodialysis treatment on 10/4/10.

f. Review of Patient #70's hemodialysis record dated 10/4/10, reflected a dialysis bath of 3K 2 CA, rather than the 2K 2 CA ordered by MD #5. Further, the record reflected that the patient received heparin 1800 units as a loading dose and 600 units as maintenance during treatment, rather than the heparin free treatment as ordered. During interview on 10/5/10, RN #4 stated that Patient #70 did receive the 2K bath as ordered and that she "wrote over" the "3" with a "2", and did not clarify the entry elsewhere in the record. RN #4 stated that MD #5 saw the patient approximately one hour into the treatment and ordered the heparin to be stopped. Although she stopped the heparin, RN #4 stated she failed to document this in the treatment record.

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g. Review of the hemodialysis treatment records dated 10/4/10, for Patient #69 and #70, reflected that the nurse failed to initiate pre and post treatment weights secondary to broken equipment. Review of the dialysis policy for patient assessment identified that the pre and post weight of the dialysis patient contributed to the evaluation of the patient's response to treatment.

The following is a violation of the Connecticut General Statutes 46a-152 (a)(1) and/or Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

21. Based on review of clinical records, review of facility policies, review of facility documentation, and interviews, the facility failed to provided documentation to reflect that the least restrictive restraint device was utilized and/or utilized for the least amount of time for three of four patients, Patients #38, #66, and #67, who had diagnoses of dementia and identified to be at risk to fall. The findings include:
    a. Patient #38 was admitted to the facility's Behavioral Health Unit on 9/22/10 with diagnoses that included alcohol related dementia/psychosis and a history of Alzheimer's disease. A fall risk assessment dated 9/22/10 identified that Patient #38 was at risk to fall. Interventions to reduce the patient's risk to fall included to keep the bed in low position and to instruct the patient on use of the call light. Review of nursing notes dated 9/22/10 to 9/28/10 identified that due to Patient #38's cognitive deficits, the patient needed frequent explanations and reinforcement of safety interventions including use of the call bell. The documentation identified that Patient #38 was at high risk to fall and was attempting to walk unassisted. Physician orders dated 9/23/10 at 7:55 PM directed the use of a Posey vest (jacket restraint) for safety for twenty four hours. The documentation failed to identify that a less restrictive device was attempted prior to use of a Posey vest.
    b. Review of the nursing assessment dated 9/23/10 at 11:55 PM identified that Patient #38 was calm though restless. The clinical record lacked documentation to reflect that an attempt to release the Posey vest or to utilize a less restrictive device was made. The nursing assessment dated 9/24/10 at 1:55 AM through 9:55 AM identified that Patient #38 was sleeping though was awakened for vital signs. Although the documentation identified no further issues with attempts by Patient #38 to ambulate unassisted as described as the reason for the restraint, a second physician order was written at 9:00 AM on 9/24/10 to continue use of the Posey vest for an additional twenty four hours. The clinical record lacked documentation to reflect that Patient #38's Posey vest was removed, that a trial release was attempted, and or that the use of a less restrictive device was attempted. The restraint was not discontinued until 11:00 AM on 9/24/10.
    c. A physician progress note dated 9/24/10 at 9:30 PM identified that Patient #38 was observed to slip off a chair onto his/her buttocks earlier in the evening. The documentation identified that the event was witnessed by facility staff, that there had been no apparent injury, but that based on Patient #38's continued unsteadiness on

his/her feet and difficulty following direction due to his/her cognitive status, a Posey vest was reordered for another twenty four hour period. The clinical record lacked documentation to reflect that a less restrictive device was attempted and/or considered prior to use of a Posey vest. Review of the restraint safety monitoring records dated 9/25/10 from 2:47 AM on 9/25/10 through 8:35 AM identified that Patient #38 remained calm and/or was sleeping without the benefit of having the Posey vest removed and/or the attempt to utilize a less restrictive device.

d. Patient #66 arrived in the Emergency Department (ED) on 9/3/10 from a skilled nursing facility with symptoms of dementia and aggressive behavior and was assessed in the ED to be at risk to fall. The documentation identified that Patient #66 became combative in the ED and that a physician order for a Posey vest was obtained at 8:30 AM on 9/3/10. The clinical record lacked documentation to reflect that a less restrictive device was attempted and/or considered prior to use of a Posey vest.

e. Patient #67 arrived in the Emergency Department (ED) on 9/1/10 from a skilled nursing facility with diagnoses that included dementia and behavioral changes and was assessed in the ED to be at risk to fall. The documentation identified that Patient #67 became combative in the ED, was striking out at staff, and that a Posey vest was applied. Patient #67 was subsequently admitted to the facility's Behavioral Health Unit on 9/1/10. A fall risk assessment dated 9/1/10 identified that Patient #67 was at risk to fall. Review of a nursing note dated 9/1/10 at 10:30 PM identified that Patient #67 remained confused and was intermittently agitated, was kicking and screaming, and that the Posey vest was maintained throughout the evening shift. Review of the nursing notes dated 9/2/10 from 1:48 AM through 9:10 AM identified that Patient #67 was sleeping and/or calm when awake. The clinical record lacked documentation to reflect that a trial release of the Posey vest was attempted until 9:10 AM and/or that a less restrictive device was attempted and/or considered.

f. Interview with the Director of the Behavioral Health Unit on 10/6/10 at 1:30 PM identified that although the unit did not utilize Posey vest restraints based on age, behaviors that could lead to use of a Posey vest restraint on the Behavioral Health Unit included the inability of a patient to follow directions due to his/her cognitive status, the inability to utilize the call bell, and physical impairments that might place a patient at high risk to fall. Review of the facility's Restraint and Seclusion policy directed that the type of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. The policy directed that a restraint may be imposed to ensure the immediate physical safety of the patient and must be discontinued at the earliest possible time The policy directed that a risk of falls was not necessarily a reason for restraining a patient but that a history of falling, a medical condition, or symptom that indicated a need for protective intervention may justify the use of a restraint to promote healing. Review of the facility's Fall Prevention and Safety Assessment and Management policy directed staff to manage patients at risk to fall through assessment and the least restrictive therapeutic/preventive interventions.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (i) General (6).

22. Based on review of the clinical record, review of hospital policy and interviews with hospital personnel for one patient undergoing a cardiac catheterization, documentation and interviews failed to reflect a complete medical record. The findings include:
    a. Patient #57 was admitted to the hospital on 9/29/10 and underwent a cardiac catheterization with contrast on 10/5/10. Review of the Assessment and Treatment of Contrast Related Adverse Reactions in the Cath Lab Policy identified that the patient would be assessed before the administration of contrast media using the Intravenous Contrast Checklist for previous reactions. Review of the clinical record identified that the Department of Cardiology Intravenous Contrast Checklist was not completed prior to the procedure for Patient #57.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (1) and/or (2).

23. Based on observation, review of hospital policy, review of hospital documentation and interviews with hospital personnel, documentation and interviews failed to reflect that the hospital medication dispensing policy was followed. The findings include:
    a. On 10/4/10, an observation of the Pyxis machine in the ED Medication Room identified that a medication discrepancy existed. Review of the Automated Dispensing System ADM- Pyxis Policy indicated that correcting the inventory count for any medication would create a discrepancy, which would be researched and resolved. Additionally, for a controlled substance medication discrepancy that could not be resolved at the time that it occurred, an Occurrence Report would be submitted to the Director of Pharmacy and would be reported to the Department of Consumer Protection. Review of the Pyxis MedStation System ED Station Undocumented Discrepancies List noted that the discrepancy for Ativan 2 mg Injection located in the 4-A drawer was unresolved since 9/18/10. Documentation and interview with the RN #5 failed to reflect that that the medication dispensing policy was followed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (g) Pharmacy (2) and/or (4) and/or (i) General (6).

24. Based on review of facility policies, observations, and interview, the facility failed to ensure that medications were stored securely from access by unlicensed personnel. The findings include:
    a. During a tour of the labor and delivery unit on 10/6/10 at 1:35 PM, four vaginal delivery case carts were observed stored in the clean utility room secured by a keypad lock. The case carts had unlocked top drawers that contained multiple medications including Lidocaine 2%, Naloxone injectable, Oxytocin, and prefilled syringes of Epinephrine.

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The clean utility room was also the storage area for the unit's blanket warmer. Interview with the Assistant Director of Nursing at the time of the observation identified that unlicensed personnel had keypad access to the room in order to access the blanket warmer. Review of facility policy directed that medications be stored in a secure location at all times.

25. Based on observation during tour of the Outpatient Endoscopy Unit and interview with hospital personnel, the hospital failed to ensure that outdated medication was discarded. The findings include:
    a. During tour of procedure rooms on 10/6/10, multiple canisters of " Hurricane " (benzocaine anesthetic) were found to have expired in 9/10. During interview on 10/6/10, the Manager of the unit stated that nursing staff review all medications for outdates on a monthly basis.
    b. Additionally, a vial of Flumazenil was found to be opened and undated. During interview on 10/6/10, the Manager of the unit stated that all vials should be dated when opened and discarded after 30 days or manufacturer ' s expiration date, whichever comes first.
    c. During tour of the Reed OR supply room on 10/4/10, identified blood tubes outdated in 9/10, which were removed by the Director of Surgical Services who stated that the supply of blood tubes fell to the Anesthesia Department. She stated that the tubes should have been removed at the end of the month.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (h) Dietary service (1) and/or (i) General (6).

26. Based on review of facility policy, observations, and interviews, the facility failed to maintain a safe and sanitary environment within the dietary department. The findings include:
    During a tour of the dietary department on 10/6/10 from 11:05 AM to 12:00 PM, the following observations were made:
    a. Tray line staff were observed to be setting up patient trays without the use of gloves. The Dietary Aide who was responsible for pulling clean plates from the rack for the serving of meats, vegetables, and potatoes, was observed to be holding a stack of napkins at the edge of each plate in order to keep his/her hands from touching the actual plate. However, observation of the practice identified that the Dietary Aide used his/her opposite hand to steady the removed stack of plates and that his/her hand made multiple contacts with the opposite plate edge as he/she placed the plates onto the counter. Subsequent to surveyor inquiry, the Dietary Aide was observed to use a glove to handle the plates. Interview with the Chief Dietician at the time of the observation identified that facility policy directed that a "no bare hands" policy would be followed directing that no bare hands would touch the food surface or come in direct contact with the food.
    b. At 11:40 AM on 10/6/10, a large dumpster like rolling cart was observed to be overflowing with cardboard boxes, some of which had fallen onto the chef's preparation

area and onto the floor. Interview with the Chief Dietician at the time of the observation identified that one of the porters was assigned to empty the trash regularly but thought that he/she had gone for lunch. Two uncovered trash cans filled with various types of trash including food substances were observed in the walkway leading to the dish room and opposite the cook's preparation area. Two food delivery carts with multiple trays of half eaten foods and paper goods were observed to be stored near the trash cans. Review of facility documentation of assigned duties of the porter identified that trash in the kitchen area be emptied at 10:30 AM and again at 3:00 PM. The Chief Dietician could not explain why the porter had not emptied the trash before leaving for lunch but assigned another staff member to remove the trash.

c. Observation in the cold storage refrigerator on 10/6/10 at 11: 45 AM identified a stainless steel bin of ground meat dated 10/2/10. A bin of sliced ham of varying color shades and dated 10/2/10 was also observed. Interview with the Chief Dietician at the time of the observation identified that ground meats were served the same day and that any unused ground meat was discarded. The Chief Dietician stated that sliced meats were used for two days and discarded at the end of the third day.
d. A large, deep plastic tub containing a bottom layer of a butternut squash and apple mixture was observed to covered only by a baking pan. Interview with the Chief Dietician at the time of the observation identified that baking pans were not an appropriate cover for foods as they do not seal the food.
e. Several spoiled and spotted apples that leaked soft brown liquid into the bottom of the storage container were observed in the produce refrigerator. Interview with the Chief Dietician at the time of the observation identified that checks of the produce refrigerator were to be conducted daily.
f. Several trays of individual jello cups were observed to be stored uncovered on a rack in the dessert refrigerator.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (1) and/or (b) Administration (2).

27. Based on observations and interview, the facility failed to store emergency equipment in a manner that promoted quick and easy access to the equipment in the event of an emergency. The findings include:
    a. During a tour of the Pomeroy 8 unit on 10/5/10 at 11:45 AM, two emergency code carts (one for adult patients and one for pediatric patients) and the portable emergency suction machine were observed to be tightly stored side by side in the unit's examining room. The adult code cart was positioned behind the door in a manner that when the door was opened, the cart was behind the door. The pediatric code cart was located next to the adult cart and was observed to have several pieces of equipment including intravenous (IV) poles stored in front of it. The portable suction machine was stored in the right corner of the room on a rolling cart but had been stored behind a computer that had been placed on a rolling stand. In an attempt to access the emergency equipment during the

observation, multiple moves of other equipment were necessary to get the equipment in a position to be removed from the room. Interview with the Director of the Acute Care Behavioral Health Unit at the time of the observation identified that some of the equipment could be stored elsewhere. Subsequent to surveyor inquiry, the examining room was cleared of excessive equipment allowing for easier access to the stored emergency equipment.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (1) and/or (b) Administration (2) and/or (g) Pharmacy (4) and/or (i) General (6).

28. Based on observations and interviews, the hospital failed to ensure that cleaning chemicals were secured. The findings include:
    a. During a tour of the 4th floor, on 10/4/10 at 11:50 A.M., it was identified that the unlocked janitor's closet contained cleaning chemicals stored on the housekeeping cart. Interview with Hospitality Staff #1, on 10/4/10 at 12:00 Noon, identified that he/she had no keys to lock the janitor's closet and he/she left the housekeeping cart unattended for the past thirty-five minutes. Interview with the Hospitality Staff Supervisor, on 10/4/10 at 1:37 P.M., identified that the janitor closets should be locked at all times and the housekeeping carts should be attended to at all times.
    In addition, tour of the ninth floor, on 10/4/10 from 2:00 to 3:00 P.M., identified that two unlocked janitor ' s closets that had cleaning chemicals stored. Interview with Hospitality Staff #5, on 10/4/10 at 1:55 P.M., identified that although he/she had a key to lock the janitor ' s closet the closet was unlocked. Interview with Hospitality Staff #6, on 10/4/10 at 2:05 P.M., identified that he/she did not have a key to lock the janitor ' s closet the closet was unlocked.
    Subsequently the hospital began an action plan- that included staff education, audit of keys needed and fabrication of keys, revision of facility policy and procedure and random audits of the security of the janitor closets throughout the hospital.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (1) and/or (4) and/or (b) Administration (2).

29. Based on observation during tour of the anesthesia workroom and interview with hospital personnel, the hospital failed to maintain an acceptable level of cleanliness and quality of supplies. The findings include:
    a. A tour of the Anesthesia workroom (location of medications and supplies) with the Director of Surgical Services on 10/4/10, identified washed coffee cups, glasses and dishware on a drain board on the counter next to the sink. Fresh fruit in a basket was observed on the counter. During interview on 10/4/10, the Director of Surgical Services identified that the anesthesia staff had a lounge available several doors away in which to keep such supplies and consume food. A tour of the heart room on 10/4/10, identified the medication pyxis, located within the room, had a screwdriver and miscellaneous

screws on top of the machine. The Director of Surgical Services stated on 10/4/10, that the room was operational and the tools should not have been left on top of the pyxis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (e) Nursing service (1) and/or (l) Infection control (1) and/or (2).

30. Based on observation during tour, interview with hospital personnel and/or review of hospital policy, the hospital failed to ensure that infection control practices were exercised by staff within the environment of the Operating Room (OR) and/or Sterile Processing Department and/or hemodialysis. The findings include:
    a. During tour of OR #9 on 10/4/10, pieces of silk tape were observed adhered to countertops and adhesive tape was found to be wrapped around the adjustment handle of equipment rendering the equipment unable to be cleaned between cases and/or at the end of the day according to hospital policy that directed all furniture to be " thoroughly scrubbed with disinfectant using effective mechanical friction " .
    b. Review of the biological testing of flash sterilizers in the Main OR identified that on 7/11/10, the staff failed to document the time biological tests were placed in the incubator. Review of the hospital policy for sterilization in the OR identified that while the policy failed to direct documentation of the time of incubation initiation, the policy directed staff to read out test results within one hour.
    c. During tour of the heart room on 10/4/10, the cardio-pulmonary bypass machine was observed to be set up (tubing and transducers in place) and covered. The set-up lacked a date of expiration. Review of the hospital policy for Cardio-pulmonary Bypass (CPB) Circuit pre-assembly Set-up identified that the CPB should remain in a locked, low traffic area with limited access. The circuit should be dated, initialed and discarded after 7 days.
    d. During tour of the semi-restricted area of the OR with the Director of Surgical Services on 10/4/10, identified that a door, (#18), failed to be locked from the stairwell, enabling entrance from the stairwell into the semi-restricted area of the OR corridor. The Director of Surgical Services stated on 10/4/10, that no access to the OR corridor should occur from any stairwell door leading into the semi-restricted zone of the OR.
    e. Upon entry into the clean side of the Sterile Processing Center, the surveyor observed that the pass-through window to the decontamination room was propped open with baskets of instruments. The window stayed open while staff answered the telephone before obtaining the instruments and closing the window. The window does not self-close. The Director of Surgical Services stated on 10/5/10 that the window should be open only long enough to pass instruments to the clean side.
    f. During tour of the hemodialysis unit on 10/5/10, white vascular clamps were observed to be attached to the handle of the supply cart. Review of the Infection Control Policy for Renal Services identified that all re-usable equipment would be thoroughly disinfected, however, the policy failed to reflect how/where the clamps should be stored following

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disinfection.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (1) and/or (b) Administration (2) and/or (i) General (2) and/or (6).

31. Upon tour of the hospital, review of hospital policies, review of hospital documentation and interviews with hospital personnel, documentation and interviews failed to reflect that the hospital cleaning policies were followed. The findings include:
    a. Tour of the Radiology Department identified that the Endovaginal Ultrasound probes were cleaned in the department. Review of the Endovaginal Ultrasound Probe Cleaning Policy identified that that Cidex OPA solution was utilized for cleaning the contaminated equipment and that the transducer would soak in the Cidex OPA solution for a minimum of 12 minutes. Review of the Ultrasound's Cidex Quality Control Log from 7/23/10 through 10/5/10 failed to reflect the time (minimum 12 minutes) the transducer was taken out of the solution on several days (9/2/10, 8/30/10, 8/27/10, 8/23/10, 8/20/10, 8/13/10, 8/9/10, 7/26/10) therfore unable to determine that the probe was soaked the required 12 minutes.
    b. Tour of the Cardiopulmonary Department identified that Transesophageal Echocardiogramn (TEE) probes were cleaned in the department. Review of the Transesophageal Echocardiogram Probe Cleaning Policy identified that Cidex OPA solution was utilized for cleaning the contaminated equipment. Review of the TEE cleaning log and the Cidex test strip container failed to reflect the expiration date for the test strips as per manufacturer's guidelines.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (i) General (6).

32. Based on review of medical records, review of hospital policy and interview with Anesthesia Personnel, the hospital failed to ensure that the total amount of a medication administered, intraoperatively, was recorded for two patients (Pts #47 &#75). The findings include:
    a. Patient #47 underwent bilateral total knee replacement on 10/4/10. Review of the Anesthesia Record identified that the patient received the medication Propofol beginning at approximately 7:45 AM until approximately 10:10 AM. The Certified Registered Nurse Anesthetist (CRNA) attending the patient failed to record the total amount of medication administered over the course of surgery.
    b. Patient #75 underwent a right total hip replacement on 10/4/10. Review of the Anesthesia Record reflected that the patient received Propofol intravenously however, the CRNA failed to document the total amount of medication administered. During interview on 10/6/10, the covering Anesthesiologist stated during interview that the total amount of medication, including that medication administered via a pump, should be documented on the Anesthesia Record.

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1).

33. Based on review of the clinical record, review of hospital policy and interviews with hospital personnel for one patient who received oxygen, documentation and interviews failed to reflect that the hospital oxygen therapy protocol was followed. The findings include:
    a. Patient #34 was admitted to the Emergency Department (ED) on 9/29/10 at 1:11 AM with bronchiolitis. Review of the admission vital signs identified that the patient's oxygen saturation (O2 Sat) was 90%. Review of the ED Physician Orders directed to administer humidified oxygen, however, failed to reflect parameters for the oxygen (the flowrate or the oxygen delivery system for administration). Review of the clinical record indicated that oxygen humidification was administered to the patient at 15 liters (L)/minute approximately an hour later at 2:04 AM. The patient's oxygen saturation was 98%, but the record failed to reflect the device utilized. Review of the Oxygen Therapy Protocol indicated that the oxygen delivery system device selected would be based on the amount of oxygen needed to maintain an oxygen saturation of $\geq$92% to $\leq$96% unless otherwise specified by the physician and that it would be documented in the Cerner system. Documentation and interview with ED Nursing Director failed to reflect that the hospital protocol was followed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1).

34. Based on review of clinical records, interview and review of facility policies and procedures for one of two patients (Patient #48) that required non-invasive ventilation, the facility failed to ensure that the therapist and/or nurse delivered respiratory care and services according to physician orders. The findings include:
    a. Patient #48 was arrived at the hospital Emergency Department (ED) via ambulance, on 9/30/10 at 4:00 P.M., from home after being found unresponsive, was diagnosed with pulmonary edema and was admitted to the hospital. The patient ' s past medical history included asthma, emphysema and heart disease. Review of the clinical record identified while in the ED Patient #48 received non-invasive ventilation and that was discontinued on 10/1/10 at 12:00 Noon. Review of the physician ' s orders, dated 10/2/10 at 8:45 P.M. directed the staff to administer non-invasive ventilation and the order did not include the inspiratory and/or expiratory pressures. Review of the respiratory flowsheet, dated 10/2/10 at 7:50 P.M., identified that the patient was placed on non-invasive ventilation on an inspiratory pressure of 18 and an expiratory pressure of 6. In addition, on 10/3/10 at 2:22 A.M. documentation reflected that the inspiratory pressure was changed to 16, at 6:22 A.M. the inspiratory pressure was changed back to 18 and review of the clinical record did not reflect physician ' s orders and/or documentation of communication between the therapist and the physician. Interview with the Assistant Director of Respiratory, on 10/4/10 at 11:00 A.M., identified that the physician order for

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

non-invasive ventilation should contain the inspiratory and expiratory pressures and/or the therapist should communicate with the physician regarding the required settings. Review of the facility policy and procedure, titled Non-invasive Positive Pressure ventilation or BiPAP, identified that the starting pressures are inspiratory of 12 and expiratory of 6 and/or as ordered by the physician.

In addition, review of the nursing flowsheet, dated 10/3/10 at 8:00 A.M., identified that the nursing staff removed the patient from the non-invasive ventilation and placed the patient on oxygen at 5 Liters per minute via nasal cannula and there was no physician order. Interview with the Assistant Director of Respiratory, on 10/4/10 at 11:00 A.M., identified that a physician order is required. Review of the policy and procedure, titled Oxygen Therapy Protocol, identified that a physician order is required for the administration of oxygen.

EXHIBIT B

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

IN RE: The Waterbury Hospital of Waterbury, CT
The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

MODIFIED CONSENT ORDER

WHEREAS, The Waterbury Hospital of Waterbury, CT (hereinafter the "Licensee"), has been issued License No. 0060 to operate a General Hospital known as The Waterbury Hospital, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on May 11, 2009 and concluding on September 15, 2009; 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 an amended violation letter dated October 20, 2009 (Exhibit A - copy attached); and

WHEREAS, the Department recognizes the measures taken by the Licensee to address certain violations identified in the amended violation letter of October 20, 2009, as more fully set forth in Licensee's corrective action plan dated November 3, 2009; and

WHEREAS, without admitting wrongdoing or fault, the Licensee is willing to enter into this Modified Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, Public Health Services Manager, and the Licensee, acting herein and through John Tobin, its President and CEO, hereby stipulate and agree as follows:

1. The Consent Order executed with the Department on January 17, 2008 (Exhibit B - copy attached) shall be incorporated and made part of this Modified Consent Order.
2. Within thirty (30) days of the execution of this document, the Licensee shall enter into one or more contracts with Clinical Consulting Firm(s) (CCF), as required to fulfill the obligations under this Consent Order.
3. The CCF shall, at a minimum, conduct onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in Paragraph 4 of this Modified Consent Order. The CCF team shall consist of credentialed healthcare professionals necessary to address the issues identified in Exhibit A of this document. As used in this Paragraph 3, the term "credentialed" means, where applicable, possessing the appropriate license, certification and/or other qualifications in the relevant discipline or area of expertise (not limited solely to individuals licensed by the State of Connecticut).
4. The CCF review shall include, but not be limited to, the following professional and hospital services and systems and to make recommendations for improvements:
    a. Systems and mechanisms relative to safety of all currently utilized clinical equipment;
    b. Review of the Hospital's preventative maintenance program for all currently utilized clinical equipment;
    c. Systems for the exchange of diagnostic information relative to radiological services and on timely sharing of said information;
    d. Review of the Facility's Patient Safety, Quality Assurance and Performance Improvement Programs with emphasis on their ability to detect and respond to system failures;
    e. Review of the Facility's professional credentialing process and adherence to same with emphasis on the temporary and summary suspension of physicians for failure to complete medical records; and
    f. Nursing assessments of patients with an emphasis on physical changes of condition.
5. The CCF and the Licensee shall enter into a written contract that includes the following requirements of this Modified Consent Order:

a. Timeframes for the initial evaluation;

b. The number of individuals with appropriate credentials for conducting the review; and

c. The timeframes for the analysis and development of recommendations.

6. The initial onsite review shall be scheduled within thirty (30) days of the execution of the contract with the CCF.

7. The CCF shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) and provide copies to the Licensee and the Department. Neither party shall be provided with the opportunity to review the report(s) prior to release and both parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. CCF recommendations shall include, as applicable, areas that need to be addressed by the Licensee, and, if applicable, continuing onsite hours per consulting staff per week. If the Licensee disagrees with any CCF findings or recommendations, the Licensee, the CCF and the Department shall meet to discuss issues. The Licensee shall have the right to present information related to the Licensee's areas of disagreement.

8. The Department shall have the final determination to accept or reject the CCF recommendations should the parties not be able to reach a mutual agreement.

