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

IN RE: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT – Licensee
d/b/a John Dempsey Hospital of the University of Connecticut Health Center
263 Farmington Avenue
Farmington, CT 06032

CONSENT AGREEMENT

WHEREAS, the University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT. (hereinafter the "Licensee"); has been issued Licensee No. 0065 to operate a General Hospital known as John Dempsey 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 May 6, 2008 and concluding on September 5, 2008, in order to determine the Licensee's compliance with the provisions of the Regulations of Connecticut State Agencies; 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 were identified in an amended violation letter dated October 10, 2008 (Exhibit A, copy attached); and

WHEREAS, the Department, entered into two (2) previous Consent Agreements with the Licensee dated February 28, 2008 and September 26, 2006 (Exhibits B and C, copies attached); and

WHEREAS, the findings identified in the amended violation letter dated October 10, 2008 are reflective of issues and previously identified in violation letters dated May 10,

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2006, August 8, 2006 and September 17, 2007 which generated two (2) previous Consent documents; and

WHEREAS, the Licensee has not been able to sustain compliance with the Regulations of Connecticut State Agencies; and

WHEREAS, the Department is compelled to incorporate the consent documents executed September 26, 2006 and February 28, 2008 into this Consent Agreement; and

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

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through James Thornton, its Administrator, hereby stipulate and agrees as follows:

1. Within thirty (30) days of the execution of this Consent Agreement, the Licensee shall contract with a Clinical Consulting Firm (CCF) that has expertise in professional/clinical health care services, evaluation of institutional systems and quality assurance program reviews.
2. The Department shall approve the CCF prior to execution of the contract between the Licensee and CCF.
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 the Consent Agreement. The CCF team shall consist of credentialed healthcare professionals necessary to address the issued identified in Exhibits A, B, C and the violation letters dated May 10, 2006, August 8, 2006, September 17, 2007 and October 10, 2008.
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. Nursing Services;

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b. Infection Control;
c. Pharmacy;
d. Operating Room;
e. Emergency Department;
f. Psychiatric Services;
g. Quality Assurance Program;
h. Nurse Staffing Levels;
i. Patient Assessments; and
j. Patient Plans of Care.

5. The CCF and the Licensee shall enter into a written contract that includes the following requirements:
   a. Timeframes for the initial evaluation;
   b. The number of individuals with appropriate credentials that will conduct 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 the report to the Licensee and 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, continuing onsite consulting initiatives, and professional staff assignments to the University of Connecticut Health Center and number of 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.

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8. The Department shall have the final determination to accept or reject the CCF recommendations should the parties not be able to reach mutual agreement.
9. Upon approval by the Department of the recommendations by the CCF, the Licensee shall have thirty (30) days to provide the Department with a plan 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 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 Consent Agreement shall be made available to the Department upon request.
11. If the CCF initially determines that continuous onsite services by consultants are not necessary, the CCF shall re-evaluate the Licensee at three (3) months and six (6) months intervals following the implementation of the Licensee's plan to implement the CCF's recommendations. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services. Upon conclusion of said reviews, the CCF shall provide the Department with a comprehensive report(s) of said assessments.
12. Within sixty (60) days of the execution of this Consent Agreement, the Licensee shall:
    a. Review and revise, as applicable, all policies and procedures regarding assessments and patient care plans;
    b. Employ or contract with Registered Nurses in sufficient numbers to evaluate and deliver care and services to patients with the Facility;
    c. Institute competency testing programs for all Licensed Nurses regarding patient assessments for changes in condition, pain management and care plan development;
    d. Review and revise, as applicable, all policies and procedures regarding infection control;

e. Employ or contract with sufficient infection control staff who are credentialed in infection control to track and monitor infections within the Facility; and

f. Provide bi-monthly compilation of statistics regarding infections which shall be prepared and made available to hospital personnel for review and include plans of remediation, if applicable.

13. Within ninety (90) days of the execution of this Consent Agreement, the Licensee shall provide inservice education to all applicable staff regarding all policies and procedures as identified in this document and shall be repeated, as applicable, at the time of employment and yearly thereafter to staff. Documentation of inservice education shall be maintained for review by the Department for a period of three (3) years.

14. The Department places the licensee of the University of Connecticut Health Center – John Dempsey Hospital on probation for a period of two (2) years in accordance with Connecticut General Statutes § 19a-494(a)(5). The Department shall review the term of probation one (1) year after the effective date of this document. If the Licensee has maintained substantial compliance with federal and state laws and regulations, the Department will rescind the probation.

15. The Licensee shall within seven (7) days of the execution of this Consent Agreement, designate an individual who shall assume overall responsibility for full implementation and monitoring of the components of this Consent Agreement. 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 Consent Agreement 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 Consent Agreement to discuss the measures implemented as a result of the attached documents and the CCF report and recommendations.

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17. All parties agree that this Consent Agreement is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Consent Agreement 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 Consent Agreement 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.
18. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
19. The Licensee shall provide inservice educational programs to all professional staff impacted by this document and shall establish measures to monitor, evaluate and measure compliance with this document.
20. The Licensee shall submit all reports required by this document to:

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

21. The Licensee understands that this Consent Agreement 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.
22. Should the Licensee not be able to maintain substantial compliance with the requirements of this Consent Agreement, the Department retains the right to issue charges including those identified in the violation letters referenced in this document.

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Licensee: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT.

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

University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT – Licensee

11/26/08
Date

By: James Thornton, Administrator

STATE OF PA)

County of DELAWARE) ss _____ 2008

Personally appeared the above-named JAMES THORNTON
Made oath to the truth of the statements contained herein.

My Commission Expires: 9/9/2012
(If Notary Public)

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

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MaryEllen Bradford, Notary Public
Middletown Twp., Delaware County
My Commission Expires Sept. 9, 2012

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

11/26/08
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 19

October 10, 2008

James Thornton, Administrator
John Dempsey Hospital
263 Farmington Avenue
Farmington, CT 06032

Dear Mr. Thornton:

This is an amended edition of the original violation letter dated September 23, 2008.

Unannounced visits were made to John Dempsey Hospital commencing on May 6, 2008 and concluding on September 5, 2008, by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure renewal inspection, a substantial allegation survey and full federal survey at the request of CMS, to review for the implementation of stipulations identified in the consent agreements dated 9/26/06 and 2/28/08, to review for the implementation of a plan of correction for a violation letter dated March 7, 2008 and to conduct multiple investigations.

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 Thursday 9th October, 2008 at 1:30 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please address each violation with a prospective plan of correction which includes the following components:

- Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
- Date corrective measure will be effected.
- 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,

Ann Marie Montemerlo, R.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section

AMM:zbj

c. Director of Nurses
Medical Director
CT#7188, #7369, #8154, #8179
CT#8188, #8283, #8391, #8426

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 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 (4)(A) and/or (5) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

1. * Based on clinical record reviews, interviews with staff, and policy review for one patient (Patient #1) with a history of a recent suicide attempt, the Hospital failed to ensure that policies and staff practices ensured a safe milieu. The findings include:

a. Patient #1 was admitted to the emergency department (ED) on 6/5/08 with a diagnosis that included depression and had a history of suicidal attempts. According to the ED record, the patient was brought to the ED under a Police Emergency Examination Request following an attempted suicide. The record identified that on 6/5/08 police found the patient in a hotel room, the patient had disassembled a plastic disposable razor, and attempted to use a blade from the razor to cut him/her self. According to the Nurse Manager on 6/11/08, the ED record is on-line and available to Hospital staff on the psychiatric unit. MD #1, MD #2, and RN #1 all assessed Patient #1 on 6/6/08 and identified that the patient had recently attempted suicide by cutting and had current suicidal ideations. The patient was placed on every 15-minute checks with no other precautions identified, such as sharps restriction, etc. On 6/9/08 at 6 AM, Patient #1 was given a plastic disposable razor by staff (per unit policy), which he/she returned to RN #2 at 6:45 AM. The patient was unsupervised while in possession of the razor (per unit practice). On 6/9/08 at approximately 3:20 PM, Patient #1 was found unresponsive in a locked bathroom. The patient was in the shower slumped on the floor in a "pool of blood". Multiple lacerations on all extremities were noted, and an emergency code was called. The patient was transferred to ICU and diagnosed with hemorrhagic shock, respiratory failure, severe metabolic acidosis secondary to hypo-perfusion, and acute renal failure. On 6/11/08, Patient #1 was identified as hemodynamically stable, all acute medical issues were resolved, and the patient was transferred back to another psychiatric unit. The unit policy for use of the safety cabinet identified that any potentially dangerous item would be stored in the safety cabinet. The cabinet would be unlocked at specified times and staff would sign-out items to patients and patients would be encouraged to return the item within one hour. The policy was reviewed with the Nurse Manager 6/11/08 at 11:10 AM and failed to identify a mechanism to ensure that potentially dangerous items were distributed appropriately and how patient's in possession of potentially dangerous items would be monitored.
Based on interview with facility staff on 6/11/08, the facility was identified as discontinuing the use of disposable razors on 6/10/08, prior to the start of this onsite investigation..

2. * Based on clinical record reviews, interviews with staff, and policy review for one patient (Patient #1) with a history of a recent suicide attempt, the Hospital failed to ensure that registered nurse supervised and evaluated the nursing care provided to each patient to ensure the patient's safety. The findings include:

a. Patient #1 was admitted to the emergency department (ED) on 6/5/08 with a diagnosis that included depression and had a history of suicidal attempts. According to the ED record, the

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

patient was brought to the ED under a Police Emergency Examination Request following an attempted suicide. The record identified that on 6/5/08 police found the patient in a hotel room, the patient had disassembled a plastic disposable razor, and attempted to use a blade from the razor to cut him/her self. According to the Nurse Manager on 6/11/08, the ED record is on-line and available to Hospital staff on the psychiatric unit. While in the ED, the patient was assessed as very suicidal and placed on constant observations. A crisis assessment was completed by MD #1 (1st year Resident) who identified that Patient #1's blood alcohol level was 289 mg/dl (over 100=intoxication) and the patient had not been taking prescribed medications for depression. MD #1 completed a High Risk Assessment that identified the patient was actively suicidal with intent, and identified the appropriate level of observation (once admitted to the in-patient unit) would be every 15-minute checks. No other precautions were identified. MD #2 (2nd year Resident) assessed Patient #1 on 6/6/08 and identified the patient was always suicidal after drinking, was positive for suicidal ideations, and admitted the patient to an in-patient psychiatric unit with orders to monitor the patient every 15-minutes. Attending Psychiatrists assessed Patient #1 on 6/7/08 and 6/8/08 and identified to continue with every 15-minute checks. No other precautions were identified. According to the Hospital policy on observation of a patient, 15-minute checks are considered routine.

An initial nursing evaluation and risk screen for self-harm was completed by RN #1 on 6/6/08. Although RN #1 identified that Patient #1 had the intent and plan to cause self-harm, the risk screen required RN #1 to identify if the patient "was or was not a risk for potential self-harm," was not completed (check off box). RN #1 did identify that the patient observation status was to be every 15-minute checks. According to the risk screen guidelines, the patient's intent and plan to cause self-harm were to be reviewed with an MD. Interview with RN #1 on 6/17/08 at 12:40 PM identified the patient's risk for potential self-harm should have been completed and that the risk screen was not reviewed with an MD, per policy. On 6/9/08 at 6 AM Patient #1 was given a plastic disposable razor by staff (per unit policy), which he/she returned to RN #2 at 6:45 AM. The patient was unsupervised while in possession of the razor (per unit practice) and the razor was not inspected when it was returned (per unit practice). On 6/9/08 at approximately 3:20 PM, Patient #1 was found unresponsive in a locked bathroom. The patient was in the shower slumped on the floor in a "pool of blood." Multiple lacerations on all extremities were noted, and an emergency code was called. The patient was found with a weak pulse, unable to maintain an effective airway, and was intubated by the code team. Between 3:20 PM and 4 PM, Patient #1 received 2 units of IV Hespan (volume expander) wide open, 2 units of IV Normal Saline wide open, and 2 units of blood. The patient was identified in sinus tachycardia throughout the code and began wincing to pain by 4:01 PM. The patient was transferred to ICU and diagnosed with hemorrhagic shock, respiratory failure, severe metabolic acidosis secondary to hypo-perfusion, and acute renal failure. On 6/11/08 Patient #1 was identified as hemodynamically stable, all acute medical issues were resolved, and the patient was transferred back to another psychiatric unit.

b. Patient #1's Master Psychiatric Nursing Treatment Plan was reviewed with the Nurse Manager on 6/12/08 at 12:50 PM. The treatment plan consisted of 15-pages of nursing assessments and interventions for Patient #1. Although Patient #1 had been transferred to the ICU on 6/9/08 and

was no longer residing on the psychiatry unit, staff continued to document assessments of Patient #1 on 6/10/08 for 2 full shifts (nights and days).

c. Staff assignment sheets titled "Inpatient Psychiatry Assignment of Personnel Forms" were reviewed with the Nurse Manager on 6/16/08 at 2:15 PM. The daily assignment sheets identified that patient's were assigned to either a nurse or a CNA/MHW on each shift. The documentation failed to reflect that an RN was consistently assigned to supervise and evaluate patient care for those patients assigned to a CNA/MHW (per policy) on the following dates: 6/8/08 night shift, 6/9/08 day shift, 6/12/08 day shift, 6/14/08 day shift, 6/15/08 day shift and 6/16/08 day shift.

3. * Based on clinical record reviews, interviews with staff, and policy review for two patients (Patients #1 and #2), the Hospital failed to develop a treatment plan that addressed patient specific safety interventions for a patient with active suicidal ideations and for a patient whose suicidality could not be assessed. The findings include:

a. Patient #1 had a diagnosis of depression with a history of suicidal attempts. The patient was admitted on 6/5/08 at 10:46 PM following an attempted suicide. The patient was identified as having disassembled a plastic disposable razor and attempted to use a blade from the razor to cut him/her self.

MD #1 completed a High Risk Assessment on 6/6/08 that identified the patient was actively suicidal with intent. MD #2 assessed Patient #1 on 6/6/08 and identified the patient was always suicidal after drinking and was positive for suicidal ideations.

RN #1 completed an initial nursing evaluation and risk screen for self-harm on 6/6/08 that identified Patient #1 had the intent and plan to cause self-harm. A multidisciplinary initial treatment plan was developed on 6/6/08 by MD #2 and RN #1 that identified the patient was at risk for violence towards self as evidenced by positive suicidal ideations and a recent plan to cut his/her wrists. An initial objective identified to ensure the patient was safe with interventions to adjust medications and "initiate initial treatment plan" in collaboration with a physician. Patient #1's initial master treatment plan was reviewed with the Nurse Manager on 6/12/08 at 8:45 AM. The plan lacked patient specific safety measures, failed to identify the patient's status (observation), and failed to address the patient's access to plastic disposable razors on the psychiatric unit. In addition to the initial master treatment plan, a master psychiatric nursing treatment plan was developed on 6/6/08, identified the patient's recent suicide attempt, but failed to address environmental interventions (page 8 of 15) to ensure that the patient's safety needs were met.

On 6/9/08 at 6 AM, Patient #1 was given a plastic disposable razor by staff (per unit policy), which he/she returned to RN #2 at 6:45 AM. The patient was unsupervised while in possession of the razor (per unit practice). On 6/9/08 at approximately 3:20 PM, Patient #1 was found unresponsive in a locked bathroom. The patient was in the shower slumped on the floor in a "pool of blood." Multiple lacerations on all extremities were noted, and an emergency code was called. The patient was found with a weak pulse, unable to maintain an effective airway, and was intubated by the code team. Between 3:20 PM and 4 PM, Patient #1 received 2 units of IV

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Hespan (volume expander) wide open, 2 units of IV Normal Saline wide open, and 2 units of blood. The patient was identified in sinus tachycardia throughout the code and began wincing to pain by 4:01 PM. The patient was transferred to ICU and diagnosed with hemorrhagic shock, respiratory failure, severe metabolic acidosis secondary to hypo-perfusion, and acute renal failure. On 6/11/08 Patient #1 was identified as hemodynamically stable, all acute medical issues were resolved, and the patient was transferred back to another psychiatric unit.

b. Patient #2 had a diagnosis of schizoaffective disorder and was admitted to the hospital on 6/6/08 for treatment of psychosis. MD #1 assessed the patient as gravely disabled due to the psychosis, identified a history of vague suicidal ideations, and the MD was unable to rule out if the patient was a current suicidal risk. Review of the multidisciplinary initial treatment plan dated 6/6/08 identified a problem of psychotic disorder as evidenced by positive audio and visual hallucinations, and that the patient was disorganized and catatonic. The nursing section of the initial treatment plan was reviewed and lacked specific interventions to address the patient's psychotic disorder. The plan identified an objective to keep the patient safe with an intervention to "initiate initial treatment plan in collaboration with the Resident and Attending" and another intervention to "identify the patient's status" was left blank.

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4. * Based on clinical record review, interviews with staff and patients, and review of policies for one patient (Patient #1) who made a suicide attempt during hospitalization, the hospital failed to ensure that staff documented pertinent information in the clinical record. The findings include:

a. Patient #1 had a diagnosis of depression with a history of suicidal attempts and was admitted on 6/5/08 at 10:46 PM following an attempted suicide. On 6/9/08 at approximately 3:20 PM, Patient #1 was found unresponsive in a locked bathroom. The patient was in the shower slumped on the floor in a "pool of blood." Multiple lacerations on all extremities were noted, and an emergency code was called. The patient was found with a weak pulse, unable to maintain an effective airway, and was intubated by the code team. Between 3:20 PM and 4 PM, Patient #1 received 2 units of IV Hespan (volume expander) wide open, 2 units of IV Normal Saline wide open, and 2 units of blood. The patient was identified in sinus tachycardia throughout the code and began wincing to pain by 4:01 PM. The patient was transferred to ICU and diagnosed with hemorrhagic shock, severe metabolic acidosis secondary to hypo-perfusion, and acute renal failure.