9. Within twenty-one (21) days of either receipt of the report(s) from the CCF or final approval by the Department of the recommendations by the CCF, whichever is later, the Licensee shall provide the Department with a proposed timeframe for implementation of the CCF recommendations. The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented by the Licensee in accordance with the Department's approved timeframe.

10. Any records maintained in accordance with any state or federal law or regulation or as required by this Modified Consent Order shall be made available to the Department upon request.

11. If the CCF initially determines onsite services by consultants are not necessary, the CCF shall re-evaluate the Licensee, at a minimum, at four (4) months and at eight (8)

months, following the completion of the initial facility evaluation. The re-evaluation shall determine the Licensee's ability to implement and maintain the professional and hospital services and systems delineated in Paragraph 4 of this Modified Consent Order and/or in the report(s) generated by the CCF. Upon conclusion of said reviews, the CCF shall provide the Department and the Licensee with comprehensive reports of said assessments.

12. Within sixty (60) days of the execution of this Modified Consent Order, the Licensee shall review and revise or implement, as applicable: (the review required by this paragraph is intended to mean a review and/or revision of relevant policies and procedures and/or, where applicable, the implementation of audit processes to demonstrate compliance with policies, procedures and/or standards of practice):
    a. All current clinical equipment policies and procedures with inclusion of the manufacturer's recommendations;
    b. A preventative maintenance program for all current clinical equipment in accordance with manufacturer's recommendations; for purposes of subparts (a) and (b) of this Paragraph 12, the reference to the manufacturer's recommendations is intended to require that the Licensee, develop a preventive maintenance program based on its clinical equipment policies and procedures, manufacturer's recommendations and preventative maintenance program history. The preventative maintenance program history should focus on failure mode analysis and evaluation.
    c. A preventative maintenance program for clinical equipment and any reports made regarding said equipment. Documentation shall be maintained for preventative maintenance and/or work orders for three (3) years and shall be made available to the Department upon request;
    d. Measures to ensure that all life saving and/or sustaining equipment is operated by individuals who have received education and have demonstrated competency regarding the operation of the particular equipment; for purposes of this Modified Consent Order, the term "life saving and/or sustaining equipment" means any device used for the purpose of sustaining life and whose failure to perform its primary function, when used according to applicable manufacturer's instructions

and clinical protocols, will lead to patient death in the absence of immediate intervention;

e. Systems for the exchange of diagnostic information with an emphasis on radiological services and on timely sharing of diagnostic information;

f. Medical staff by laws with an emphasis on physician credentialing and the temporary and/or summary suspension of physicians for failure to complete medical records;

g. Emergency Department Triage Protocol;

h. Pain Assessments;

i. Nursing Assessments relating to a significant change in clinical status;

j. Compliance with Physician orders; and

k. Mechanism for the reporting of abnormal diagnostic testing to the Physician of Record.

13. Within ninety (90) days of the execution of this Modified Consent Order, the Licensee shall provide inservice education to all applicable staff regarding all policies and procedures as identified in Paragraphs 4 and 12 of this document. To the extent applicable staff is not available during the ninety (90) day period for inservice education, the Licensee shall develop a plan to ensure those staff members receive the inservice education as soon after the ninety (90) days as is possible. This inservice education shall also be provided, as applicable, at the time of employment and shall be repeated at appropriate intervals as determined by Licensee. Documentation of inservice education shall be maintained for review by the Department for a period of three (3) years.

14. Within sixty (60) days of the execution of the Modified Consent Order, the Licensee shall establish a mechanism, whereby the Licensee's Quality Assurance Performance Improvement (QAPI) program, reviews and evaluates the following:

a. Compliance with Facility policies regarding preventative maintenance of all currently utilized life saving and/or sustaining clinical equipment;

b. Operation and maintenance of all currently utilized life saving and/or sustaining equipment;

c. Compliance with systems which ensure the timeliness of sharing and/or communication of diagnostic radiological results to the ordering physician;

d. The Licensee shall incorporate into the Hospital's Quality Assurance program indicators to analyze data and track quality pertinent to the specifications as outlined in this paragraph; and

e. Responsibility for the ongoing review and evaluation of the items identified in subparts (a) through (c) of this Paragraph 14 shall be undertaken at the appropriate departmental level, with continued oversight, including analyzing and tracking applicable quality indicators, by the QAPI program.

15. The Licensee shall within seven (7) days of the execution of this Modified Consent Order, designate an individual who shall assume overall responsibility for full implementation and monitoring of the components of this Modified Consent Order. Said individual assigned this responsibility shall submit monthly summary reports, which addresses the components of this document to the Department.

16. The individual designated as responsible for the implementation and monitoring of this Modified Consent Order shall meet with the Department and the designated Department's representative every four (4) weeks for the first six (6) months and every two (2) months thereafter for the duration of this Modified Consent Order.

17. All reports required by this document shall be directed to:

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

18. All parties agree that this Modified 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 this Modified Consent Order or of any statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Modified Consent Order may be admitted by the Department as evidence in any

proceedings 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.

19. The terms of this Modified Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
20. The Licensee understands that this Modified Consent Order and the terms set forth herein are not subject to reconsideration, collateral attach 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.
21. Should the Licensee not be able to maintain substantial compliance with the requirements of this Modified Consent Order, the Department retains the right to issue charges including those identified in the October 20, 2009 amended violation letter referenced in this document.
22. The Licensee had the opportunity to consult with an attorney prior to the execution of this Modified Consent Order.

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

THE WATERBURY HOSPITAL OF WATERBURY, CT
LICENSEE

February 16, 2010 By: _____
Date John Tobin, President and CEO

STATE OF Connecticut)
County of New Haven) ss February 16 2010

Personally appeared the above named John Tobin and made oath to the truth of the statements contained herein.

My Commission Expires: August 31, 2014
(If Notary Public)

Kelly L Keating
Notary Public [X]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

2-26-2010
Date

By: Barbara Cass
Barbara Cass, Public Health Services Manager
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

October 20, 2009

John H. Tobin, President & CEO
Waterbury Hospital
64 Robbins St
Waterbury, CT 06721

Dear Mr. Tobin:

This is an amended edition of the violation letter originally dated October 8, 2009.

Unannounced visits were made to Waterbury Hospital beginning on May 11, 2009 and concluding on September 15, 2009 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure and a full federal 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. The state violations cannot be edited by the provider in any way.

An office conference has been scheduled for October 15, 2009 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

It will not be necessary for you to bring a plan of correction to this meeting as Department staff will be discussing alternative remedies to address the non-compliance issues identified during the course of the inspection/investigation.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Elizabeth S. Andstrom, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ESA:jpf

c.
Complaints #9782, #8408, #7938, #8508, #7958, #7943, #9572, #9435, #8631 and #7800

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

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-D3 (b) Administration (2).

1. Based on review of the clinical record, review of hospital policy and procedure, review of hospital documentation and interviews with hospital personnel for one of four patients (Patient #1) who required advanced cardiac life support, the hospital's governing body failed to assume full accountability and responsibility for hospital oversight. The findings include:
   a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital on 6/26/09 at 1:59 P.M. Review of the Computed Tomography (CT) of the Chest completed on 6/26/09 at 3:35 P.M. and interpreted on 6/26/09 at 3:56 P.M. by MD #21, identified that Patient #1 had a large amount of thrombus within the pulmonary arteries including a saddle thrombus at the bifurcation extending into the left and right pulmonary arteries, thrombus nearly completely blocking the left lower pulmonary artery branch vessels, a near complete obstruction of the left upper lobe anterior segment pulmonary artery and a large amount of thrombus seen filling all segments of the right lung. On 6/27/09, Patient #1 ambulated with RN #1 on the nursing unit and up two flights of stairs and the patient experienced respiratory distress and an increased heart rate. Patient #1 was transferred to the Surgical Intensive Care Unit (SICU) on 6/27/09 at 2:30 P.M. On 6/27/09 Patient #1 had an Inferior Vena Cava (IVC) filter placement and was back in the SICU at 5:45 P.M. and was intubated on 6/27/09 between 9:25 P.M. and 9:40 P.M., due to a respiratory distress.
      On 6/27/09 at 10:26 P.M., the clinical record reflected that Patient #1 had no pulse and/or no respirations and advanced cardiac life support was again provided by a multi-disciplinary team including the use of a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support (ACLS), two defibrillator machines were not able to be charged four times (due to battery "dead" and/or no charge when machine was plugged into wall outlet) although after the defibrillator cable to the right paddle was connected the patient was defibrillated four times with the first defibrillator. MD #13 added that the time between the first attempt to defibrillate Patient #1 and the first shock that was delivered was five minutes. The clinical record reflected that on 6/27/09 at 10:50 P.M. Patient #1 was pronounced dead. Interview with RN #5, the RN Supervisor who was present and part of the ACLS team, identified that he/she did not remove and/or direct the staff to remove the two defibrillators from a patient care area for an evaluation by the clinical engineering department and/or contact and/or direct the staff to contact the clinical engineering department subsequent to the defibrillator malfunctioning and as per Hospital policy and procedure. Review of the Hospital policy and procedure, titled "Identifying and Correcting problems with Patient Care Equipment", identified that if a problem with

patient care equipment is identified the Clinical Engineering Department is notified and the back-up equipment is brought to the area.
Interview with the Medical Director of the Intensive Care Units, on 7/28/09, identified that although he/she was informed about Patient #1's clinical condition and the treatment interventions on 6/27/09, he/she was not aware of any problems with the defibrillators.
Interviews with Clinical Engineering Technician #1 and #2, on 7/22/09, identified that every defibrillator is tested quarterly to ensure that the machine can charge and discharge, these tests were last completed on 5/1/09, and the defibrillators are comprehensively inspected annually. On 7/23/09 Clinical Engineering Technician #1 completed testing of 9 of the 20 defibrillators-including 7 defibrillators located in the Intensive Care Units, and it was identified that one of the seven defibrillators in the Intensive Care Units had not been tested quarterly since 12/2008.
Review of the Hospital Medical Staff Bylaws identified that the Governing Body (the Board of Trustees) has overall responsibility for conduct of the Hospital and delegates to the Medical Staff the responsibility of ensuring that quality patient care is provided in a safe manner in the Hospital.

b. During a review of the Medical Records Department with the Director of Health Information Management, on 7/31/09, it was identified that four physicians were summarily suspended (MD #16, 17, 18 and 19) and this level of suspension includes that the physician will voluntarily give up all of his her privileges at the Hospital-including his/her privileges to attend to patients, consult to patients and/or the use of Gastroenterology procedure areas. The documentation reflected that MD #16, #17 and #18 were summarily suspended since 6/5/09 and MD #19 was summarily suspended since 7/10/09. Review of Hospital documentation, dated 6/5/09 to 7/27/09, identified that MD #16 attended to 14 patients and consulted to 4 patients, MD #17 attended to 31 patients, performed gastroenterology procedures on 30 patients and consulted on 4 patients and MD #18 attended to 69 patients and consulted to 5 patients after he/she were summarily suspended. Review of the Hospital Medical Staff Bylaws, Section 2.11, identified that if a physician has a temporary suspension (for incomplete medical records) for more than three consecutive weeks, the physician will be summary suspended which means he/she will voluntarily lose his/her privileges including to attend to patients, consult to patients and/or use the gastroenterology procedure areas. The policy further identified that the pertinent Hospital departments are notified of the physician suspensions. In addition, review of the Hospital Credentialing Policy, Article 2, identified that after appointed, the Medical Staff member must adhere to the Credential Policy. Review of the Credential Policy, Section 20.2, identified that when privileges are lost, due to not completing medical records, the privilege loss continues until all the identified records are completed.
Interview with the Operating Room Scheduler, on 7/31/09, identified that he/she reviewed the physician suspension list via electronic mail and the most current electronic mail physician suspension list that he/she had was dated 6/8/09. Interview with the Nursing Assistant Director of the Operating Room, on 7/31/09, identified that the current physician suspension list that he/she had was dated 7/24/09.
Interview with the Hospital Staff at the Gastroenterology procedure areas, on 7/31/09,

identified that he/she is not aware if the privileges of the physician who is performing a gastroenterology procedure are suspended and that the Patient Registration staff completes the scheduling for the gastroenterology procedures. Interview with the Director of Patient Registration, on 7/31/09, identified that he/she is not aware of the physicians whose privileges are suspended.
The governing body failed to ensure that the Hospital policies and procedures, the Medical Staff Bylaws and/or the Credential Policy were followed and enforced.

The following is a violation of the Connecticut General Statutes 46a-152(a) and/or the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

2. Based on clinical record reviews, interviews with staff, and review of policies for 1 patient (Patient #31) who was placed in behavioral restraints, the Hospital failed to ensure that appropriate orders were obtained. The findings include:
   a. Patient #31 was admitted on 2/18/09 with diagnoses that included schizophrenia and antisocial traits. The clinical record was reviewed with the Director and Assistant Director of Behavioral Health and identified that on 2/24/09 at 2:46 PM, Patient #31 was placed in 4-point restraints without a physician (LIP)'s order. The Hospital policy for physical restraints identified that a physician 's order must be obtained when a patient is physically restrained.

The following is a violation of the Connecticut General Statutes 46a-152(a) and/or (d) and/or the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

3. Based on clinical record reviews, interviews with staff, and review of policies for 3 patients (Patients #29, #30, and #31) who were placed in behavioral restraints, the Hospital failed to ensure that the restraints were reduced or removed at the earliest possible opportunity. The findings include:
   a. Patient's #29, #30, and #31 were placed in physical restraints for behavioral purposes. The clinical records were reviewed with the Director and Assistant Director of Behavioral Health on 9/10/09 at 11 AM. In all three physical restraint episodes, there were multiple times when the documented assessments did not support the continued use of the restraint and or demonstrate that a restraint reduction was attempted at the earliest opportunity, per policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (i) General (6).

4. Based on review of the clinical record, review of hospital policies and procedures, review of hospital documentation and interviews with hospital personnel for one patient (Patient #1) who required advanced cardiac life support and/or for other patients that required care and services provided by medical staff, the facility's governing authority failed to assume full accountability

and responsibility for medical staff conduct and/or the medical staff failed to follow the Medical Staff Bylaws. The findings include:

a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital on 6/26/09 at 1:59 P.M. Review of the Computed Tomography (CT) of the Chest completed on 6/26/09 at 3:35 P.M. and interpreted on 6/26/09 at 3:56 P.M. by MD #21, identified that Patient #1 had a large amount of thrombus within the pulmonary arteries including a saddle thrombus at the bifurcation extending into the left and right pulmonary arteries, thrombus nearly completely blocking the left lower pulmonary artery branch vessels, a near complete obstruction of the left upper lobe anterior segment pulmonary artery and a large amount of thrombus seen filling all segments of the right lung. On 6/27/09, Patient #1 ambulated with RN #1 on the nursing unit and up two flights of stairs and the patient experienced respiratory distress and an increased heart rate. Patient #1 was transferred to the Surgical Intensive Care Unit (SICU) on 6/27/09 at 2:30 P.M. On 6/27/09 Patient #1 had an Inferior Vena Cava (IVC) filter placement, was back in the SICU at 5:45 P.M., and was intubated on 6/27/09 between 9:25 P.M. and 9:40 P.M., due to a respiratory distress. The clinical record, dated 6/27/09 at 10:12 P.M., identified that Patient #1 had no pulse, no respirations and the patient's cardiac rhythm was pulseless electrical activity (PEA) and advanced cardiac life support measures were started and at 10:18 P.M. Patient #1 had a pulse and blood pressure and advanced cardiac life support measures were stopped.

   On 6/27/09 at 10:26 P.M., the clinical record reflected that Patient #1 had no pulse and/or no respirations and advanced cardiac life support was again provided by a multi-disciplinary team including the use of a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support (ACLS), two defibrillator machines were not able to be charged four times (due to battery "dead" and/or no charge when machine was plugged into wall outlet) although after the defibrillator cable to the right paddle was connected the patient was defibrillated four times with the first defibrillator. MD #13 added that the time between the first attempt to defibrillate Patient #1 and the first shock that was delivered was five minutes. The clinical record reflected that on 6/27/09 at 10:50 P.M. Patient #1 was pronounced dead. Interview with RN #5, the RN Supervisor who was present and part of the ACLS team, identified that he/she did not remove and/or direct the staff to remove the two defibrillators from a patient care area for an evaluation by the clinical engineering department and/or contact and/or direct the staff to contact the clinical engineering department subsequent to the defibrillator malfunctioning and as per Hospital policy and procedure. Review of the Hospital policy and procedure, titled "Identifying and Correcting problems with Patient Care Equipment", identified that if a problem with patient care equipment is identified the Clinical Engineering Department is notified and the back-up equipment is brought to the area.

   Interview with the Medical Director of the Intensive Care Units, on 7/28/09, identified that although he/she was informed about Patient #1's clinical condition and the treatment

interventions on 6/27/09, he/she was not aware of any problems with the defibrillators. Interviews with Clinical Engineering Technician #1 and #2, on 7/22/09, identified that every defibrillator is tested quarterly to ensure that the machine can charge and discharge, these tests were last completed on 5/1/09, and the defibrillators are comprehensively inspected annually. On 7/23/09 Clinical Engineering Technician #1 completed testing of 9 of the 20 defibrillators-including 7 defibrillators located in the Intensive Care Units, and it was identified that one of the seven defibrillators in the Intensive Care Units had not been tested quarterly since 12/2008.
Review of the Hospital Medical Staff Bylaws identified that the Governing Body (the Board of Trustees) has overall responsibility for conduct of the Hospital and delegates to the Medical Staff the responsibility of ensuring that quality patient care is provided in a safe manner in the Hospital.

b. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital on 6/26/09 at 1:59 P.M. Review of the clinical record did not reflect documentation that the results of the CT of the Chest for Patient #1 were communicated to any physician. Interview with the Medical Director of the Radiology Department, on 7/28/09, identified that the Radiology Department clinical communication is guided by the American College of Radiology Practice Guidelines for Communication of Diagnostic Imaging Findings, 2005. Clinical communication includes those instances wherein the findings of the diagnostic test requires immediate intervention; the findings of the diagnostic test are discrepant with preceding diagnostic tests and failure to act may adversely effect the patient's health; and the findings that the diagnostic imager reasonably believes are adverse to the patient's health and are unexpected by the ordering physician-and these cases may not require immediate attention but if not acted upon, may worsen over time and possible result in an adverse patient outcome. In addition the Medical Director added that the results of the CT of the Chest for Patient #1 were available via a report on 6/26/09 at 4:05 P.M. A second interview with the Medical Director of the Radiology Department, on 7/29/09, identified that he/she would not expect the Radiologist to call the physician on the outcome of Patient #1's CT of the chest. Interview with MD #1, Patient #1's attending physician on 7/29/09, identified that the VQ San and the CT Of the Chest provided different information on Patient #1's clinical condition, he/she was expecting to be called with the result of Patient #1's CT of the Chest and those results would have changed the patient's treatment plan. In addition MD #1 identified that he/she reviewed the results of Patient #1's CT of the Chest on 6/27/09 at the time of his/her dictation of the patient's discharge summary (identified as 6/27/09 at 12:22 P.M.).

c. During a review of the Medical Records Department with the Director of Health Information Management, on 7/31/09, it was identified that four physicians were summarily suspended (MD #16, 17, 18 and 19) and this level of suspension includes that the physician will voluntarily give up all of his her privileges at the Hospital-including his/her privileges to attend to patients, consult to patients and/or the use of

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

Gastroenterology procedure areas. The documentation reflected that MD #16, #17 and #18 were summarily suspended since 6/5/09 and MD #19 was summarily suspended since 7/10/09. Review of Hospital documentation, dated 6/5/09 to 7/27/09, identified that MD #16 attended to 14 patients and consulted to 4 patients, MD #17 attended to 31 patients, performed gastroenterology procedures on 30 patients and consulted on 4 patients and MD #18 attended to 69 patients and consulted to 5 patients after he/she were summarily suspended. Review of the Hospital Medical Staff Bylaws, Section 2.11, identified that if a physician has a temporary suspension (for incomplete medical records) for more than three consecutive weeks, the physician will be summary suspended which means he/she will voluntarily lose his/her privileges including to attend to patients, consult to patients and/or use the gastroenterology procedure areas. The policy further identified that the pertinent Hospital departments are notified of the physician suspensions. In addition, review of the Hospital Credentialing Policy, Article 2, identified that after appointed the Medical Staff member must adhere to the Credential Policy. Review of the Credential Policy, Section 20.2, identified that when privileges are lost, due to not completing medical records, the privilege loss continues until all the identified records are completed.

Interview with the Operating Room Scheduler, on 7/31/09, identified that he/she reviewed the physician suspension list via electronic mail and the most current electronic mail physician suspension list that he/she had was dated 6/8/09. Interview with the Nursing Assistant Director of the Operating Room, on 7/31/09, identified that the current physician suspension list that he/she had was dated 7/24/09.

Interview with the Hospital Staff at the Gastroenterology procedure areas, on 7/31/09, identified that he/she is not aware if the privileges of the physician who is performing a gastroenterology procedure are suspended and that the Patient Registration staff completes the scheduling for the gastroenterology procedures. Interview with the Director of Patient Registration, on 7/31/09, identified that he/she is not aware of the physicians whose privileges are suspended.

The Medical Staff failed to ensure that the Hospital policies and procedures, the Medical Staff Bylaws and/or the Credential Policy were followed and enforced.

The Medical Staff failed to ensure that pertinent Hospital staff received a current list of summary suspensions and/or failed to enforce Hospital privileges.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (e) Nursing services (1) and/or (i) General (6).

5. Based on review of the clinical record, interviews, review of Hospital documentation and review of Hospital policies and procedures for one patient (Patient #1) that had changes in his/her clinical condition and/or that required care according to physician orders and/or that required advanced cardiac life support services including the use of a defibrillator, the Hospital failed to ensure that the patient was comprehensively and/or appropriately assessed and/or provided care according to physician orders and/or failed to ensure that the emergency equipment that was not in working order was removed from service. The findings include:
   a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with

complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. Review of the ED Triage note, at 8:04 A.M., identified that Patient #1 was triaged at a Level 3, had chest and head pain, chest palpitations, was lethargic and diaphoretic and his/her vital signs included temperature 96.0 degrees Fahrenheit (normal 98.6 degrees), pulse was 106 beats per minute (normal 60-80 beats per minute), respirations were 18 breaths per minute (normal 16-20 breaths per minute) and blood pressure was 96/30 millimeters of Mercury (normal is 90/60 to 160/90 millimeters of Mercury). Interview with the Assistant Nursing Director of the Emergency Department (ED), on 7/28/09, identified that Patient #1 should have been triaged to a Level 2 due to his/her low blood pressure with high pulse and presence of chest pain, chest palpitations and head pain. Review of the Hospital policy and procedure, titled "Triage Levels", identified that a Level 2 includes a patient that is experiencing chest pain and has unstable vital signs.

In addition review of the ED nursing assessment, at 8:22 A.M., did not reflect any information regarding the patient's pain-including location, severity, duration, quality and/or relieving factors. Interview with the Assistant Nursing Director of the ED, on 7/23/09, identified that there is no documentation of an assessment of Patient #1's pain. Review of the Hospital policy and Procedure, titled "Pain Assessment and Management", identified that if the patient has pain an assessment of the pain is completed and includes pain location, intensity, onset, quality and pain relief methods.

The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital. On 6/26/09 at 1:59 P.M. RN #4 documented that the patient was transferred to an inpatient unit. Review of the ED clinical record failed to reflect that the Registered Nurse re-assessed Patient #1 after the initial assessment at 8:22 A.M. and at the time of transfer, when the patient's condition was different than admission. Interview with the Assistant Nursing Director of the ED, on 7/23/09, identified that the documentation of the patient's clinical status is not complete. Review of the Hospital policy and procedure, titled "Interdisciplinary Admission Assessment and Reassessment" identified that the Registered Nurse reassesses the patient for any change in the patient's condition.

Review of Patient #1's Computed Tomography (CT) of the Chest completed on 6/26/09 at 3:35 P.M. and interpreted on 6/26/09 at 3:56 P.M. by MD #21, identified that Patient #1 had a large amount of thrombus within the pulmonary arteries including a saddle thrombus at the bifurcation extending into the left and right pulmonary arteries, thrombus nearly completely blocking the left lower pulmonary artery branch vessels, a near complete obstruction of the left upper lobe anterior segment pulmonary artery and a large amount of thrombus seen filling all segments of the right lung.

Review of the physician orders, dated 6/26/09 at 1:45 P.M. directed the nursing staff to maintain strict intake and output records. The clinical record failed to identify accurate documentation of output. Interview with the Assistant Director of Nursing of the unit, on 7/22/09, identified that the output documented for Patient #1 is not recorded as an amount but the number of times that the patient went to the bathroom.

The physician orders, dated 6/26/09 at 1:45 P.M., directed that Patient #1's activity was bedrest with bathroom privileges and to provide supplemental oxygen to maintain the

patient's oxygen saturations greater than 95 %. The Physician Order, noted 6/27/09 at 1:00 P.M., directed the staff to discharge Patient #1 to home. Review of the Discharge Summary, dated 6/27/09 at 12:22 P.M., identified that Patient #1 was ambulating. Review of the nursing progress notes, entered on 6/27/09 at 2:16 P.M. and 6/28/09 at 8:10 A.M. (a late entry into the chart), identified that Patient #1 ambulated the "full length" of the nursing unit and that his/her oxygen saturations were between 94-97 %. Review of the clinical record failed to identify a physician order for Patient #1 to ambulate and/or failed to identify that staff provided oxygen for the patient while ambulating to maintain his/her oxygen saturation above 95 %. Interview with the Assistant Director of Nursing of the Unit, on 7/22/09, identified that Patient #1's activity level was bedrest and out of bed to the bathroom only. Interview with RN #1, on 7/28/09, identified that he/she did ambulate Patient #1 twice around the nursing unit after receiving a verbal order from MD #1, did not provide the patient with oxygen during the walk and did not write the verbal order that MD #1 gave to him/her. Interview with MD #1, on 7/29/09 identified that he/she did give a verbal order to RN #6 to ambulate Patient #1 on the unit. Review of the Hospital policy and procedure, titled "Interdisciplinary Admission Assessment and Reassessment" identified that the Registered Nurse reassesses the patient for any change in the patient's condition. Review of the Hospital's Rules and Regulations identified that verbal orders are used only in an emergency and the order will be documented and countersigned by the practitioner.

The nursing progress notes, entered on 6/27/09 at 2:16 P.M. identified that Patient #1 was ambulated up a flight of stairs by RN #1 and documentation did not reflect a physician order for this level of activity. In addition, documentation reflected that after the patient walked up the flight of stairs his/her condition changed, RN #1 left the patient and documentation failed to identify an assessment of the patient's status at the time of change in condition. Interview with RN #1, on 7/28/09, identified that he/she received a verbal order from MD #1 to ambulate Patient #1 up a flight of stairs, he/she directed the patient to ambulate up one to two steps, he/she did not provide oxygen to the patient, and Patient #1 "ran" up two flights of stairs. RN #1 identified that he/she did not document the verbal order he/she received from MD #1. In addition, RN #1 identified that after running up the two flights of stairs Patient #1's heart rate was elevated and he/she had an increased work of breathing. RN #1 left the patient on the stairwell ran approximately 30 feet to get MD #1 for assistance. Patient #1 was transferred to the Surgical Intensive Care Unit (SICU) on 6/27/09 at 2:30 P.M. Review of the Hospital policy and procedure, titled "Interdisciplinary Admission Assessment and Reassessment" identified that the Registered Nurse reassesses the patient for any change in the patient's condition. Review of the Hospital's Rules and Regulations identified that verbal orders are used only in an emergency and the order will be documented and countersigned by the practitioner.

The clinical record reflected that on 6/27/09 at 5:45 P.M., Patient #1 was recovering from placement of an Inferior Vena Cava (IVC) filter and at 6:00 P.M. was in SICU. Review of the physician orders, dated 6/27/09 at 5:45 P.M., directed the nursing staff to obtain Patient #1's vital signs and monitor the patient's right neck puncture sight every

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15 minutes four times, every 30 minutes twice then every 60 minutes twice. Review of the clinical record failed to reflect documentation that the vital signs had been completed and/or that the staff assessed the patient's right neck puncture site according to the physician order. Interviews with the Nursing Director and Nursing Assistant Director of the Critical Care Units, on 7/22/09, identified that there was no documentation that the staff completed the vital signs and/or assessment of the patient's right neck site according to the physician orders.

Review of Patient #1's clinical record, dated 6/27/09 at 8:00 P.M., reflected that Patient #1 required intubation and the clinical record did not reflect an assessment of the patient change in clinical status. Interview with RN #2, on 7/23/09, identified that immediately prior to the intubation Patient #1's respiratory rate was increasing to 40 breaths per minute and the patient's heart rate was increased to 120 to 130 beats per minute and this information was not documented. Review of the Hospital policy and procedure, titled "Interdisciplinary Admission Assessment and Reassessment" identified that the Registered Nurse reassesses the patient for any change in the patient's condition.

Review of the physician ' s orders, dated 6/27/09 at 9:45 P.M. directed the nursing staff to administer Versed via a bolus dose of 2 to 5 milligrams (mg) intravenously and Fentanyl via a bolus dose of 25 to 50 micrograms (mcg) intravenously, according to the patient ' s level of sedation (according to the Richmond Agitation Scale-RASS) with a RASS sedation goal of -1. The clinical record reflected that RN #2 administered Versed 5 mg and Fentanyl 50 mcg intravenously to Patient #1 and the record did not document the an assessment of the patient ' s level of sedation and/or the time of administration. Interview with RN #2, on 7/23/09, identified that the Versed and Fentanyl boluses were administered approximately at 9:55 P.M. and a RASS assessment was not documented. Review of the Hospital policy and procedure, titled " Interdisciplinary Admission Assessment and Reassessment" identified that the Registered Nurse reassesses the patient for any change in the patient ' s condition.

Review of Hospital documentation, "Code 3 Cart/Defibrillator Daily Check List" dated 6/27/09 identified that the defibrillator was in working order-including able to be charged.

On 6/27/09 at 10:26 P.M., the clinical record reflected that Patient #1 had no pulse and/or no respirations and advanced cardiac life support was again provided by a multi-disciplinary team to Patient #1 including the use of a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support (ACLS), two defibrillator machines were not able to be charged four times (due to battery "dead" and/or no charge when machine was plugged into wall outlet) although after the defibrillator cable to the right paddle was connected the patient was defibrillated four times with the first defibrillator. MD #13 added that the time between the first attempt to defibrillate Patient #1 and the first shock that was delivered was five minutes. The clinical record reflected that on 6/27/09 at 10:50 P.M. Patient #1 was pronounced dead.

Interview with RN #5, the RN Supervisor who was present and part of the ACLS team, identified that he/she did not remove and/or direct the staff to remove the two defibrillators from a patient care area for an evaluation by the clinical engineering

department and/or contact and/or direct the staff to contact the clinical engineering department subsequent to the defibrillator malfunctioning and as per Hospital policy and procedure. Review of the Hospital policy and procedure, titled "Identifying and Correcting problems with Patient Care Equipment", identified that if a problem with patient care equipment is identified the Clinical Engineering Department is notified and the back-up equipment is brought to the area.
Review of Hospital documentation did not reflect that any tracking and/or labeling were on each defibrillator to identify the location. Review of the Intensive Care Unit Staff Meeting Minutes, dated 7/13/09 and 7/14/09, with the Nursing Director of the Critical Care Units, on 7/28/09, identified that the defibrillator number will be part of the daily defibrillator checks. Review of the July 2009 "Code 3 Cart/Defibrillator Daily Check List" from 7/13/09 to 7/22/09 did not indicate the defibrillator number as part of the daily defibrillator check.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing services (1) and/or (i) General (6) and/or (k) Maternity services (2).

6. Based on medical record review, review of hospital policy/procedures, observation and interviews the hospital failed to ensure two identification (ID) bracelets were intact for one (Patient #16) of two infants observed in the Neonatal Intensive Care Unit (NICU). The findings include:
    a. Patient #16 was admitted to the NICU on 9/6/09. The special care nursing flow sheets from 9/6/09 to 9/8/09 identified that Patient #16's security sensor and ID band were checked each shift. The flow sheets also noted that the patient had a peripheral intravenous (IV) in the left hand from 9/6/09 at 11:30 AM to 1PM on 9/8/09. Observation on 9/8/09 at 2:30 PM noted that Patient #16 had a sensor on the right ankle, an ID band on the left ankle and the second ID band was taped to Patient #16's bassinette. Interview with RN #6 on 9/9/09 at 2:30 PM indicated that Patient #16's ID band was removed for IV placement and that the ID band may have been able to be reapplied to Patient #16's right wrist. Review of the hospital infant identification policy identified to place one bracelet on the infant's ankle and one on the wrist. Although the policy directed staff to reapply new bracelets if mother's or infant's bracelets needed to be changed, the policy did not direct staff for procedure to follow if an ID band needed to be removed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing services (1) and/or (i) General (6).

7. Based on clinical record review, interviews with staff, and review of policies for two patients (Patient #9 and #17), the hospital failed to ensure that the patient's pain was reassessed following pain medication administration, and/or failed to ensure that a patient (Patient #9) was assessed for self-administration of medications, prior to leaving medication at the bedside. The following includes:

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a. Patient #9 was treated in the ED (emergency department) on 9/7/09 for a fractured ankle. The patient was identified with a pain level of 10 (rated 1-10 with 10 being the most pain), and received a pain medication on 9/7/09 at 12:52 PM. The clinical record was reviewed with the Interim Director of Emergency Services. The record lacked a reassessment of the patient ' s pain and/or the effectiveness of the pain medication within one hour, per policy. In addition, Patient #9 was observed on 9/8/09 at 10:30 AM with a nasal medication at the bedside without staff in attendance. Review of the clinical record identified that the patient had not been assessed for self-administration of medications.

b. Patient #17 was admitted to the P7 Unit and underwent revision of a left hip fracture on 9/7/09. Patient #17 received Morphine for left hip pain on 9/7/09 at 2:22 AM for a pain score level of "5" and at 1:48 PM for a pain level of "8". Patient #17 also complained of left hip pain and received Percocet on 9/8/09 at 9:19 AM for a pain score level of "4". Although each nurse documented that the pain medication was effective after each pain medication administration, the assessment did not include the patient's pain level after the pain medication intervention. Interview with the Unit Manager on 9/9/09 at 10 AM noted that staff was required to document a pain score level after a pain intervention. The hospital pain assessment and management policy identified that an assessment for pain included intensity, indicated using an acceptable and recognized pain measurement scale, preferably the 0-10 numeric scale. In addition to admission screening and assessment, pain, as reported by the patient will be assessed, documented and addressed following each pain management intervention.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing services (1) and/or (i) General (6).

8. Based on medical record review, review of hospital policy, observation and interview for one patient who received intravenous fluids (Patient #16), the hospital failed to discard/discontinue the fluid per physician order and hospital policy. The findings include:

   a. Patient #16 was born prematurely on 9/6/09 at 34 weeks gestational age and was admitted to the Neonatal Intensive Care Unit following birth. Physician orders dated 9/7/09 directed a peripheral intravenous (IV) of D10 and 1/4 Normal Saline at 2cc/hour. The IV profile indicated that the IV infusion was started at 10 AM on 9/7/09 in the left hand. Physician orders dated 9/8/09 at 9:30 AM directed to discontinue the patient's peripheral IV. Observation on 9/8/09 at 11:50 AM identified that an IV of D10 and 1/4 Normal Saline was dated 9/7/09 at 10 AM and was infusing at 2cc/hour into Patient #16's left hand. Interview with RN #6 on 9/8/09 at 11:50 AM noted that Patient #16's nurse was busy discharging a patient and had not yet had time to remove/change Patient #16's IV. The IV profile identified that Patient #16's IV was discontinued after 12:30 PM (3 hours after the discontinuation order) on 9/8/09 and had been infusing for a total of 26.5 hours. The facility policy for intravenous therapy noted that the intravenous solution shall be changed at least every 24 hours.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1) and/or (2) and/or (c) Medical staff (2) and/or (i) General (6).

9. Based on review of the clinical record, review of hospital policies and procedures, review of hospital documentation and interviews with hospital personnel for patients that required care and services provided by medical staff, the hospital failed to assume full accountability and responsibility for ensuring that the suspended medical staff did not provide care and services to patients in accordance with facility policy. The findings include:
    a. During a review of the Medical Records Department with the Director of Health Information Management, on 7/31/09, it was identified that four physicians were summarily suspended (MD #16, 17, 18 and 19) and this level of suspension includes that the physician will voluntarily give up all of his her privileges at the hospital-including his/her privileges to attend to patients, consult to patients and/or the use of Gastroenterology procedure areas. The documentation reflected that MD #16, #17 and #18 were summarily suspended since 6/5/09 and MD #19 was summarily suspended since 7/10/09. Review of hospital documentation, dated 6/5/09 to 7/27/09, identified that MD #16 attended to 14 patients and consulted to 4 patients, MD #17 attended to 31 patients, performed gastroenterology procedures on 30 patients and consulted on 4 patients and MD #18 attended to 69 patients and consulted to 5 patients after he/she were summarily suspended. Review of the hospital Medical Staff Bylaws, Section 2.11, identified that if a physician has a temporary suspension (for incomplete medical records) for more than three consecutive weeks, the physician will be summary suspended which means he/she will voluntarily lose his/her privileges including to attend to patients, consult to patients and/or use the gastroenterology procedure areas. The policy further identified that the pertinent hospital departments are notified of the physician suspensions. In addition, review of the hospital Credentialing Policy, Article 2, identified that after appointed, the Medical Staff member must adhere to the Credential Policy. Review of the Credential Policy, Section 20.2, identified that when privileges are lost, due to not completing medical records, the privilege loss continues until all the identified records are completed.
    Interview with the Operating Room Scheduler, on 7/31/09, identified that he/she reviewed the physician suspension list via electronic mail and the most current electronic mail physician suspension list that he/she had was dated 6/8/09. Interview with the Nursing Assistant Director of the Operating Room, on 7/31/09, identified that the current physician suspension list that he/she had was dated 7/24/09.
    Interview with the hospital staff at the Gastroenterology procedure areas, on 7/31/09, identified that he/she is not aware if the privileges of the physician who is performing a gastroenterology procedure, are suspended and that the Patient Registration staff completes the scheduling for the gastroenterology procedures. Interview with the Director of Patient Registration, on 7/31/09, identified that he/she is not aware of the physicians whose privileges are suspended.

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-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (1) and/or (3).

10. Based on review of a clinical record, interviews and review of Hospital documentation for one patient (Patient #1) that required an accurate and/or complete medical record and/or for other patient medical records that required storage to maintain the integrity of the record, the Hospital failed to ensure that the medical record was accurate and/or complete and/or failed to ensure that storage for patient records ensured that the integrity of the record would be maintained. The findings include:
    a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours.

       The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital. Patient #1 was transferred from a medical unit to the Surgical Intensive Care Unit (SICU) on 6/27/09 at 2:30 P.M. due to a change in his/her clinical status. Review of the SICU clinical record reflected that on 6/27/09 Patient #1's cardiac rhythm varied between sinus tachycardia with a bundle branch block, ventricular tachycardia, ventricular fibrillation, nodal, pulseless electrical activity, junctional and agonal. Review of the clinical record failed to include documentation (rhythm strips) of these changes. Review of the Hospital documentation reflected that a cardiac rhythm strip is obtained with any cardiac rhythm changes.

       The physician orders, dated 6/26/09 at 1:45 P.M., directed that Patient #1's activity was bedrest with bathroom privileges. Review of the clinical record, dated 6/27/09 at 12:22 P.M., identified that Patient #1 was ambulating. Although review of the nursing progress notes, entered on 6/27/09 at 2:16 P.M., identified that Patient #1 ambulated the "full length" of the nursing unit and up one flight of stairs, interview with RN #1, on 7/28/09 identified that he/she ambulated Patient #1 around the 4 hallways of the unit twice and two flights of stairs.

       Review of the Waterbury Anesthesiology Associates Intubation Record, dated 6/27/09 reflected that Patient #1 was intubated on 6/27/09 between 9:25 P.M. and 9:40 P.M., the patient was given the medication Propofol and the record failed to reflect the dosage administered and/or route of administration and/or the Anesthesia staff that completed the procedure. Interviews with the Anesthesiology Department Chairperson (MD #4), MD #3 and CRNA #1, on 7/22/09, identified that only anesthesia staff can administer a Propofol bolus intravenously, the dose should be documented and CRNA #1 performed the intubation on Patient #1.

       The clinical record, dated 6/27/09 at 10:12 P.M., identified that Patient #1 had no pulse, no respirations and the patient's cardiac rhythm was pulseless electrical activity (PEA) and advanced cardiac life support measures were started. Review of the Waterbury Hospital Code 3 Sheet, dated 6/27/09 at 10:12 P.M., identified the sheet was not complete. The document did not include the patient's weight, if a hospital wide resuscitation was activated, if the event was witnessed, the presence of monitors present

at onset of event and/or the patient's level of consciousness. In addition, the documentation reflected that MD #9 was the Code 3 physician leader, although during an interview with MD #9, on 7/29/09, identified that he/she was not the team leader for this Code 3 for Patient #1. In addition there were no cardiac rhythm strips documented during this event and MD #12 did not sign the document. Review of the Hospital policy and procedure, titled "Code III (Adult)", identified that all of the areas of the Code 3 sheet must be completed, any change in the patient's cardiac rhythm must be documented (via rhythm strips) and all team members involved must sign the Code 3 sheet.

In addition Patient #1's clinical record, dated 6/27/09 at 10:26 P.M., identified that Patient #1 had no pulse, no respirations and advanced cardiac life support measures were started. Review of the Waterbury Hospital Code 3 Sheet, dated 6/27/09 at 10:26 P.M., identified the sheet was not complete. The document did not include the patient's weight, the presence of monitors present at onset of event, the type of airway in place and the first documented cardiac rhythm and/or the signatures of the entire multi-disciplinary teams present (no signature for MD #7, MD #9 and MD #12). In addition there were no cardiac rhythm strips documented during this event. Review of the Hospital policy and procedure, titled "Code III (Adult)", identified that all of the areas of the Code 3 sheet must be completed, any change in the patient's cardiac rhythm must be documented and all team members involved must sign the Code 3 sheet.

Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support for Patient #1, two defibrillator machines were not able to be charged four times and this information was not documented on the Code 3 sheet or on the patient's discharge summary.

The clinical record, dated 6/27/09 at 10:26 P.M., reflected that part of the advanced cardiac life support that was provided by a multi-disciplinary team to Patient #1 included a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support for Patient #1, two defibrillator machines were not able to be charged four times and four charges were discharged to the patient. Review of the discharge summary did not include that Patient #1 required defibrillation as part of the advanced cardiac life support. Interview with MD #2, on 7/27/09 could not identify why he/she did not include this information in the discharge summary.

b. During a tour of the Medical Records Department, on 7/31/09, with the Director of Health Information Management it was identified that approximately 1/5 of the 56,000 to 65,000 medical records were stored on open shelves. Interview with the Director of Health Information Management, on 7/31/09, identified that these records would be covered in plastic in the event of a fire. Review of the Hospital policy and procedure, titled "Recovery Plan", identified that Medical Records Department must protect patient records and in the event of a fire and/or water damage, the staff are required to cover the records with a plastic sheet and/or remove the records.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (8).

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

11. Based on clinical record reviews and interviews with facility personnel for one patient (Patient #11), the facility failed to ensure that informed consent for procedures and/or treatments were completed. The findings include:
    a. Patient #11 was admitted to the hospital on 9/2/09 with COPD. Review of the informed consent documentation dated 9/4/09 identified that although the consent was signed by the patient, the consent form failed to indicate what type of procedure the patient was to have completed. In addition, review of the blood transfusion consent dated 9/4/09 identified that although the consent was signed by telephone consent, the consent form was not completed as per hospital policy. Review of hospital policy identified that informed consent includes the specific procedure or treatment to be performed, the general purpose, potential benefits, reasonable alternatives and risks. Interview with the P-5 nurse manager on 9/8/09 identified that the consent form was not completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (e) Nursing Services (1) and/or (g) Pharmacy (1) and/or (i) General (6).

12. Based on medical record review, review of hospital policy, and interviews for one patient who received titratable medications (Patient #15), the hospital failed to ensure that titratable medication orders were complete and/or in accordance with accepted standards or policy. The findings include:
    a. Patient #15 was admitted to the Family Birthing Unit on 9/3/09 with a diagnosis of premature ruptured membranes at 34 weeks gestation. The physician order dated 9/5/09 at 6 PM directed Pitocin (Oxytocin) 5 units in 500 cubic centimeters (cc) of Lactated Ringers (LR). The order further directed to increase the Pitocin by 1-2 milliunits (mu) every 5-10 minutes (min) and lacked a starting dose (area for starting dose left blank). The 12 hour labor record indicated that the Pitocin was started at 1mu/min at 7:45 PM. Interview with Assistant Director #3 on 9/8/09 at 11 AM noted that the Pitocin start dose should be included in the order because a standard starting dose for Pitocin was not identified in a hospital policy. The hospital policy for Induction of Labor/Aumentation of Labor identified to initiate the Oxytocin infusion per the physician's order.
    In addition, the physician's order for Patient #15 directed that the Pitocin be increased every 5-10 minutes (instead of every 30 minutes). The hospital policy for Induction of Labor/Augmentation of Labor directed to increase Oxytocin 1-2 mu/min every 30 minutes. According to the Nursing 2010 Drug Handbook by Lippincott Williams and Wilkins page 1042, to induce or stimulate labor, initially administer 10 units in 1000cc of LR or normal saline solution intravenously infused at 0.5 to 2 mu/min. Increase rate by 1-2 mu/min at 30- to 60- minute intervals.
    In addition, the physician's order for Patient #15 directed Pitocin be increased by 1 or 2 mu/min every 5 or 10 minutes. The order did not contain specific parameters for each milliunit increase or the time increment choice. The hospital policy for Induction of Labor/Augmentation of Labor lacked specific parameters for the variations in milliunit increases in the Pitocin and time increment variations.

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-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (g) Pharmacy (1).

13. Based on review of facility documentation, review of facility policies, and interviews, the facility failed to ensure that discrepancies in the count of controlled substances were reviewed for resolution in a timely manner. The findings include:
    a. During a tour of Pomeroy 9 on 9/9/09, a discrepancy report printed from the facility's Pyxis medication storage system identified discrepancies in the count of the medication, Dilaudid, on 9/4 and 9/5/09 that had not been resolved. Interview with the Nurse Manager on 9/9/09 identified that a discrepancy report was generated each shift and that licensed staff were expected to resolve the discrepancy at that time. The Nurse Manager stated that if the discrepancy could not be resolved, staff was expected to notify her for assistance and further review but that she had not been made aware of the discrepancies on those dates. Interview with Pharmacy Technician #1 on 9/10/09 identified that although the Pharmacy receives reports of discrepancies daily, she would not pursue further action for "a few days" at which time she would email the Nurse Manager to investigate the unresolved discrepancy. Pharmacy Technician #1 stated that she had not contacted the Nurse Manager regarding the 9/4 and 9/5/09 discrepancies. Review of facility policy directed that the individual creating the discrepancy was expected to make concerted effort to resolve the event at the time of occurrence and that those that could not be resolved, be reported to the Nurse Manager/Administrative Manager.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (1).

14. Based on observation, review of hospital policy and interview with hospital staff, the hospital failed to ensure that medications delivered to the Anesthesia Department, inclusive of medications with a limited life outside of refrigeration, were stored, labeled and stocked appropriately. The findings include:
    a. During tour of the Anesthesia Workroom on 9/8/09, observation of the emergency box, identified vials of succinylcholine, at room temperature, that failed to be labeled when removed from refrigeration. Further, observation of an anesthesia medication cart on 9/8/09, identified two vials of succinycholine labeled " 8/28 " , however, the anesthesia providers did not know what that meant. During interview on 9/9/09 at 1:15 PM, Pharmacist #1 provided manufacturer's directions that identified limited times of room temperature storage for several drugs utilized by anesthesia inclusive of succinylcholine and rocuronium, that were delivered to the pharmacy under refrigeration. Pharmacist #1 stated that although the pharmacy provided the Anesthesia Department with medications, no policy existed for storing requirements of medications, dating medication vials and/or stocking of the anesthesia carts.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (e) Nursing service (1) and/or (g) Pharmacy

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

(1) and/or (i) General (6).

15. Based on medical record review, review of hospital policy, and interviews the pharmacist failed to ensure that medication orders were complete and/or in accordance with accepted standards or policy. The findings include:
    a. Patient #15 was admitted to the Family Birthing Unit on 9/3/09 with a diagnosis of premature ruptured membranes at 34 weeks gestation. The physician order dated 9/5/09 at 6 PM directed Pitocin (Oxytocin) 5 units in 500 cubic centimeters (cc) of Lactated Ringers (LR). The order further directed to increase the Pitocin by 1-2 milliunits (mu) every 5-10 minutes (min) and lacked a starting dose (area for starting dose left blank). According to the Nursing 2010 Drug Handbook by Lippincott Williams and Wilkins page 1042, to induce or stimulate labor, initially administer 10 units in 1000cc of LR or normal saline solution intravenously infused at 0.5 to 2 mu/min. Increase rate by 1-2 mu/min at 30- to 60- minute intervals. Interview with Pharmacist #1 on 9/10/09 at 2:40 PM noted that the Unit Clerk faxes orders to the pharmacy from the Family Birthing Center. He/she indicated that the pharmacist checks orders and if orders are incomplete or not per usual facility protocol, the pharmacist should contact the patient's unit and the physician who wrote the order. The hospital policy for Patient Order Verification identified that the pharmacist will review each order for medication. Orders requiring clarification will be discussed with the prescriber before transcription into the information system.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (1) and/or (2).

16. Based on a review of hospital policy, observations and interviews, the hospital failed to lock medication/procedure carts. The findings include:
    a. During tour of the GI lab on 9/9/09, it was identified that that a GI cart was unlocked and contained multiple vials of medications. Review of hospital policy identified that medication carts must be locked when not in use. Interview with the Director of the GI lab on 9/9/09 identified that the GI cart needed to be secured.
    b. A tour of the Family Birthing Center was conducted on 9/8/09 at 10:30 AM with Assistant Director #3 and the Director of Quality. The storage room was accessed by keypad entry system and two anesthesia carts were observed in the storage room. One of the anesthesia carts that contained medications, Lidocaine, Bupivacane and Atropine, was observed unlocked. Assistant Director #3 subsequently locked the cart using the combination lock that was located on the outside of the cart. Interview with Assistant Director #3 at 10:30 AM on 9/8/09 noted that Patient Care Assistants as well as nurses and anesthesiology staff had access to the storage room and that the anesthesia cart should be locked. The hospital policy for drug storage identified that the medication carts must be locked when not in use.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (f) and/or (i) General (4) and/or (6).

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

17. Based on review of a clinical record, interview and review of Hospital documentation for one patient (Patient #1) that required abnormal diagnostic tests results to be communicated, the Hospital failed to ensure that clinical communication about a diagnostic test was completed. The findings include:
    a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. Review of the clinical record, dated 6/26/09, identified that the Emergency Department MD #20 ordered a Computed Tomography (CT) of the Chest due to Patient #1's shortness of breath and that the Ventilation and Perfusion (VQ) Scan identified a pulmonary embolism. The CT of the Chest, completed on 6/26/09, identified that the reason for the test was that the patient was short of breath and a pulmonary embolism was identified on the VQ Scan. Interpretation of the CT of the Chest, completed on 6/26/09 at 3:56 P.M. by MD #21 identified that Patient #1 had a large amount of thrombus within the pulmonary arteries including a saddle thrombus at the bifurcation extending into the left and right pulmonary arteries, thrombus nearly completely blocking the left lower pulmonary artery branch vessels, a near complete obstruction of the left upper lobe anterior segment pulmonary artery and a large amount of thrombus seen filling all segments of the right lung. Review of the clinical record did not reflect documentation that the results of the CT of the Chest for Patient #1 were communicated to any physician. Interview with the Medical Director of the Radiology Department, on 7/28/09, identified that the Radiology Department clinical communication is guided by the American College of Radiology Practice Guidelines for Communication of Diagnostic Imaging Findings, 2005. Clinical communication includes those instances in which the findings of the diagnostic test requires immediate intervention; the findings of the diagnostic test are discrepant with preceding diagnostic tests and failure to act may adversely effect the patient's health; and findings that the diagnostic imager reasonably believes are adverse to the patient's health and are unexpected by the ordering physician- and these cases may not require immediate attention but if not acted upon, may worsen over time and possible result in an adverse patient outcome. In addition the Medical Director added that the results of the CT of the Chest for Patient #1 were available via a report on 6/26/09 at 4:05 P.M. A second interview with the Medical Director of the Radiology Department, on 7/29/09, identified that he/she would not expect the Radiologist to call the physician on the outcome of Patient #1's CT of the chest. Interview with MD #1, Patient #1's attending physician on 7/29/09, identified that the VQ San and the CT Of the Chest provided different information on Patient #1's clinical condition, he/she was expecting to be called with the result of Patient #1's CT of the Chest, and those results would have changed the patient's treatment plan. In addition MD #1 identified that he/she reviewed the results of Patient #1's CT of the Chest on 6/27/09 at the time of his/her dictation of the patient's discharge summary (identified as 6/27/09 at 12:22 P.M.).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (f) and/or (i) General (6).