Patient #1's clinical record was reviewed with the Nurse Manager on 6/12/08 at 12:15 PM and with RN #3 on 6/12/08 at 1:20 PM. Documentation in the clinical record was lacking to reflect Patient #1's 6/9/08 attempted suicide, resulting injuries, and subsequent resuscitation efforts. The Nurse Manager identified that after Patient #1's suicide attempt, the patient was discharged from psychiatry, the record was closed, and the patient was re-admitted to the ICU.

Interview with and observation of Patient #1 on 6/12/08 at 3:20 PM identified six sutured lacerations to the bilateral wrists, bilateral antecubital areas, and bilateral inner calves.

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Patient #1's clinical record including the CNA/MHW Admission Checklist was reviewed with the Nurse Manager on 6/12/08 at 8:45 AM. The checklist was incomplete and failed to identify that a breath analysis was obtained, clothing and body searches were done, that contraband and medications were confiscated, and was not signed or dated.

5. * Based on medical record reviews, review of facility documentation, review of facility policies, review of Medical Staff Bylaw Rules and Regulations and staff interviews, the facility failed to ensure quality medical care for Patient #25, who had a change in neurological status, and/or for Patient #22, who was in the ED and experienced baseline changes, and/or for Patient #37, who underwent a second operation for a retained foreign body. The findings include:

a. Patient #25 was admitted to Medicine 4 with complaints of head and neck pain on 1/18/07. Diagnoses included upper gastrointestinal bleed and hypertension. The assessment dated 1/18/07 identified that the patient had a normal neurological assessment and was alert and oriented. Nursing flow records dated 1/18/07 and 1/19/07 indicated that the patient was alert and eyes opened spontaneously. The nursing flow record dated 1/20/07 at 11 AM noted that the patient was confused and opened eyes to speech as opposed to previously being alert and oriented and opening eyes spontaneously. The nursing narrative dated 1/20/07 at 4:30PM identified that the patient was delusional, delirious, and was incontinent (previously continent). Untimed physician orders by MD #15 dated 1/20/07 were signed off by the Unit Secretary at 3:35 PM and directed a CT scan of the head to rule out bleed (ordered as routine). MD #10's progress note dated 1/20/07 identified that the patient had delirium, systolic blood pressure was 206 the previous night, and questioned hypertensive encephalopathy. MD #10's note further documented to check the CT scan to rule out cerebral vascular accident (CVA). The test was not ordered to be done STAT. Nursing narratives dated 1/20/07 for the 7 AM to 7:30 PM shift identified the patient was awaiting a CT scan of the head. The CT scan requisition slip identified that the request was entered into the radiology department computer at 5 PM on 1/20/07 (1 hour and 25 minutes after the order was noted on the chart by the unit secretary). Review of the CT scan film dated 1/20/07 with the Director of Radiology on 7/31/08 noted that the scan was performed on 1/20/07 at 8:15 PM (4 hours and 40 minutes after the test was noted on the chart by the unit secretary). Radiologist #10 noted that Patient #25's need for the CT scan was emergent based on the diagnosis (rule out CVA/bleed) and it's priority would be based on the priority of other CT scans that needed to be done during the same time period. Radiologist #10 noted that if a physician desired a test to be performed right away, the physician could call and speak with radiology staff and/or order the test STAT. Interview with the Neurosurgeon on 8/7/08 at 10:20 AM indicated the following: The CT scan performed on 1/20/07 identified that the Patient had the beginning of an infarct (stroke) and resultant hydrocephalus (fluid accumulation within the ventricles of the brain). If a stroke was caught early enough, it could be managed medically. Although interview with MD #10 on 8/22/08 at 2:40 PM indicated that the patient's delirium on 1/20/07 was not acute and that the patient had no neurofocal changes at the time, the record lacked a neurological assessment by either MD #10 or MD #15. The patient continued to deteriorate neurologically and expired on 1/22/07. The death certificate dated 1/22/07 noted stroke onset 48 hours as the immediate cause of death.

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

The hospital Emergency Department policy for CVA, suspected, identified that the patient will have immediate evaluation and appropriate treatments to prevent the progression of symptoms and to prepare the patient for non-contrast CT scan per the Licensed Practitioner's order. The hospital did not have a policy regarding suspected CVA for In-Patient units.

Patient #25's progress notes by MD #10 dated 1/20/07 (at approximately 3:30 PM) identified that the patient was examined, had delirium, systolic blood pressure was 206 the previous night, and questioned hypertensive encephalopathy. MD #10's note further indicated to check the CT scan to rule out cerebral vascular accident (CVA). Nursing narratives and/or medication records dated 1/20/07 identified that the patient, received stat antihypertensive medications at 9 PM and 10 PM and that the medical resident was in to see the patient at 10:15 PM. The record failed to provide documentation that the patient was assessed/examined by the physician after MD #10 saw the patient at approximately 3:30 PM until the neurology resident assessed the patient at 11 PM (6hours and 30 minutes) and the patient was determined to be critical and required transfer to the ICU.

b. Patient #22 arrived to the ED on 12/18/08 at 6 AM via ambulance after getting up at home around 4:45 AM with severe symptoms of dizziness, worse with movements, nausea, "fuzzy" head, and actively vomiting fluid upon arrival. The patient's blood pressure was 130/70. The patient reported no medical history, and had not seen his / her primary physician recently. A neurological exam by ED Physician #50 indicated that the symptoms were persistent, that the patient appeared distressed from nausea, and that symptoms of dizziness were worse with right eye gaze and turning head to the right. The patient was diagnosed with vertigo, and treated with Antivert 50 milligrams (mg) by mouth, Reglan 10mg intravenously (IV), Zofran 4mg IV, Sodium Chloride IV at 250 centicubes per hour (cc/hr) and Ativan 1mg IV. At 9:32 AM, Registered Nurse (RN) #56 documented that Patient #22 was out of bed, ambulated a short distance, felt a little better, still had some vertigo and leaned to the right during ambulation. RN #56 notified Physician #51 of the findings, and medicated the patient with Antivert. In an interview on 07/30/08 at 1:20 PM, Physician #51 did not recall being told about the patient's right-sided leaning during ambulation. Physician #51 recalled being told about the patient's persistent dizziness, and explained that patients were frequently discharged with vertigo, a symptom that did not resolve promptly. Physician #51 further indicated that dizziness possibly was an early sign of stroke, even in the absence of hemiparesis, therefore patients were instructed to return to the ED in the absence of improvement. Patient #22 was discharged from the ED on 12/18/07 at 9:49 AM via wheelchair. Review of the ED record identified a lack of neurological re-assessment by the ED physician prior to discharge, and failure to conduct a work-up of the patient's presenting symptoms.

The following day, on 12/19/07, Patient #22 continued with dizziness, weakness, difficulty standing and walking, and had developed slurred speech. The patient ' s blood pressure was 151/96. The patient was brought by ambulance to another ED, where CT Scan of the head and MRI revealed a right cerebellum acute ischemic infarct. The patient was admitted to the hospital, where the work-up included a magnetic resonance angiogram (MRA) of the neck, which revealed a 2.5 millimeters (mm) aneurysm of the left middle cerebral artery. The patient was discharged from the hospital on 12/25/07, with recommendations for follow-up of the

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aneurysm on an outpatient basis, follow-up with the neurologist, the need for an outpatient cardiac MRI for suspicion of a partial anomalous vein drainage, and the need for an outpatient hypertensive workup and treatment.

c. Patient #37 underwent an arthroscopy with extensive debridement, excision of the right os trigonum and a lateral ligament reconstruction of the right ankle on 6/23/08. During interview on 7/31/08, RN #21 stated that she reported to MD #22 that a piece of a curved needle was missing as MD #22 was closing Patient #37's surgical wound. During interview with MD #22 on 8/4/08, the surgeon stated that he was not sure that the needle was broken but perhaps blunted during surgery. MD #22 stated that the wound, prior to closure, had been fluoroscoped and failed to identify a retained object and that hospital policy directed that x-rays should not be utilized to identify any needle smaller than 13 mm that may be "lost" in a surgical wound secondary to being inconsistently visible on x-ray. During a post surgical follow-up on 7/8/08, a foreign body was observed on x-ray in the surgical wound. On 7/10/08, a foreign body identified as a needle on the Operative Report, was removed. Review of the Operative Report dated 6/23/08, from the initial surgery, failed to identify the possibility of a retained object and/or actions taken to ensure location of the missing item. Review of the surgical record dated 7/10/08, failed to identify that the retrieved foreign object was sent to surgical pathology. Interview on 8/4/08 with MD #22 identified that he did not submit the needle tip because he knew what the object was.
Review of the Rules and Regulations of the Medical Staff Bylaws identified that all specimens should be submitted to surgical pathology for both gross and miscroscopic evaluation with the exception of the stated specimens exempt from gross examination. Additionally, the facility policy for Counts: Sponge, Sharp, Accessory Item and Instrument, directed that an x-ray be completed and read by a radiologist to rule out retention of a foreign body rather than use fluoroscopy which does not allow for the same image quality to detect a retained needle. Although the policy directed that no x-ray, secondary to inconsistent visibility, be utilized to determine if a needle smaller than 13 mm was lost in a wound, the policy failed to address recourse for the practitioner that needed to identify what method would be used when an object smaller than 13 mm was lost in a wound.

6. * Based on a review of Nurse staffing and interview with staff, the Hospital failed to ensure that staffing met the minimum nursing staffing levels as set by the Hospital. The findings include:

a. Nursing staffing for the patient care units of Psychiatry 1 and Psychiatry 3 were reviewed with the Manager of Psychiatry on 7/30/08 at 10 AM. Staffing levels for Registered Nurses and Mental Health Workers/Nurse Aides from 7/11/08 to 7/30/08 failed to meet the minimum staffing levels set by the Hospital on all 19 days that were reviewed. According to the Nurse Manager, she and administration are aware of the staffing shortage on the Psychiatry units and have been actively recruiting for new staff.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (i) General (6) and/or (l) Infection control (1)(A).

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

7. * Based on medical record reviews, review of hospital policy and staff interviews, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for Patients #11, 13, 17, 18, 19 and 25. The findings include:

a. Patient #11 underwent a laparoscopic partial colectomy with anastomosis on 07/25/08. Interview and review of the intra-operative record with the Operating room (OR) Clinical Nurse Specialist (CNS) on 07/28/08 indicated that the final count of instruments, sharps, and sponges was correct, but the documentation failed to reflect the names of staff members performing the count. The facility policy on sponge, sharp and instrument count directed the documentation of the names and initials of the persons performing the count, along with the results of the final closing count. In addition, the intra-operative record failed to reflect the documentation of sponge, sharp, and instrument count at the time of permanent relief of the scrub person (12:10 PM) and / or the circulating nurse (3:31 PM).
On 07/25/08, Patient #11's analgesic orders were changed from prn (as needed) doses to a patient-controlled analgesia (PCA) intravenous infusion of morphine at 1 milligram (mg) per demand every six minutes, to a maximum of 10 mg per hour. Interview and review of the nursing flow sheets dated 07/27/08 and 07/28/08 with the Clinical Nurse Manager on 07/28/08 at 11 AM indicated that respiratory rate, sedation and pain assessments were performed every five to six hours, instead of every four hours as directed by the facility policy on the Care of Patients receiving PCA analgesia.

b. Patient #13 was transferred to the Labor and Delivery Unit on 7/22/08. Review of the medical record for physician orders dated 7/23/08 at 11:57 AM for a blood test and to "start Pitocin per protocol" identified a failure of the order to be signed as acknowledged by the nurse. Further review identified additional physician orders for fluids, medication adjustments and oxygen saturations dated and timed from 7/24/08 at 2 AM until 7/24/08 at 4:15 PM that failed to be signed as acknowledged by the RN until 7/24/08 at 8:15 PM. Review of the record and interview with the Manager of Labor and Delivery on 7/28/08 identified that although the orders were carried out as directed, the physician orders were expected to be signed off as completed by the nurse.

c. Patient #17's diagnoses included lung cancer with metastasis to the brain. Physician orders dated 07/26/08 directed the implementation of comfort measures only (CMO), and the initiation of a continuous intravenous (IV) infusion of morphine at 1 mg/hr, increased to 2mg/hr at 1 PM, with available bolus doses of Morphine IV 1mg every hour for breakthrough pain with a score of 1 to 3, 2mg with a score of 4 to 7, and 4mg with a score of 8 to 10. Interview and review of the nursing flow sheets dated 07/26/08, 07/27/08, and 07/28/08 with the Oncology Unit Manager on 07/29/08 at 3 PM identified non-invasive assessments of pain (observation of comfortable position, and lack of grimacing or trashing in bed) performed every eight hours, instead of every four hours as directed by the facility policy on the Care of Patients receiving continuous narcotic infusion.

d. Patient #18 underwent a total abdominal hysterectomy, salpingo-oophorectomy, partial vaginectomy, and pelvic lymph node sampling on 07/25/08. The intra-operative record failed to reflect the documentation of sponge, sharp, and instrument count at the time of permanent relief

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of the scrub person (3:29 PM) and/or the circulating nurse (3:25PM).
In an interview on 07/28/08 at 11:30 AM, the OR Clinical Nurse Specialist (CNS) indicated that counts of sharps, sponges, and instruments might have been performed at the time(s) of permanent relief, but were not documented. The 2008 Standards from the Association of Peri-Operative Nurses (AORN) directed the count of sponges, sharps, and instruments at the time of permanent relief of either the scrub person or the circulating nurse (pp.293, 295 and 296), and the documentation of the counts in the patient's intra-operative record by the registered nurse circulator (p. 299).

e. Patient #19 was admitted to the facility on 06/03/08 with diagnoses that included sickle cell pain crisis. Physician orders dated 07/21/08 and 07/28/08 directed the administration of intravenous (IV) patient-controlled analgesia (PCA) Dilaudid at 13mg per hour, Benadryl 50mg IV every four hours as needed for pruritis, Phenergan 25mg IV every four hours as needed for nausea or vomiting. Interview and review of the nursing flow sheets with the Oncology Nurse Manager on 07/28/08 at 2 PM indicated that from 07/26/08 through 07/27/08, Patient #19 received six doses of Benadryl and six doses of Phenergan. Review of the nursing documentation failed to identify follow-up assessments of the effect of the twelve prn medications. The Oncology Unit Manager explained that Patient #19 was well-known to the nursing staff from many previous admissions during sickle cell crises, had a pattern of experiencing pruritus and nausea during the infusion of narcotic analgesics, routinely requested Phenergan and Benadryl, therefore the nurses did not document the effect of the prn medications after each administration.

f. Patient #25's diagnoses included hypertension. Emergency Department (ED) documentation dated 1/18/07 identified that the patient had neck and right parietal (head) area and back pain. ED physician documentation dated 1/18/07 identified that the controlling headache and neck pain is the main issue in the ED. Physician orders dated 1/19/07 directed to start Morphine Sulfate (MS) 2.5 milligrams intravenously every 4 hours as needed. Progress notes dated 1/19/07 identified that the patient complained of headache and neck pain. Although the medication administration record indicated that the patient received MS on 1/19/07 at 9:20AM, 1:30 PM and 8:30 PM and at 1:40 AM on 1/20/07, an assessment of the patient's level of pain prior to or after pain medication administration was not documented in the patient's record. The facility protocol for pain directed to use the pain scale (levels 1-10) to determine the patient's level of comfort. Elicit a patient's perception of pain at least every four hours or more frequently for unresolved pain, or following an intervention.
Patient #25 was admitted to the Medicine 4 Unit on 1/18/07 on the evening shift with diagnoses that included hypertension and right head, neck, and back pain. The assessment dated 1/18/07 identified that the patient had a normal neurological assessment and was alert and oriented. The nursing flow records dated 1/18/07 to 1/20/07 at 8 AM noted that the patient's neurological assessments included documentation of the patient's eye opening, motor response, verbal response, motor functioning, and that the patient was oriented. The assessments failed to document the patient's pupil size/reaction. The nursing flow record dated 1/20/07 at 11 AM noted that the patient was confused and opened eyes to speech as opposed to previously being alert and oriented and opening eyes spontaneously. The 1/20/08 flow record for 11 AM and/or

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nursing progress notes failed to document an assessment of the patient's pupils and motor function at this time. Interview with the Med 4 Nurse Manager on 8/1/08 at 1:10 PM indicated that although the hospital did not have a specific neurological assessment policy, the nursing flow sheet directed the areas to be assessed when conducting a neurological assessment (pupil size/reaction, eye opening, motor response, verbal response, motor functioning).

Flow records and/or progress notes for Patient #25 identified that the patient had a neurological assessment on 1/18/07 at 11 PM and did not have a neurological assessment documented from 12 AM to 8 PM on 1/19/07 (was not done for over 20 hours). The neurologic assessment dated 1/20/07 at 11 AM identified that the patient had a decline in neurological status with decreased verbal and eye opening response and neurological status was not reassessed until 4 hours later at 3 PM and further decline in neurological status was documented (decreased verbal reponse). Nursing narratives documented at 4:30 PM on 1/20/07 indicated that the patient was delirious yet nursing staff did not neurologically reassess the patient until 9 PM on 1/20/07 (6 hours after the last assessment). Interview with the Medicine 4 Nurse Manager on 8/1/08 at 1:10 pm noted that the facility did not have a specific neurological assessment policy. The 1/07 Medicine 4 Nursing Structure Standards policy identified each patient is reassessed by a registered nurse every eight hours and more frequently as their condition warrants.