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

18. Based on review of a clinical record, interview, review of Hospital policy and procedure and review of Hospital documentation that routine maintenance be performed on Radiology safety devices for Hospital personnel, the Hospital failed to ensure that routine maintenance was performed on radiology safety devices for Hospital personnel. The findings include:
    a. Review of the Radiation Safety Committee Minutes, from 9/18/08 to 6/4/09, identified that inspection of the Radiology safety devices-including lead aprons must be completed on an annual basis. Interview with the Assistant Director of Radiology, on 7/31/09, identified that a selected Radiology Technologist annually inspects all Radiology safety devices. The check includes a visual and fluoroscopic examination of the device and the device will be labeled with the inspection date. Review of Hospital documentation, dated 7/2/09, identified that in the Reed Center, 7 of the 7 apron protectors were not checked annually. Documentation identified that 2 apron protectors were last checked in 5/05, 1 in 6/06, 1 in 4/07 and 3 in 5/07. Documentation further identified that 6 of the 9 thyroid protectors were not checked annually, 2 thyroid protectors were last checked in 5/05 and 4 in 5/07. In addition the document identified that one of the thyroid protectors, checked on 6/18/09, had a tear the device and documentation did not reflect that the device was taken out of use and/or repaired. Additional interview with the Assistant Director of Radiology, on 7/31/09, identified that these protective safety devices are used for Hospital Personnel only. Review of the Hospital policy and procedure, titled "Protective Device Inspection", identified that the protective devices will be inspected annually by a Radiology Technologist and any device that is identified by either visual or fluoroscopic examination to have an impaired integrity will be discarded or repaired.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (h) Dietary Services (1) and/or 9l) Infection Control (1) and/or (2).

19. Based on observations and interviews with facility personnel, the facility failed to ensure safe food handling practices. The findings include:
    a. During tour of the facility on 9/9/09, it was observed that during the tray line, dietary staff had personnel beverage containers on a shelf above the tray line, while food was being served. Subsequently, the Director of Food Services immediately removed the beverage containers. Review of hospital policy identified that only ice water may be consumed in the kitchen serving area. Interview with the Director of Food Services on 9/9/09 identified that the beverage containers should not be around the tray line while food is being served.
    b. During tour of the facility on 9/9/09, it was observed that a dietary aide was cutting raw chicken on a tray. Further observation identified that a hair net did not cover the dietary aide's head. Review of hospital policy identified that a hair restraint must cover all of the hair. Interview with the Director of Food Services on 9/9/09 identified that the dietary aide's hair was not completely covered.

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

c. During tour of the P-5 unit on 9/8/09 and the kitchen on 9/9/09,. it was observed that single serve apple, prune and orange juice containers had no expiration dates on them. Review of hospital policy identified that manufacturer expiration dates will be used for commericially packaged single serve items including juices. Interview with the Director of Food Services on 9/9/09 identified that the juices come frozen and are good for two weeks however, the Director of Food Services identified that she could not guarantee that juices kept in patient refrigerators were not stored beyond the two week period.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (i) General (6).

20. Based on a review of hospital policy, observations and interviews the hospital failed to maintain equipment and/or to discard equipment that had expired. The findings include:
    a. A tour of the Family Birthing Center was conducted on 9/8/09 at 9:45 AM with Assistant Director #3 and the Director of Quality. Four blood collection kits were observed in the medication room. Four blood culture tubes in one kit and two in a second kit had the expiration date of 8/2009 observed on the outside of each tube. Assistant Director #3 subsequently discarded the expired culture tubes. Interview with Assistant Director #3 on 9/8/09 at 9:45 AM noted that it was the responsibility of the Patient Care Assistants to draw blood and to check the blood draw kits for outdated blood collection tubes. The hospital laboratory policy for blood and urine collection tubes identified that the tubes expire at the end of the month noted on the tube.
    b. A tour of the two Cesarean Section Operating Rooms was conducted on 9/8/09 at 1:40 PM with Assistant Director #3 and the Director of Quality. Four castors on two of two suction canister holders were observed totally rusted. One of two OR bed bases was also observed to be rusted on three of four sides. Interview with the Assistant Director of Plant Engineering on 9/10/09 at 11:40 AM indicated that castors and "beds" are checked for rust as part of the hospital facility preventive maintenance program on a yearly basis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (2) and/or (6) and/or (l) Infection Control (1) and/or (2).

21. Based on observations and interviews with facility personnel, the facility failed to ensure adherence to infection control practices. The findings include:
    a. During tour of the P-5 unit, it was observed that the soiled utility room contained multiple clean items including, IV tubing sets, phones, phonebooks and a housekeeping cart. In addition, further observation identified that dirty mop heads were placed in bags and located on the floor in the hallway. Interview with the P-5 nurse manager on 9/8/09 identified that clean items are not to be in the soiled utility room and dirty items were not to be placed on the floor.
    b. During tour of the P-5 unit, it was observed that the patient refrigerator/freezer was heavily soiled. Interview with the P-5 nurse manager on 9/8/09 identified that housekeeping staff are responsible for cleaning the refrigerator daily.
    c. During tour of the GI laboratory on 9/9/09, it was observed that the cidex strips for

disinfection of scopes was dated 11/07 and was currently being utilized by staff for scope cleaning. Review of hospital policy identified that manufacturer's instructions for disinfectant dilution, activation, contact time, and appropriate use must be strictly followed. Interview with the GI Director on 9/9/09 identified that the cidex strips were outdated and should not be used.

d. During tour of the Medical Intensive Care Unit (MICU), Clinical Engineering Technician #1 entered Room 2012 and touched the patient's ventilator. After leaving Room 2012, Clinical Engineering Technician #1 proceeded to Room 2014 and touched the patient's ventilator. Doors to both rooms had contact isolation signage posted. Review of the Contact Isolation Policy identified that hand washing would be completed prior to entering and upon leaving the room and that gloves and gown would be worn in the room. Clinical Engineering Technician #1 failed to follow the contact isolation policy.
e. During tour of the Cardiovascular Unit (CVU) a chair scale and a commode that were identified as clean were in the dirty utility room.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (i) General (2) and/or (6) and/or (l) Infection Control (1) and/or (2).

22. Based on observations of patients, a tour of the ED on 9/8/09 with the Director of Emergency Service, and interviews with staff, the hospital failed to ensure that the environment and supplies were clean and free of environmental hazards, and that medications, supplies and blood products were secured, attended, and followed infection control principles. The findings include:
    a. Patient #8 was being treated in the ED on 9/8/09 following a seizure. Observation of the patient and the environment on 9/8/09 at 11 AM with the Assistant Director, identified that there were 5 vials of Patient #8 ' s blood on a bedside table unsecured and unattended. The Assistant Director identified that the blood should not have been left unattended.
    b. IV (intravenous) and other medical supplies were observed stored on counters in patient examination rooms in close proximity of a hand-washing sink. The supplies were noted to have water/fluid droplets on them, compromising the cleanliness and/or sterility of the items.
    c. In the ED medication room, multiple bottles of multi-dose medication bottles were observed to be opened and not dated. The hospital policy for multi-dose medication bottles identified that the bottle was to be dated when opened and only good for 30 days once opened.
    d. In the ED hallway, an ENT (ear, nose, and throat) cart was unlocked and unattended. The cart contained needles, syringes, and an opened vial of Heparin that was not dated when opened.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (6) and/or (l) Infection Control (1) and/or (2).

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

23. Based on observation during tour of the Operating Room Suite (OR) on 9/8/09 with the Director of Surgical Services and review of the hospital policy, the hospital failed to ensure that the restricted and semi-restricted environments of the OR promoted a decrease in the potential for cross-contamination. The findings include:
    a. Multiple chairs throughout the semi-restricted area of the OR were observed to be covered in cloth, rendering the cleaning of the chair impossible. All chairs were removed from the semi-restricted area during tour.
    b. Upon entering the soiled utility room from the outer hallway of the OR suite, the door was observed to be held open by a magnetic latch until manually disengaged by staff members.
    c. Observation in all of the Main ORs identified a large storage unit with multiple shelves holding anesthesia supplies positioned against the wall adjacent to the anesthesia medication cart. During interview on 9/8/09 at 11:30 AM, the covering anesthesiologist identified that the understanding was that such storage was acceptable. Observation of other storage areas in the OR identified available shelving behind glass doors. Additionally, the anesthesia provider was observed to have a trash bag located between the storage shelves and the medication cart that was utilized for the entire day rather than on a case by case basis. Review of the hospital policy for Routine Sanitation of the Operating Room identified that all trash would be discarded into appropriate plastic bags and discarded at the end of the case.
    d. Observation of the Room #1 between cases identified soiled lithotomy straps were attached to leg supports that were hung on the wall. The straps were removed and discarded by the Manager of the OR.
    e. Observation of the cardio-pulmonary machine located in the Reed OR identified that the circuit was preassembled and threaded through the machine. The circuit failed to be dated and/or labeled. During interview on 9/9/09 at 11:30 am, the Director of Surgical Services stated that the circuit and machine were set up to be utilized for educational purposes. Review of the hospital policy for Cardio-pulmonary bypass Circuit Set Up identified that the integrity of the preassembled circuit was good for seven (7) days however that the preassembled circuit should be covered and sealed at all times with a date and the initials of the person assembling circuit placed on the container.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B).

24. Based on clinical record reviews and interviews with facility personnel, the facility failed to ensure that a post anesthesia evaluation was completed after a procedure. The findings include:
    a. Patient #28 was admitted to the hospital on 9/9/09 for Panendoscopy and a Colonoscopy. Review of the clinical record identified that the post anesthesia evaluation was not completed. Review of hospital policy identified that at least one post anesthesia visit is recorded, describing the presence or absence of anesthesia related complications. Interview with MD # 24 identified that an evaluation from anesthesia is to be completed after the procedure.

EXHIBIT A

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-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (i) General (6).

25. Based upon review of the clinical record, review of hospital policies, review of hospital documentation and interviews with hospital personnel for one patient with pneumonia (Patient #14), the hospital failed to ensure that medical orders were written to direct respiratory care. The findings include:
    a. Patient #14 was admitted to the hospital on 8/25/09 with community acquired pneumonia. The patient's past medical history included cerebral vascular accident (CVA), hyperhomocysteinemia, type 2 diabetes mellitus and chronic kidney disease. Review of the record identified that Patient #14 was to be discharged on 8/27/09. However, the next day, the patient's respiratory status declined (demonstrated by poorer arterial blood gases, chest x-ray and an increased in oxygen requirements). On 8/29/09 Patient #14 was found unresponsive and required cardiopulmonary resuscitation (CPR). After the patient was successfully resuscitated, Patient #14 required mechanical ventilation and was transferred to the MICU. Although the patient's pneumonia had resolved, Physician Progress Notes dated 9/9/09 identified that the patient had anoxic brain injury and lacked any signs of neurologic recovery or brain activity above the brain stem. Review of the Oxygen Therapy Policy identified that a physician order was needed for oxygen administration. From admission through 8/29/09 Patient #14 required oxygen therapy. Physician Orders failed to reflect oxygen administration orders until 8/28/09 at 1:30 PM and on 8/29/09 failed to reflect oxygen titration requirements.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (4) and/or (b) Administration (2) and/or (i) General (6).

26. Based in a tour of the facility, the hospital failed to ensure that the required automatic sprinkler system was continuously maintained in reliable operating condition and was inspected and tested periodically as required by the referenced LSC.
    a. On 09/09/09 at 11:40 AM, the surveyor along with the Director of Facility Operations observed that the sprinkler heads in the main kitchen were date coded 1953 past the 50 year requirement for replacement of the sprinklers for this area and/or that test samples were not sent to a lab as required by NFPA 25 chapter 5 section 3.1.1.1 to continue using these heads. The surveyor was not provided with documentation by the Director of Facility Operations that this testing had been completed for this area and/or that the hospital had been surveyed for any other sprinkler heads of this age or were in the process of replacing them.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (b) Administration (2) and/or (i) General (6).

27. Based on review of documentation the Hospital did not ensure that all employees are

periodically instructed as to their duties during a fire emergency as required by NFPA 101 "Life Safety Code" 19.7.1 and annually as required in NFPA 99 " Health Care Facilities " 11-5.3.8 and 12-4.1.2.10 (d)2.

a. On 09/10/09 at 10:45 AM, The surveyor was not provided with documentation by the Director of Security that all employees are in serviced annually as to their duties and part in the facility emergency prepardness plan and/or that all employees are trained as to their department specific duties during an emergency. Documentation reviewed indicated only 93% of employees attended the mandatory fire safety in service conducted in 2008 and the 2009 inservice was not complete at time of survey.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1) and/or (2) and/or (i) General (6).

28. Based on a review of the clinical record, review of hospital policies and procedures, review of hospital documentation and interviews with hospital personnel for one patient (Patient #1) who required advanced cardiac life support, the Hospital's quality assurance and performance improvement program failed to prioritize and implement appropriate interventions in order to ensure patient safety and quality of care. The findings include:

a. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital on 6/26/09 at 1:59 P.M.

On 6/27/09 at 10:26 P.M., the clinical record reflected that Patient #1 had no pulse and/or no respirations and advanced cardiac life support was again provided by a multi-disciplinary team to Patient #1 including the use of a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support to Patient #1, two defibrillator machines were not able to be charged four times (due to battery "dead" and/or no charge when machine was plugged into wall outlet). Once MD #13 identified the defibrillator cable to the right paddle was not connected, the cable was connected and the patient was defibrillated four times with the first defibrillator. MD #13 added that the time between the first attempt to defibrillate Patient #1 and the first shock that was delivered was five minutes. The clinical record reflected that on 6/27/09 at 10:50 P.M. Patient #1 was pronounced dead.

Interview with RN #5, the RN Supervisor who was present and part of the ACLS team, identified that he/she did not remove and/or direct the staff to remove the two defibrillators from a patient care area for an evaluation by the clinical engineering department and/or contact and/or direct the staff to contact the clinical engineering department subsequent to the defibrillator malfunctioning and as per Hospital policy and procedure. Review of the Hospital policy and procedure, titled "Identifying and Correcting problems with Patient Care Equipment", identified that if a problem with patient care equipment is identified the Clinical Engineering Department is notified and the back-up equipment is brought to the area.

Interview with the Medical Director of the Intensive Care Units, on 7/28/09, identified

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

that although he/she was informed about Patient #1's clinical condition and the treatment interventions on 6/27/09, he/she was not aware that two defibrillators would not charge. Interviews with Clinical Engineering Technician #1 and #2, on 7/22/09, identified that every defibrillator is tested quarterly to ensure that the machine can charge and discharge, these tests were last completed on 5/1/09, and the defibrillators are comprehensively inspected annually. On 7/23/09 Clinical Engineering Technician #1 completed testing of 9 of the 20 defibrillators-including 7 defibrillators located in the Intensive Care Units, and it was identified that one of the seven defibrillators in the Intensive Care Units had not been tested quarterly since 12/2008.

Review of Hospital documentation did not reflect that any tracking and/or labeling were on each defibrillator to identify the location. Review of the Intensive Care Unit Staff Meeting Minutes, dated 7/13/09 and 7/14/09, with the Nursing Director of the Critical Care Units, on 7/28/09, identified that the defibrillator number will be part of the daily defibrillator checks. Review of the July 2009 "Code 3 Cart/Defibrillator Daily Check List" from 7/13/09 to 7/22/09 did not indicate the defibrillator number as part of the daily defibrillator check.

Interview with the Director of Quality Management, on 7/23/09, identified that this patient's case was sent from the Quality Management Department to the Serious Event Committee on 7/6/09 for a physician review of Patient #1's medical care. Review of the minutes of the Hospital's Serious Event Committee, dated 7/6/09, reflected that this case would undergo a physician review of Patient #1's medical care and documentation did not reflect that there was any issue to be investigated regarding the defibrillators that were used in Patient #1's Code on 6/27/09.

In addition interview with MD #13 (the physician that was assigned to deliver the defibrillator during the Code), on 7/29/09, identified that during the provision of advanced cardiac life support for Patient #1, two defibrillator machines were not able to be charged four times and this information was not documented on the Code 3 sheet or on the patient's discharge summary.

The Hospital's staff failed to inform the appropriate department, according to Hospital policy, of the two defibrillators that were not able to be charged during the Code for Patient #1 (on 6/27/09) and therefore the Quality Management Department failed to prioritize and implement appropriate interventions in order to ensure patient safety and quality of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2) and/or (b) Administration (2) and/or (i) General (2) and/or (6).

29. Based on a review of facility documentation and procedures, staff interviews and facility tours with the Director of Facility Operations and the Director of Clinical Engineering on 07/28/09, the facility did not ensure that the portable fire extinguishers were provided and maintained in accordance with NFPA 10 "Standard for Portable Fire Extinguishers" as evidenced by the fire extinguishers that were observed during tour of the facility as pre-dated for August 2009 and this tour was conducted on 07/28/09. The Director of Facility Operations and the Director of Security were interviewed on 07/28/09 and the information provided was that the employee

who normally checked the fire extinguishers was off during the upcoming weekend so he did not want to shift his work load so he inspected them early and predated them;

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (i) General (6).

30. Based on a facility tour of Electrical Room # 0712 in the area of medical records along with the Director of Quality and Safety, the facility did not ensure that required clearances were maintained around high voltage electrical equipment. It was observed that the facility was storing combustible medical records and data being prepared to be destroyed directly against an energized buss panel/switch/breakers not maintaining the required 36 inches of clearance required by NFPA 70 for working space around switches and or panel boards

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (b) Administration (2) and/or (i) General (2) and/or (6).

31. Based on a review of facility documentation, policies and procedures and staff interviews and facility tours on 07/28/09, 07/30/09, 07/31/09 and 08/02/09, it was determined that the facility failed to ensure that the Clinical Engineering and Respiratory Departments conducted internal preventative maintenance service and/or preventative maintenance as required by the manufacturers recommendations and the facility Medical Equipment Management Plan for the Environment Of Care and/or the Hospital failed to ensure that preventative maintenance was performed on life saving equipment according to facility policy. The findings include:
    a. The surveyor along with the Director of Clinical Engineering observed that ventilator #28 hospital asset tag #002260 in Patient Room 2020 of the MICU was not in compliance with the clinical engineering next due dates of 61,006 hours of use as listed on the preventive maintenance sticker. Observation of the hours meter on the ventilator identified 66,732 hours. Interview with the Assistant Director of Respiratory Services on 07/28/09 indicated that the patient was a longtime ventilator patient and that is why the ventilator was past due for preventive maintenance. When the Assistant Director of Respiratory Services was questioned as to why the ventilator had not been pulled for service and replaced when the patient was out of the room at dialysis, she offered no explanation. Further investigation revealed that the patient had been placed on a ventilator that was 5,246 hours past due for full preventive maintenance.
    b. During a tour of the facility Respiratory Services storage room on 07/28/09 it was observed that there were many machines in various states of repair and/or operational checks before being returned to service. Machine # 005061 was marked as ready for use and had a preventive maintenance sticker on the machine listing that it was due for maintenance at 38,870 hours. Observation of the hour meter indicated the ventilator had 39,520 hours. This machine was 650 hours past its maintenance requirement. The Director of Clinical Engineering was informed and concurred that the facility would need to inventory all ventilators and ascertain the hours of use and if any other machines were due for preventive maintenance (pm).
    c. During a tour of the MRI treatment and reception area along with the Director of

Clinical Engineering on 07/28/09 it was observed that the defibrillator charging light was not illuminating on the crash cart defibrillator. The crash cart log indicated that the crash cart had been checked on 07/28/09. When the area staff were interviewed on 07/28/09 they didn't realize that the charge indicator was not illuminated and that the cord to charge the unit was not fully inserted. The charging cord was immediately fully inserted into the rear of the unit and the charge indication light was observed to be illuminated.

d. During a record review and tour of the hospital along with the facility Director of Clinical Engineering on 07/30/09, 07/31/09 and 08/02/09 to determine compliance with an immediate corrective action plan instituted on 07/29/09, it was observed that the facility had two patients on ventilators that had exceeded the facility requirements for preventative maintenance. The patient in ICU Room # 214 on a ventilator with hospital asset tag 005063, had a preventive maintenance sticker indicating 39,520 hours as when it was due for service. Observation of the hours meter by the clinical engineering staff indicated the ventilator had 40,084 hours. This ventilator was 421 hours past due for full preventive maintenance on 07/25/09, the day of admission for this patient, and 565 hours past due on the day of survey. A second patient in SICU Room 229 was identified, on a ventilator with hospital asset tag # 002275 with a preventive maintenance sticker indicating 62,269 hours as when it was due for service. Observation of the hours meter by the clinical engineering staff indicated the ventilator had 64,539 hours. This machine was 2,246 hours past it maintenance requirement on 07/29/09 the day of admission of this patient, and on the day of survey it was 2,270 hours past due for full preventive maintenance.

e. During a record review and tour of the hospital along with the facility Director of Clinical Engineering on 07/30/09, 07/31/09 and 08/02/09 to determine compliance with a immediate corrective action plan instituted on 07/29/09 it was observed that the hospital had three (3) additional ventilators past the full preventive maintenance requirement identified on the ventilator pm tag that had not been identified prior to this plan of correction. The ventilator with hospital asset tag 005793 was due for service at 26,600 hours. Observation of the hours meter by the clinical engineering staff indicated the ventilator had 31,212 hours, or 5,612 hours past due for full preventive maintenance. The ventilator with hospital asset tag 005796 was due for service at 29,324 hours. Observation of the hours meter by the clinical engineering staff indicated the ventilator had 37,780 hours or 8,456 hours past due for full preventive maintenance.

f. During a tour of the hospital along with the weekend Nursing Supervisor on 08/02/09 to determine compliance with an immediate corrective action plan instituted on 07/29/09 and 07/31/09, it was observed that the radiology department crash cart in room 0245 had not been checked per hospital policy on 08/01/09 and 08/02/09 and when interviewed on 08/02/09, the weekend technologist identified that in a code situation she would use the cart that was in Room 0245. Tour of the Post Anesthesia Care Unit for the operating room and review of the crash cart log indicated that the cart had been checked on 08/01/09 and 08/02/09 and the defibrillator #18 asset tag # 006766 had a test strip indicating last test was 08/01/09. When interviewed on 08/02/09 the PACU Nurse stated that she had not tested the defibrillator as of yet but would right away.

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

g. Patient #1 arrived at the Emergency Department (ED) on 6/26/09 at 8:03 A.M. with complaints of chest pain and palpitations, head pain, lethargy and diaphoresis for two hours. The clinical record identified that Patient #1 underwent multiple diagnostic tests, was diagnosed with pulmonary emboli and was admitted to the Hospital on 6/26/09 at 1:59 P.M. On 6/27/09 at 10:26 P.M., the clinical record reflected that Patient #1 had no pulse and/or no respirations and advanced cardiac life support was again provided by a multi-disciplinary team to Patient #1 including the use of a defibrillator. Interview with MD #13, on 7/29/09, identified that during the provision of advanced cardiac life support, two defibrillator machines were not able to be charged four times (due to battery "dead" and/or no charge when machine was plugged into wall outlet), although after the defibrillator cable to the right paddle was connected, the patient was defibrillated four times with the first defibrillator. MD #13 added that the time between the first attempt to defibrillate Patient #1 and the first shock that was delivered was five minutes. The clinical record reflected that on 6/27/09 at 10:50 P.M. Patient #1 was pronounced dead. Review of Hospital documentation, "Code 3 Cart/Defibrillator Daily Check List" dated 6/27/09 identified that the defibrillator was in working order including that it was able to be charged.
Interviews with Clinical Engineering Technician #1 and #2, on 7/22/09, identified that every defibrillator is tested quarterly to ensure that the machine can charge and discharge, these tests were last completed on 5/1/09, and the defibrillators are comprehensively inspected annually. On 7/23/09 Clinical Engineering Technician #1 completed testing of 9 of the 20 defibrillators-including 7 defibrillators located in the Intensive Care Units, and it was identified that one of the seven defibrillators in the Intensive Care Units had not been tested quarterly since 12/2008.
Review of Hospital documentation did not reflect that any tracking and/or labeling were on each defibrillator to identify the location. Review of the Intensive Care Unit Staff Meeting Minutes, dated 7/13/09 and 7/14/09, with the Nursing Director of the Critical Care Units, on 7/28/09, identified that the defibrillator number will be part of the daily defibrillator checks.
Review of the July 2009 "Code 3 Cart/Defibrillator Daily Check List" from 7/13/09 to 7/22/09 failed to indicate the defibrillator number as part of the daily check.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (c) Medical staff (2)(B), and/or (e) Nursing service (1), and/or (i) General (6).

32. Patient #106 was admitted to the hospital on 2/21/09 for coronary artery bypass surgery. The patient's diagnoses included coronary artery disease, hypertension and bipolar disorder. Review of the patient's Medication Administration Record reflected that the patient received Seroquel 150 mg po q AM; Seroquel 300 mg po q PM; Lexapro 10 mg po q AM; Lamactil 200 mg Q HS and Lithium 600 mg po BID during the hospitalization. Nurse's Notes dated 2/24/09 indicated that Patient #6 was "a little off" and was shuffling; on 2/25/09 the patient was pacing the room and "manic"; on 2/26/09, Patient #106 was incontinent of urine and crying. Review of the record and interviews with hospital personnel indicated that the patient was to have a

psychiatric consultation on 2/25/09. However, the patient's private psychiatrist did not have privileges. Interview with APRN #1 indicated that she spoke with the hospital staff psychiatrist for consultation. APRN #1 indicated that the psychiatrist was "too busy" and asked her if it was an emergency. Review of the record and interviews with APRN #1 and SW #2 identified that Patient #6 was discharged to home on 2/26/09 without a psychiatric evaluation. Review of the clinical record identified that Patient #106 was admitted to another acute care hospital on 2/28/09 with suicidal ideation, auditory/visual hallucinations and delirium and was hospitalized for 10 days. Documentation and interviews failed to reflect that Patient #106, with history of psychiatric disorders and exhibiting behavioral symptoms, had a comprehensive psychiatric assessment prior to discharge.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

33. Based on observation, review of hospital policy and staff interview, the hospital failed to ensure that medications in an emergency cart were not expired. The findings include:
    a. During a tour of the PACU on 5/13/09 at 1:25 PM, the defibrillator cart was observed to contain Epinephrine Injections 10 ml's dated 1/08, and 4/08. Subsequent to surveyor inquiry the expired medications were discarded. Interview at 1:35 PM with the Unit Manager (PACU) identified the cart should be checked after each emergency use.
    b. During a tour of the Reed Open Heart Operating Room on 5/13/09 at 11:40 AM, the medication refrigerator was observed to contain seven (7) 1 ml vials of Propanolol dated 4/09 on an open anesthesia tray. Subsequent to surveyor inquiry the expired medications were removed from the refrigerator. Review of the Anesthesia Tray Refill Instructions Policy directed that a used (dirty) tray will be returned to pharmacy for refilling. Interview on 5/13/09 at 11:30 AM with the Assistant Director (Operating Room) identified that once trays are used, and the case is over, the trays are removed from the operating room and taken back to pharmacy to be restocked.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

34. Based on review of the clinical record, review of hospital policy and staff interview for one patient (Patient #105), the hospital failed to ensure that medication was administered according to the physician's orders. The findings include:
    a. Patient #105 was admitted on 1/28/08 with a diagnosis of chronic cholecystitis/ cholelithiasis and underwent a laparascopic cholecystectomy. Review of the clinical record dated 1/28/08 at 2:00 PM directed Patient #105 to receive Mefoxin (antibiotic) intravenously every eight (8) hours for 3 doses. Review of the Medication Administration Record dated 1/28/08 identified that Mefoxin 1 gm/50 ml was administered on 1/28/08 at 8:30 PM and on 1/29/08 at 4:30 AM however failed to identify that a third dose was administered. Review of the hospital Medication Administration Policy directed that a nurse should administer medications by the method ordered by the prescribing practitioner. Interview on 5/20/09 at 1:00 PM with

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Assistant Director #5 identified that the medication was not administered in accordance with physician's orders.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

35. Based on review of the clinical record, review of hospital policy and staff interview, for the only sampled patient who underwent a laparoscopic cholecystectomy (Patient #105), the hospital failed to ensure that comprehensive nursing assessments were conducted in accordance with hospital policy. The findings include:
    a. Patient #105 was admitted on 1/28/08 with a diagnosis of chronic cholecystitis/ cholelithiasis and underwent a laparoscopic cholecystectomy. Review of the clinical record dated 1/28/08 at 2:00 PM identified that the patient had a Jackson Pratt drain to bulb suction. On 1/28/08 during the 3-11 PM shift, the patient was transferred to the Medical/Surgical Unit. A Progress Note identified that a JP drain to the right lower quadrant was present however failed to reflect that an assessment of the patient's drain was conducted. On 1/29/08 during the 7AM – 3 PM shift the clinical record failed to provide documented evidence that a drain assessment was conducted. Subsequently, on 1/29/08 during the 3-11 PM shift, Patient #105 was transferred to the MICU and upon admission noted the JP drain to have a scant amount of dark green drainage. Patient #105 was subsequently diagnosed with cholelithiasis complicated by duodenal perforation. Review of the hospital Interdisciplinary Admission Assessment And Reassessment policy directed that all patients be reassessed every eight (8) hours unless a standard of care for patient diagnosis requires more frequent assessment. Interview and review of the clinical record on 5/21/09 at 1:30 PM with Assistant Director #5 failed to reflect that an assessment of the patient's Jackson Pratt drain was conducted every shift.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

36. Based on review of the clinical record, review of hospital policy and staff interview, for the only sampled patient who underwent a laparascopic cholecystectomy (Patient #105), the hospital failed to ensure that the "time out" verification was completed according to hospital policy. The findings include:
    a. Patient #105 was admitted on 1/28/08 with a diagnosis of chronic cholecystitis/ cholelithiasis and underwent a laparascopic cholecystectomy. Review of the clinical record dated 1/28/08 identified the procedure site, "time out" verification had been dated by the pre-operative/pre-procedure team member. The documentation however failed to reflect a time of pre-procedure verification and a team member signature for "time out" final verification just prior to the start of the procedure. Review of the hospital "Time Out" Verification Policy directed that the "time out" verification is documented on the pre procedure checklist and "time out" final verification form, or the preoperative nursing record by a member of the procedure or operative team.

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3(c) Medical staff (2)(B) and/or (i) General (6) and/or (l) Infection control (1)(A).

37. Based on observation, staff interview and review of facility policy and procedure for one (1) of one (1) patient observed (Patient #117), the facility failed to ensure that the staff followed the Contact Isolation policy and procedures. The findings include:
    a. During a tour of the Emergency Department, on 5/11/09, signage was observed on the doorway to Patient #117's cubicle that the patient required contact isolation and that all staff entering the room must don gloves. A cart containing isolation supplies was observed located at the left side of the doorway and on top of the cart was an isolation manual. At 11:09 A.M., it was observed that a staff member was in Patient #117's room in an isolation gown, mask and gloves and was providing care. At 11:10 A.M., MD #1 was observed in Patient #117's cubicle without gloves and upon exiting the room MD #1 did not wash his/her hands. Interview with MD #1, on 5/11/09, identified that he/she did not see the isolation sign and would wash his/her hands at that time. At 11:15 A.M., MD #2 was observed entering Patient #117's cubicle without gloves and upon exiting the room MD #2 did not wash his/her hands. Interview with MD #2, on 5/11/09, identified that he/she entered the room to direct the staff. Review of Patient #117's clinical record identified that he/she was on contact isolation for Methicillin Resistant Staphylococcus Aureus in the blood. Interview with the Nursing Director of the Emergency Department, on 5/11/09, reflected that staff must use the appropriate personal protection equipment for patients that are on contact isolation. Review of the facility policy and procedure, titled "Contact Isolation", identified that hospital staff must wear gloves and wash hands upon exiting the room.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

38. Based on review of the clinical record, review of facility documentation and staff interviews, the facility failed to ensure that the appropriate care and services were provided to Patient #103. The findings include:
    a. Patient #103 was admitted to the Hospital on 7/30/08 for the elective surgical intervention of a left hip fusion take down and conversion to a left total hip arthroplasty on that day. The patient's past medical history included a left hip fusion approximately fifty years prior, hypertension, right total knee replacement, right total hip replacement, degenerative hip disease in the left knee and back pain. Review of the clinical record, from 8/1/08 to 8/3/08, identified that the patient's left lower leg was rotated outward, the musculature in the area was weak and a second intervention, application of Wilke boots and a stabilizing bar, was scheduled for Patient #103 on 8/4/09. Review of the physician orders, dated 8/3/08 at 10: 45 A.M. directed the staff to obtain a chest x-ray and an electrocardiogram today for Patient #103 prior to the application of Wilke boots and a stabilizing bar on 8/4/08. Review of the nursing

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

assessment, on 8/3/08 at 4:00 P.M., identified that Patient #103 was alert, had pain at a level of 5 (on a scale of 0=no pain and 10= most pain) in his/her left hip area forty-four minutes after receiving an intravenous dose of an opioid analgesic medication (Dilaudid), that the left hip was swollen, tender to touch, with limited motion and was externally rotated. Review of the Physical Therapy notes, dated 8/3/08 at 4:05 P.M. reflected that Patient #103 ambulated one hundred twenty feet twice with staff assistance utilizing a rolling walker although the patient had decreased weight bearing and stride length. Review of the Radiology documentation, dated 8/3/08, identified that the chest x-ray was completed on 8/3/08 at 2:57 P.M. Review of the Nursing progress note, dated 8/3/08 at 3:20 P.M., reflected that Patient #103 complained of "severe left hip pain" after returning from the radiology department, was "unable to ambulate", was given an additional dose of Dilaudid and that the physician was notified. In addition, a hip x-ray, read on 8/4/08, identified that Patient #103's left hip prosthesis was dislocated. Interview with the Director of Radiology, on 5/14/09, reflected that when a patient arrives in the Radiology department for a chest x-ray the staff asks the patient if he/she can stand upright (the best position for a chest x-ray), reviews the chart for level of assistance required and ensures that sufficient radiology staff is present to assist the patient. Interview with Patient #103's surgeon, MD #7 on 5/14/09, identified that the patient's hip was not dislocated prior to completing the chest x-ray and that Patient #103 had a higher risk to dislocate the left hip due to his/her history of the fusion. Interview with Quality Staff #1, on 5/14/09, reflected that the Hospital did investigate this event, that the radiology staff member involved only asked the patient if he/she could stand and that Patient #103 had difficulty returning to the stretcher after the radiology test. Interview with the Assistant Nurse Director of Pomeroy 7, on 5/14/09, identified that prior to 8/3/08, it was identified that Patient #103's left leg was externally rotated and that the application of Wilke boots and a stabilizing bar was scheduled prior to 8/3/08. Review of the clinical record and/or interviews did not indicate that the radiology staff reviewed Patient #103's chart to determine the level of assistance required and/or provided the patient the level of assistance that he/she required during the radiology test. Interview with the Director of Radiology, on 5/14/09, identified that presently, any patient with a hip replacement does not stand for a postoperative radiological test.

b. Review of the physician's orders, dated 8/3/08 at 3:10 P.M., directed the staff to obtain an x-ray of the left hip. Orders, dated 8/3/08 at 4:20 P.M. directed the staff to obtain a portable hip x-ray. The hip x-ray, completed on 8/3/08 at 5:14 P.M. and read on 8/4/08 at 10:28 A.M. by MD #8, identified that Patient #103's left hip prosthesis was dislocated, and that MD #8 contacted the patient's physician. Interview with the Director of Radiology, on 5/14/09, reflected that at the time that Patient #103's hip x-ray was completed, there was no Radiologist present at the Hospital and that it is the responsibility of the ordering physician to read the x-ray when the Radiologist is not at the Hospital. Interview with Patient #103's surgeon, MD #7 on 5/14/09, identified that he/she assumed that the physician that ordered the x-ray, MD #10, was aware that he/she had to read the hip x-ray. Interview with Quality Staff #1, on 5/14/09, reflected that the ordering physician was responsible to read the hip x-ray on 8/3/08 and all of the physicians were re-educated that they are responsible to read x-rays when the

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Radiologists are not present at the Hospital.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (g) Pharmacy (1) and/or (i) General (6).

39. Based on medical record review, review of hospital documentation, review of hospital policy, observation, and interview for one of two patients observed during medication administration (Patient #124), the Pharmacy and Nursing departments failed to ensure the correct dosage of medication. The findings include:
    a. Patient #124 was admitted to the hospital on 5/7/09 for altered mental status and hyponatremia. Physician orders dated 5/8/09 directed to change Verapamil to 400 milligrams (mg) to Verapamil Sustained Release (SR) 360mg by mouth daily. Interview with RN #6 on 5/12/09 at 9:40 AM identified that he/she checks a patient's medication three times prior to administering the medication. RN #6 indicated that he/she obtained medications from the patient's drawer, checked the medication for proper dosage against the medication administration record (MAR), will verify that the medications are correct prior to entering the patient's room, and again at the patient's bedside. Observation on 5/12/09 at 9:40 AM noted that RN #6 checked Patient #124's medications outside of the patient's room and against the MAR. The MAR identified that the patient was to receive Verapamil SR 360mg as a morning dose in accordance with the physician's order. RN #6 removed Verapamil 240mg and a Verapamil 180 mg (total of 420mg) from the patient's medication cup. RN #6 verified the medication against the MAR, indicated that the 2 tablets would be administered per the physician's order, and placed the packaged tablets back into the patient's medication cup. Subsequently, the dosage was questioned by the surveyor, RN #6 verified that the two Verapamil medications, if administered together, would be an inaccurate dose, and the pharmacy was notified that an incorrect medication dose had been sent. Review of facility documentation dated 5/11/09 noted that the pharmacy technician had filled the patient medication drawers and the pharmacist had verified that all medication drawers contained the correct medications. The facility policy for Drug Distribution identified that the technician prepares the doses and the pharmacist checks all doses before being sent to the unit. The hospital policy for medication administration indentified to bring the prepared medication to the patient along with the MAR to verify the patient's identity.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6) and/or (j) Emergencies (2).

40. Based on medical record review for one of three patients admitted to the Emergency Department (ED) with an elevated temperature (Patient #108), the hospital failed to notify the physician in a timely manner of the patient's elevated temperature. The findings include:
    a. Patient #108 was admitted to the ED on 7/31/08 with complaints of cough and inability to ambulate. The triage nursing assessment dated 7/31/08 at 4:42 PM noted that the patient was assessed as a level 3, urgent acuity, had a tympanic temperature of 102 degrees Fahrenheit (F), and did not have pain. The events information sheet identified

that the patient was admitted to an ED room at 4:58 PM on 7/31/08. The patient's tympanic temperature was reassessed and documented as 102.3 degrees F at 7:30 PM. The ED medication record indicated that the patient received Tylenol 675mg by mouth at 7:15 PM, 2 hours and 33 minutes after the first elevated temperature was documented, and without a physician's order. The events information sheet also noted that the physician assessed the patient at 8:05 PM and documented that the patient's temperature was "high". Interview with Nursing Director #5 on 5/14/09 at 8:45 AM identified that if a patient had an elevated temperature the primary ED nurse would be expected to address a patient's elevated temperature when the patient arrived to the assigned ED room. Director #5 indicated that the ED did not have standing orders for Tylenol administration and that the administrating of Tylenol would require a physician's order.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 Administration (2).

41. Based on medical record review, review of hospital documentation, review of hospital policy, and interviews for one of two patients or patient's family who complained about care received during a hospital admission (Patient #108), the hospital failed to investigate the complaint. The findings include:
    a. Patient #108 was admitted to the ED on 7/31/08 with complaints of cough and inability to ambulate. The patient was diagnosed with pneumonia, admitted to the Pomeroy 5 Unit as an in- patient and was discharged on 8/4/08. Documentation by Person #1 dated 9/5/08 identified patient care complaints related to the ED physician's assessment, timeliness of Tylenol administration in the ED, staffing concerns, communication of test results, intravenous antibiotic administration, blood sugar monitoring, and additional care and environmental issues. Although the response indicated that staffing was investigated/addressed, the response lacked documentation regarding Person #1's remaining concerns. Interview with Assistant Director #4 on 5/14/09 at 10:15 AM noted that he/she addressed what the patient complaints were with Pomeroy 5 staff during unit meetings to inform staff. Interview with the Director of Patient Relations on 5/14/09 at 1:45 PM indicated that MD #5 did not have any additional documentation regarding care concerns involving Patient #108. The hospital policy for patient complaint/grievance process identified that all concerns will be investigated using the patient's perception of the experience, the medical record, interviews with staff when appropriate, and other measures to ensure as complete a process as possible.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

42. Based on medical record review and interview for one patient (Patient #108), the hospital failed to maintain an accurate or complete record. The findings include:
    a. Patient #108 was admitted to the hospital with a diagnosis of pneumonia. Physician orders dated 8/1/08 directed blood sugar monitoring before meals, at bedtime, and insulin coverage using a sliding scale. The Hyperglycemia Management Protocol

directed fingerstick blood glucose monitoring at 7:30 AM, 11:30 AM, 4:30 PM and 8:30 PM. Blood sugar testing from 8/1/08 at 7:30 AM to 8/3/08 at 7:30 AM noted that the patient's blood sugar was monitored before each meal and at 10 PM not 8:30 PM. The medication administration record dated 8/3/08 at 11:30 AM noted that 8 units of insulin coverage had been administered. The patient's record failed to document the fingerstick blood glucose result that necessitated the patient's need for insulin on 8/3/08 at 11:30 AM. Interview with Assistant Director #4 on 5/14/09 at 10 AM identified that the patient's fingerstick blood sugars are to be recorded on the MAR and/or the lab sheet (Point of Care Tests form) in the patient's record.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or(c) Medical Staff (2) (B) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

43. Based on review of the clinical record, facility documentation and interview with the facility personnel, for three patients (Patient #113, #139 and #146) who received hemodialysis treatments and/or blood transfusions, the hemodialysis staff failed to document post-dialysis weight, auto-test of alarms and/or failed to verify physician orders prior to initiation of dialysis treatment and/or the nursing staff failed to document vital signs and observation of transfusion reaction in accordance with the facility policy. The findings include:
    a. Patient #113 received a hemodialysis treatment on 04/10/09. The orders for hemodialysis included three and a half hours of treatment. The Acute Hemodialysis flow sheet indicated that the patient's systolic blood pressure should be kept above 90 millimeters of mercury (mmHg). Review of the flow sheet indicated that the patient's systolic blood pressure declined to 88 mmHg after three hours and ten minutes of dialysis. The physician was contacted and gave the verbal order to end the treatment early. The hemodialysis flow sheet identified a pre-dialysis weight of 82 kilograms (kg) but failed to identify a post-weight. Review of the hemodialysis policy from the contracted agency indicated that pre and post dialysis treatment data collection included weights, for the purpose of planning the dialysis treatment and reviewing the patient's response to the treatment.
    b. Patient #113 received the first unit of packed red blood cells (PRBCs) on 04/12/09 from 6:30 AM to 10:30 AM. Review of the Documentation of Blood Transfusion with the Assistant Director of Nursing on Pomeroy 7 on 05/11/09 indicated that the nursing staff failed to document Patient #113's vital signs upon completion of the blood transfusion at 10:30 AM, and failed to indicate the presence or absence of transfusion reaction following the transfusion. The facility policy on blood transfusion directed the documentation of vital signs at completion of the transfusion, and observed or lack of transfusion reaction following the transfusion. The next set of vital signs was not performed until 11:40 AM, upon initiation of the second unit of blood transfusion.
    c. On 05/12/09, Patient #139 received a physician order for a hemodialysis treatment. The Heparin order included in the handwritten hemodialysis order was illegible, and could not be read by either the Nursing Director of the Intensive Care Unit (ICU) or the hemodialysis nurse (RN #1). However, the patient's hemodialysis flow sheet identified

the total administration of 2,000 of Heparin during the hemodialysis treatment. In an interview on 05/13/09 at 2:35 PM, RN #1 indicated that he/she listened to assignments recorded on telephone voice-mail at the contracted hemodialysis agency, and used this information to conduct patient's treatments at the hospital. RN # 1 recalled that the telephone message specified a total of 2,000 units of heparin for Patient # 139. In addition, RN #1 recalled speaking to the Nephrologist in the same practice as the patient's attending physician, prior to delivering hemodialysis treatment to the patient, and the Associate Nephrologist was made aware of the Attending's order for 2,000 units of heparin. However, the hemodialysis nurse failed to verify the written physician order for dialysis in the patient's chart in the ICU and/or failed to document the verbal order for heparin following the conversation with the Associate Nephrologist. Interview with the Administrative Director of Medical-Surgical-Critical Care Services on 05/14/09 indicated that hemodialysis nurses were to verify physician orders in the patient's chart prior to delivery of the hemodialysis treatment, and were not to accept telephone messages from the agency as actual orders.

d. Patient #146 received a hemodialysis treatment on 05/12/09. Review of the facility documentation indicated that the testing of alarms was conducted for hemodialysis machine prior to the treatment. However, the hemodialysis nurse failed to document successful alarm testing on the patient's hemodialysis flow sheet prior to initiating the treatment.

e. Review of patient #146's hemodialysis treatment flow sheet dated 05/12/09 also identified a pre-dialysis weight of 143.6 kg, but failed to identify a post-dialysis weight. Review of the hemodialysis policy from the contracted agency indicated that pre and post dialysis treatment data collection included weights, for the purpose of planning the dialysis treatment and reviewing the patient's response to the treatment.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

44. Based on observation, review of the facility documentation and interview with the facility staff, the nursing staff practice failed to meet the requirements established for the storage of reagents and/or the outpatient center staff failed to safely store syringes and needles. The findings include:

    a. A tour of unit Pomeroy 7 on 05/11/09 at 10:15 AM identified four glucometer kits, each containing two opened bottles of control solutions. Interview with the Assistant Nursing Director on 05/11/09 at 10:35 AM and inspection of the control solution bottles failed to identify a documented opening date for all eight bottles. The facility policy directed the dating of control solutions when opened, and the disposition of any unused portion three months after opening.

    b. Interview and observation of the Outpatient Infusion Center with the Nursing Director of Outpatient Services on 05/13/09 at 1:30 PM identified an area occupied in one corner by a patient receiving an intravenous infusion and the patient's family member. In the opposite corner of the room was an unlocked cabinet containing a plastic basket with needles and syringes. The Nursing Director of Outpatient Services indicated that the

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Post Anesthesia Care Unit (PACU) shared the use of the room with the outpatient Center and the unlocked cabinet was the property of the PACU.

c. Interview and observation of the Outpatient Gastro-Intestinal (GI) Unit with the Nursing Director of Outpatient Services on 05/13/09 at 2 PM identified an unlocked cabinet inside an unlocked room directly accessed from the hallway. Inside the cabinet were several boxes filled with packaged needles and syringes.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

45. Based on review of the clinical record and interview with the facility staff, the nursing staff failed to notify the physician of the nursing staff's inability to execute the physician orders for fourteen days for one patient (Patient #111).
    a. Patient #111 was admitted on 04/09/09 with diagnoses that included anasarca secondary to malnutrition with low oncotic pressures, insulin dependent diabetes mellitus, stage IV decubitus ulcer, para-sacral spine abscess, osteomyelitis, Addison's disease and anemia. On 04/14/09, Patient # 111 was provided with a Clinitron bed (low air loss). Review of the patient's bloodwork identified albumin levels of 2.5 g/dL on 04/11/09 (normal range 3.2 to 5.1 g/dL), 2.6 g/dL on 04/20/09, 2.5 g/dL on 04/22/09, 2.6 g/dL on 04/27/09, 2.9 g/dL on 05/10/09 and 2.8 g/dL on 05/13/09. On 04/28/09, the physician ordered daily weights "if possible." A nutrition consult dated 05/08/09 requested a recent weight. Interview and review of the clinical record with the Assistant Nursing Director of Pomeroy 7 on 05/11/09 at 11 AM failed to identify documentation of daily weights since 04/28/09. The Assistant Nursing Director explained that the Clinitron bed did not have a built-in scale, and the facility did not have a hydraulic lift equipped with a digital scale, to weigh the patient out of bed. However, documentation in the clinical record failed to indicate that the physician was notified of the nursing staff inability to weigh the patient for the past thirteen days. Upon the surveyor's inquiry, the physician was notified by the nursing staff on 05/12/09 of the staff's inability to conduct daily weights as ordered.

The following are violations of Connecticut State Agencies Section 19-13-D3 (h) Dietary Services (3) and/or (i) General (6).

46. Based on observation, review of facility documentation and interview with facility staff, the dietary services staff failed to comply with the facility policy on food storage, tray line temperature recording, dishwasher temperature recording, and concentration of sanitizer solution in the dish and pot wash areas. The findings include:
    a. Interview and tour of the Dietary Services department with the Chief Clinical Dietician (CCD) on 05/12/09 at 11 AM identified refrigerated trays of sandwiches, cooked meat, cold cuts, cold pasta salad, containers of sauce and pesto labeled with the day of the week, such as (Monday, Thursday, etc.), but without the actual date in month and day, or with remote dates such as Monday "2-12", or Saturday "2-19." The CCD was unable

to determine whether those were the dates that the food was prepared or the dates to be discarded. The facility policy directed to label all food in process and leftovers with the date (month and day) the food was stored, label with an expiration date all food prepared for use other than a one time use, and to label sandwiches with a day dot sticker and date.

b. Interview and review with the Chief Clinical Dietician (CCD) on 05/12/09 at 11 AM of the tray line temperature recording and the solution strength recording in the dish and pot wash areas indicated that the dietary staff failed to record daily tray line temperatures and solution testing as required on 01/04/09, 01/15/09, 01/25/09, 02/28/09, 03/13/09, 03/17/09, 03/22/09, 03/30/09, and 05/07/09.

c. Interview and review with the Chief Clinical Dietician (CCD) on 05/12/09 at 11 AM of the dishwasher temperature recording indicated that the Dietary Services staff failed to record daily dishwasher temperatures as required on 02/15/09, 02/28/09, 03/01/09, 03/02/09, 03/07/09, 03/08/09, and 04/18/09.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (e) Nursing service (1), and/or (i) General (6), and/or (l) Infection control (1).

47. Observations during tour of SICU on 5/11/09 identified that the patients located in Rooms 2026 and 2032 were on contact isolation. While in Room 2026, SW #1 placed her gown in a laundry bag opposite the door and removed her gloves prior to leaving the room. SW #1 proceeded to touch the patient's bedside stand and left the room without the benefit of washing her hands. SW #1 was observed in Room 2032 without gloves and left the room without washing her hands. Review of the contact isolation policy identified that all hospital personnel with direct patient contact must wear gown and gloves and hands must be thoroughly washed after removal of gown and gloves, before leaving the patient's room.

48. During tour of SICU on 5/11/09, several full laundry bags were located on the floor in the dirty utility room. The cart in the dirty utility room (that was utilized for dirty laundry bags) was noted to have room for the bags.

49. Patient #144 had diagnoses that included Clostridium difficile infection. MD #9 was noted to be wearing gloves, but no gown while in the patient's room. Visitors were observed in the patient's room without gowns and/or gloves and left the room without washing their hands. Review of the hospital's Clostridium difficile Policy identified that gown and gloves were indicated when caring for the patient or touching environmental surfaces and that all visitors must wash their hands with soap and water upon leaving the room.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (e) Nursing service (1), and/or (i) General (6).