A progress note for Patient #25 dated 1/20/07 (un-timed) by Resident #10 identified that the patient had high blood pressure and a headache. Physician orders by Resident #10 dated 1/20/07 at 9:45 AM directed the administration of blood pressure medication, Lopressor, and Tylenol for headache. The medication administration record (MAR) indicated that the patient received Tylenol for headache at 9 AM and blood pressure medication, Lopressor, at 9:30 AM on 1/20/07. The nursing flow record dated 1/20/07 at 11 AM noted that the patient had a change in neurological status, was confused, and opened eyes to speech as opposed to previously being alert and oriented and opening eyes spontaneously. Nursing narratives dated 1/20/07 by RN #10 at 4:30 PM identified that the patient was delusional, Haldol (antipsychotic) was given as ordered, and the patient was awaiting a head scan. Interview with Person #10 on 8/6/08 indicated the following: Person #10 was with Patient #25 on 1/20/07, the patient became confused at 11 AM, and Person #1 immediately notified RN #10. Person #10 stayed with the patient from 11 AM to 12 PM and a physician had not been in to see the patient. Person #10 returned to the hospital at 3 PM on 1/20/07, Patient #25 was unresponsive, staff was notified, and a Physician saw the Patient and ordered a head scan. Interview with RN #10 on 7/31/08 at 2:50 PM noted that the patient had initial mental status changes around lunchtime on 1/20/07. She indicated that she went to lunch and when she returned from lunch at approximately 1 PM -1:30 PM, the patient was more delirious. Although interview with RN #10 on 7/31/08 at 2:50 PM indicated that Resident #10 was aware of the change in the patient's mental status, the medical record failed to provide documentation that the physician had been notified of the patient's initial confusion at 11AM. Nursing flow records and MAR's for Patient #25 dated 1/18/07 at 10 PM identified that the patient's blood pressure was 198/96 (high) and Toprol was given by mouth as ordered at 11:10 PM. Nursing flow records noted that the patient's blood pressure was not reassessed for medication effectiveness. The patient's blood pressure was assessed at 5 AM (6 hours and 50 minutes after medication) on 1/19/07, was 206/94, and

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Lopressor was administered per the physician's order at 5:30 AM. According to the facility assessment policy, all patients housed on Medicine 4 will have vital signs obtained every eight hours or more frequently as their condition warrants. The facility did have a policy regarding assessment after pain medication administration but the policy did not include reassessment when other as needed medications were administered.

Patient #25's nursing flow records dated 1/20/07 noted that the patient's blood pressure was 180/106 at 5 AM and Hydralazine was administered intravenously (IV) as ordered at 5:30 AM. Flow records dated 1/20/07 at 7 AM identified that the patient's blood pressure was 192/90. Although nursing narratives dated 1/20/07 at 7:40 AM indicated that the patient's blood pressure remained elevated after the Hydralazine administration, and that the patient complained of increased right ear hearing loss since admission to the hospital, the record lacked documentation that the physician had been notified of the patient's continued blood pressure elevation or hearing loss. Interview with RN #11 on 7/31/08 at 8:15 AM indicated that she did not recall if she notified the physician of the patient's continued high blood pressure after 7 AM on 1/20/07 but informed the next shift nurse of the patient's continued blood pressure elevation. RN #10 at 9 AM on 1/20/07 subsequently rechecked the patient's blood pressure, the physician was notified that the patient's blood pressure was 200/99, and the patient received additional antihypertensive medication.

8. Based on medical record review, observation and staff interview, the facility failed to develop and/or revise a comprehensive plan of care for Patient #24 who had been identified with an active infection. The findings include:

a. Patient #24 was admitted to the hospital on 7/23/08 with a diagnosis of active gastrointestinal infection with Clostridium difficile (C-diff). Physician orders dated 7/23/08 directed a sputum culture and directed the administration of Vancomycin and Flagyl antibiotics. A sputum culture result dated 7/26/08 identified, in part, Methicillin Resistant Staphylococcus Aureus (MRSA) in large numbers susceptible to Vancomycin. Observation on 7/29/08 at 9:15 AM with the Med 4 Nursing Manager noted that the patient exhibited a congested cough when the RN repositioned the patient. Further observation identified an isolation precaution sign in the patient's room that instructed glove and gowns be worn. The sign did not direct staff to utilize a mask/safety glasses. The patient's plan of care failed to identify that the patient was positive for MRSA infection. Interview with the Nursing Assistant on 7/29/08 at 9:55 AM indicated that she wore a mask because the patient coughs alot. Review of the Patient's medical record with the Med 4 Nursing Manager on 7/29/08 at 10:15 AM identified that the patient's plan of care failed to document the patient's problems of infection and altered respiratory status and subsequently failed to direct nursing interventions for care. (masks/safety glasses required). Interview with the Infection Control Nurse (ICN) on 7/31/08 at 11:25 PM indicated that if a patient was positive for MRSA and was coughing, this would generate droplets. The ICN noted that the sign in the patient's room should have directed the use of a mask. Review of the facility infection control policy identified Significant Organism Associated Precautions (SOAP) isolation for MRSA infections, to wear safety glasses and a mask when droplets are generated. Interview with the Med 4 Nursing Manager on 7/29/08 at 10:15 AM indicated that although the

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patient did not utilize oxygen, the patient had a cough with active infections and these should have been identified as problems on the patient's care plan. Review of the facility policy for documentation noted that general nursing care included the development of an individualized plan of care addressing nursing problems identified, and include appropriate desired outcomes.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (g) Pharmacy (4) and/or (i) General (6).

9. Based on tours of the facility and staff interviews, the facility failed to ensure that medications were prepared and/or safeguarded appropriately. The findings include:

a. A tour of the Psychiatry 3 unit was conducted on 7/30/08 at 11:50 PM with RN #30. The unit had a staff desk/work area in the center. The work area was comprised of several smaller areas defined by the shape of the work area. There were no doors to the work areas. One of the work areas was identified as the unit's medication area. Within this area, there was a medication cabinet that contained a Pyxus (medication dispensing machine). During the tour of the unit, the medication cabinet was noted to be opened with the medication keys hanging in the lock. There were no staff in the area and the area was opened and accessible to patients, visitors, and other staff. In addition, the medication kardex was noted to be on a table in the center of the area. The kardex was noted to have each patient's medications for the 12PM and 2 PM medication passes. The medications were individually wrapped and were tucked into each patient's kardex. The medications included opioid analgesics (Ultram) and controlled substances (Klonopin). Interview with RN #30 identified that the medication cabinet should have been locked, the keys should have been secured, that medications should not have been placed inside the kardexes and that medications should have been secured.
Interview with RN #32 on 7/30/08 at 11:50 PM identified that she was the Charge Nurse of Psychiatry 3. RN #32 was unable to identify who was responsible for the unattended medications and keys. RN #32 identified that although one nurse prepared all of the medications, each nurse passed/administered the medications to their own patients. Interview with RN #31 on 7/30/08 at 11:50 PM identified that she had prepared all of the medications and placed them in the Kardex, then was called away to draw blood from a patient (non-emergent). RN #31 identified that there are times when she pre-pours patient medications. RN #31 could not identify why the medications were pre-poured or why the medications were left unattended.

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 service (1) and/or (g) Pharmacy (1) and/or (i) General (6).

10. Based on medical record reviews and review of facility documentation for Patients #25 and 56, the facility failed to document the time the patient was admitted as an in-patient and/or transported for testing and/or consistently time progress note entries and/or follow facility policy for noting medication allergy/effectiveness. The findings include:

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a. Patient #25 had diagnoses that included upper gastrointestinal bleed and hypertension. Patient #25's emergency department (ED) record dated 1/18/07 identified that the patient was admitted to Medicine 4 at 3:45 PM, report was called to Medicine 4 at 6:35 PM, and the patient was transported via cart to Medicine 4 but did not note the actual time that the patient left the ED. Initial Medicine 4 nursing documentation, the In-Patient Data Base (assessment), failed to reflect the time that the patient was admitted to the Medicine 4 Unit on 1/18/07. Review of the In-Patient Data Base form noted that both the date and time of form completion were required. A Physician progress note by Resident #10 dated 1/20/07 identified that the patient had a headache and high blood pressure. A subsequent physician progress note by MD #10 dated 1/20/07 indicated that the patient had delirium, and to check the CT scan for rule out cerebral vascular accident. Both physician progress notes failed to identify the time that the entry was made. Review of the progress note form entitled Clinical Record- Inpatient required the date and time for entries made.
The patient's CT scan dated 1/30/07 recommended an Magnetic resonance imaging (MRI) of the brain for further evaluation. The MRI was performed on 1/21/07 and read by the radiologist on 1/21/07 at 3:16 PM. Review of he patient's record with the Director of Regulatory Compliance on 9/5/08 noted lack of a physician's order for the MRI testing.
Emergency Department (ED) documentation dated 1/18/07 identified that the patient had neck, right parietal (head) area, and back pain. ED physician documentation dated 1/18/07 identified that controlling headache and neck pain is the main issue in the ED. Progress notes dated 1/19/07 and 1/20/07 identified that the patient complained of headache and/or neck pain. The medication administration records indicated that the patient received Morphine Sulfate as ordered on 1/19/07 at 9:20AM, 1:30 PM and 8:30 PM and at 1:40 AM on 1/20/07. The record failed to provide documentation of the type and level of pain that the patient experienced prior to medication administration and how effective the medication was in controlling the patient's pain.

b. Patient #56 was admitted on 3/29/08 with hypotension, pancytopenia, and pneumonia. Progress notes for Patient #56 by the Infectious Disease Physician dated 4/4/08 identified that the patient had a diffuse rash and to stop the antibiotic, Fortaz. The note also directed that the antibiotic Levaquin be initiated if the concern for gram-negative organisms persists. A subsequent note by hematology/oncology dated 4/4/08 indicated to discontinue the Fortaz because it may be contributing to the rash. Physician orders by a day shift physician dated 4/4/08 directed to discontinue the Fortaz as recommended. Review of the patient's medication reconciliation form and medication record noted that the Fortaz medication was entered into the patient's medical record as allergy/reaction on 4/6/08, 2 days after the reaction was identified. Interview with Pharmacist #10 on 8/1/08 at 9 AM noted that the physician records a suspected allergic reaction in the progress note and any licensed staff can report this by entering the information into the electronic system. Pharmacist #10 indicated that a physician would then have to override the system to order any drug that falls within the same drug classification as the drug that was entered as an allergy/possible allergy. Subsequently, the evening physician reordered the patient's Fortaz on 4/4/08, the patient received two additional doses and the medication was again discontinued on 4/6/08 for suspected patient allergy. The hospital policy for allergies

indicated that clear notation of any identified allergy would be made in the patient record. Progress notes and consultations for Patient #56 were reviewed on 8/1/08. Progress notes dated 3/28/08, 4/4/08, 4/5/08 and 46/08 lacked inconsistent documentation of the time that the note was made. Written consultations in the patient's record dated 4/4/08 and 4/8/08 lacked the time that the entry was made. The hospital's medical staff rules and regulations identified that all written entries made in the medical record should include a date and time of the note and be legibly authenticated by the health professional indicating professional designation.

11. Based on medical record reviews, interview with facility personnel and review of the Medical Staff Bylaw Rules and Regulations, the facility failed to ensure that the history and physical (H&P) was complete and legible for Patient #35 who was undergoing an invasive procedure and/or for Patient #21, who was evaluated in the Emergency Department (ED), that the discharge documentation was accurate. The findings include:

a. Patient #35 underwent a left cardiac catheterization on 7/29/08. Review of the patient's H&P dated 7/28/08 identified illegible documentation with cross-outs under "mental status" and "heart". Although the physician initialed the form, the document failed to define the overall condition of the patient prior to the procedure and/or the assessment and plan for the patient. Review of the Medical Staff Rules and Regulations identified that a complete history and physical should be in the medical record prior to a procedure requiring conscious sedation and/or general anesthesia and authenticated by the attending practitioner.
b. Patient #21 was evaluated in the ED on 05/05/08. Review of the electronic record indicated that the patient came in by ambulance, and was seen by the triage nurse at 12:30 PM. The ED Physician documented that the patient was discharged to the group home at 7:55 PM via private car. Registered Nurse (RN) #50 documented at 8:19 PM that the patient drove home unaccompanied, after the discharge instructions and follow-up care were discussed with the patient, who verbalized understanding. Interview with the ED Nurse Manager on 03/31/08 at 11:30 AM indicated that Patient #21 was unable to drive, could not be discharged unaccompanied, and could not understand discharge instructions. The ED Nurse Manager concluded that the nursing documentation was inaccurate.

12. Based on medical record review and review of facility documentation, the facility failed to consistently time physician orders for Patient #25. The findings include:

a. Patient #25 was admitted to Medicine 4 with complaints of head and neck pain on 1/18/07 and had diagnoses that included upper gastrointestinal bleed and hypertension. Physician orders dated 1/18/07 and 1/19/07 lacked consistent documentation of the time that the orders were written. A physician order dated 1/20/07 directed a CT scan of the head to rule out bleed also lacked the time that the order was written. Review of the physician order form noted that the form required that the date and time be entered for each order. The hospital's medical staff rules and regulations identified that all written entries made in the medical record should include a date and time of the note and be legibly authenticated by the health professional indicating professional designation.

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

13. Based on observation, review of facility documentation, review of facility policy, and staff interview, the facility failed to consistently monitor medication refrigerator temperatures. The findings include:

a. A tour of the pharmacy department was conducted on 7/29/08 at 12:45 PM. Observation noted a medication refrigerator within the narcotic vault that contained controlled medications. The refrigerator temperature control log for July 2008 was posted inside of the narcotic vault and lacked documented refrigerator temperatures for 7/4, 7/5, 7/6, 7/12, 7/13, 7/26 and 7/27/2008. Review of the refrigerator temperature logs for April, May, and June 2008 noted 28 out of 91 days lacked medication refrigerator temperature documentation for monitoring. Interview with the Assistant Director of Pharmacy on 7/29/08 at 1:50 PM indicated that facility policy required daily monitoring of medication refrigerator temperatures. She further indicated that the Central Pharmacist should be monitoring the temperatures when the Pharmacist who routinely monitors temperatures is not scheduled to work.

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)(A).

14. Based on tours of the facility, review of facility policy, review of facility documentation and interview with facility personnel, the facility failed to ensure that the infection control officer(s) developed a system for identifying, investigating and/or controlling infections. The findings include:

a. During tour of the Neonatal Intensive Care Unit (NICU) on 7/29/08 with the Nurse Manager and Clinical Nurse Specialist, observation was made of an infant's bassinette surrounded with screening panels, inclusive of a counter and a sink, within the large special care area. The infant was "isolated" secondary to a MRSA infection. The NICU's isolation room was observed to contain two bassinettes that were occupied by non-infected infants. Observation on 7/29/08 identified a nurse exiting the "isolated" area immediately adjacent to another occupied bassinette and crossing the room to wash her hands. Review of facility policy for MRSA for Nurseries identified that the infected infant would be placed on S.O.A.P. precautions (significant organism-associated precautions). Review of the SOAP Isolation policy identified that the infected or colonized patient should be placed in a single room or co-horted with other patients with the identical organism. Interview with the Infection Control Nurse on 7/31/08 identified that the expectation was that infected infants were to be placed in the isolation rooms within the NICU.

b. During tour of the labor and delivery unit on 7/28/08, a review of the log book for the Cidex OPA solution utilized for high level disinfection of the probes, failed to reflect that the solution was changed every fourteen days according to manufacturer's directions for numerous periods from 11/13/07 through 4/3/08.

c. During tour of Delivery Room #2 on 7/28/08 at approximately 11:30 AM, a spiked intravenous

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

bag, lacking a time and date of set-up, was observed to be hanging from an IV pole. During interview with the scrub tech, who stocking the room, identified that she was unaware of how long the bag had been spiked. She stated she routinely removed them when they were undated.

d. During tour of Central Sterile and review of the biological indicator testing log on 7/29/08 it was identified that for the period of time from 5/15/08 through 7/17/08, the log documentation failed to reflect either the time in or out of the testing ampule from the incubator or the results of the test including the status of the control ampule. During interview on 7/29/08 the Central Sterile Supervisor identified that the testing parameters required the control and test ampules to be incubated for at least 24 hours prior to reading results.

e. A tour of the Step-Down unit was conducted on 7/29/08 at 10:50 AM. RN #33 was noted to place a hand-held supply caddy on top of a biohazardous waste basket. The caddy contained clean and/or sterile bandage and dressing supplies. Interview with the Infection control nurse on 7/31/08 at 11:20 AM identified that placing a supply caddy on a biohazardous waste basket was not in keeping with good infection control practices.

f. Patient #24 was admitted to the hospital on 7/23/08 with a diagnosis of active gastrointestinal infection with Clostridium difficile (C-diff). Physician orders dated 7/23/08 directed a respiratory (sputum) culture. The sputum culture result dated 7/26/08 identified, in part, Methicillin Resistant Staphylococcus Aureus (MRSA) in large numbers. Observation on 7/29/08 at 9:15 AM with the Med 4 Nursing Manager noted that the Registered Nurse (RN) entered the patient's room after donning gloves and gown. The patient exhibited a congested cough when the RN repositioned the patient. Further observation noted a precaution sign (SOAP) in the patient's room that instructed glove and gowns be worn. The sign did not direct staff to utilize a mask/safety glasses. Interview with the Physical Therapist (PT) on 7/29/08 at 10:30 am indicated that she and another PT transferred the patient out of the bed the morning of 7/29/08, wore only gowns and gloves, and were unaware that the patient had MRSA in the sputum. Interview with the Infection Control Nurse on 7/31/08 at 11:25 PM indicated that if a patient was positive for MRSA and was coughing, this would generate droplets. The Infection Control Nurse noted that the sign in the patient's room should have directed the use of a mask. Review of the facility infection control policy identified SOAP (significant organism-associated precautions) isolation for MRSA infections. Wear safety glasses and a mask when droplets are generated.

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

15. Based on observation, review of facility policy and interview of facility personnel, the facility failed to ensure that the facility policy for Surgical Attire was followed. The findings include:

a. During tour of the Operating Room Suite on 7/29/08 with the Manager of the OR, numerous operating rooms were observed to contain hospital staff that failed to hair covered in its entirety. Although a variety of head coverings were utilized (cloth and skull caps) the hair failed to be covered on the sides and back of the head with hair escaping the perimeters of the cloth cap. Additionally, many OR staff were identified to have loose fitting tops that failed to be

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

secured at the waist. Review of facility policy for Surgical Attire identified that loose fitting tops should be secured at the waist or tucked into the pants and that head and facial hair must be covered in the semi and restricted areas of the surgical suite.
Although the facility policy directed that scrub attire worn into the building from outside must be changed prior to entering the semi and restricted areas of the surgical suite to minimize the potential for contamination, a contradictory statement within the policy directed scrub attire worn from a neighboring surgical facility be covered when traveling between the two facilities restricted areas.