50. An observation made during tour of the Behavioral Health Child/Adolescent Unit identified that the dietary room door was open and not secured. The Behavioral Health Child/Adolescent Unit

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Manager identified that the door was to be closed and locked.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1), and/or (c) Medical staff (2)(B), and/or (d) Medical records (3), and/or (e) Nursing service (1), and/or (i) General (6).

51. Patient #145 was admitted to the hospital on 3/19/09 for a cardiac catheterization. Review of the clinical record identified that the informed consent form obtained was for contrast injection for Computed Tomography (CT) scan (not cardiac catheterization) and lacked a physician signature. The record failed to reflect a signed informed consent for the cardiac catheterization procedure.

52. Patient #110 was admitted to the hospital on 5/6/09 for a total hip replacement (THR). Review of the record indicated that the patient received a blood transfusion on 5/6/09. Review of the Crossmatch Transfusion Tag indicated that two separate individuals must identify the patient and sign the tag. Review of the Crossmatch Transfusion Tag reflected failed to reflect the transfusionist signature. Review of the Blood Transfusion Policy failed to reflect that two signatures (including the transfusionist's signature) were required.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 Short Term Hospitals, General and Special (a) Physical Plant (2).

53. The facility did not ensure that personnel servicing the fire alarm system met the standards set forth by NFPA 72, section 10.2.2.5.1 (1) (2) (3) (4).
    a. It was observed that the ceilings throughout the surgical suites were rusty.
    b. It was observed that there were gouges and peeling paint on the wall surfaces in operating room #11.
    c. It was observed that there was an excessive amount of storage within the "inner core" of the operating suite, obstructing a clear path to the means of egress from the suite.
    d. It was observed that the flooring in the "outer core" of the surgical suite had rips, tears, and cuts.

On May 26, 2009, as part of the periodic hospital licensure inspection, the Nuclear Medicine, and Radiology Departments of Waterbury Hospital were inspected for compliance with Sections 19-24-1 through 19-24-14 of the Connecticut Administrative Regulations.

The inspection consisted of a review of records, procedures, equipment and facilities, including the following: (a) in-house physics reports and follow-up corrective actions; (b) personnel dosimetry records; records of receipt of radioactive materials; (d) quarterly inventories; (e) records of area surveys; (f) records of calibration of available radiation detection instrumentation; (g) calibration of the dose calibrator, including linearity, and constancy determinations; and (h) leak test records.

In the Radiology Department, three items of non-compliance were identified within the scope of

the inspection. In the Nuclear Medicine Department, no items of non-compliance were identified.

1. Sec.19-24-7 Surveys – requires in part that an evaluation of the radiation hazards incident to the use of sources of radiation under a specific set of conditions be performed.
2. Sec. 19-24-7(2) in part requires such surveys, as may be necessary, to comply with the regulations.
3. Sec. 19-24-7(b) in part requires records of surveys be available for inspection by the department's representatives upon request.

Contrary to the above, surveys of the radiation hazard were not performed for diagnostic x-ray equipment in the radiology department and were not available upon request.

19a-36-D38(b) Minimum standards for the Operation of Clinical Laboratories.

54. Based on surveyor inspection of the laboratory and interview with the microbiology supervisor, it was determined that adequate safety precautions were not enforced to protect against biological hazards. The findings include:
    a. A tour of the laboratory on May 12, 2009, revealed that there were 7 vinyl-covered chairs in use at the lab benches, and throughout the Microbiology laboratory. There were large tears and exposed padding in the covers of all the 7 chairs. These chairs cannot be properly cleaned and disinfected. An interview with the supervisor on May 12, 2009 at 2:00 PM revealed that the chairs were very old and she was aware they could not be disinfected.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (i) General (6).

55. Based on clinical record review, review of hospital policy and interviews with facility personnel for one patient (Patient #110), the facility failed to ensure that physician orders were complete. The findings include:
    a. Patient #110 was admitted to the hospital on 5/6/09 for a total hip replacement (THR). Review of the record identified that the patient had a history of alcohol dependence and experienced acute alcohol withdrawal during the hospitalization. Alcohol Withdrawal Management Orders dated 5/9/09 directed that Ativan would be administered according to the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale. Alcohol Withdrawal Management Physician Orders written by PA #1 and dated 5/7/09 initiated a CIWA protocol for a patient with no previous history of prolonged, heavy consumption of alcohol. However, the clinical record clearly identified that Patient #110 had a history of alcohol dependence. Orders dated 5/9/09 directed the following: CIWA at or > 16, give Ativan 2 mg IV push every (q) 5 minutes; CIWA 8-16, give Ativan 4 mg PO/IV; CIWA <7, give Ativan 1-2 mg PO/IV. Review of the ICU Resident admission note dated 5/10/09 identified that the patient received a dose of Ativan for a CIWA score of 12 and shortly after was found to be apneic and subsequently, became pulse

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less. The patient was successfully resuscitated. Review of the Medication Administration Record (MAR) indicated that the patient received over 100 mg of Ativan IV between 5/6/09 and 5/10/09 and had received 40 mg IV within 24 hours prior to the arrest. Although Hospitalist #1 stated upon interview on 6/4/09 that the Ativan dose administered was not excessive, documentation and interviews with hospital staff failed to reflect that the Alcohol Withdrawal Management Orders/CIWA protocol was selected according to the patient's documented history and/or that the protocol included a maximum dose parameter for Ativan administration.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing services (1) and/or (i) General (6).

56. Based on review of the clinical record, review of hospital policies and interviews with hospital personnel for one patient (Patient #110) requiring treatment for alcohol withdrawal, the facility failed to ensure that the patient was assessed in accordance with facility protocols. The findings include:
    a. Patient #110 was admitted to the hospital on 5/6/09 for a total hip replacement. Review of the clinical record identified that the patient had blood loss anemia and experienced alcohol withdrawal during hospitalization. Alcohol Withdrawal Management Orders dated 5/7/09 and 5/9/09 directed Ativan to be administered according to the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) Scale. The orders included vital signs every four hours with oxygen saturation, mental status checks every four hours per the Ramsey scale and application of the CIWA scale. The orders further directed the following: CIWA at or > 16 (severe withdrawal), give Ativan 2 mg IV push every five minutes and monitor CIWA every hour. Review of the CIWA Scale assessment on 5/10/09 at 12:25 PM identified the patient's assessment as 17 and the patient received Ativan 4 mg IV. The next CIWA assessment was two hours later, versus one hour per protocol. The clinical record also lacked documentation of Ramsey scale assessments for sedation. The clinical record identified that the patient was found in respiratory arrest at 8:30 PM. Review of the Medication Administration Record (MAR) identified that the patient received 40 mg of Ativan IV within 24 hours prior to the arrest. Documentation and interviews with hospital staff failed to reflect monitoring of mental status for increasing levels of sedation and/or that CIWA assessments were completed per protocol. Interview with hospital staff on 5/28/09 identified that the patient was being monitored continuously on telemetry, however, Ramsey Scale assessments for sedation are done only in the intensive care units and not on medical-surgical units.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (g) Pharmacy (1) and/or (i) General (6).

57. Based on review of the clinical record, review of hospital policies and interviews with hospital personnel for one patient (Patient #110) requiring treatment for alcohol withdrawal, documentation and interviews failed to reflect that the Alcohol Management Physician Orders/CIWA protocol identified a maximum Ativan dose. The findings include:

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a. Patient #110 was admitted to the hospital on 5/6/09 for a total hip replacement (THR). Review of the record identified that the patient had a history of alcohol dependence and experienced acute alcohol withdrawal during the hospitalization. Alcohol Management Orders dated 5/7/09 directed Ativan would be administered according to the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale. The Orders dated 5/7/09 directed the following: CIWA at or > 16, give Ativan 2 mg IV push every (q) 5 minutes; CIWA 8-16, give Ativan 4 mg PO/IV; CIWA <7, give Ativan 1-2 mg PO/IV. Review of the ICU Resident Admission Note dated 5/10/09 identified that the patient received a dose of Ativan for a CIWA score of 12 and shortly after was found to be apneic and then became pulse less. The patient was successfully resuscitated. Review of the Medication Administration Record (MAR) indicated that the patient received over 100 mg of Ativan IV between 5/6/09 to 5/10/09 and had received 40 mg IV within 24 hours prior to the arrest. Interview with the Director of Pharmacy identified that prescriber orders were reviewed daily by decentralized pharmacists. Documentation and interviews with hospital staff failed to reflect that the Alcohol Withdrawal Management Orders/CIWA protocol included a maximum dose parameter for Ativan administration.

EXHIBIT B

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

IN RE: The Waterbury Hospital of Waterbury, CT.
The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

CONSENT ORDER

WHEREAS, The Waterbury Hospital of Waterbury, CT (hereinafter the "Licensee'), has been issued License No. 0060 to operate a General Hospital known as The Waterbury Hospital, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department'); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on March 21, 2007 and concluding on June 7, 2007; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in amended violation letter dated June 7, 2007 (Exhibit A – copy attached); and

WHEREAS, the Department recognizes the measures taken by the Waterbury Hospital to address violations identified in the amended violation letter dated June 7, 2007; and

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

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through John Tobin, its President and CEO, hereby stipulate and agree as follows:

Licensee: The Waterbury Hospital of Waterbury, CT.

1. The Licensee shall execute a contract with an Independent Wound Care (IWC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The IWC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the IWC.
2. The IWC shall be a registered nurse with additional credentialing in wound care and who holds a current and unrestricted license in Connecticut. The Registered Nurse (RN) assuming the functions of the IWC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The IWC shall provide consulting services for a minimum of four (4) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with federal and state statutes and regulations. The IWC shall be at the Facility thirty-two (32) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the IWC at the end of the four (4) month period and may, in its discretion, reduce or increase the hours of the IWC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the IWC shall include all pertinent provisions related to pressure sore assessments, prevention, implementation of orders and monitoring contained in the Consent Order.
4. The IWC shall have a fiduciary responsibility to the Department.
5. The IWC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of the contract with the IWC.
6. The IWC shall confer with the Licensee's Administrator/Chief Executive Officer/Vice President of Nursing Services and other staff determined by the IWC to be necessary to the scope of his/her duties and responsibilities regarding pressure sore prevention and care.

7. The IWC shall make recommendations, which may be in a report format, to the Licensee's Administrator/Chief Executive Officer and Vice President of Nursing Services, for improvement in the delivery of care related to his/her responsibilities. If the IWC and the Licensee are unable to reach an agreement regarding the IWC's recommendation(s), the Department, after meeting with the Licensee and the IWC shall make a final determination, regarding the IWC's recommendations(s) after it receives and considers relevant input and information from the facility, which shall be binding on the Licensee:
8. The IWC shall submit weekly written reports to the Department documenting:
    a. The assessment of care and services provided to patients at risk for or with actual skin impairment; and
    b. Any recommendations made by the IWC and the Licensee's response to implementation of the recommendations.
9. Copies of all IWC reports shall be simultaneously provided to the Vice President of Nursing Services and the Department.
10. The IWC shall have the responsibility for:
    a. Assessing, monitoring of patients at risk for and/or with actual pressure ulcers and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses and nurse aides, and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Recommending to the Department an increase in the IWC's contract hours if the IWC is unable to fulfill the responsibilities within the stipulated hours per week; and
    c. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the amended violation letter dated June 7, 2007 as related to pressure sores.

11. The IWC, the Licensee's Administration/Chief Executive Officer and the Vice President of Nursing 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 twelve (12) week intervals throughout the duration of this Consent Order. 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.
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 IWC and the Department, upon request.
13. The Department shall retain the authority to extend the period the IWC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance regarding pressure sore prevention and care. 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.
14. Effective immediately upon execution of the Consent Order, the Licensee shall either employ or contract with a full time Infection Control Nurse (ICN) whose sole responsibility is to implement an infection prevention, surveillance and control program which shall have as its purpose, the protection of patients. The RN shall have expertise and experience specific to infection control. The ICN, in conjunction with the Vice President of Nursing Services shall implement a mechanism to ensure that each patient with an infection and/or requiring precautions is properly identified and receives the appropriate care and services pertinent to the identified infection and/or risk of infection. The ICN shall ensure the following:
    a. Maintenance of an effective infection control program;

b. Review of the facility's policies/procedures pursuant to infection control prevention with the Vice President of Nursing Services and revise, as necessary;
c. Inservicing of staff pursuant to infection control principles and practices;
d. Development of policies and procedures relative to comprehensive infection control and employee health and/or specific criteria for the identification of health care associated infections and requires precaution techniques; and
e. Development of specific written criteria for an environmental surveillance program.

15. The Licensee shall continue to incorporate into the Hospital's Quality Assurance Program indicators to analyze data and track quality pertinent to the prevention and care of at risk for and/or with actual skin impairment and infection control.
16. Effective upon the execution of this Consent Order, the Licensee through its Governing Body/Chief Executive Officer and Vice President of Nursing Services, shall ensure substantial compliance with the following:
    a. Patients treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    b. Patient assessments, inclusive of skin assessments are performed in a timely manner, documented and accurately reflected the condition of the patient;
    c. Each patient care plan is reviewed and revised to reflect the individual patient's problem, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    d. The personal physician or covering physician is notified in a timely manner of any significant changes in patient conditioning including, but not limited to, decline in skin integrity and/or presence of any infection;

e. Patient's skin pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

f. Necessary pressure relieving devices are provided to patients at risk for and/or with actual skin impairment;

g. Patients admitted to the psychiatric unit shall receive the necessary supervision to ensure the rights of all patients on this unit are maintained and free from abuse and/or harassment;

h. Master Treatment Plans shall be individualized and reflect the necessary care and/or supervision required for patients admitted to the psychiatric unit; and

i. The patient's environment shall be maintained to ensure cleanliness, safety and upkeep.

17. The Licensee shall initiate a mechanism to review the accuracy of radiology interpretations and shall maintain a record of said reviews.

18. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said time frame.

19. The Licensee shall pay a monetary penalty to the Department in the amount of eight thousand dollars ($8,000.00) by money order or bank check payable to the treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of the Consent Order. The money penalty and any reports required by this document shall be directed to:

Ann Marie Montemerlo, R.N. Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12FLIS
P.O. Box 340308
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, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department ad 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.
21. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
22. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
23. The Licensee had the opportunity to consult with any attorney prior to the execution of this Consent Order.

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Licensee: The Waterbury Hospital of Waterbury, CT.

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.

THE WATERBURY HOSPITAL OF
WATERBURY, CT. - Licensee

1/11/08
Date

By: Mary Prybylo, COO on behalf of John Tobin
John Tobin, President and CEO

STATE OF Connecticut)

County of New Haven) ss Waterbury 20078

Personally appeared the above named Mary Prybylo and made oath to the truth of the statements contained herein.

My Commission Expires: _____
(If Notary Public)

Susan Marie Keeley
Notary Public
My Commission Expires May 31, 2009

Susan M Keeley

Notary Public	[ ]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

1/17/08
Date

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 26

June 7, 2007

John Tobin, President & CEO
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

Dear Mr. Tobin:

This is an amended edition of the violation letter originally sent on April 26, 2007

Unannounced visits were made to Waterbury Hospital on March 21, 22, 23 and 26, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigation and review of the implementation of the plan of correction for the violation letter dated November 15, 2006 and the violation letter dated December 27, 2006.

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

An office conference has been scheduled for May 10, 2007 at 1:30 P.M. the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

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

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

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

Respectfully,

Judy McDonald

Judy McDonald, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

JFM:PMG:lsl

c. Director of Nurses
Medical Director
President
CT #6224, #6248, #6532, #6553

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

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administrator (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1).

1. Based on clinical record reviews and interview for one of one patients (Patient #39), the facility failed to notify the next of kin for one patient who was unable to make medical decisions. The findings include:
   a. Review of the clinical record identified that Patient #39 had driven himself to the Emergency Department (ED) on 12/24/06 for treatment related to chest pain and alcohol withdrawal, was alert and oriented upon arrival and was subsequently admitted to the hospital. Review of the central registration log identified that although upon admission the patient requested not to list an emergency contact person an attempt to contact a family member was not completed when the patient's condition deteriorated on or around 12/27/06 and he could no longer make decisions for himself. Further record review identified that old discharge summaries were reviewed and emergency contact information was listed, however Patient #39's family was not notified of his grave condition. It was not until 1/4/07, that MD #14 identified emergency contact information and contacted Patient #39's family. On 1/4/07, the patient's family made decisions regarding the patient's care and the patient died on 1/5/07. Review of hospital policy identified that in a medical emergency when a next of kin or emergency contact is not listed, a search process will begin as outlined on the next of kin identification worksheet including reviewing old medical records and searching valuables for a contact person. Interview with Person #5 identified that although Patient #39's belongings included his current license and emergency contact information when he was admitted to the facility, a family member was not contacted in a timely manner when he became comatose.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (4) and/or (b) Administrator (2) and/or (i) General (2) and/or (3) and/or (7).

2. Based on observations and interviews with facility personnel, the facility failed to ensure that the hospital environment was maintained for the well being of patients. The findings include:
   a. During tour of the Pomerey 8 unit (psychiatric unit) on 3/21/07, it was identified that enclosed heating vents in the patient lounge areas and patient rooms were noted to have paper and straws inside the units. These units also were noted to be heavy soiled with dust and debris. Interview with the Nurse Manager on 3/21/07 identified that a complete walk through was performed with the Director of Hospitality on 3/18/07 and environmental issues were identified at that time. Interview with Assistant Director of

Maintenance on 3/21/07 identified that he could not recall the last time the heating vents were cleaned. Subsequently, on 3/22/07 heating vents in the lounge area were cleaned and the facility immediately implemented a plan to have all heating vents cleaned on Pomerey 8. Interview with the Director of Patient Relations on 3/27/07 identified that Patient #3 had filed a complaint regarding the heating vents on 3/22/07 and she alerted the Nurse Manager of Pomerey 8. Interview with the Waterbury Deputy Fire Marshall on 3/30/07 identified that he had made a visit to hospital on 3/23/07 and had no fire hazard concerns.

b. During tour of the Pomerey 8 unit on 3/21/07 and 3/22/07 it was identified that air vents in all patient rooms and lounge areas were noted to be heavily soiled with debris. Interview with the Director of Hospitality on 3/21/07 identified that that housekeeper is responsible for cleaning the outside part of vent however it was noted that the vents needed to be removed and thoroughly cleaned. Subsequently on 3/21/07 and 3/22/07, the air vents were starting to be removed and cleaned by housekeeping staff.

c. During tour of the Pomerey 8 unit on 3/21/07 and 3/22/07, it was identified that multiple trash cans in patient lounge areas and in patient rooms were noted to be full and/or overflowing. Review of the cleaning schedule identified that trash is to be emptied in the lounge areas, group areas and patient rooms in the morning and through out the day. Interview with the Director of Behavioral Health on 3/21/07 identified that the trash was full and needed to be emptied.

d. During tour of the Pomerey 8 unit on 3/21/07 it was identified that the soiled utility room was unable to be closed due to multiple bags of opened soiled bags of linen on the floor. Interview with the Director of Behavior Health on 3/21/07 identified that the soiled linen is picked up regularly and didn't know why it had not been removed. Interview with the Director of Hospitality on 3/22/07 identified that laundry pick up is done on a regular basis and did not know why it was not picked up.

e. During tour of the Pomerey 8 unit on 3/21/07, it was observed that multiple patient rooms failed to identify room numbers outside doorways. Review of environmental rounds completed on 9/15/06 identified that signage for patient rooms were missing and needed to be replaced however had not been completed. Subsequently, on 3/26/07 the facility placed temporary signage over patient rooms until a more formal sign could be manufactured.

f. A tour of the Pomerey 8 unit on 3/21/07 identified that refrigerators in the patient lounges, occupational therapy area had multiple containers of uncovered food that was unlabeled and/or undated. Also, the refrigerators were soiled with debris. Subsequently, the Director of Behavioral Health immediately discarded the items in the trash. Interview with the Director of Hospitality on 3/22/07 identified that the dietary department checks for unlabeled and undated food items during their rounds and housekeeping staff cleans the refrigerators daily.

g. A tour of the Pomerey 8 unit on 3/21/07 identified that the carpets in the hallways were soiled and stained. Also, the floors in the patient lounge areas and patient rooms were noted to be heavily soiled and/or stained with black marks. Interview with the Director

of Hospitality on 3/21/07 identified that the floors and carpets needed to be cleaned. Interview with the Assistant Director of Engineering on 3/21/07 identified that some of the floors needed to be replaced and was not sure if cleaning the floors would remove black marks and might damage the floors. Subsequently, on 3/21/07 and 3/22/07 the patient lounge area floors and carpets were cleaned by housekeeping staff and soiled areas and black marks were removed.

h. A tour of the Pomerey 8 unit on 3/21/07 identified that multiple patient rooms had stained shower stalls and/or wallpaper coming off the walls. Observation of Rooms 8025 and 8026 identified that these rooms had broken tiles that needed replacing. Review of environmental rounds dated 9/15/06 identified that broken tiles were identified in Rooms 8025 and 8026 and this was a second request for repair. Interview with the Assistant Director of Engineering on 3/22/07 identified that he was aware of the multiple issues with patient rooms and the repairs had not been completed.

i. A tour of the Pomerey 8 unit on 3/21/07, it was identified that the adolescent lounge area couch was heavily soiled. Further observation identified soiled areas on tables in the patient lounge areas. Review of the cleaning schedule with the Director of Hospitality on 3/26/07 identified that patient lounges are to be cleaned during the morning hours. Subsequently, the couch in the adolescent room was removed on 3/26/07.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

3. Based on clinical record review, observations and interviews with hospital personnel, the facility failed to ensure that master treatment plans were updated to reflect required supervision and/or to ensure the rights of other patients to be free of abuse and/or harrassment. The findings include:

   a. Patient #8 was admitted to the hospital on10/25/06 with Schizophrenia, Mental Retardation and Seizure disorder.. Review of the master treatment plan dated 10/27/06 identified that the patient was highly impulsive and delusional with interventions to redirect as needed. Further review of the master treatment plan dated 3/9-3/21/07 identified that Patient #8 was sexually inappropriate, intrusive inappropriately touching others and required increased redirection, however the master treatment plan failed to identify other interventions to prevent the patient from inappropriate contact with other patients. Review of the progress notes dated 2/20/07-3/21/07 identified that on multiple occasions, Patient #8 was sexually inappropriate, inappropriately touching other patients/visitors and was going into other patients rooms. Patient #8 required redirection and time out in his room. Interview with Patient #3 identified that while she was taking a nap, Patient #8 touched her on the buttocks. Patient #3 had stated that she had screamed and nobody came to her room until she went to the nurses station to report what happened. Subsequently, Patient #8 was told to go to his room. Patient #3 also

identified that during the night while she was sleeping in a recliner chair in TV room, she woke up to see Patient #8 inappropriately touching himself. Patient #3 stated that she screamed and nobody came to the TV room until she went to nurses station to report what happened. Interview with Patient #7 on 3/21/07 identified that he had requested his room be changed due to Patient #8 inappropriately touching him during the night. Interview with Patient #24 on 3/27/07 identified that he was currently sharing a room with Patient #8 and the patient has touched him during his admission. Patient #24 also identified that the staff were aware of Patient #8 inappropriately touching other patients. Observation of Patient #8 on 3/21/07 identified that the patient was touching himself in a sexually inappropriate manner in the hallway. Review of hospital policy identified that the multidisciplinary reviews and revisions of the treatment plan of each patient will be held at least three times a week. Further review identified that patients are to be treated with dignity, respect and privacy. Interview with the Assistant Director on 3/22/07 identified that they were aware of Patient #8's issues however they needed the private beds for patients that had infections. Further review identified that they were redirecting Patient #8 each time there was an issue with touching others.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

4. The facility failed to ensure compliance with conducting assessments, care planning and preventative care for patients at risk for the development of pressure ulcers and/or for patients with identified skin impairment. For six of eight patients, Patients #4, #5, #6, #12, #20, and #26, who had existing pressure ulcers, the facility failed to ensure that nursing assessments of the patients' pressure ulcers included complete and/or accurate measurements, descriptions, and/or staging of the pressure ulcers and/or that assessments and/or treatments were consistently documented. In addition, for three of eight patients, Patients #17, #20, and #22, who had existing pressure ulcers, the facility failed to ensure that a pressure relieving/pressure reducing chair cushion was provided when the patients were out of bed in a chair. In addition, for 1 of 1 patients, Patient #8, the facility failed to provide adequeate supervision to protect other patients. In addition, for one of one patients, the facility failed to ensure that Patient #38 was consistently monitored. The findings were based on review of clinical records, review of facility policies, observations, and interviews and include the following:
   a. Patient #26 was admitted to the facility from a skilled nursing facility on 3/7/07 with diagnoses of dehydration and failure to thrive. Review of the Braden assessment dated 3/8/07 identified Patient #26 as at high risk for pressure ulcer development. Review of the nursing admission assessment dated 3/8/07 at 2:50 PM identified that Patient #26 was admitted with a sacral wound/pressure ulcer measuring 5.0 centimeters (cm.) by 7.0 cm that was red and warm to touch. The clinical record lacked documentation of the staging of Patient #26's sacral wound for three days until 3/11/07 when the area was

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identified as a Stage III pressure ulcer. Review of the documentation dated 3/13/07 at 3:35 AM identified the same wound as a Stage II coccyx pressure ulcer. The documentation dated 3/15/07 at 10:57 AM identified the same area as a stasis ulcer as gaping with tunneling and with necrotic tissue. On 3/17/07 at 12:00 AM, the documentation described Patient #26's pressure ulcer as a Stage II coccyx pressure ulcer followed by a description at 8:00 AM on 3/17/07 of a Stage IV coccyx pressure ulcer with undermining. Documentation on 3/19/07 at 8:00 AM described Patient #26's wound as a Stage III pressure ulcer and on the same date at 8:00 PM, described the area as a Stage II stasis ulcer. Review of an assessment by the facility Wound Care Nurse, RN #7, dated 3/23/07 identified that Patient #26 had 6.0 cm. by 6.5 cm by 2.0 cm. Stage III coccyx pressure ulcer with 1.5 cm. tunneling with serosanguineous drainage surrounded by a 13.0 by 11.0 Stage I area of erythema at the outer perimeter. Interview with Nurse Manager #1 on 3/26/07 identified that although the facility utilized an electronic record system, licensed nurses have been trained to look back at previous computer screens to view previous assessments for comparison to their current assessment in order to identify changes in wound status.