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 (e) Nursing Service (1) and/or (i) General (6).

16. Based on review of the medical record for Patient #37, review of facility policy and interview with facility personnel, the facility failed to ensure that a sharps count was completed and recorded accurately according to facility policy. The findings include:

a. Patient #37 underwent an arthroscopy with extensive debridement, excision of the right os trigonum and a lateral ligament reconstruction of the right ankle on 6/23/08. During a post surgical follow-up on 7/8/08, a foreign body was observed on x-ray, in the surgical wound. Review of the Operative Report dated 7/10/08, identified that a foreign body identified as a needle was removed. Review of Pt. #37's operative record dated 6/23/08, identified that all counts of sponges, needles and instruments were correct. The record failed to identify that a needle or any portion of the needle was unaccounted for and/or that the surgical team including the surgeon was notified. During interview on 7/31/08, RN #21 stated she notified the attending surgeon, MD #22, that a portion of a needle was missing. RN #21 stated that she failed to inform the circulating nurse of the missing needle tip. According to the 2008 Perioperative Standards and Recommended Practices, documentation of a count discrepancy should include all measures taken to recover the missing item and all communications made regarding the outcome. Additionally, the operative record failed to identify that RN #21 had permanently relieved the scrub tech, and upon interview RN #21 could not recall if she or the scrub tech had completed the sharps count prior to closure of the wound. Review of the facility policy for Counts: Sponge, Sharp, Accessory Item and Instrument identified that sharps count should be performed at the time of permanent relief of the scrub person and that an RN circulating nurse must participate in any and all counts other than that of temporary hand-off between scrub personnel.

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-36-A51 (c) Responsibilities of Director.

17. Based on surveyor inspection of the Blood Bank refrigerator and interview with the Blood Bank supervisor, it was determined that the laboratory failed to monitor expiration dates to ensure that supplies were not used beyond the expiration dates. The findings include:

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

a. An inspection of the Blood Bank refrigerator on 07/28/2008 at 10:00 A.M. revealed that an Immucor antibody identification panel, (Lot # 20722, Expiration Date 07/25/2008) was stored with reagents used for patient testing. Quality control records indicated that patient testing with this panel was last performed on 7/24/2008. The supervisor confirmed that the expiration dates were not adequately monitored and that the reagents should have been discarded after use on 7/25/2008.

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 (d) Medical Records (3), and/or (e) Nursing Service (1) and/or (g) Pharmacy (2), and/or (i) General (6).

18. Based on clinical record reviews, review of Hospital policies, and interview with staff for 1 of 4 patients (Patient #5) who had physician orders to titrate a medication, the Hospital failed to ensure that the titration order identified parameters. The findings include:

a. Patient #5 had a diagnosis of a lung mass and was admitted to the ICU on 4/27/08. On 5/6/08 the patient's medications profile was reviewed with the Nurse Manager and Pharmacist. A physician's order for IV Norepinephrine dated from 5/1/08 to 5/6/08 identified to administer Norepinephrine 4 mg in 250 cc of Sodium Chloride 0.9%, start at 0.03mg/min, and to titrate. The order failed to include titration parameters. The Hospital policy for IV Titrate Medications identified that medication orders were to include a therapeutic goal and the Dose Guidelines for IV Titratable Medications included the rate of infusion, incremental rates, maximum dose for specified time, and when to call the MD/LIP. The nurse manager identified that between 5/1/08 and 5/6/08, staff followed the Dose Guidelines for IV Titratable Medications. Subsequent to surveyor inquiry, the medication order was re-written to include titration parameters.

EXHIBIT B

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

IN RE: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT – Licensee
D/b/a John Dempsey Hospital of the University of Connecticut Health Center
263 Farmington Avenue
Farmington, CT 06032

MODIFIED CONSENT AGREEMENT

WHEREAS, the University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT (hereinafter the "Licensee"), has been issued Licensee No. 0065 to operate a General Hospital known as John Dempsey Hospital, (hereinafter the "Facility"), 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 inspections on June 1, 4, 5 and 7; July 11, 12, 13, 16 and August 9, 2007 in order to determine the Licensee's compliance with the provisions of the Regulations of Connecticut State Agencies, and

WHEREAS, as a result of the Department's inspections a violation letter dated September 17, 2007 (copy attached – Exhibit A) was issued by the Department to the Licensee; and

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

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through James Thornton, its Administrator, hereby stipulate and agree as follows:

FEB 2 6 2008

Licensee: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT.

1. The Consent Agreement executed with the Department on September 26, 2006, (Exhibit B – copy attached) shall be incorporated and made part of this Modified Consent Agreement.
2. Within fourteen (14) days of the execution of this Modified Consent Agreement, the facility shall develop and/or review and revise, as necessary, policies and procedures related to:
    a. Physician orders for intravenous medication administration, which at a minimum, identify the medication, volume and type of mixture solutions, specific dosage ranges, dosage, increments, frequency, route and reason for medications;
    b. Patient assessments to determine medication effect relative to medication administration;
    c. Assessment of current patient problem(s), psychiatric/medical/social histories, medications, stressors and behavioral issues that may affect the patient's psychiatric and/or medical condition(s) or symptoms; and
    d. Patient assessments to determine safety risks, including but not limited to suicidality, homicidility and elopement; and
    e. Master Treatment Plans ("MTPs") to include, but not be limited to, identification of individual 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.
3. Each patient shall have nursing assessment and treatment plan developed within twenty-four (24) hours of admission, and an MTP developed within seventy-two (72) hours of admission. The MTP 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 reviews shall be documented.

4. The Licensee shall employ sufficient personnel to monitor and meet the physical, safety and psychiatric needs of the patient population in accordance with applicable federal and state laws and regulations.
5. Within twenty-one (21) days of the review and/or revision of policies identified in paragraph two (2), all facility staff, as applicable, shall be inserviced regarding said policies.
6. Within fourteen (14) days of the execution of this Modified Consent Agreement, the Licensee shall appoint a pharmacist licensed in Connecticut to participate in staff rounds. This individual shall be responsible for ten (10) weekly audits of patients receiving intravenous infusion medications to ensure compliance with facility policy and procedures.
7. The pharmacist, in conjunction with appropriate professional staff shall:
    a. Document said audits and maintain said documentation for a period of two (2) years;
    b. Provide copies of the weekly audits to each patient's physician; and
    c. Review the implementation of current standards of practice relative to physician orders and/or protocols for medication with emphasis on intravenous medication used for analgesia and/or sedation and/or blood pressure.
8. Within fourteen (14) days of the execution of this Modified Consent Agreement, the Licensee shall ensure the following:
    a. An environmental 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;

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 general standards for details and finishes for psychiatric hospitals as found in the 2006 Edition of the "Guidelines for the Design and Construction of Health Care Facilities"; and

d. The unit specific environmental risk assessment tool shall be submitted to the Department for review, comments and approval prior to its implementation.

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

10. The Department shall retain the authority to extend the period of the Modified Consent Agreement 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.

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

a. Assessing all incidents which have occurred in the Facility, to identify all situations which had a potential risk of harm and to determine what preventive measure(s) shall be implemented by staff;

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

c. Establishment of inservice education program for licensed and unlicensed personnel which shall reflect topics pertinent to those identified by the Quality Assurance Committee.

12. 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 Agreement. 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 address the components of this document to the Department.
13. 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 first year this agreement is in effect and then every six (6) months for the remaining duration of this Agreement.
14. In accordance with Connecticut General Statutes Section 19a-494, the Commissioner of the Department of Public Health hereby issues a reprimand to the Licensee.
15. The License 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 this Modified Consent Agreement. The monetary penalty and any 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
Hartford, CT 06134-0308

16. All parties agree that this Modified Consent Agreement 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 Agreement 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 Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

17. The terms of this Modified Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
18. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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Licensee: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT.

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

UNIVERSITY OF CONNECTICUT HEALTH CENTER - JOHN DEMPSEY HOSPITAL OF FARMINGTON, CT – LICENSE

2/21/08
Date

By: James Thornton, Administrator

STATE OF Connecticut)

County of Hartford) ss Farmington 2/21/2008

Personally appeared the above named James Thornton and made oath to the truth of the statements contained herein.

My Commission Expires: 10/31/08
(If Notary Public)

MARILYN H. GLENN
NOTARY PUBLIC
MY COMMISSION EXPIRES OCT. 31, 2008

Marilyn H. Glenn

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

STATE OF CONNECTICUT,

2/28/08
Date

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 39

September 17, 2007

James Thornton, Administrator
John Dempsey Hospital
263 Farmington Ave
Farmington, CT 06032

Dear Mr. Thornton:

Unannounced visits were made to John Dempsey Hospital commencing on June 1, 2007 and concluding on August 9, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a substantial allegation and full federal survey at the request of CMS.

An office conference has been scheduled for October 1, 2007 at 9:30 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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

Respectfully,

Ann Marie Montemerlo, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

amm:amm

c. Director of Nurses
Medical Director
President
vljohndempsey
Investigations # CT 6496, 6509, 6576, 6680, 6715, 6818, 6846, 6908

Phone:

Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134
Affirmative Action / An Equal Opportunity Employer

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (3) and/or (c) Medical staff (2)(A) and/or (2)(D) and/or (4)(E) and/or (d) Medical Records (2) and/or (3) and/or (e) Nursing service (1) and/or (i) General (7).

1. * Based on a review of medical records, review of facility policies and procedures, review of medical staff bylaws and interviews with facility personnel, the facility failed to ensure for Patient #1, who committed suicide, that medical staff documented justification of a decrease in the supervision levels and/or increased the level of monitoring when clinically indicated in accordance with facility policy, that for Patient #16 an accurate medication history was obtained prior to ordering medications and for Patient #15, who experienced high blood pressure, the medical staff failed to provide adequate management and stabilization of the patient's blood pressure. The findings include:

   a. Patient #1 was admitted 2/27/07 on a PEC due to psychosis with diagnoses that included paranoid schizophrenia with visual and auditory hallucinations. Review of the admission Master Treatment Plan (MTP) dated 2/28/07 identified problems that included altered thought process. Initial physician interventions to address this problem were lacking. Review of progress notes dated 2/28/07 through 3/14/07 identified that the patient was physically aggressive, not redirectable, and required seclusion, restraints, one-to-one observation and/or constant observation for safety. Although weekly treatment plan reviews dated 3/7/07 and 3/14/07 by the attending physician reflected a decision to continue with the current treatment plan, interventions to address altered thought process were not identified on the initial MTP from 2/28/07 and were not added during weekly treatment reviews. Additionally, review of the weekly MTP review sheets dated 3/7/07 through 5/29/07 lacked consistent documentation from the attending physician in regard to the status of the established goal, outcome of objectives and/or interventions to address the specific problem. Review of facility guidelines for the Multidisciplinary Treatment Plan identified that the team would identify interventions to be initiated to achieve identified goals and would review the plan every seven (7) days.

   b. Patient #1 had diagnoses that included paranoid schizophrenia. The MTP dated 2/28/07 identified a problem of altered thought process with a short-term goal that the patient and the milieu would be safe. Review of the clinical record during the period of 2/28/07 through 3/5/07 identified that Patient #1 was paranoid, delusional, physically and verbally aggressive, and threatening to the unit milieu.

Interventions included the use of seclusion, physical restraints, chemical restraints and one to one (1:1) supervision. Review of a nurse's note dated 3/5/07 at 1:30 PM identified that the patient remained paranoid, continually inspected bed linens, refused to sleep on the mattress and appeared fearful to close his eyes. Review of a physician's order on 3/5/07 at 2:00 PM identified that the patient's monitoring status was decreased from 1:1 supervision to constant observation but lacked a rationale as to why the level of monitoring was decreased within the context of exhibited behavioral symptoms. Review of the observation of patients' policy directed that the physician write the order for discontinuation of special observation level including a note stating rationale for discontinuation of the special observation status.

c. Review of Patient #1's clinical record during the period of 3/6/07 through 4/3/07 identified that the patient had intermittent episodes of agitation, self-injurious behavior (head banging, hitting self), and exhibited bizarre bathroom behaviors (drinking water from the toilet, self disimpaction). Physician orders during this period reflected that the patient was constantly monitored initially, and then was constantly monitored on the evening shift only. Although a Physician's order dated 4/3/07 directed that constant monitoring in the evening shift be discontinued, the physician failed to document the rationale for a decrease in monitoring status.

d. Review of Patient #1's clinical record during the period of 4/16/07 through 4/19/07 (at 9:30 AM) reflected that the patient required monitoring every fifteen-minutes. Progress notes dated 4/16/07 identified that the patient was hitting himself and had been refusing medication for two (2) days. On 4/17/07, the patient was described as psychotic, delusional, responded to auditory hallucinations, had disorganized thinking, displayed threatening behavior, was difficult to redirect, restless, and was moved to a private room due to inability to relax. Physician notes dated 4/18/07 identified that the patient was gravely disabled, irritable, very paranoid, hitting his hands repeatedly to injure himself and put his head in the toilet. Progress notes dated 4/19/07 identified the patient remained psychotic, was responding to internal stimuli, hitting himself repeatedly, uncooperative, angry, impulsive, and required HAC (Haldol, Ativan, Cogentin) for agitation. Although the patient exhibited unsafe behaviors and met criteria for 1:1 observation and/or constant observation, the hospital failed to implement their special observation policy until 4/19/07 at 9:30 AM when 1:1 observation of Patient #1 was initiated. Review of the special observation policy identified that constant observation of a patient would be instituted when a patient is actively

psychotic, disorganized and/or impulsive to assure patient safety. The policy further identified that 1:1 observation is implemented when a patient exhibits impulsive behavior that may be harmful to self or others.

e. Review of the clinical record identified that Patient #1 was maintained on 1:1 observation from 4/19/07 through 5/1/07. A nurse's note dated 5/1/07 identified that the patient was maintained on 1:1 observation secondary to continued unpredictability. A physician's order dated 5/1/07 at 6:25 PM directed the use of physical restraints (four-point) as the patient was determined to be a risk to others and the patient's behavior was disruptive and threatening to the unit milieu. Although a Physician's order dated 5/10/07 discontinued 1:1 observation, the physician failed to document the rationale for a decrease in monitoring status. During an interview on 6/7/07 MD #1 stated that 1:1 observation was discontinued based upon a team decision, however, the rationale was not documented.

f. Review of the clinical record during the period of 5/10/07 through 5/15/07 identified that Patient #1 required monitoring every fifteen-minutes. On 5/15/07, fifteen-minute checks were discontinued by the Psychiatric Resident, however, documentation failed to reflect a rationale as to why this level of monitoring was no longer required. Nurse's note dated 5/20/07 at 6:15 AM identified that two loud bangs were heard coming from Patient #1's room. Upon entering the room, the patient had thrown a chair at the mirror located in the ceiling of the room and broke the mirror. Although a Physician note dated 5/20/07 at 10:30 AM identified that the patient's Clozapine blood level was barely adequate with a plan to adjust the patient's medications, the physician failed to identify the type and frequency of supervision the patient required to ensure safety. Additionally, the physician failed to ensure that the patient's MTP reflected the patient's aggressive and impulsive behavior with interventions that addressed these behaviors.

g. Review of Patient #1's clinical record with MD #1 (on 6/7/07) identified that although fifteen-minute monitoring was initiated on 5/22/07 at 9:00 AM, the clinical record failed to identify an assessment and/or rationale as to why fifteen-minute monitoring was initiated. The hospital's policy identified that fifteen-minute checks are indicated when a patient is determined to be at risk for suicide or AWOL, or their psychiatric and/or medical condition warrants close monitoring.

h. On 5/27/07, a physician's order discontinued fifteen-minute monitoring checks for Patient #1. Review of the record failed to document the rationale for discontinuation of all safety checks. Interviews with staff who worked on 5/30/07

(RN #5, RN #6, Mental Health Worker #1, and the Substance Abuse Counselor) identified that Patient #1 had not been seen since approximately 2:15 PM. On 5/30/07 at approximately 5:15 PM, Patient #1 was found hanging by the shower rod in his private room and although resuscitation efforts were made, the patient expired.

i. Patient #16 was admitted to the facility on 4/20/07 with diagnoses that included seizure disorder and mental retardation. The medication reconciliation form identified that prior to admission, Patient #16's medication regimen included Phenobarbital 120 milligrams (mg) every other day and Tegretol XR 800 mg daily and that this information was obtained from the patient's group home. A list of physician's orders from the patient's group home was also noted in the medical record which identified that the patient was taking Phenobarbital 120 mg at bedtime and Tegretol XR 800 mg twice daily. Physician's orders dated 4/21/07 included Phenobarbital 120 mg every other day and Tegretol XR 800 mg daily. Progress notes dated 4/23/07 identified that Patient #16's medications were transcribed incorrectly from information provided by the patient's group home. Review of the medication reconciliation form on 7/16/07 with MD #11 identified that the form was not dated or signed and the medications (Phenobarbital and Tegretol) were encircled with the word "error" notated adjacent to the medications. MD #11 stated that the medication reconciliation form was completed upon admission by the intern and the orders should have been transcribed according to the list from the patient's group home. MD #10, the attending physician, stated that Patient #16's status was difficult to control and that the seizures could have resulted from the incorrect medication dosages. The facility Admission Reconciliation Policy identified that medication reconciliation is a formal process of obtaining a complete and accurate list of each patient's current medications and that the admitting physician reconciles the medications from the patient's history.

The Resident Supervision policy identified that the attending physician is responsible for the supervision of residents in the care of his/her patients. While residents may write orders and progress notes in patient charts, attending physicians retain responsibility for the care of their patients. Residents must communicate with attending physicians to ensure that orders they write are consistent with the attending physician's medical treatment plan for the patient.

j. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. The patient sustained a head laceration; CT Scan in the Emergency Department (ED)

was negative for acute hemorrhage, and the patient was admitted to Med 4 (telemetry unit) with working diagnoses of syncope, rule-out myocardial infarction, and acute renal failure. Physician admit note and nurse's notes on 02/18/07 (no time) indicated that patient's blood pressure (BP) was 197/88, pulse (P) was 67 lying down, 178/94 and 72 sitting, 134/81 and 76 standing. Nursing documented that the physician was notified, with no new order. The Physician's note also indicated that the plan was to re-hydrate, recheck orthostatics, check echocardiogram, and to ask cardiologist to review first ECG. Nursing continued to document that the BP was rechecked at 11AM, was 198/91, physician was notified and ordered to increase intravenous fluid (IVF) from 100cc/hr to 125cc/hr. Nurse also documented that Lopressor IV and Cardizem 30mg po were given with no change in BP. A resident addendum note at 11:10AM mentioned a discussion with the cardiologist about the patient's dehydration, and the plan to increase IVF, monitor intake and output (I&Os), follow blood urea nitrogen (BUN) and creatinine ratio, "this might be the cause for hypertension with orthostasis." Nurse then documented that BP was 201/101 at 2PM, and that physician was notified, but no response from physician was documented. The Nurse Notes identified that BP was rechecked at 4PM, was 188/91, physician was notified and ordered Vasotec IV 0.625mg x 1 with good effect, BP decreased to 151/72. The next order on the physician order sheet (no time) on 2/18/07 directed to "hold fluids for now". Interview with Physician #12 on 08/09/07 at 2 PM indicated that Physician #12 found Patient #15 to experience orthostatic hypotension from the fluctuations in blood pressure with the change in position. Physician #12 discussed the patient's treatment with the cardiologist and concluded that the patient was suffering from dehydration, therefore Physician #12 ordered to increase the intravenous fluid rate to 125cc/hr, in the setting of a BP of 198/91 at 11:00 AM. Interview with RN #26 on 08/09/07 at 11:30AM indicated that Physician #12 was notified at 2PM of Patient #15's BP of 201/101, but RN #26 did not recall receiving any new order from the physician, in response to the update in vital signs. Physician #12 did not recall giving the nurse any new order in response to the BP of 201/101 at 2PM.

2. * Based on medical record reviews, interviews with facility personnel, review of facility documentation and review of facility policies and procedures, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for Patients #1, #2, #4, #15, #16 and #17. The findings include the following:

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

a. Review of facility documentation dated 2/27/07 identified that local authorities were summoned to Patient #1's home where he was observed to be agitated, stated he "wanted to kill himself", wanted the police to shoot him and refused to go to the hospital for an evaluation. Review of the Police Emergency Examination Request reflected that Patient #1 was believed to be a danger to self, others, gravely disabled and in need of immediate care and treatment. The patient was physically restrained (Taser shock three times), taken into protective custody and brought to the Emergency Department. Review of Patient #1's clinical record with RN #1 (on 6/5/07) identified that although the patient arrived on 2/27/07 at 12:11 PM, vital signs were not evaluated until 7:04 PM. Further review of the record failed to indicate that a comprehensive nursing assessment was performed including but not limited to the patient's physical and/or psychosocial status. The hospital's protocol for care of the behavioral patient includes completion of assessment for active suicide and homicide intent, aggressive behavior, self-harming behavior, elopement risk, impairment from alcohol/drugs, and admission vital signs.

b. Review of Patient #1's ED record identified that on 2/27/07 at 12:15 PM constant observation/monitoring of Patient #1 was initiated. Review of MD #2's crisis assessment dated 2/27/07 at 5:00 PM identified that the patient had a history of Schizophrenia, was currently psychotic, delusional and experiencing auditory hallucinations. MD #2 performed a high-risk assessment that described the patient as psychotic, agitated and bizarre. Review of the constant observation flow sheet dated 2/27/07 with Nurse Aide (NA) #1 (on 6/5/07) identified that although Patient #1 attempted to leave the ED between 3:15 PM and 3:30 PM while she was constantly observing the patient, she was able to keep the patient in his room. NA#1 identified that she requested a break at 6:00 PM on 2/27/07, which was granted by RN #1 (Charge Nurse) who informed NA #1 that he would monitor the patient until she returned. NA #1 identified that when she returned to monitor Patient #1 at approximately 6:15 PM, the patient was not in his room and NA #1 was subsequently informed that Patient #1 went Absent Without Authorized Leave (AWAL). Interview with RN #1 (on 6/5/07) identified that although he agreed to monitor Patient #1 while NA #1 was on her break, he was called away from Patient #1 when another patient in cardiac arrest had arrived to the ED. RN #1 stated that when he went back to check on Patient #1, the patient's bed was made. RN #1 assumed the patient was transferred and was unaware that Patient #1 was missing until he received a telephone call from the Hospital's Fire Department who informed him that they had found Patient #1 on hospital grounds

on 2/27/07 at 6:32 PM. Record review and interview with RN #2 (on 6/5/07) who was the nurse assigned to Patient #1 stated that he also went on a break at 6:00 PM and when he returned at 6:30 PM, heard from another staff member that Patient #1 left the ED but was subsequently returned. Hospital procedure for observation of patients directed staff to maintain full visual contact of the patient when on constant observation. Additionally, although review of the police report described the patient as agitated, uncooperative and required handcuffs for transport back to the ED, the hospital failed to assess the patient upon return to the ED and/or document the incidence of AWAL in the record.

c. Patient #1 was admitted to the hospital on 2/27/07 with a diagnosis of Schizophrenia. The Master Treatment Plan (MTP) dated 2/28/07 identified a problem of altered thought process as evidenced by paranoid delusions, auditory and visual hallucinations and behavioral disturbance. Nursing interventions included assessment of symptoms, intensity, patient response to thoughts, triggers and current coping patterns every shift or more often as needed. Although nursing progress notes referenced the problem of altered thoughts, review of the Master Psychiatric Nursing Treatment Plan failed to reflect nursing assessments during the first four (4) days (2/27/07 through 3/2/07) of the patient's inpatient stay. Upon interview, the Nurse Manager on 6/4/07 identified that the patient's monitoring status, nursing assessments, and interventions as identified on the MTP should be documented every shift on the Master Psychiatric Nursing Treatment Plan. Additionally, although Patient #1 experienced command-type auditory hallucinations to harm others, severe paranoia, statements of intent to harm others, unpredictable behavior including unprovoked outbursts of rage, impulsive behavior, self-injurious behavior (head banging, hitting self), and exhibited bizarre bathroom behaviors (drinking water from the toilet, self-impaction), review of the clinical record during the period of 2/27/07 through 5/30/07 with the Nurse Manager failed to identify that the patient's mental status was consistently assessed in accordance with the treatment plan. Nursing documentation failed to reflect assessments in a sufficiently descriptive manner to provide an objective baseline for future comparisons.

d. Review of Patient #1's MTP dated 2/28/07 identified a problem of altered thought process with a short-term goal that the patient and the milieu would be safe. Review of the clinical record during the period of 2/28/07 through 5/30/07 identified that the patient continued to exhibit violent, paranoid and self-injurious behaviors requiring chemical and physical restraints at times. Although the nursing treatment plan identified that the patient was determined to be at risk to

self, risk to others and/or at risk for elopement, record review with the Nurse Manager failed to identify that nurses consistently assessed the patient's risk for suicide, homicide and/or elopement every shift in an attempt to meet the goal of safety.

Additionally, review of the suicide risk assessment, homicide risk assessment and elopement (AWOL) risk assessment utilized by nurses on the inpatient psychiatric unit, failed to accurately reflect how nurses make the determination as to whether the patient is at low, moderate or high risk for suicide, homicide and/or elopement. Nursing staff failed to develop a mechanism to ensure a consistent approach among staff when a patient is evaluated for these risk factors. During an interview, the Nurse Manager identified that the nurse makes an individual assessment and based on that assessment, scores the patient as low, moderate or high risk for suicide, homicide and/or elopement. The basis for this score was not reflected in documentation of the patient's behavioral symptoms.

e. Patient #1 had a diagnosis of Paranoid Schizophrenia. Review of the clinical record dated 2/27/07 identified that the Patient was six (6) feet two (2) inches tall and weighed 247 pounds (on 5/21/07). Review of the physician's progress note dated 5/30/07 at 5:48 PM identified that Patient #1 was found hanging by a sheet in the shower stall, had asphyxiated and although cardiopulmonary resuscitation was initiated, the Patient was pronounced dead at 5:41 PM. Review of the CPR Report with APRN #1, MD #5, MD #6, RN #5 and RN #6 failed to identify the time of the arrest, whether the arrest was witnessed, time CPR began, dosages of medications administered (epinephrine, bicarbonate, and atrophine), cardiac rhythm, joules administered during defibrillation, and a complete list of staff who responded to the code. Interview with APRN #1 (on 6/5/07) identified that she was unable to determine the patient's cardiac rhythm upon arrival to the code as the psychiatric unit didn't have a defibrillator available. While waiting for ICU staff to bring the defibrillator, in accordance with hospital policy, a central intravenous line was inserted by APRN #1 at 5:31 PM. APRN #1 identified that ICU staff arrived to the code without the defibrillator resulting in an approximate two minute delay before a defibrillator from the ICU was retrieved. Although review of the code sheet with APRN #1 indicated the patient was defibrillated subsequent to the administration of epinephrine at 5:35 PM, the exact time of defibrillation was unknown as documentation was obliterated. Further interview with APRN #1 identified that Patient #1 received 200 joules during defibrillation, however, interview with MD #6 stated that 300 joules was delivered twice, neither of which is documented in the clinical record.

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

f. Patient #1 had a diagnosis that included paranoid schizophrenia. The MTP dated 2/28/07 identified a problem of altered thought process with a short-term goal that the patient and the milieu would be safe. Review of the clinical record during the period of 2/28/07 through 5/8/07 identified that the patient experienced command-type auditory hallucinations to harm others, severe paranoia, statements of intent to harm others, unpredictable behavior including unprovoked outbursts of rage, impulsive behavior, self-injurious behavior (head banging, hitting self), and exhibited bizarre bathroom behaviors (drinking water from the toilet, self-disimpaction). On 5/15/07, fifteen-minute checks were discontinued by the Psychiatric Resident, however, the clinical record failed to reflect a rationale as to why this level of monitoring was no longer required. Nurse's notes dated 5/20/07 at 6:15 AM identified that two loud bangs were heard coming from Patient #1's room. Upon entering the room, the patient had thrown a chair at the mirror located in the ceiling of the room and broke the mirror. Although a Physician note dated 5/20/07 at 10:30 AM identified that the patient's Clozapine blood level was barely adequate with a plan to adjust the patient's medications, the nursing staff failed to identify the type and frequency of supervision the patient required to ensure Patient #1's (and others) safety.

g. Review of the clinical record identified that although fifteen-minute monitoring was initiated on 5/22/07 at 9:00 AM for Patient #1, the clinical record failed to identify an assessment and/or rationale as to why fifteen-minute monitoring was initiated at that time. The hospital's policy identified that fifteen-minute checks are indicated when a patient is determined to be at risk for suicide or AWOL, or their psychiatric and/or medical condition warrants close monitoring.

h. Patient #2 was admitted to the hospital on 5/7/07 with a diagnosis of depressed mood with suicidal ideation with constant observation of the patient initiated. Review of the MTP dated 5/7/07 identified the problem, mood disorder, with interventions that included safety assessments every shift. The clinical record failed to identify that self-harm assessments (safety assessments) were consistently completed every shift in accordance with the MTP.

i. Patient #4 was admitted to the inpatient psychiatric unit from 5/2/07 through 5/21/07 under a physician's emergency certificate for treatment related to Bipolar Affective Disorder and profound mental retardation. The patient was assessed as a risk to self and others upon admission due to aggression and the Master Psychiatric Nursing Treatment Plan identified the need to assess the patient's risk level every shift. Review of nursing assessments identified that although the patient was assessed on the evening shift of 5/2/07 as a low risk, no further risk

assessments were completed for the periods 5/3/07 through 5/9/07 and 5/11/07 through 5/21/07 despite a documented need for restraints on 5/10/07 and 5/14/07.

j. Patient #16's diagnoses included seizure disorder and mental retardation. Physician progress notes dated 4/23/07 at 6:00 AM identified that the patient had an episode of grand mal seizure overnight. Nursing progress notes dated 4/23/07 identified that the patient had two seizures, Ativan was administered and medications were given as ordered. The neurological assessment form identified that the patient's motor function was assessed at 10:00 AM and 4:00 PM; however, the assessment did not include pupillary response. Although the medical record dated 4/21/07 to 4/23/07 identified that seizure precautions had been implemented, review of the medical record on 7/16/07 with RN #18 identified that it failed to reflect that Patient #16's neurological status had been assessed when the patient exhibited three episodes of seizure activity. RN #22 stated that although he "kept an eye" on Patient #16, he could not recall when the seizures occurred or when the Ativan was administered. RN #18 stated that she would have expected the medical record to reflect documentation of the nurses' response, maintenance of patient safety, MD notification, vital signs, and neurological assessments. The Seizure Precautions protocol identified that during a seizure, the nurse remains with the patient, the patient's safety is maintained, and the physician is notified. After a seizure, the patient's level of consciousness is assessed, vital signs are obtained, and the patient's status is assessed.

k. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. A CT Scan in the Emergency Department (ED) was negative for acute hemorrhage. The patient received two staples to a 2.5cm scalp laceration on the right side of the head, and was admitted to Med 4 (a telemetry unit). Interview and review of the neurological assessments with the Unit Manager of Med 4 on 07/16/07 indicated that pupil size and reaction were not assessed on 02/17/07, 02/18/07 and 02/19/07. The reference used by the hospital (Lippincott Manual of Nursing Practice) directed the assessment of unequal or unresponsive pupils following injuries to the head, spine and face.

l. On 02/18/07 at 10:15AM, the physician ordered ambulation with physical therapy for Patient #15. Interview with the Unit Manager on 07/12/07 at 3:00 PM indicated that since 02/18/07 was a Sunday and the physician order did not specify the urgency of the request, the Physical Therapist would not evaluate the patient until the next day, Monday 02/19/07. Review of nursing flowsheets dated 02/17/07 and 02/18/07 indicated that the patient was on bedrest, ambulated with

staff assistance, and that the use of the commode was not documented. However, interview with the Unit Manager on 07/16/07 indicated that the commode had been placed at the bedside since 02/17/07, and interview with Registered Nurse (RN) #23 on 07/16/07 at 10:55 AM indicated that RN #23 was told at shift change (7:00 PM on 02/18/07) that Patient #15 had been using the bedside commode independently. On 02/19/07 at 4:45 AM, Patient #15 was found out of bed, ambulating without assistance, fell forward before the nurse could reach her, and sustained a large left frontal scalp hematoma and a large right subdural hematoma. Patient #15 expired later the same day. Interview with the Unit Manager and the Vice-President of Patient Care Services on 07/16/07 indicated that the nursing staff should have provided the patient with assistance for ambulation at all times, and should not have allowed independent use of the bedside commode until the patient was evaluated by Physical Therapy.

m. Patient #17 was admitted to the hospital from a nursing facility on 05/23/07 with a diagnosis of hydronephrosis. Nursing flow sheets dated 05/23/07 through 06/04/07 identified clear skin on coccyx and buttocks, and indicated that the patient was at high risk for skin breakdown. On 06/05/07, the nursing flowsheet identified a "one centimeter stage I coccyx", followed by the next line notation of a "linear breakdown right gluteal, Duoderm placed 06/05". The flowsheet lacked documentation of the size and stage of the gluteal wound, and did not specify whether the Duoderm (hydrocolloid dressing) was applied to one or both affected areas. Patient #17 was discharged back to the nursing facility on 06/05/07. The nurse's note dated 06/05/07, the discharge summary and the W-10 failed to indicate communication on the patient's impairment in skin integrity and current wound treatments to the nursing facility staff. In an interview on 08/09/07 at 1:45 PM, RN #25 recalled applying a Duoderm dressing on Patient #17's coccyx, did not recall the size or stage of the "linear breakdown" in the left gluteal area (verbally described as "reddened abraded skin from rubbing against the plastic of disposable briefs"), and clearly recalled informing the nursing facility about the wounds in a telephone report on the day of the patient's discharge. The hospital policy on "Skin care" directed the assessment of size and staging (I to IV) of skin breakdowns. The hospital policy on the "discharge planning process" directed the physician to complete the sections related to treatments and medications." RN #25 indicated during an interview on 08/09/07 that she updated the W-10 on the day of the patient's discharge by indicating the date of last bowel movement, and the date the medications were given last, but failed to document the stage, size and treatment of nosocomial wounds.