In addition, the 3/8/07 admission nursing assessment further identified that Patient #26's heels and bilateral ankles were boggy and warm to the touch. Documentation was lacking of ongoing assessment of the patient's heels and/or ankles through 3/11/07. Review of a wound assessment by RN #7 dated 3/12/07 identified that Patient #26 had developed multiple pressure ulcers including a 1.0 cm. by 1.0 cm unstageable area on the right ankle, a 1.0 cm. by 1.0 cm. unstageable area on the left ankle and a 1.5 cm. by 1.0 cm. unstageable area on the left heel. Documentation was lacking of ongoing assessments that included measurements of the patient's heel and ankle areas for an additional ten days until 3/22/07. Review of the wound assessment documentation dated 3/23/07 identified that Patient #26 had developed a 3.40 cm. by 2.50 cm. Stage II (90%) unstageable necrotic area and a 1.5 cm. by 1.0 cm. Stage II black blister both on the left heel, a 1.0 cm. by 1.90 cm. unstageable necrotic area on the left ankle, a 3.20 cm. by 2.50 cm. Stage II black blister on the right heel, a 1.0 cm. by 1.20 cm. unstageable necrotic area on the right ankle, and Stage I reddened areas on the second, third, fourth, and fifth toes of the patient's left foot. The facility's policy directed that wound measurements must be documented every seventy two hours.

In addition, review of physician orders dated 3/12/07 directed treatment to Patient #26's sacral/coccyx wound using Accuzyme followed by a wet to moist saline dressing to be done twice daily. Review of the clinical record lacked documentation to reflect that the treatment was performed in accordance with physician orders on 3/14, 3/15, 3/16, 3/17, 3/19, and 3/21/07. Although documentation dated 3/13/07 and 3/15/07 identified that treatment to Patient #26's pressure ulcer was performed with "pastes/powders/beads," interviews with facility staff failed to identify what treatment was rendered based on that documentation.

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

b. Patient #5 was admitted to the facility on 3/13/07 with diagnoses that included a pneumothorax of the right lung with symptoms of dyspnea and shortness of breath, diabetes, and a history of and existing multiple skin tears on her bilateral upper and lower extremities. Review of Braden Scale assessments dated 3/15/07 through 3/21/07 identified that Patient #5 was at moderate to high risk to develop pressure ulcers. Review of the clinical record dated 3/15/07 identified that Patient #5 developed a Stage II stasis ulcer on the buttocks and that a Duoderm dressing was applied. Review of the clinical record dated 3/15/07 identified that Patient #5 developed a Stage II stasis ulcer on the buttocks, that a Duoderm dressing was applied but lacked an assessment that included description, color, and/or measurements of the ulcer. On 3/16/07, the clinical record identified that Patient #5's Duoderm dressing was reapplied but did not describe the status of the ulcer. On 3/17/07 and 3/18/07, the documentation identified that Patient #5 had a Stage I pressure ulcer on the buttocks and that barrier cream was applied. Documentation was lacking of ongoing assessments that included measurements and/or documentation of treatments to the patient's buttocks or coccyx through 3/21/07. On 3/22/07 at 9:30 AM, observation of Patient #5's buttocks/coccyx area identified that RN #4 removed an undated Duoderm dressing from Patient #5's coccyx area and identified an approximate one inch "slit like" Stage II pressure ulcer. Patient #5's right buttocks area was observed to be nearly covered in a deep purple color with an approximate 1.5 centimeter (cm.) very slightly cratered area at the right center that was closed over with shiny appearing skin.

c. Patient #6 was admitted to the facility on 3/14/07 with diagnoses that included hydropneumothorax and a history of asthma. Review of Braden Scale assessments dated 3/14/07 through 3/21/07 identified that Patient #5 was at moderate risk to develop pressure ulcers. Review of the clinical record dated 3/14/07 identified that Patient #6 had developed a Stage II pressure ulcer on the bilateral buttocks but lacked measurements and/or other description of the area. Review of the clinical record identified that treatment to Patient #6's pressure areas included the application of barrier cream on 3/14/07 but lacked documentation that the barrier cream or other treatment was applied through 3/16/07. On 3/16/07, the documentation identified that 3M spray was applied to the Stage II pressure ulcer. On 3/17/07 at 10:24 PM, the documentation identified that a hydrocolloid (Tegasorb) dressing was "intact" but the record lacked documentation of when the hydrocolloid was actually applied. Documentation was lacking of treatment to the area and/or reapplication of the Tegasorb dressing for four more days through 3/21/07. On 3/21/07 at 10:30 AM, RN #2 described Patient #6 as having three Stage II pressure ulcers to the bilateral buttocks. Measurements of the areas documented by RN #2 on 3/21/07 included a 0.5 by 0.75 centimeter (cm.) area on the right buttocks, a 0.25 by 0.25 cm. area also on the right buttocks, and a 1.0 by 0.3 cm. area on the left buttocks. No previous measurements were documented in the clinical record for comparison.

d. Patient #12 was admitted to the facility on 2/8/07 with diagnoses that included aspiration

DATES OF VISIT: March 21, 22, 23 and 26, 2007

EXHIBIT A

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

pneumonia and bilateral pleural effusions. Review of Braden Scale assessment dated 2/9/07 identified that Patient #12 was at moderate risk to develop pressure ulcers. Review of the care plan dated 2/16/07 identified an active problem of skin impairment but lacked documentation of the location of skin impairment and/or prescribed treatment. Review of the clinical record dated 2/26/07 identified that Patient #12 had a 1.0 cm. by 0.5 cm. Stage II shearing wound on the left buttocks and a 2.0cm. by 1.5 cm. Stage II shearing wound on the right buttocks, that treatment to the area included the application of Calmoseptine ointment covered by Saran wrap, and that an Accumax pump (for pressure redistribution) was applied to the patient ' s Accumax mattress. Documentation was lacking of measurements of the areas until 3/22/07. Observations on 3/22/07 at 9:45 AM identified that Patient #12 had three small open areas on the buttocks/coccyx area and that the surrounding skin was reddened and dry. Review of the documentation dated 3/22/07 identified that Patient #12 had a 1.0 cm. by 1.0 cm. Stage I pressure ulcer on the left buttocks near the coccyx, a 0.5 cm. by 0.5 cm. Stage I pressure ulcer on the coccyx, and a 1.0 cm. by 1.0 cm. Stage I pressure ulcer on the right buttocks near the coccyx. Although the documentation identified that the areas were assessed as Stage I pressure ulcers, observation of the areas identified that the skin at these sites was not intact. Subsequent to the observation, Patient #12's care plan updated to include the location and treatment to the patient's buttocks areas.

e. Patient #17 was admitted to the facility on 3/13/07 with diagnoses that included a small bowel obstruction. Review of the Braden assessment dated 3/21/07 identified that Patient #17 was at moderate risk to develop pressure ulcers. Review of the care plan dated 3/19/07 identified that Patient #17 had developed reddened areas on the right buttocks and an intact blister also on the right buttocks. Interventions included an air cushion to be placed on the patient's chair when out of bed and that Patient #17 should be up in a chair for two hours at a time. Documentation dated 3/21/07 identified that Patient #17 had a 3.5 centimeter (cm.) by 2.0 cm. reddened area on the left buttocks and a small blister on the right buttocks. Interview with Patient #17 at 1:40 PM identified that the patient had been sitting in the chair since approximately 11:00 AM after returning from a Physical Therapy session. Observation of Patient #17 on 3/22/07 at 1:30 PM identified that Patient #17 was sitting in a bedside chair without the benefit of an air cushion in accordance with the plan of care. Patient #17 was not assisted back to bed by facility staff until 2:20 PM, a period of three hours and twenty minutes after first sitting in the chair.

f. Patient #20 was admitted to the hospital on 2/25/07 with Chronic Obstructive Pulmonary Disease and Bronchitis. Review of the initial Braden Scale Assessment dated 2/25/07 identified that the patient was assessed as a 17 (low risk) and a 14 (moderate risk) on 3/17/07. Review of the nursing flowsheets dated 3/18/07 identified that the patient had a Stage II open area to buttocks. Further review failed to identify further assessments including measurements of Patient #20's opea area and/or that the physician was notified and/or a wound treatment was ordered. Interview with the Director of Quality and hospital staff on 3/22/07 identified that skin assessments are to

be completed every shift and noted that they were putting barrier cream to the patient's buttocks. Review of hospital policy identified that an assessment is to be completed for moderate risk patients every four hours and also a pressure reduction support surface if needed for the bed and/or chair bound patient.

In addition, on 3/22/07 Patient #20 was observed up in a recliner chair without apressure relieving cushion. Patient #20 was out of bed for 3 1/2 hours. Observation of the patient's skin with the Director of Quality and hospital staff on 3/22/07 indicated a Stage I pressure area to the upper back and right elbow and also a Stage II pressure area to the sacral area. Although the patient had an air mattress on the bed, the hospital failed to address the patient's Stage II to sacral area and Stage I reddened back/elbow area.

In addition, the care plan directed that the patient be weighed daily. Review of the medical record failed to reflect that the patient's weight was consistently monitored. (no weight on 12 days).

In addition, the dietitian's recommendations pertinent to daily fluid volume (1080 cc's) and increasing the patient's tube feeding volume to 60 cc's per hour failed to be implemented. Interview with the dietician on 4/10/07 identified that she did not know why her recommendations were not followed. Review of hospital policy identified that weights are to be documented on the nursing flowsheets and completed daily for patient's in the intensive care unit. Further review identified that requests for dietary changes are to have the practitioner contacted if queries are not addressed within three days.

g. Patient #22 was admitted to the hospital on 3/20/07 with Respiratory Failure and Pneumonia. Review of Patient #22's initial Braden Scale Assessment dated 3/20/07 identified that the patient was a 12 (moderate risk) and a 17 (low risk) on 3/21/07. During tour on 3/22/07, it was observed that Patient #22 was up in a recliner chair without a pressure relieving cushion. Patient #22 was out of bed for 3 hours. Review of hospital policy identified that patient's with low and/or moderate risk are to have bed and/or chair pressure reducing support surfaces. Interview with the Director of Quality and hospital staff on 3/22/07 identified that Patient #20 did not have a pressure relieving cushion under him while out of bed. Although the patient had an air mattress on the bed, the hospital failed to implement measures addressing pressure-relieving devices on the chair.

h. Patient # 4 was admitted to the hospital on 11/14/06 with atrial fibrillation and cardiomyopathy. Review of the nursing progress notes dated 11/19/06 identified that Patient #4 had skin breakdown to the buttock area. Despite turning and repositioning and a Accu-max pump to bed further review failed to identify measurements and sizing of the patients skin breakdown. Further review of the progress notes identified that a nursing order was initiated for calmoseptine ointment and the MD was notified of the

need for a first step mattress. Review of the physician's orders identified that the first step mattress was not ordered until 11/22/06 (3 days later). Review of nursing flowsheets and/or wound care sheets on 11/22/06 identified that Patient #4 had a Stage II to the right buttock measuring 2.0cm X 1.0cm. Further review failed to identify continued assessments of the patient's pressure area and/or measurements and/or if the area healed. Review of the nursing flowsheets dated 12/12/06 identified that Patient #4 had a Stage II to the right buttock. Further review failed to identify measurements of the area. Review of hospital policy identified that nursing documentation includes assessment, wound status, progress of healing and treatments in use. Review of facility policy directed that all pressure ulcers needed to be staged. In addition, facility policy directed that nurses were responsible for accurate documentation of wound status, progress in healing, current treatments in use, assessment findings, and patient education. Review of facility policy directed that wound measurements must be documented every seventy two hours during the hospital stay.

i. Patient #8 was admitted to the hospital on10/25/06 with Schizophrenia, Mental Retardation and Seizure disorder. Review of the master treatment plan dated 10/27/06 identified that the patient was highly impulsive and delusions with interventions to redirect as needed. Further review of the master treatment plan dated 3/9-3/21/07 identified that Patient #8 was sexually inappropriate, intrusive inappropriately touching others and required increased redirection however the master treatment plan failed to identify other interventions to prevent the patient from harassing other patients. Review of the progress notes dated 2/20/07-3/21/07 identified that on multiple occasions, Patient #8 was sexually inappropriate, inappropriately touching other patients/visitors and going into other patients rooms. Patient #8 had to be redirected and/or directed to his room. Interview with Patient #3 identified that while she was taking a nap, Patient #8 had touched her on the buttocks. Patient #3 had stated that she had screamed and nobody came to her room until she went to the nurses station to report what happened. Subsequently, Patient #8 was told to go to his room. Patient #3 also identified that during the night while she was sleeping in a recliner chair in TV room, she had woke up to see Patient #8 inappropriately touching himself. Patient #3 stated that she screamed and nobody came to the TV room until she went to nurses station to report what happened. Interview with Patient #7 on 3/21/07 identified that he had requested his room be changed due to Patient #8 inappropriately touching him during the night. Interview with Patient #24 on 3/27/07 identified that he is sharing a room with Patient #8 and the patient has touched him during his admission. Patient #24 also identified that the staff were aware of Patient #8 inappropriately touching other patients. Observation of Patient #8 on 3/21/07 identified that the patient exhibited sexually inappropriate behaviors in the hallway. Facility staff failed to properly supervise Resident #8 to ensure that other patients would not be touched in a manner that was inappropriate. Interview with the Assistant Director on 3/22/07 identified that they were aware on Patient #8's issues however they needed the private beds for patient's that had infections. Further review identified that they were redirecting Patient #8 each time there was an

issue with touching others.

j. Patient #38 arrived at the Emergency Department (ED) at 12:10AM on 12/22/06 with complaints of an acute onset of abdominal pain and vomiting and subsequently admitted to the hospital with a diagnosis of acute pancreatitis. Review of Patient #38 ' s clinical record identified that the patient was transferred to the inpatient unit at 5:32 PM. Review of RN #12 ' s admission assessment identified that RN #12 assessed Patient #38 at 5:56 PM. The admission assessment identified upon arrival, Patient #38 that included complaints of pain at a level of nine out a possible ten (zero being no pain and ten being the worst pain) The documentation identified that Patient #38 complained " severe abdominal pain ...patient thrashing in bed. " Review of the clinical record identified that Patient #38 received two doses of the narcotic analgesic, Dilaudid two milligrams (mg.), one at 6:15 PM and the second at 6:45 PM were administered by RN #12. Interview with RN #12 on 4/10/07 identified that although she did not document a full reassessment of the effectiveness of the second dose of Dilaudid utilizing the pain scale, that she documented an observation of Patient #38 and observed the patient to be comfortable and talking with his girlfriend. In addition, RN #12 did not document the time of her observation. Interview with Person #6 on 4/18/07 at 11:50 AM identified that she remained with Patient #38 from the time of arrival to the ED until 10:30 PM. Person #1 stated that after the second dose of Dilaudid, although she was talking to the patient, Patient #38 was not talking with her. Person #6 stated that Patient #38 was " out of it " after the second dose of Dilaudid and that when she left, she was unable to wake him up. Person #6 stated that there was a nurse in the room as she tried to arouse Patient #38 so she assumed that Patient #38 was " okay " or the nurse would have done or said something. Review of the documentation by RN #12 at 11:00 PM identified that Patient #38 was unresponsive with a blood pressure of 60/40. MD #12 was notified and directed that Narcan 0.4 mg. be administered intravenously (IV). Subsequent to the administration of Narcan, Patient #38 became alert, began thrashing in bed. Review of the clinical record identified that IV fluids were administered at a wide open rate, oxygen was administered via Venti-mask, that the patient complained of severe abdominal pain, and was subsequently transferred to the Medical Intensive Care Unit (MICU). Review of the facility ' s pain management policy directed that upon admission, patients would be questioned or screened for the presence of pain and for the patient ' s personal goal for pain relief (0-10). In addition, the policy directed that pain, as reported by the patient, would be assessed, documented, and addressed following each pain management intervention.

In addition, review of the clinical record identified that at 9:30 PM, Patient #38 experienced a drop in blood sugar at 9:30 PM from an elevated 236 in the ED to 63 (Normal 65-110) that required physician ordered intervention of fifty percent Dextrose administered intravenously (IV). Documentation was lacking of an assessment by RN #12 for signs and symptoms of hypoglycemia.

EXHIBIT A

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

5. For a total of thirteen (13) patients, the facility failed to ensure the development of comprehensive and/or individualized care plans. For five of fourteen patients at risk to develop pressure ulcers and/or with existing pressure ulcers, Patients #5, #6, #22, #26, and #27, the facility failed to ensure that an individualized plan of care was developed to address preventive measures and/or current treatment orders. In addition, for four of ten patients, Patients #5, #6, #15, and #18 who had current infections and/or had the potential to develop an infectious process, the facility failed to ensure that an individualized plan of care was developed to address the type of infectious process that led to the implementation of isolation precautions, the type of precautions required, and/or the source of the infection. In addition, for one of fourteen patients, Patient #20, the facility failed to ensure that the individualed plan of care was followed related to dietary recomendations. In addition, for 2 of 5 patients (Patient #8, #23) with changes in behaviors and/or medical conditions, the master treatment plans failed to identify a revision to reflect a change in condition and/or current medical status. The findings are based on review of clinical records, review of facility policies, observations, and interviews and include the following:
    a. Patient #5 was admitted to the facility on 3/13/07 with diagnoses that included a pneumothorax of the right lung with symptoms of dyspnea and shortness of breath. The clinical record identified that Patient #5 also had a diagnosis of Diabetes. Review of Braden Scale assessments dated 3/15/07 through 3/21/07 identified that Patient #5 was at moderate to high risk to develop pressure ulcers. Review of the clinical record dated 3/15/07 identified that Patient #5 developed a Stage II stasis ulcer on the buttocks and that a Duoderm dressing was applied. On 3/22/07 at 9:30 AM, observation of Patient #5's buttocks/coccyx area identified that RN #4 removed a Duoderm dressing from Patient #5's coccyx area and identified an approximate one inch "slit like" Stage II pressure ulcer. Patient #5's right buttocks area was observed to be a deep purple color with an approximate 1.5 centimeter (cm.) very slightly cratered area that was closed over with shiny appearing skin. In addition, RN #4 identified an approximate 0.5 centimeter oval shaped area and a two inch slit like open area under the patient's left abdominal fold. RN #4 described the areas as pressure ulcers due to the weight of the patient's abdomen and related moisture. Review of the care plan with facility staff failed to reflect that the problem regarding the potential for skin breakdown and/or interventions to address said problem had been incorporated into the care plan.
    b. Patient #6 was admitted to the facility on 3/14/07 with diagnoses that included hydropneumothorax and a history of asthma. Review of Braden Scale assessments dated 3/14/07 through 3/21/07 identified that Patient #5 was at moderate risk to develop pressure ulcers. Review of the clinical record dated 3/14/07 identified that Patient #6 had a Stage II pressure ulcer on the bilateral buttocks. Although review of Patient #6's care

plan dated 3/15/07 identified Patient #6's impairment in skin integrity, the plan lacked individualized preventive measures to address the patient's impaired skin integrity and/or the location of patient's current pressure ulcers. Review of the clinical record identified that treatment to Patient #6's pressure area included the application of barrier cream on 3/14/07 though lacked documentation that the barrier cream or other treatment was applied through 3/16/07. On 3/16/07, the documentation identified that 3M Spray was applied to the Stage II pressure ulcer. On 3/17/07 at 10:24 PM, the documentation identified that a hydrocolloid (Tegasorb) dressing was "intact" but the record lacked documentation of when the hydrocolloid was actually applied. Observation of Patient #6's wound care by RN #2 on 3/21/07 at 10:30 AM identified that RN #2 removed an undated Tegaderm dressing on the coccyx that extended over both sides of the patient's buttocks. Review of the documentation dated 3/21/07 identified that Patient #6 had three Stage II pressure ulcers to the bilateral buttocks, a 0.5 by 0.75 centimeter (cm.) area on the right buttocks, a 0.25 by 0.25 cm. area also on the right buttocks, and a 1.0 by 0.3 cm. area on the left buttocks. Subsequent to the observation, RN #2 revised the care plan to include providing a waffle cushion when out of bed to the chair and to restrict Patient #6's out of bed activity to no longer that two hours.

c. Patient #20 was admitted to the hospital on 2/25/07 with Chronic Obstructive Pulmonary Disease and bronchitis. Review of the initial Braden Scale Assessment dated 2/25/07 identified that the patient was assessed as a 17 (low risk) and a 14 (moderate risk) on 3/17/07. Review of the nursing flowsheets dated 3/18/07 identified that the patient had a Stage II open area to buttocks. Although the nursing care plan dated 3/3/07 identified that Patient #20 had no skin breakdown, further review identified that the nursing care plan was not initially completed for skin integrity until eight days after the patient was admitted. Also, the care plan failed to identify that the patient had a Stage II to buttocks on 3/18/07 with interventions for treatment and/or preventative measures. On 3/22/07 Patient #20 was observed up in a recliner chair without a pressure relieving cushion. Patient #20 was out of bed for 3 1/2 hours. Observation of the patient's skin with the Director of Quality on 3/22/07 and hospital staff indicated a Stage I to the upper back and right elbow and also a Stage II to the sacral area. Subsequent to surveyor observation on 3/22/07, the care plan dated 3/23/07 identified that Patient #20 had an open area on the middle of back however failed to identify measurements and/or treatments initiated. Review of hospital policy and interview with the Director of Quality on 3/27/07 identified that care plans are to be updated twice a day in the intensive care units.

d. Patient #26 was admitted to the facility from a skilled nursing facility on 3/7/07 with diagnoses of dehydration and failure to thrive. Review of the Braden assessment dated 3/8/07 identified Patient #26 to be at high risk for pressure ulcer development. Review of the nursing admission assessment dated 3/8/07 at 2:50 PM identified that Patient #26 was admitted with a sacral pressure ulcer measuring 5.0 centimeters (cm.) by 7.0 cm that was red and warm to touch. The clinical record identified that Patient #26's sacral ulcer was washed with saline and left open to the air on 3/8/07. The documentation dated

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3/9/07 at 12:00 AM identified that Patient #26's sacral ulcer was cleansed with soap and water and left open to air. The documentation dated 3/10/07 at 8:52 AM identified that the patient's coccyx wound was treated with 3M spray. Although an active patient problem care plan was initiated on 3/8/07, the plan lacked individualized interventions that included the type and frequency of treatments to be provided to ensure consistent treatment interventions. In addition, although the plan of care dated 3/8/07 identified the need to obtain a wound care consult in accordance with facility policies for patients assessed at high risk for pressure ulcer development, a wound care consult was not obtained until 3/12/07, five days after admission. Review of the documentation by the facility's Wound Care Nurse, RN #7, dated 3/12/07 identified that Patient #26 had a coccyx pressure ulcer that measured 6.0 cm. by 9.0 cm. by less than 0.25 cm in depth, eighty percent eschar, twenty percent red tissue, a halo of erythema, was non-blanchable and malodorous. The Licensed Practitioner's orders written on 3/12/07 directed treatment to the sacral/coccyx wound using Accuzyme followed by a wet to moist saline dressing to be done twice daily. Patient #26's mattress was upgraded from an Accumax mattress to a Kin-Air mattress (a pressure redistribution mattress) on 3/13/07.