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

3. * Based on a review of medical records, review of facility policies and procedures, and interview with facility personnel, the facility failed to ensure that treatment plans were developed and/or kept current for Patients #1, #3, #6, #15, #17 and #42. The findings include:

   a. Review of Patient #1's clinical record during the period of 2/28/07 through 5/30/07 identified that the patient had episodes of self-injurious behavior, was aggressive toward staff (staff utilized hospital police), exhibited bizarre bathroom behaviors (drinking water from the toilet, self dis-impaction), required restraints and ongoing medication intervention. The weekly MTP review sheets dated 3/7/07 through 5/29/07 lacked consistent documentation by team members (MD, RN, SW, OT, and Case Manager) as to the patient's status of the identified problem, documented outcomes (short-term goals) and/or whether a decision to continue with the current plan or revision of the plan was recommended.

   b. Review of Patient #1's MTP dated 2/28/07 identified a problem of altered thought process as evidenced by paranoid delusions, auditory and visual hallucinations and behavioral disturbance. Short-term goals for this problem included safety for the patient and maintenance of the milieu, that the patient will verbalize altered thoughts, and that the patient will have a decrease in symptoms by discharge. Nursing interventions to address this problem included assessment of the patient's mental status to evaluate the nature and severity of the altered thoughts at a minimum of every eight (8) hours and development of appropriate interventions. The Master Psychiatric Nursing Treatment Plan (an integrated part of the MTP) for altered thought process listed interventions such as...provide structure as needed and retain firm boundaries when interacting with patients who have persecutory delusions, but failed to specifically list interventions to address Patient #1's individualized needs. Review of the Multidisciplinary Treatment Plan policy identified that interventions to achieve the short-term goals would specify "what and how often" by each discipline for each specific problem.

   c. Review of Patient #1's clinical record dated 3/13/07 identified that the patient was observed drinking water from the toilet. Although this behavior was noted on the weekly MTP update on 3/14/07, the IDT failed to review, revise and/or specify interventions that addressed this behavior.

   d. Review of nurse's notes during the period of 2/28/07 through 5/4/07 identified that Patient #1 required restraint and/or seclusion at times, required a private room to decrease stimulation, and required medications against will due to uncontrolled and psychotic behaviors. The MTP review sheets failed to reflect the patient's need for restraints and/or the need for a private room despite documentation that

included delusional behavior, aggressive behavior, and/or self-injurious behavior requiring restraint and/or seclusion. Additionally although the patient intermittently refused medication, the treatment plan failed to reflect interventions to address this behavior until 4/19/07 when a court order for medication against will was granted.

e. Review of a progress note dated 3/18/07 identified that Patient #1 was fixated on his bowels, feels he is impacted and stated that he used an inappropriate object to disimpact himself. On 3/19/07, Patient #1 spent over an hour in the bathroom, continued to touch his rectum and was observed placing his fingers into his rectum. Although MD #1 identified in a progress note on 3/20/07 that staff needed to limit Patient #1's time in the bathroom, and constipation was noted on the 3/21/07 weekly MTP update, the IDT failed to develop a plan of care regarding constipation and the patient's behaviors associated with this concern.

f. Review of a nurse's note dated 3/20/07 identified that Patient #1 had swelling and redness of the left leg, the physician was notified and the patient was subsequently started on antibiotic therapy for cellulitis. Although cellulitis of the left leg was noted on the 3/21/07 weekly MTP update, the IDT failed to revise the plan of care that identified the patient had cellulitis, intermittent refusal of antibiotic therapy and/or interventions to guide care.

g. Review of the clinical record during the period of 3/19/07 through 5/5/07 identified that Patient #1 exhibited self-injurious behaviors including punching and hitting himself. Although the weekly MTP updates during this period of time identified the patient had periods of agitation, and experienced auditory and visual hallucinations, the IDT failed to develop a plan of care regarding the patient's self-injurious behaviors.

h. Review of a Nurse's note dated 5/20/07 at 6:15 AM identified that two loud bangs were heard coming from Patient #1's room. Upon entering the room, the patient had thrown a chair at the mirror located in the ceiling of the room and broke the mirror. Although the patient exhibited aggressive and impulsive behavior, nursing staff failed to update the MTP with interventions that addressed these behaviors. Review of the Nursing Treatment Plan policy identified that the RN would initiate an appropriate nursing treatment, review and evaluate the plan in regards to patient progress and update the plan of care as required.

i. Patient #3 was admitted to the inpatient psychiatric unit on 5/21/07 for treatment of refractory depression. The MTP of 5/22/07 identified groups and activities as part of the patient's overall treatment. Review of Daily Group Notes from 5/24/07 through 5/27/07 identified that the patient did not attend groups for that period. A

subsequent MTP review dated 5/29/07, however, identified Occupational Therapy progress as " engaging in activities " and failed to revise interventions or objectives based on the patient's lack of participation in groups. In addition, although the MTP physician review of 5/29/07 indicated that the patient exhibited increased tearfulness, increased guilt, decreased sleep and decreased appetite along with passive suicidal ideation, nursing documentation on the MTP review of 5/29/07 related to mood disorder identified improvement of mood as evidenced by decreased tearfulness.

j. Patient #6 was admitted to the inpatient psychiatric unit on 5/27/07 under a physician's emergency certificate with behavioral symptoms related to Dementia of the Alzheimer's type. Upon admission, the patient was identified as a risk to others due to unpredictable behavior, including unprovoked outbursts of rage. The initial Master Treatment Plan (MTP) of 5/29/07 identified the patient's risk for violence towards others. Despite documentation that included aggressive behavior, angry outbursts and hallucinations requiring restraint in a geri-chair on at least two occasions (6/2/07 and 6/4/07) the MTP review of 6/5/07 failed to identify the patient's continued behavioral symptoms and need for restraints.

k. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. The patient sustained a head laceration; CT Scan in the Emergency Department (ED) was negative for acute hemorrhage, and the patient was admitted to Med 4 (telemetry unit) with working diagnoses of syncope, rule-out myocardial infarction, and acute renal failure. A pre-printed Care Plan entitled "Safety" dated 02/17/07 listed "bedrest" as the "actual / potential problem", while a column marked "Desired Patient Interventions, Outcomes, Goals" listed the following: "ambulates safely per order/patient ability, verbalizes comfort with ambulation/transport/physical therapy, ID (identification) band in place, allergy/fall risk band in place, prn (as needed), in bed with 2-3 siderails up maximum when not on restraint protocol". On 02/18/07, another pre-printed Care Plan indicated that Patient #15 was at high risk for falling; and that "falls precautions were implemented per protocol". Review of fall protocol for high-risk patients identified twenty-eight standard interventions; with at least nine interventions not implemented for Patient #15. Interview with the Unit Manager on 07/15/07 indicated that the twenty-eight interventions were "suggested" interventions; however, Patient #15's care plan did not specify which of the "suggested" interventions were implemented for the patient. A nurse's notes dated 02/19/07 at 3:00 AM indicated that Patient #15 "pulled off telemetry monitor,

climbed out of bed, and wanted to go home." Registered Nurse (RN) #23 further documented under "action", "as per patient outcome", and under "results", "continue to monitor". In an interview on 07/16/07, RN #23 explained that writing "as per patient outcome" would refer the reader to the section of the care plan entitled "desired patient interventions, outcomes and goals". However, that section of the care plan listed a mix of interventions and outcomes unspecific to the patient's behavior of "climbing out of bed and wanting to go home", and also made a reference to the fall protocol with the twenty-eight "suggested" interventions. At about 4:45 AM on 02/19/07, Patient #15 was found out of bed again, and fell head forward before the nurse could reach the patient. The patient sustained a large left frontal scalp hematoma, and a large right subdural hematoma, became unconscious and expired on the same day. The hospital protocol on " all Risk Identification and Prevention Management" directed the implementation of an individualized fall prevention treatment plan determined by the fall risk identification score and the documentation of the interventions on the patient's care plan.

l. Patient #17 was admitted to the hospital on 05/23/07 with hydronephrosis, and discharged back to the nursing facility on 06/05/07. Although the "Nursing Flowsheet" dated 06/05/07 on the 12AM-7AM shift indicated that the patient had "no skin breakdown" but was at high risk, the care plan dated 06/05/07 on the 12AM-7AM shift identified a one centimeter, stage I coccyx linear breakdown of the left gluteal with Duoderm applied.

m. Patient #42 was admitted to the hospital on 7/7/07 with a chief complaint of difficulty breathing. The nursing assessment dated 7/7/07 identified that the patient was over 75 years old and had altered circulation and "ruddy shins". The assessment further noted that the patient was at risk for breakdown and recommended to initiate the skin care protocol. Review of the Patient's medical record with RN #11 and RN #14 on 7/11/07 noted that the plan of care did not identify the patient's skin integrity as a problem with goals and interventions to include the skin care protocol. Review of the facility policy for Standard Care Plans (SCP) indicated that on a daily basis, each RN or LPN is responsible for initiating, updating and/or revising the SCP for each assigned patient.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(C) and/or (4)(D) and/or (d) Medical Records (2) and/or (3) and/or (e) Nursing service (1) and/or (i) General (7).

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

4. Based on a review of the medical record, review of facility policy and staff interview, the facility failed to administer medication to Patient #1 in accordance with the physicians order. The findings include:
   a. Patient #1 had a Physician's order dated 4/19/07 that directed administration of the antibiotic, Keflex 500 mg (milligrams) four (4) times daily for seven (7) days. Review of the medication administration record (MAR) with RN #8 (on 6/7/07) failed to identify that the patient received this medication on 4/20/07 at 11:00 PM, 4/21/07 at 11:00 PM, and 4/22/07 at 11:00 PM. Interview with RN #8 identified that although Patient #1 would intermittently refuse medication, nursing documentation failed to reflect the Patient #1's refusal on these instances.

5. Based on medical record reviews, review of facility policy and procedure and staff interview, the facility failed to maintain a medical record for Patients #1, #16 and #52, that were accurately written and/or promptly completed. The findings include:
   a. Patient #52 was admitted to the Intensive Care Unit (ICU) on 2/8/07. The Patient's diagnoses included narcotic overdose, hypoxia, sepsis, and respiratory failure. The vital sign record dated 2/9/07 at 11:20 AM reflected that the patient's blood pressure was 191/153, the patient became short of breath, agitated, cyanotic and APRN #2 was called to the patient's bedside. The vital sign record further indicated that seven medications were administered to the patient between 11:35 AM and 12:07 PM (Lasix, Hydrocortisone, Epinephrine, Levophed, Sodium Bicarbonate and Norepinephrine intravenously (IV) and Nitropaste topically) by nursing staff. Interview with APRN #2 on 7/16/07 at 11:40 AM noted that the medication orders were verbally given to nursing staff at the time the Patient began to decompensate and that APRN #2 informed the Medical Residents to be sure to write the orders for the medications. APRN #2 indicated that only orders written on the resuscitation sheet did not have to be rewritten on the physician order sheet, all other medication orders must appear on standard physician order sheet. Review of the patient's record and interview with RN #14 on 7/16/07 at 1:35 PM noted that the seven medications administered to the patient between 11:35 AM and 12:07 PM should have been documented on the Medication Administration Record (MAR) and that this had not been done. Review of the facility policy identified that the Medication Administration Record is used to document all medications with the exception of continuous drips. Further interview with RN #14 noted that all medications including continuous drips were documented on the MAR by the unit staff although the facility policy did not reflect this practice.

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

b. Patient #52 was admitted to the ICU on 2/8/07 with diagnoses that included a history of pulmonary embolism and deep vein thrombosis treated with anticoagulants (Coumadin). The transfusion record identified that the administration of fresh frozen plasma (FFP) was initiated at 11am on 2/9/07 and vital signs were taken prior to the transfusion and at 11:15 AM. The transfusion record lacked documentation for post- transfusion vital signs, the time the transfusion ended, volume transfused, presence or absence of a transfusion reaction and a signature of the person who administered the transfusion. Interview with RN #9 on 7/16/07 at 10:20 AM noted that RN #9 administered the FFP to the patient on 2/9/07. RN #9 indicated that it was RN #9's responsibility to complete the transfusion record but that it had not been done in "all the confusion." In addition, physician orders and Progress notes were reviewed on 7/16/07. The physician orders and/or progress notes lacked consistent documentation for the dates and/or times that entries were made. Interview with the Associate Vice President of Operations on 7/16/07 at 1:20 PM reflected that a date and a time should be documented for all progress note and physician order entries.

c. Patient #52's diagnoses included narcotic overdose, hypoxia, sepsis, and respiratory failure. The care plan dated 2/8/07 identified impaired breathing pattern and interventions included Pulse Oximetry Protocol. Flow sheets dated 2/8/07 and 2/9/07 reflected that the patient received 4 liters of oxygen via nasal cannula to maintain oxygen saturation levels between 94 and 98% (normal= 90 - 100%). Physician orders dated 2/8/07 and 2/9/07 failed to direct oxygen use. Interview with the Associate Vice President of Operations on 7/13/07 at 1:30 PM reflected that although a policy did not reflect the requirement, a physician's order was required for oxygen use.

d. Patient #16's diagnoses included seizure disorder and mental retardation and the patient was admitted to the facility on 4/20/07. Although the admission history and physical was dated 4/20/07 at 8:30 p.m. and medication orders were dated 4/20/07 at 10:50 PM, review of the medical record on 7/13/07 with RN #16 identified admission orders were lacking. RN #16 stated that the admission orders were missing from the medical record. The Associate Vice President of Operations verified that Patient #16's admission orders could not be located.

e. Physician's orders dated 4/23/07 at 8:00 AM included Ativan 0.5 milligrams intravenously. Although notation was made on the physician's order sheet that the medication was administered, the medication administration record failed to reflect when the medication was administered. RN #22 stated that although he "drew up" the Ativan, the physician administered the medication and he could not

recall the time that the medication was administered. RN #19 stated that when a physician administers the medication, it is documented as "given by physician" on the record.

f. Review of the medical record on 7/16/07 with RN #18 identified that although Patient #16 experienced three seizures on 4/23/07, the medical record failed to reflect the status of the patient during these episodes. RN #18 stated that she would have expected the medical record to reflect documentation of the nurses' response, maintenance of patient safety, MD notification, vital signs, and neurological assessments.

g. Patient #1 was admitted to the Emergency Department on 2/27/07 with a chief complaint of agitation and bizarre, aggressive behavior. Review of the clinical record with RN #2 (on 6/5/07) identified that MD #3 noted a genitourinary assessment of a female patient in the review of systems (ROS) section of the medical record. Interview with RN #2 identified that this assessment was that of another patient as Patient #1 is a male. Additionally, further review of the record with RN #2 identified that although Patient #1 was admitted to the inpatient psychiatric unit, MD #4 documented in the clinical record that Patient #1 was discharged with abdominal pain and follow-up instructions detailed in the record. During an interview with RN #2 she identified that staff utilize computers on wheels and that MD #4 must have utilized the wrong patient record to document.

h. Review of Patient #1's clinical record dated 5/30/07 identified that the patient was found hanging from the shower rod with resusitation efforts initiated. Review of code sheet with APRN #1 (on 6/5/07) failed to identify documentation of the time of the arrest, whether the arrest was witnessed, time CPR began, dosages of medications administered (epinephrine, bicarbonate, and atrophine), cardiac rhythm, joules administered during defibrillation, and/or a complete list of staff who responded to the code. Additionally, review of the document with APRN #1, identified that although the time of the defibrillation was initially documented, the entry was subsequently written over with a different number making the exact time of defibrillation unclear.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (7).

6. Based on observation, staff interviews and review of facility policies, the facility failed to ensure that patient's medical records were in a secured location. The findings include:

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

a. During tour of the Cardiac Catheter Lab on 7/11/07, the soiled utility room contained copies of completed cardiac catheterization patient records from 4/05-6/07 on a shelf. Review of hospital policy identified that all patient medical information needs to be secured. Upon surveyor inquiry on 7/11/07, the patient records were removed from the soiled utility room. Interview with the Nurse Manager of the Cardiac Catheter lab on 7/11/07 identified that the copies of patient records were being reviewed for quality assurance purposes and needed to be in a secure location.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(D) and/or (d) Medical Records (3) and/or (8) and/or (i) General (7).

7. Based on a review of medical records and staff interview, the facility failed to ensure that the physicians dated and timed the consent forms for blood transfusions for Patients #15 and #17. The findings include:
   a. Patient #15 was admitted to the hospital on 02/17/07 with diagnoses of syncope, head injury, atrial fibrillation, atrial flutter and a history of myocardial infarction and ablation. The patient's medications included Aspirin 81milligrams (mg) by mouth once a day, Plavix 75mg by mouth daily, and Lovenox 30 mg subcutaneously (SQ) daily. Patient #15 sustained a fall in the hospital on 02/19/07. CT Scan performed after the fall identified a large left frontal scalp hematoma, and a large right subdural hematoma. The physician ordered to transfuse four units of fresh frozen plasma, and obtained written consent from the patient's family for the transfusion of blood products. Review of the consent form indicated that the physician failed to date and time the consent form. The transfusion was later cancelled as the patient's coagulation studies were within normal limits.
   b. Patient #17 was admitted to the hospital on 05/23/07 with a diagnosis of hydronephrosis, and underwent percutaneous nephrostomy on 05/24/07. On 05/26/07, Patient #17's hematocrit was 25.6% (normal range 35 to 47%), the nephrostomy tubes were draining sero-sanguinous fluids, and the physician ordered the transfusion of one unit of packed red blood cells. Review of the clinical record indicated that the physician obtained written consent from Patient #17, but failed to date and time the consent form.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) (e) Nursing service (1) and/or (i) General (7).

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

8. Based on a review of medical records, review of facility documentation and staff interviews, the facility failed to ensure that the medical records for Patients #1 and #50, contained information necessary to monitor the patient's condition. The findings include:
   a. Patient #1 had a diagnosis of Paranoid Schizophrenia. Review of the clinical record identified that Patient #1 was found hanging by a sheet in the shower stall, had asphyxiated and although cardiopulmonary resuscitation was initiated, the Patient was pronounced dead at 5:41 PM. Review of the CPR Report with APRN #1 lacked documentation to reflect the time of the arrest, whether the arrest was witnessed, the time CPR began, dosages of medications administered (epinephrine, bicarbonate, and atrophine), cardiac rhythm, joules administered during defibrillation, and a complete list of staff who responded to the code. Although review of the code sheet with APRN #1 indicated the patient was defibrillated subsequent to the administration of epinephrine at 5:35 PM, the exact time of defibrillation was unknown as documentation was obliterated. Interview with APRN #1 identified that Patient #1 received 200 joules during defibrillation, however, interview with MD #6 stated that 300 joules was delivered twice, neither of which was documented in the clinical record.
   b. Patient #50 was admitted into the facility on 5/19/07. Review of the record on 7/13/07 identified that on 5/20/07 at 8:00 AM, the patient was found on the floor complaining of a fall and bumping her head on the door. The note identified that upon examination the patient had complained of being nauseated and had no apparent injuries. Review of the addendum note identified that nuero checks had been done and were unremarkable. Interview and review of the record with Assistant Nurse Manager #8 on 7/13/07, identified that the nuero checks had been completed in a flow sheet but were not identified in the record. Interview with the Director of Nursing on 7/24/07 identified that although the facility failed to have a nuero check policy, they followed the guidelines from Lippincott. Review of Lippincott, Chapter 15, Neurologic Disorder Assessment identified that a baseline nuerological assessment was needed to detect changes in neurological function and that documentation using appropriate terminology and comparison of right to left for asymmetrical findings was important.

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 (g) Pharmacy (1).

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

9. Based on reviews of facility policies and procedures, observation and staff interviews, the facility failed to ensure that sample medications were accurately inventoried. The findings include:
   a. Review of the Drug Representative Medication book with the manager of outpatient psychiatric services on 7/13/07 identified that the drug sample lot number and quantity received is logged into the book upon entry into to the facility. The manager of outpatient psychiatric services stated that the samples are placed in the locked cabinet. The Medication Sample Inventory Form identified that when medication samples are issued to patients, the quantity distributed to the patient is noted; however, the facility lacked a mechanism to account for the entire inventory of the sample that was initially provided. The manager of the outpatient psychiatric clinic stated that although the drug sample is signed out for a patient, the amount of the sample remaining is not tracked or inventoried. The manager further stated that when a drug sample is noted to be expired, the APRN takes it to the main pharmacy for disposal; however, pharmacy does not provide oversight to the drug storage cabinet. The facility medication sample policy identified that pharmaceutical representatives providing samples will initiate a log sheet which includes medication name, strength, manufacturer, lot number, expiration date, and quantity and the log sheets are maintained. Medication samples are placed in a locked medication sample closet and providers will document medication samples on a log sheet inclusive of the quantity dispensed. Expired medication samples are routinely monitored by the clinical staff and will be sent to the main pharmacy for disposal.

10. Based on a tour of the facility, review of facility documentation, review of facility policy, and staff interviews, the facility failed to ensure that an account of scheduled drugs, to include discrepancy checks, were conducted according to facility policy. The findings include:
   a. Tours of the Intensive Care, Cardiac Step-down, and Surgical 7 units were conducted on 7/11/07 and identified that each unit utilized an automated dispensing system (Pyxis) to access, in part, controlled medications. Interview with RN#15 on 7/12/07 at 1:40pm noted that the nurses on the Surgical 7 unit checked for medication discrepancies every shift yet did not record that the checks had been done. Interview with RN #14 on 7/12/07 at 1:45pm reflected that nursing staff on the Intensive care and Cardiac Step- down units reported discrepancies when they were first observed and that routine checks for discrepancies were not done. Review of the facility policy for Pyxis Controlled Substance Security identified that monitoring of controlled substances is performed by change of shift discrepancy checks and weekly inventory

of the Pyxis. Documentation of the change of shift discrepancy checks and/or weekly inventory checks could not be provided. In addition, Interview with Pharmacist #1 on 9/16/07 at 9:50am noted that the Pharmacy department runs a weekly discrepancy report for all Pyxis machines. Scheduled medication is counted and verified by the pharmacy technician at the time the medication is replenished. Review of the facility policy for pharmacy services identified that a physical inventory of controlled substances in each "medstation" will be performed by assigned pharmacy personnel monthly and during the standard unit inspection. Further interview with Pharmacist #1 on 7/16/07 at 9:50 AM reflected that Pharmacy did not conduct monthly physical inventories as per policy.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(D) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (i) General (7).

11. * Based on a review of medical records, review of facility policy and protocol and staff interview for two (2) of two (2) patients in the sample (e.g. Patients #15 and #17) who required new medication orders, the pharmacy staff failed to ensure the orders were accurate and/or complete in accordance with the facility guidelines. The findings include:
    a. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. The patient sustained a head laceration; CT Scan in the Emergency Department (ED) was negative for acute hemorrhage, and the patient was admitted to Med 4 (telemetry unit) with working diagnoses of syncope, rule-out myocardial infarction, and acute renal failure. On 02/19/07 at 4:45 AM, Patient #15 sustained a fall in the hospital, and CT Scan revealed a large left frontal scalp hematoma and a large right subdural hematoma. The patient was transferred to the Intensive care Unit (ICU). Admission orders to the ICU included "Dopamine continuous infusion, start at 5mcg/kg/min (micrograms per kilogram per minute)", with no route or concentration specified, no titration parameters, and no maximum indicated. Nurse's note and attending physician note dated 02/19/07 indicated that the Dopamine continuous infusion was titrated up to 20mcg/kg/min by 6:05 AM, and discontinued at 8:25 AM. The admission orders also included "Levophed (Norepinephrine) continuous infusion, start at 0.5mcg/min, titrate to keep systolic blood pressure between 120 and 140mmHg (millimiters of mercury)", with no route or concentration specified. Interview with Pharmacist #2 on 07/16/07 at 10:00 AM indicated that the orders for Dopamine and Norepinephrine were incomplete. The hospital protocol on Dopamine continuous infusion suggested

two different concentrations, with the dosage determined by the physician, and advancement in vital signs ordered by the physician. The hospital protocol on Norepinephrine continuous infusion suggested two different solution concentrations.

b. Patient #17 was admitted to the hospital on 05/23/07 with the diagnosis of hydronephrosis. Pain medication orders written on 05/25/07 consisted of Dilaudid 0.5 milligrams (mg) by mouth every four hours as needed for pain rated from 2 to 5, and Dilaudid 1mg by mouth every four hours as needed for pain rated from 6 to 10. On 05/31/07 at 10:45 AM, the physician ordered to "change Dilaudid 0.5mg from as-needed to around-the-clock", without specifying route, frequency or clarifying the status of the remaining half of the original order (Dilaudid 1mg by mouth every four hours as needed for pain rated 6 to 10). The order was transcribed by the nurse and implemented until the patient was discharged on 06/05/07. Interview with the Interim Director of Pharmacy on 07/15/07 at 11:30 AM indicated that the order for Dilaudid dated 05/31/07 was incomplete, required clarification from the physician, and should not have been approved by the pharmacist on duty or implemented by the nurses. The hospital policy on Inpatient Drug Distribution directed the documentation of the route and frequency of administration of ordered medications.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (g) Pharmacy (4) and/or (i) General (7).

12. Based on observation and staff interviews, the facility failed to ensure that outdated or otherwise unusable drugs and/or biological were not available for patient use. The findings include:
    a. The medication room of the OR suite was observed to contain four (4) specialty tackle boxes with medications in them that were located on the floor. One specialty tackle box observed by the surveyor contained expired vials of Epinephrine (6/07).
    b. GI procedure room A, was observed to contain an expired vial of Solumedrol (6/07) in the emergency box.
    c. During tour of the outpatient surgical building (MARB) on 7/12/07, three (3) expired Cyclogyl (3/07) eye medications were observed mixed in with the regular dated medications.
    d. In OR #2 of the (MARB) building, two (2) Lidocaine 50 ml vials were noted with expiration dates of 6/07.
    e. During a tour of the labor and delivery unit on 7/11/07, Lantus insulin was noted to be expired on 11/06 and Tetanus Diptheria was noted to be expired on 7/06.

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f. The medication refrigerator of the OR contained vials of NPH and Regular insulin that had been punctured and not dated as to when opened. Review of the facility's unit dose policy, identified that all partially used multidose vials that are not labeled with a "date opened", should be discarded.

g. The refrigerator labeled Malignant Hyperthermia refrigerator that contained biological testing supplies, was observed with an undated, opened insulin vial.

h. During tour of the outpatient PT/OT area, an unlocked and wide opened metal cabinet was observed to contain vials of Dexamethasone medication. One of the vials contained a needle-less syringe in the punctured top of the vial. The door of this room was also observed opened and unlocked. Interview with the Director of the Rehabilitation area identified that they leave the syringe in the vial until the vial is empty and that the cabinet door and the room door is locked at the end of the day.

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 (f) Diagnostic and therapeutic facilities and/or (g) Pharmacy (1) and/or (h) Dietary service (1) and/or (i) General (2) and/or (7).

13. Based on observation and staff interview, the facility failed to ensure that kitchen fans were clean and/or received periodic cleaning. The findings include:

a. A tour of the facility kitchen was conducted on 7/12/07 with the Director of the Dietary Department at 9:30 AM. A large fan in the dishwasher area and two smaller fans in the food preparation area were observed in use. Dust debris attached to the outer framework of the fans was observed blowing outward toward the sanitized dishes and/or freshly washed lettuce and/or toward an area where meat was being cut. Interview with the Director of the Dietary Department on 7/12/07 at 9:30 AM identified that the kitchen fans were to be cleaned on the weekend. Review of the cleaning list failed to specify that the fans had been included on the weekend cleaning schedule.

14. Based on a tour of the facility, the facility failed to ensure that a patient call system was available in the Electroconvulsive Therapy (ECT) units bathroom. The findings include:

a. Tour of the ECT unit on 7/12/07 with the Manager of Psychiatric Services identified that the unit contained three patient stations and a bathroom outside of the station area. Observation of the area identified that the patient bathroom lacked a call bell system.

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15. Based on tours of the facility, review of facility documentation, review of facility policy, and staff interview, the facility failed to ensure that the facilities, supplies and/or equipment was maintained to ensure an acceptable level of safety and quality. The findings include:

a. A tour of the intensive care unit was conducted on 7/11/07 with RN #14. Medication refrigerator temperature logs and the emergency equipment checklist were reviewed from February 1 to July 11, 2007. Documentation was inconsistent for refrigerator temperatures for the months of June and July and for emergency equipment checks for the months of February, June, and July. Interview with RN #11 on 7/11/07 at 10:10am identified that on a daily basis, the nurse responsible to perform the checks and maintain the logs was written on the assignment sheet.

b. A tour of the Cardiac Step-down unit was conducted with RN #14 on 7/11/07. Medication and refrigerator temperature logs and the emergency equipment checklist were reviewed from May1 to July 11, 2007. Documentation was inconsistent for refrigerator temperatures for the months of May and June and for emergency equipment checks for the month July. Review of the facility policy for management of the unit medication refrigerator identified that appropriately designated unit staff shall maintain a documented log of daily refrigerator temperature and date. According to the emergency equipment checklist, emergency equipment will be checked daily to include code carts and defibrillators.

c. A tour of the Electroconvulsive Therapy unit was conducted on 7/12/07. Multiple blood collection tubes were noted with expiration dates ranging from 1/07 to 5/07.

d. In the infusion treatment room, the Malignant Hyperthermia box that contained the medication Dantrolene, failed to be readily accessible to the staff. During the tour of this infusion room, this box was observed to have a combination lock that could not be accessed by the OR Manager after numerous attempts. The OR Manager then was able to locate a RN who was able to access it. Subsequent to the unsuccessful attempts to gain entry into this box, a plastic rip off lock was attached.

e. Tour of the outpatient PT/OT area identified two (2) hot pack hydrocollators and one (1) cold pack chilling unit. The inside edges of the hydrocollators were noted to be rusty on all 3 pieces of equipment. Review of the Infection control policy on the cleaning of hydrocollators and chilling unit, directed that the hydrocollators would be cleaned at a minimum of once a month and the cold pack unit every six months. Interview with the Director of that Rehabilitation area identified that the units are drained and cleaned on the inside and wiped on the outside. Interview further identified that they were unable to provide documentation when the equipment had last been cleaned.

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f. A tour of Oncology 6 (inpatient unit) on 07/11/07 at 2:20PM identified gaps in documentation of crash cart equipment monitoring and testing for 07/02/07 and 07/03/07. The hospital policy on "Emergency Resuscitation Equipment Check" directed the investigation and documentation "once each shift" of the integrity of security locks on the emergency carts, the integrity of designated ancillary devices, and the function of the defibrillator/monitor.

g. The specimen refrigerator in the dirty utility room of Oncology 6 failed to identify documentation of daily temperature monitoring from 06/08/07 forward. At the time of the observation on 07/11/07, no specimen was found inside the refrigerator. According to the Unit Manager in an interview on 07/11/07 at 2:30PM, twenty-four hour urine samples collected on Oncology 6 for the work-up of multiple myeloma no longer required refrigeration. However, the hospital policy on "Urine Collection" directed to cover and refrigerate the containers holding twenty-four hour urine samples until delivered to the laboratory for testing.

h. A tour of the Outpatient Cancer Center on 07/11/07 identified a specimen refrigerator located in the dirty utility room. According to the Unit Manager, the Cancer Center staff shared the use of the refrigerator with the Physician Offices located in the same building. The refrigerator held several specimen containers at the time of the inspection. However, no daily temperature recording was identified for the specimen refrigerator. The Unit Manager acknowledged that the refrigerator temperature should be monitored on a daily basis, and immediately gave instructions to the staff to initiate a recording log.

i. During tour of the OR suite on 7/11/07, the fluid warmer of the OR was observed to contain two (2) 50 ml vials of Mannitol. Interview with the Director of Nursing on 7/24/07 identified that the facility lacked a policy for the general storage of medications.

The following are violations 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 (7) and/or (l) Infection control (7).

16. Based on tours of the facility, review of facility policies and procedures, review of facility documentation and staff interviews, the facility failed to that the infection control officer(s) developed and/or implemented a system for identifying, investigating and/or controlling infections. The findings include:

a. A review of the committee member attendance for 2006 to date with the Infection Control Nurse on 7/16/07 identified that representatives from obstetrics/gynecology,

pharmacy, and neo-natal fell at or below fifty percent. Additional department representatives, inclusive of surgery safety/environmental, nursing administration, facilities management, dental, and laboratory medicine fell at or below sixty-six percent. The Infection Control Nurse stated that the hospital follows the Public Health Code for attendance requirements. The facility Infection Control Committee consists of representatives from the clinical services of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, dental medicine, nursing service, hospital administration, and an individual employed in a surveillance or epidemiological capacity. The Infection Control Committee was to meet at least monthly.

b. During a surgical procedure in OR #10, an RN and a CRNA were observed with cloth surgical caps that failed to cover the entire head, leaving hair exposed. Review of the facility's surgical attire policy identified that personnel should cover their head when in restricted areas of the surgical suite.

c. Additionally in OR #10, a black leather bag was observed on the floor, next to the anesthesia cart. Interview with the Chief of Anesthesia on 7/12/07 identified that the bag belonged to the CRNA doing the case and contained extra supplies and items that the CRNA carried with him.

d. A tour of the Cardiac Catherization Lab on 7/11/07 identified that clean paper items, biologicals and equipment were stored in the soiled utility room. Interview with the Nurse Manager of the Cardiac Catheter Lab on 7/11/07 identified that these items are to be kept in the clean utility room.

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

17. Based on medical record reviews and interviews with facility personnel for one (1) of one (1) sampled patients (Patient #20), the facility failed to ensure that the discharge planning evaluation was complete. The findings include:

a. Patient #20 was admitted to the Emergency Department (ED) on 3/14/07 with complaints of neck burning, spasms and throbbing lower extremity pain. Patient #20 stated that he signed out against medical advice (AMA) from a nursing home. Review of the ED physician assessment dated 3/14/07 identified that Patient #20 was to be evaluated by a psychiatry consultant. Review of the psychiatry consult dated 3/14/07 identified that the patient had no acute issues but had problems with dislike of the nursing home. Further review identified that the patient was to be sent back to the nursing home. The clinical record, however, failed to identify that a complete

discharge evaluation and/or social service evaluation was completed for Patient #20 based on his discharge AMA. Review of the clinical resume (W10) and the Emergency department record failed to reflect that Patient #20 was given discharge instructions, response to discharge and/or had signed the instruction sheet. Patient #20 was sent by wheelchair car back to the nursing home. Interview with the Director of Social Service (nursing home) on 7/18/07 identified that Patient #20 had signed out of facility against medical advice and that the hospital never called the facility to discuss the patient's readmission. Patient #20 was sent to the facility despite not wanting to return. Interview with Person #2 indicated that Patient #20 had AMA paperwork with him when he went to the ED. Interview with RN #17 (ED nurse manager) indicated that there was some miscommunication regarding who was responsible for Patient #20's discharge plan (nursing or psychiatry departments). Review of hospital policy identified that the nurse will facilitate resolution of problems including contacting appropriate departments for a referral and/or service out in the community. Further review of hospital policy identified that instructions for discharge and signatures are documented on the discharge sheet. In addition, the patient's response to discharge instructions is documented in the Emergency department record.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (7).

18. Based on a review of medical records, review of facility policies and procedures, and staff interviews for three (3) of four (4) patients reviewed status post Cesarean sections (e.g. Patients #13, #47 and #48), the facility failed to provide documentation that surgical counts were completed in accordance with facility policy. The findings include:
    a. Patient #13 underwent a Cesarean section on 7/10/07. Review of the medical record on 7/11/07 with RN #20 identified that although the surgical count was noted as being "correct", the operative record lacked documentation that counts were completed at each stage of the surgery. In addition, the medical record lacked documentation that two staff members participated in the surgical count.
    b. Patient #47 underwent a Cesarean section on 7/11/07. Review of the medical record on 7/11/07 with RN #20 identified that although the surgical count was noted as being "correct", the operative record lacked documentation that counts were completed at each stage of the surgery. In addition, the medical record lacked documentation that two staff members participated in the surgical count.

c. Patient #48 underwent a Cesarean section on 7/8/07. Review of the medical record on 7/11/07 with RN #20 identified that although the sponge and needle counts were noted as being "correct" three times and the instrument count was noted as being "correct" twice, the operative record lacked documentation that two staff members participated in the surgical count.
Interview with RN #20 identified that sponges, needles and instruments are counted at the beginning of the case, sponges and needles are counted again when the uterus is closed, and a final count of sponges, needles, and instruments is completed when the fascia is closed. RN #20 also stated that sometimes staff indicates that the count was done two or three times; however, if the surgical count is noted as being "correct" than it is correct according to the protocol. The facility policy for surgical counts identified that initial counts are done prior to every procedure. The first closing count is performed when a cavity within a cavity is entered and when the inner cavity is being closed and will include an instrument count. Surgical counts are performed by two people, one of who is a registered nurse. The Nursing Operative Record policy identified that the initials of the circulating nurse and scrub must appear under the final count.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(D) and/or (d) Medical records (8).