In addition, the 3/8/07 admission nursing assessment further identified that Patient #26's heels and bilateral ankles were boggy and warm to touch. Although an active patient problem care plan was initiated on 3/8/07 with interventions that included elevating the patient's heels off the mattress, the clinical record lacked consistent documentation to reflect that the patient's heels remained off loaded when in bed. On 3/12/07, RN #7 assessed Patient #26's wounds and identified that Patient #26 had developed multiple pressure ulcers including a 1.0 cm. by 1.0 cm unstageable area on the right ankle, an 8.0 cm. by 7.0 cm. questionable unstageable deep tissue injury to the left hip, a 1.0 cm. by 1.0 cm. unstageable area on the left ankle and a 1.5 cm. by 1.0 cm. unstageable area on the left heel. Treatment orders directed that Patient #26's right and left hips were to be sprayed with 3M spray and that patient's heels were to be painted with Betadine although did not direct treatment to the patient's bilateral ankles. The clinical record failed to reflect that the care plan was revised to include the new pressure ulcers that had developed and/or directed treatments until 3/22/07. Review of the wound assessment documentation dated 3/23/07 identified that Patient #26 had developed a 3.40 cm. by 2.50 cm. Stage II (90%) unstageable necrotic area and a 1.5 cm. by 1.0 cm. Stage II black blister both on the left heel, a 1.0 cm. by 1.90 cm. unstageable necrotic area on the left ankle, a 3.20 cm. by 2.50 cm. Stage II black blister on the right heel, a 1.0 cm. by 1.20 cm. unstageable necrotic area on the right ankle, and Stage I reddened areas on the second, third, fourth, and fifth toes of the patient's left foot.

e. Patient #27 was admitted via the Emergency Department, to the hospital on 12/1/06 with the complaints of chest pain and nausea and was diagnosed with a myocardial infarction. The patient's past medical history included diabetes mellitus, transient ischemic attack, hyperlipidemia, gastroesophageal reflux disease, peripheral vascular disease,

hypertension, diabetic retinopathy and cardiovascular disease. The patient 's admission skin assessment, dated 12/1/06, identified that the patient's skin was intact and the patient was not at risk for skin breakdown. On 12/5/06 Patient #27 had the surgical intervention of a coronary artery (five vessel) bypass graft with an endoscopic saphenous vein harvest and an open chest wound (subsequently closed six days later). The patient's interdisciplinary care plan, dated 12/7/06, identified that the patient had impaired skin integrity (and the patient's coccyx was intact) with interventions that included turning and repositioning every two hours. Review of the Intensive Care Unit (ICU) flowsheet, dated 12/11/06 at 8:00 A.M., identified that the patient had a stage one (persistent area of skin redness) ulcer on the coccyx. Review of the practitioner orders, dated 12/13/06, directed the staff to use a pressure relieving bed (Kin-Air) for Patient #27, to complete wound care twice a day to the coccyx ulcer and to continue to turn and reposition the patient every two hours. Review of an Infectious Disease consult, dated 12/13/06 at 4:13 P.M., identified that Patient #27 had a ten centimeter (cm) by fifteen cm coccyx decubitus/ulcer with superficial ischemia. Subsequently the coccyx decubitus was surgically debrided on 12/19/06, and on 12/20/06 the measurements of the ulcer were 7.1 cm by 9.5 cm by 2.1 cm. Also identified on 12/20/06 Patient #27 was out of bed sitting in a chair, without documentation of any type of pressure relieving device used in the chair. Review of the patient's interdisciplinary care plan for altered skin integrity, dated 12/7/06, failed to identify that the plan of care was reviewed and/or revised regarding the patient's skin care needs. Patient #27 had further wound debridement of the coccyx ulcer on 12/24/06, 12/26/06, and 1/8/07. Interview with the Director of Quality Management, on 3/26/07, identified and reviewed on the computer system, daily documentation of the coccyx ulcer. Interview with the Director of the critical care units, on 3/26/07, identified that due to Patient #27's open chest wound it was not appropriate to turn and reposition the patient every two hours (potential to have life threatening complications). The Director added that the interdisciplinary care plan related to Patient #27's coccyx decubitus was not revised and/or did not reflect the patient's needs, including the use of pressure relieving devices when out of bed.

f. Patient #5 was admitted to the facility on 3/13/07 with diagnoses that included pneumothorax of the right lung. During a tour of the facility on 3/21/07 at 9:00 AM, a "special contact isolation" sign was noted on the door of Patient #5's room. Interview with Assistant Director of Nursing #2 at the time of the observation identified that the "special contact precaution" sign was used to identify patients who required isolation precautions for a diagnosis of Clostridium Difficile (C-Diff). Review of Documentation was lacking in the care plan to address Patient #5's current infectious process, the source of the infection, and required precautions. Subsequent to surveyor inquiry, the facility provided additional documentation dated 3/22/07 to identify that Patient #5 had also been diagnosed with Vancomycin Resistant Enterococcus (VRE) in the sputum.

g. Patient #6 was admitted to the facility on 3/14/07 with diagnoses that included hydropneumothorax and a history of asthma. Review of the clinical record identified that Patient #6 required contact isolation precautions based on a history of Vancomycin

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Resistant Enterococcus (VRE) in the urine and Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum. Documentation was lacking in the care plan to address Patient #6's current infectious process, the source of the infection, and required precautions.

h. Patient #15 was admitted to the facility on 3/19/07 with exacerbation of the patient's Chronic Obstructive Pulmonary Disease (COPD). In addition, Patient #15's clinical record identified a recent diagnosis (3/10/07) of Clostridium Difficile (C-Diff). During a tour of the Surgical Intensive Care Unit (SICU) on 3/22/07, an isolation precaution sign was observed posted outside Patient #15's door. Documentation was lacking in the care plan dated 3/19/07 to address Patient #15's current infectious process, the source of the infection, and required precautions.

i. Patient #18 was admitted to the facility on 3/10/07 with diagnoses of pneumonia and prostate cancer. During a tour of the SICU on 3/22/07 a sign posted outside the door of Patient #18's room requesting visitors to wash their hands upon entering the room as Patient #18 was receiving oral chemotherapy. Review of the care plan with facility staff lacked documentation to reflect Patient #18's increased risk of developing an infectious process due to oral chemotherapy and/or interventions to reduce the risks. At 2:10 pm, several visitors were observed to re enter Patient #18's room without the benefit of hand hygiene upon reentry. Subsequent to surveyor inquiry, the visitors were re educated by Assistant Director of Nursing #3.

j. Patient #8 was admitted to the hospital on10/25/06 with Schizophrenia, Mental Retardation and Seizure disorder. Review of the master treatment plan dated 3/9-3/21/07 identified that Patient #8 was sexually inappropriate, intrusive, inappropriately touching others and required increased redirection. Review of the progress notes dated 2/20/07-3/21/07 identified that on multiple occasions, Patient #8 was sexually inappropriate, inappropriately touching other patients/visitors and was going into other patients rooms. Although the Assistant Director on 3/22/07 identified that they were redirecting Patient #8 each time there was an issue with touching others, the Master Treatment Plan failed to identify other interventions to prevent the patient from harassing other patients. Review of hospital policy identified that multidisciplinary reviews and revisions of the treatment plan for each patient will be held at least three times per week.

k. Patient #23 was admitted to the hospital on 3/17/07 with Psychotic disorder with ecchomotic areas to her hands and wrists. Review of the progress notes dated 3/18/07 identified that Patient #23 ' s wrists and hands were bruised, cracked, swollen and oozing serous fluid. On 3/19/07, Patient #23 had fluocinonide 0.05mg topical ointment ordered twice a day. Review of the medication administration record dated 3/21/07-3/22/07 identified that Patient #23 was refusing the treatment ordered. Review of the master treatment plan dated 3/19/07-3/21/07 failed to identify Patient #23 ' s change in condition and prescribed treatment interventions. The psychiatric record policy identified that the treatment plan will address medical conditions and prescribed treatment interventions. Review of facility policy directed that nursing care plans be

individualized, kept current, and updated upon transfer or discharge. The policy directed that the plan was to be used for shift to shift report. Additionally, for inpatient psychiatric patients, the Multidisciplinary Treatment Plan serves as the official Patient Plan of Care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administrator (2) and/or (e) Nursing Service (1) and/or (i) General (7) and/or (l) Infection Control (1) and/or (4)(B) and/or (4)(D) and/or (4)(E):

6. Based on a review of facility documentation, facility policies and procedures, and facility staff interviews, the facility failed to ensure that the Infection Control program included comprehensive infection control policies that included precautionary measures for visitors to patients at the facility who required isolation precautions due to an infectious process and/or criteria for surveillance/monitoring of visitors to the facility for non-compliance with isolation requirements. For three of nine patients who required contact isolation and/or neutropenic precautions, Patients #5, #6, and #36 the facility failed to ensure that all visitors having direct contact with the patient and/or the patient's environment donned personal protective wear before entering the isolation rooms. The findings were based on review of clinical records, review of facility policies, observations, and interviews and include the following:
    a. Patient #5 was admitted to the facility on 3/13/07 with diagnoses that included pneumothorax of the right lung. During a tour of the facility on 3/21/07 at 9:00 AM, a "special contact isolation" sign was noted on the door of Patient #5's room. Interview with Assistant Director of Nursing #2 at the time of the observation identified that the "special contact precaution" sign was used to identify patients who required isolation precautions for a diagnosis of Clostridium Difficile (C-Diff). A visitor was observed to be in Patient #5's room, feeding the patient and was observed to have repeated direct contact with the patient and with multiple surfaces of the patient's environment without the benefit of an isolation gown and/or gloves. Interview with facility staff at the time of the observation identified that facility policy did not require visitors to don protective wear before entering a patient's room and/or when providing care to the patient. A second observation on 3/21/07 at 9:15 AM identified that Person #4 was assisting facility staff to position and turn Patient #5 who had been incontinent of stool. Interview with the visitor, Person #4, at the time of the first observation identified that he was told by facility staff that he did not need to don protective wear before entering and/or caring for Patient #5 but that he should wash his hands well before leaving the room and not to visit other patients in the hospital. Subsequent to surveyor inquiry, the facility provided additional documentation dated 3/22/07 to identify that Patient #5 had also been diagnosed with Vancomycin Resistant Enterococcus (VRE) in the sputum.
    b. Patient #6 was admitted to the facility on 3/14/07 with diagnoses that included hydropneumothorax and a history of asthma. Review of the clinical record identified that

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Patient #6 required contact isolation precautions based on a history of Vancomycin Resistant Enterococcus (VRE) in the urine and Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum. During a tour of the Pomeroy 5 unit on 3/21/07 at 8:50 AM, a visitor was observed in Patient #6's room without the benefit of an isolation gown and/or gloves. The visitor was observed to have direct contact with the patient and the patient's environment. Interview with Person #5, through an interpreter on 3/21/07 at 10:05 AM identified that although he was required to wear a gown and gloves when visiting Patient #6 in the Intensive Care Unit (ICU), no one had told him that he needed to wear a gown or gloves since the patient had been transferred to her current room. Although the facility provided documentation dated 3/15/07 of visitor education related to Patient #6's required isolation precautions, the education does not identify the visitor/visitors who were educated. The documentation provided identified that the recipient had no barriers to learning including a language barrier.

c. Patient #36 was admitted to the hospital on 3/22/07 secondary to sepsis with neutropenia. During tour on 3/22/07, it was identified that Patient #36 was on neutropenic precautions and staff were caring for the patient utilizing gowns and gloves. Later observation identified a visitor in the room with the patient without proper isolation attire. Review of the hospital policy identified that patients on neutropenic precautions may require the use of gowns, gloves, and masks by staff members and visitors. While the facility identified an article on neutropenic precautions (dated 2005) the facility failed to provide a specific policy and procedure for neutropenic precautions. Interview with the Director of Quality on 3/22/07 indicated that the staff identified that visitors do not need to wear isolation attire when visiting patients on neutropenic precautions. Review of facility policy identified that all hospital personnel with direct contact with a patient on isolation must wear a gown and gloves. The policy directed that hands must be washed thoroughly after removal of the gown and gloves and before leaving the patient's room. Current facility policy did not require visitors to don protective apparel (gown and gloves) when the visitors entered the same isolation rooms. Interview with the facility's Infectious Disease (ID) physician, MD #2 on 3/23/07 at 10:05 AM identified that the facility based its policy on the belief that the prevention of transmission of infectious processes in the acute care setting focused on transmission from patient to patient by healthcare workers. MD #2 stated that although it was difficult to monitor visitors when they left patient room (patients who required isolation precautions) that they are leaving to interact with healthy persons. MD #2 stated that facility policy required that hospital staff provide education regarding handwashing prior to leaving a patient's room.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d)

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Medical Records (3) and/or (e) Nursing Service (1).

7. Based on clinical record reviews and interviews for one patient (Patient #39), the facility failed to ensure that an order for restraints was completed per policy. The findings include:
   a. Patient #39 was admitted to the hospital on 12/24/06 with chest pain and alcohol withdrawal. Review of the clinical record identified that Patient #39 had wrist restraints applied on 12/26/06 due to pulling at tubes. Review of the physicians orders dated 12/26/06-1/4/07 failed to identify that a physicians order for restraints was renewed on 12/29/06 and 1/1/07 even though the patient continued with restraints due to medical reasons. Review of hospital policy identified that a physicians order is required every 24 hours for medical restraints.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (7).

8. Based on clinical record review and interviews with facility personnel for 1 of 1 sampled patients (Patient #4), the facility failed to ensure that x-rays were read accurately by the radiology department. The findings include:
   a. Patient #4 was admitted to the hospital on 11/14/06 with atrial fibrillation and cardiomyopathy. On 11/16/06, Patient #4 had a triple lumen catheter placed by a second year Surgical Resident #1 into the superior vena cava. A chest x-rat completed on 11/28/06 identified that a guide wire was in the superior vena cava (12 days later). The guide wire failed to be identified in prior chest x-rays and CT scans (total 26 opportunities) by radiology. Surgical Resident #1 identified that he was distracted when placing the triple lumen catheter in Patient #4 and failed to count for the guide wire. Interview with the Chief of Radiology on 3/27/07 identified that for the 26 films that were taken, it was difficult to see the guide wire since Patient #4 had numerous tubes and cardiac monitoring leads. Subsequently, Patient #4 had the guide wire removed by MD #7 without any adverse outcome on 11/28/06. Subsequently, the facility implemented a new enhanced imaging system for the radiology department.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (h) Dietary Services (3) and/or (i) General (7).

9. Based on a tour of the dietary department, observations, and interviews, the facility failed to ensure that infection control practices were maintained during food handling. The findings include:

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a. During a tour of the dietary department on 3/22/07 Dietary Aide #1 was observed in the tray line participating in preparation of the noon meal. Dietary Aide #1 was observed to touch various areas of her uniform as well as her face and neck with her ungloved hand. Dietary Aide #1 then placed her ungloved hand into a bag of bread rolls without the benefit of handwashing, and placed the rolls onto patients' trays. Upon surveyor inquiry, Dietician #2 intervened and reeducated Dietary Aide #1. Interview with Dietary Aide #1 immediately following the observation identified that she was not aware of her actions prior to the intervention by Dietician #2. Interview with Dietician #2 at 12:05 PM identified that facility policy did not require dietary aides to wear gloves at that point in the tray line but that even if Dietary #1 had been wearing gloves, that after touching her face and neck, the dietary aide would have been expected to wash her hands before handling any food item directly.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(D) and/or (d) Medical Records (3).

10. Based on review of the clinical record, review of facility policies, and interview, the facility failed to ensure that a consent form for one patient who required a bone marrow biopsy, Patient #1, was completed in accordance with facility policies. The findings included:
    a. Patient #1 was admitted to the hospital on 6/23/05 with diagnoses that included Acute Myleogenous Leukemia (AML). Review of the clinical record identified that Patient #1 had two bone marrow biopsies performed during the hospital stay, one on 6/24/05 and a second biopsy on 7/12/05. Review of the clinical record identified that although the consent form for the 7/12/05 bone marrow biopsy was signed by Patient #1, the consent form lacked a date and time of the patient's signature. In addition, although a physician initialed the same consent form, the form lacked a date or time of when the physician obtained the consent from Patient #1. Interview with facility staff on 3/27/07 failed to provided an explanation for the incomplete information identified on the consent form. Review of facility policy directed that the consent of a patient must be obtained prior to a bone marrow biopsy procedure. The facility's consent forms require documentation of the date and time that the consent is obtained by both the physician and the patient.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

11. Based on review of the clinical record, review of transfusion records, review of facility documentation, and interview, the facility failed to ensure that the medical record for one patient, Patient #1, contained complete information including a post transfusion assessment

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after the patient experienced a blood transfusion reaction. The findings include:

a. Patient #1 was admitted to the hospital on 6/23/05 with diagnoses that included Acute Myleogenous Leukemia (AML). Review of the clinical record identified physician orders dated 7/11/05 for two units of Packed Red Blood Cells (PRBC) to be infused over two hours due to the patient's diagnoses of AML and anemia. Review of Patient #1's transfusion tag dated 7/12/05 identified that Patient #1 had a blood transfusion reaction to the second unit of blood9 beginning at 1:55 AM on 7/12/05. Although the transfusion tag identified that the blood was stopped at 3:15 AM and that the physician and Blood bank were notified, review of physician progress notes and nursing progress notes lacked documentation of the transfusion reaction and/or a description of the patient's symptoms or recovery process. In addition, the clinical record lacked documentation that Patient #1 and/or that the patient's family was notified of the blood transfusion reaction.

   In addition, review of the transfusion tag identified that at 3:00 AM on 7/12/05, Patient #1 developed an increase in temperature (101.6) with chills, nausea, and vomiting during the second transfusion. The transfusion tag identified that at 3:15 AM, RN #10 obtained Patient #1's temperature again and documented the temperature as 101.9. RN #10 stopped the infusion and notified the physician and the Blood Bank. Review of the Daily Frequent Observation Record dated 7/11-7/12/05 identified that no addition assessment of Patient #1's vital signs was performed after 3:15 AM on 7/12/05 through the remainder of the night shift ending at 7:00 AM on 7/12/05. Review of the clinical record lacked documentation of a post transfusion assessment in accordance with facility policies.

   Review of facility policies identified that clinical intervention for a blood transfusion reaction included monitoring the patient every fifteen minutes including vital signs or as indicated by the severity and type of presenting reaction. The policy directed that the time and date of the transfusion reaction, the type and amount of blood or blood product infused, the clinical signs in order of occurrence, notification of the physician and Blood bank, and vital signs should be recorded in the medical record. The policy for blood transfusion reactions did not include direction for notification of the patient and/or family of the transfusion reaction. Facility policies related to Disclosure of Outcome of Care identified that the purpose of the policy was to ensure appropriate communication between health care providers and patient/families. The policy identified the hospital's recognition of a patient's right to know about their medical status, treatment plan, and anticipated outcomes of care, treatment, or procedures. The policy identified an unanticipated outcome was one that differed significantly from what was anticipated to be the result of the intervention, treatment or procedure.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (j) Emergencies (2).

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12. Based on review of the clinical record and interviews, the facility failed to ensure that a physician order for a diagnostic chest x-ray was performed and/or that a written physician order for a diagnostic CT Scan was transcribed onto the clinical record, and/or that entries into the clinical record were dated and timed in accordance with facility policies for one patient, Patient #2, who sought treatment in the Emergency Department (ED) for complaints of sudden onset of chest pain and numbness of the right arm. The findings include:
    a. Patient #2 was brought to the Emergency Department (ED) via ambulance on 1/8/06 at 9:32 PM after complaining of chest pain and numbness of the right leg after the ingestion/inhalation of one gram of cocaine at home. Review of the ED record identified that Patient #2 was triaged at 9:40 PM and was examined by MD #1. Review of the ED physician order sheet identified physician orders for an Electrocardiogram (EKG), and an x-ray (without an accompanying specific order for the type of x-ray the physician had requested), multiple blood tests, and a urine toxicity screen. Review of the clinical record with facility staff failed to identify that an x-ray was performed prior to Patient #2's discharge from the ED. Interview with MD #1 on 3/26/07 at 1:00 PM identified that when a patient arrives in the ED with complaints of chest pain, a chest x-ray and EKG would be the standard diagnostic tests ordered and are typically obtained as part of the diagnostic workup. MD #1 was unable to explain why Patient #2's chest x-ray was not obtained.
    b. In addition, review of Patient #2's ED record identified that a CT Scan of the head was performed on 1/8/06 and was reported as negative. Review of the ED physician order sheet lacked documentation of a physician order to obtain the CT Scan. Interview with MD #1 on 3/26/07 at 1:00 PM identified that she most likely gave a verbal order for Patient #2's CT Scan that did not get transcribed into the clinical record.
    c. In addition, review of the ED physician history and physical assessment of Patient #2 in the ED clinical record lacked documentation of the time that the physician assessment was performed. Review of facility policy directed that all entries into the clinical record be dated and timed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff and/or (d) Medical Records (3) and/or (e) Nursing Service (1).

13. Based on review of the medical records, review of facility policies, and interviews, the facility failed to ensure that documentation in medical records was completed in accordance with standards of practice that included identification of the time of the patient contact and/or the time of the entry into the record. The findings included:

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a. Patient #38 was admitted to the facility on 12/22/06 with diagnosis of acute pancreatitis. Review of the physician progress notes dated 12/22 through 12/23/06, lacked documentation to reflect the time of the practioner visits/evaluation and/or the time of their entry into the medical record for eleven of twenty three (11 of 23) progress notes by various physicians and five of twenty one (5 of 21) physician order entries. Interview with MD #10 on 4/11/07 identified that the facility's medical staff was aware of the need to date and time all entries into the clinical record. Review of the facility's Medical Staff By-Laws directed that all entries into the patient's medical record shall be accurately dated, timed, and signed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1).

14. Based on review of the medical records, review of facility policies, and interviews, the facility failed to ensure that documentation in medical records was completed accurately and/or in accordance with standards of practice that included identification of the time of the patient contact and/or the time of the entry into the record. The findings included:
    a. Patient #38 was admitted to the facility on 12/22/06 with diagnosis of acute pancreatitis. Review of the physician progress notes dated 12/22 through 12/23/06, lacked documentation to reflect the time of the practioner visits/evaluation and/or the time of their entry into the medical record for eleven of twenty three (11 of 23) progress notes by various physicians and five of twenty one (5 of 21) physician order entries.
    b. Review of the clinical record identified two physician order entries by MD #11 dated 12/22/06. The orders were timed as entered at 9:00 AM and 9:30 AM respectively. Interview with MD #11 on 4/11/07 at 10:AM identified that he had made an error in entering the time and that the time should have read 9:00 PM and 9:30 PM not AM. Interview with MD #10 on 4/11/07 identified that the facility's medical staff was aware of the need to date and time all entries into the clinical record. Review of the facility's Medical Staff By-Laws directed that all entries into the patient's medical record should be accurately dated, timed, and signed.
    c. Review of an Emergency Department (ED) physician document dated 12/22/06 at 1:35 PM identified that MD #1 provided a history and physical examination of Patient #38 while in the ED. Review of the history and physical examination identified that MD #1 documented that Patient #38 had "negative" vomiting episodes. Review of the ED nursing assessment of Patient #38 dated 12/22/06 at 1:37 PM identified that Patient #38 reported six vomiting episodes prior to arrival at the ED that began when the pain began. Interview with MD #1 on 4/17/07 at 11:10 AM identified that she did not recall being made aware of Patient #38's vomiting episode at the time of her examination. MD #1 stated that as Patient #38 was receiving antiemetics (for nausea relief) while in the ED and had not vomited since the ED admission, she would not have provided addition

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intervention based on that information

d. Review of the clinical record identified a computerized nursing note entry by RN #12 dated 12/23/06 at 12:40 AM. The documentation identified that Patient #38's heart rate had increased to 125-128 beats per minute (Normal 60-80), and that MD #11 was notified of the increased rate and the patient's abnormal blood work results. The documentation identified that an EKG was obtained, read by MD #11, and that the patient was to be transferred to the telemetry unit. In addition, the documentation identified that Patient #38 was lethargic and that RN #12 applied monitor leads in preparation for the patient's impending transfer to telemetry. Documentation was lacking of the time of RN #12's assessments and/or observations and/or the time of interventions provided. Interview with the Director of Quality Management on 4/11/07 at 3:00 PM identified that because a nurse may be involved in the direct care of a patient and may not be able to immediately document his/her assessment following the assessment, that the time of the actual assessment should be included when completing the computerized documentation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B).

15. Based on review of the clinical record, review of facility policies, review of facility documentation, and interviews, the facility failed to ensure that one patient, Patient #38, who was assigned to physicians working in the facility's hospitalist program and/or that the physicians provided a full assessment of the patient when the patient experienced changes in clinical status. The findings include:

    a. Patient #38 arrived at the Emergency Department (ED) at 12:10AM on 12/22/06 with complaints of an acute onset of abdominal pain and vomiting and was subsequently admitted to the hospital with a diagnosis of acute pancreatitis. Patient #38 was transferred to the inpatient unit at 5:32 PM. An admission assessment was performed at 5:56 PM and identified that Patient #38's Blood Pressure (B/P) was 150/68 with a pulse rate of 68. The clinical record identified that blood work including a follow up Troponin level (a diagnostic blood test used to identify cardiac muscle damage) were drawn at 6:15 PM. Patient #38's Troponin level rose from < 0.1 in the ED to 0.7 (Normal 0.0-0.1). MD #11, the hospitalist assigned to Patient #38, ordered a repeat electocardiogram (EKG) obtained at 8:15 PM, directed the administration of Aspirin, three hundred and twenty five milligrams (mg.)"now," and a cardiology consult. Interview with MD #11 on 4/11/07 at 10:00 AM identified that he spoke with the cardiologist, MD #15, via telephone at approximately 9:00 PM on 12/22/06 and that they agreed that no other anticoagulants were to be administered at that time based on the patient's admission diagnosis of pancreatitis and that the patient was to be transferred to telemetry for closer cardiac monitoring. Although the decision was made

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to transfer Patient #38 to the telemetry unit for closer monitoring at approximately 9 PM, the facility failed to transfer the patient to the telemetry unit until just prior to 11 PM on 12/22/06. MD #11 stated that he last saw Patient #38 just before he left the hospital at approximately 9:30 PM, that he discussed Patient #38's care with MD #12, another hospitalist, and that MD #12 then assumed the care of Patient #38. MD #11 was unable to recall the details of his discussion with MD #12. MD #11 was unable to explain why Patient #38 was not transferred to the telemetry unit just prior to11:00 PM.

b. Interview with MD #12 on 4/17/07 at 8:45 AM identified that although the facility's Hospitalist program included a system for the outgoing and oncoming hospitalists to share patient information through "sign out" notes on the computer, that the "sign out" notes are deleted after the patient is discharged. MD #12 stated that she was unable to recall what information she was given by MD #11 regarding Patient #38's status upon her arrival on 12/22/06. MD #12 stated she had given a telephone order at approximately 10:45 PM to transfer Patient #38 to telemetry after being called by RN #12 who reported that the order to transfer the patient was not written on the physician's order sheet earlier by MD #11. MD #12 stated that her first encounter with Patient #38 was sometime between 11:00 PM and 11:30 PM on 12/22/06 when she was called by the nursing staff who reported that Patient #38's blood pressure was now 60/40. MD #12 stated that she went to the nursing unit to evaluate Patient #38. Review of the clinical record identified that Patient #38 was found unresponsive, was placed on a fifty percent Venti-mask, and transferred to the Medical Intensive Care Unit (MICU). Review of the MICU nursing documentation dated 12/22/06 at 11:30 PM identified that Patient #38 was received from the inpatient nursing unit, that the patient's abdomen was flat but firm, lower extremities were mottled, oxygen saturation was 80 % (Normal 95-100), respirations were 50 (Normal 16-20) and that the patient had experienced a small bloody bowel movement. Patient #38 was subsequently diagnosed with an aortic dissection and underwent surgery for repair of the dissection as well as repair of a necrotic bowel. MD #12 was not able to recall why there was a delay in transferring Patient #38 to the telemetry unit. Interviews with facility staff that included MD #10, MD #11, MD #12, and RN #12 failed to identify a clear reason as to why Patient #38 was not transferred to telemetry and/or to the MICU as a "telemetry boarder" prior to 11:00 PM when the transfer had been requested by MD #11 at 9:00 PM on 12/22/06. Although staff believed that there may have been a bed availability issue, the record lacked documentation to reflect that problem and/or that other options were considered. Interview with MD #13, the cardiac thoracic surgeon, on 4/17/07 at 9:10 AM identified that even with telemetry monitoring, he did not believe that any earlier EKG changes would have been noted that would have led physicians to the diagnosis of aortic dissection. Review of facility policy/ Medical Staff By-Laws identified that pertinent progress notes should be recorded daily at the time of observation, sufficient to document continuity of care ability to transfer. The Medical Staff By-Laws directed that whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes, correlated with specific orders, as well as results of tests and treatments. Progress notes

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should be written at least daily on all patients and more frequently on those cases in which there is difficulty in diagnosis or management of the clinical problems.