19. Based on reviews of the medical records and review of facility policy, the facility failed to ensure a properly executed informed consent was in place as per facility policy for Patients #30, #33, #35, and #48. The findings include:
   a. Patient #45 underwent an exploratory laparotomy on 7/1/07. Review of the medical record on 7/13/07 with the Director of Perioperative services on 7/16/07 identified that the surgical consent authorization lacked documentation of the time that the consent was obtained.
   b. Patient #48 underwent a Cesarean section on 7/8/08. Review of the medical record on 7/11/07 with RN #20 identified that the surgical consent authorization lacked documentation of the time that the consent was obtained.
   c. Patient #30 was admitted to the facility on 7/11/07 for a right thigh muscle biopsy. Review of the medical record identified that although the authorization for medical/surgical procedure form had been signed on 7/11/07, it failed to have a time documented when the practitioner had signed it.
   d. Patient #33 was admitted on 7/11/07 for a bilateral reconstruction of the mandibular rami and removal of an implant. Review of the medical record identified that

although the authorization for medical/surgical procedure form had been signed on 7/9/07, it failed to have a time documented when the practitioner had signed it. Review of the Authorization for Medical/Surgical Procedure form specified that the practitioner's signature, date, and time was required for all consents.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (3) and/or (c) Medical staff (2).

20. Based on medical record review and interviews with facility personnel for one (1) of one (1) sampled patient (Patient #21), the facility failed to ensure that a consulting on-call physician was available in a timely manner. The findings include:
    a. Patient #21 was admitted to the Emergency Department (ED) on 4/7/07 at 11:31am with complaints of throat pain, duration of three months, but that now was constant. The evaluation of Patient #21 indicated that the right side of the oropharynx was injected, with positive exudate and swelling. Further review identified that PA #1 was concerned that the patient may have an abscess or mass. Patient #21 was treated with IV antibiotics and was told that an ENT consultant would see him. Further review of the clinical record identified that PA #1 spoke with ENT Resident #2 and that Patient #21 would be seen in the ED, however ENT Resident #2 was delayed due to emergencies in an other hospital. Review of the phone logs indicate that the initial call to the ENT consultant was made at 12:13pm, second call at 2:10pm and third call at 5:13pm. At 5:10 PM, Patient #21 removed his own IV and left the ED without being seen. At 5:40 PM, the ENT consultant came in to see Patient #21 but was told that the patient left without being seen. Interview with PA #1 identified that he had the ENT consultant paged numerous times but was told that they were delayed in another hospital. Interview with ENT Resident #2 identified that they cover five hospitals and she was new to taking call and was required to work with a senior resident for the first two months of on call duty. ENT Resident #2 identified that she did not call the attending ENT consultant to see Patient #21. Interview with Attending MD #13 identified that he was not paged to come in to see Patient #21. Subsequently, Patient #21 went back to the ED on 4/8/07 with similar complaints and was seen by an ENT consultant immediately. Review of the pathology report dated 4/9/07 identified that the patient had a right peritonsillar mass. Review of hospital policy identified that when a specialty service is called to respond to an Emergency Department patient, the response time for a resident was listed as non-applicable and the response time for an attending physician is 60 minutes.

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (3) and/or (c) Medical staff (4)(C) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (7).

21. Based on medical record review and review of facility documentation, the facility failed to provide documentation of the planned type of anesthesia and documentation that anesthesia had discussed the risk, benefits and alternatives with Patient #32. The findings include:
    a. Patient #32 was admitted to the facility on 7/11/07 for a surgical laparoscopic recurrent left inguinal hernia repair. Review of the pre-induction re-evaluation and prescription of anesthesia plan, failed to identify the type of planned anesthesia, that the risks, benefits and alternatives had been discussed and if the patient had agreed or not as noted on the form. Review of the Anesthesiology suggested guidelines on basic standards for pre-anesthesia care that were provided by the facility, identified that the risks, benefits and alternatives of the proposed anesthetic would be discussed with the patient and that the patient's consent to the procedure would be documented in the chart.

22. * Based on medical record review, staff interviews, review of facility documentation, and review of facility policies, the facility failed to ensure the safety of one patient (Patient #1) who was determined to be a threat to self or others who left the Emergency Department for an undetermined amount of time. The findings include the following:
    a. Review of facility documentation dated 2/27/07 identified that local authorities were summoned to Patient #1's home where he was observed to be agitated, stated he "wanted to kill himself, wanted the police to shoot him" and refused to go to the hospital for an evaluation. Review of the Police Emergency Examination Request reflected that Patient #1 was believed to be a danger to self, others, gravely disabled and in need of immediate care and treatment. The patient was physically restrained (Taser shock three times), taken into protective custody and brought to the Emergency Department. Patient #1 arrived at the ED on 2/27/07 at 12:11 PM with constant observation/monitoring of Patient #1 initiated at 12:15 PM. Review of the constant observation flow sheet dated 2/27/07 with Nurse Aide (NA) #1 on 6/5/07 who was the assigned caregiver, identified that Patient #1 attempted to leave the ED between 3:15 PM and 3:30 PM on 2/27/07, however, NA #1 stated that she was able to keep the patient directed in his room. NA#1 identified that she requested a break at 6:00 PM on 2/27/07, which was granted by RN #1 (Charge Nurse) who informed NA #1 that he would monitor the patient until she returned. NA #1 identified that when

she returned to monitor Patient #1 at approximately 6:15 PM, the patient was not in his room and NA #1 was subsequently informed that Patient #1 went AWAL (Absent Without Authorized Leave). Interview with RN #1 (on 6/5/07) identified that although he agreed to monitor Patient #1 while NA #1 was on her break, he was called away from Patient #1 when another patient in cardiac arrest had arrived to the ED. RN #1 stated that when he went back to check on Patient #1, the patient's bed was made, he assumed the patient was transferred and was unaware that Patient #1 was missing until he received a telephone call from the Hospital's Fire Department who informed him that they had found Patient #1 on hospital grounds on 2/27/07 at 6:32 PM. Record review and interview with RN #2 on 6/5/07 who was the nurse assigned to Patient #1, identified that he also went on a break at 6:00 PM and when he returned at 6:30 PM, heard from another staff member that Patient #1 left the ED but was subsequently returned. Review of the hospitals procedure for observation of patients directed staff to maintain full visual contact of the patient when on constant observation.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(E) and/or (d) Medical records (3) and/or (f) Diagnostic and therapeutic facilities.

23. Based on a review of medical records, review of facility policies and procedures, and staff interviews, the hospital failed to ensure that Occupational Therapy Treatment Plans were comprehensive, consistently reviewed and/or revised to meet the individualized care needs of Patients #1, #2 and #3. The findings include:
    a. Patient #1 was admitted 2/27/07 on a PEC due to psychosis with diagnoses that included paranoid schizophrenia with visual and auditory hallucinations. Review of the MTP dated 2/28/07 developed by Occupational Therapy (OT) identified that Patient #1 would attend a minimum of one session per day from a list of (10) groups/activities noted in the treatment plan. This preprinted list included: Communication Skills, Relaxation Education, Relapse Prevention, Task Group, Stress Management, Focus Group, Mobilization, Social Skills, Activities and Wellness. Although OT developed a treatment plan for Patient #1, this plan of care was not individualized to meet the specific needs of the Patient based on his presenting behavioral symptoms. Review of the weekly MTP update sheets during the period of 3/7/07 through 5/4/07 failed to reflect that OT consistently participated in the treatment planning process in accordance with hospital policy. Additionally, although the weekly MTP update of 3/28/07 reflected the patient made no progress in meeting

the identified goal and was not engaged in activities, the OT plan of care lacked specific approaches to meet the goal and/or establish a new goal based on the patient's needs. Review of the Daily Group Notes during the period of 2/28/07 through 5/30/07 identified that notes were blank and/or incomplete and/or reflected the patient didn't show for the group and/or that the patient was excused from the group. The interdisciplinary treatment team (IDT) failed to document inquiries as to why the patient had refused and/or not attended groups and/or revised the treatment plan to meet the patient's needs. Review of the Multidisciplinary Treatment Plan policy identified that all disciplines involved with the patient's treatment would participate in the multidisciplinary process and identify interventions to be initiated to achieve identified goals including the master treatment plan updates every seven (7) days.

b. Patient #2 was admitted to the hospital on 5/7/07 with a diagnosis of depressed mood with suicidal ideation. Review of the MTP dated 5/7/07 developed by Occupational Therapy identified that Patient #2 would attend a minimum of one session per day from a list of preprinted groups/activities noted in the treatment plan. Review of the Daily Group Notes during the period of 5/20/07 through 6/3/07 identified that notes were incomplete and/or reflected that the patient didn't show for the group and/or that the patient refused the group. The IDT failed to document inquiries as to why the patient had refused and/or not attended groups and/or revise the treatment plan to meet the patient's needs.

c. Patient #3 was admitted to the inpatient psychiatric unit on 5/21/07 for treatment of refractory depression. The MTP of 5/22/07 identified groups and activities as part of the patient's overall treatment. Review of Daily Group Notes from 5/24/07 through 5/27/07 identified that the patient did not attend groups for that period. A subsequent MTP review dated 5/29/07, however, identified Occupational Therapy progress as " engaging in activities " and failed to revise interventions or objectives based on the patient's lack of participation in groups.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(D).

24. Based on review of Patient #33's medical record, staff interview and review of the Medical Staff Bylaws, the facility failed to ensure that the Medical Staff Bylaws included a requirement that when an H&P is completed within 30 days before admission that an updated medical record entry must be completed and documented in the patient's medical record within 24 hours after admission. The findings include:

DATES OF VISITS: Commencing on June 1, 2007 and concluding on August 9, 2007

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

a. Patient #33 was admitted into the facility on 7/11/07 for bilateral reconstruction of the mandibular rami and removal of an implant. Review of the Pre-op History and Physical/Orders form in the medical record identified that the H&P had been completed on 4/16/07 and had been identified as updated with no changes on 7/9/07. Interview with the VP of Nursing on 7/18/07 identified that the facility did not have a policy for the H&P but referred to the Medical Staff Bylaws. Review of the facility's Medical Staff Bylaws failed to identify the timing of the expected completion of the H&P prior to surgery.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(D) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (4) and/or (i) General (7).

25. Based on a review of the medical record and interview with facility personnel, the facility failed to ensure that physician orders for Patient #15 documented the time the orders were written, in accordance with the hospital bylaws. The findings include:
    a. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. The patient sustained a head laceration; CT Scan in the Emergency Department (ED) was negative for acute hemorrhage, and the patient was admitted to Med 4 (telemetry unit) with working diagnoses of syncope, rule-out myocardial infarction, and acute renal failure. On 02/18/07, the physician ordered bloodwork, and later ordered to "hold fluids" (did not specify oral or intravenous) and failed to document the times the orders were written. On 02/19/07 at 4:45AM, Pt #15 sustained a fall in the hospital and was transferred to the Intensive Care Unit (ICU). The admission orders were dated but not timed. The medical Staff Bylaws stipulated that all entries made in the medical record should include the date and the time.

26. Based on review of medical records, review of facility documentation and interview with facility staff, the facility failed to ensure that verbal orders were dated, timed and/or authenticated promptly by the ordering physician for Patients #1, #2, and #15. The findings include:
    a. On 02/17/07, Patient #15 was admitted to the hospital from an independent living setting where the patient was found unconscious on the floor after a fall. The patient sustained a head laceration; CT Scan in the Emergency Department (ED) was negative for acute hemorrhage, and the patient was admitted to Med 4 (telemetry unit) with working diagnoses of syncope, rule-out myocardial infarction, and acute renal

failure. On 02/19/07 at 4:45AM, Patient #15 sustained a fall in the hospital, was unresponsive and hypertensive (BP 230/110). According to the nurse's note dated 02/19/07 and interview with Registered Nurse (RN) #24 on 07/16/07 at 8:35AM, the physician verbally ordered Labetalol 10 milligrams (mg) intravenously (IV), which RN #24 gave to the patient, but failed to document the verbal order and obtain the prescriber's signature. Review of the Medication Administration Record (MAR) on 02/19/07 also indicated that RN # 24 failed to record the administration of the medication. The hospital policy on "Inpatient Drug Distribution" directed to include the signature of the prescriber on the dated and timed medication orders, and to document the date and time the medication was administered, with the signature of the nurse who administered the medication.

b. Review of RN #24's note dated 02/19/07 also indicated that after the Labetalol IV was given, Patient #15 underwent a CT Scan of the head that identified a large left frontal scalp hematoma and a large right subdural hematoma, and the patient was transferred to the Intensive Care Unit (ICU). At 5:45AM, RN #24 received an order to initiate a continuous IV infusion of Nitroprusside at 0.5mcg/kg/min, with no concentration specified. According to RN #24's note, attending physician's note and interview with RN #14 (who was the ICU Nurse Manager in February 2007) on 07/16/07, the IV Nitroprusside infused from 5:45 AM to 6:02 AM. However, the prescriber or the nursing staff failed to document the orders for initiating and discontinuing the medication in the "physician order" section of the clinical record, with the date and times of the orders, and the prescriber's signature. RN #24's note and attending physician note dated 02/19/07 also indicated that Patient #15 was given 5% Albumin 250 milliliters (mL) intravenously twice, at 6:30AM and 6:40AM on 02/19/07; however, no written order was identified in the physician order section of the record for the two doses. The hospital protocol on Nitroprusside continuous infusion suggested two different concentrations of Nitroprusside solutions, and the hospital Medical Staff Bylaws stipulated that emergency orders would be considered in writing if dictated by the responsible physician or designee to a graduate nurse or other certified professional with Medical Board approval in their respective area, and that the orders required signature by the practitioner or designee within twenty-four hours.

c. Review of Patient #1's clinical record during the period of 2/28/07 through 5/10/07 identified on numerous occasions (approximately 22) that verbal and/or telephone orders lacked a date and time in which the prescribing physician authenticated the order. Review of the hospitals policy for verbal/telephone orders with the Nurse

Manager (on 6/4/07) identified that the LIP or the attending physician must electronically/manually sign, date and time orders within 24 hours.

d. Review of Patient #2's clinical record dated 5/7/07 identified verbal orders were written by the RN at 3:00 PM and 3:30 PM for blood work. Although these verbal orders were signed by a physician, the physician failed to date and time the verbal orders.

27. Based on observation, staff interview and review of facility policy, the facility failed to ensure that all drugs were kept in a secured area, and locked when appropriate. The findings include:

a. An anesthesia cart in the outer core hallway of the OR suite was observed unlocked and unattended with the key inserted in the lock. Interview with the Chief of Anesthesia on 7/12/07, identified that although the facility did not have a policy for the integrity of the anesthesia carts, the cart should have been locked and the key kept in a secured area.

b. During a tour of the labor and delivery unit on 7/11/07, suture material, syringes, two bottles of Xylocaine, and one vial of Pitocin were noted in an unlocked cabinet in an unoccupied patient room. RN #20 stated that the items should have been in a locked cabinet.

c. During tour of the Cardiac Catheter Lab on 7/11/07, the Electrophysiology room had two cabinets with the keys in the unlocked cabinets which contained multiple vials of lidocaine, epinephrine, atropine and also syringes. Review of hospital policy identified that medications are to be stored in a locked area and secured from unauthorized personnel. Interview with the Nurse Manager of the Cardiac Catheter lab on 7/11/07 identified that all medications needed to be locked and secured.

28. Based on tours of the facility, review of facility documentation, review of facility policy and staff interview, the facility failed to ensure that only authorized personnel had access to locked areas. The findings include:

a. During a tour of the outpatient psychiatric services area on 7/13/07, drug samples were noted to be stored in a locked closet. The manager of outpatient psychiatric services stated that after the medication samples are logged into the Medication Sample book, the samples are placed into the locked cabinet. Although the facility Advance Practice Registered Nurses (APRN's) have keys to the locked storage cabinet, the manager of the outpatient psychiatric clinic stated that psychiatrists can access a key to the locked cabinet from the front desk support staff. The facility medication sample policy identified that medications must be maintained in a locked

cabinet and providers may request a registered nurse to log out the requested medication samples.

b. During tour of the Emergency Department on 7/11/07, the medication cart in Beds 1-4 were unlocked and observed to contain multiple vials of medications including Lidocaine, Lasix, Metropolol, Adenosine and unsecured needles. Further observation on 7/11/07 identified that licensed staff were in the room at the time. Review of hospital policy identified that medications are to be stored in a locked area and secured from unauthorized personnel. Interview with the Nurse Manager of the Emergency Department on 7/11/07 identified that all medications needed to be locked and secured.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (4) and/or (i) General (7).

29. * Based on a tour of the inpatient psychiatric units, review of hospital documentation and interviews with staff, a determination was made that the Hospital failed to ensure that the physical environment was safe for one patient (Patient #1) and subsequent to the death of this patient, the Hospital failed to implement immediate safety interventions to correct the environmental safety issues. The finding includes the following:

a. Patient #1 was admitted to the inpatient psychiatric unit on 2/27/07 with a diagnosis of Paranoid Schizophrenia. Review of the clinical record dated 2/27/07 identified that the Patient was 6 feet tall with a weight of 275 pounds on 3/7/07. A progress note dated 5/30/07 at 5:20 PM identified that Patient #1 was found hanging by a sheet in the shower stall located in his private bathroom. Patient #1 had asphyxiated and although cardiopulmonary resuscitation was initiated, the Patient was pronounced dead at 5:41 PM.

30. * During a tour of both psychiatric inpatient units on 6/1/07 during the hours of 1:00 PM to 2:30 PM, the following was observed:

a. The shower curtain rods in each individual patient bathroom throughout the units were made by the facilities maintenance department; the rods were made of PVC schedule #40 & #80 pipe and not of an approved material for the proper break-away.

b. The exhaust vents in each patient bathroom and bedroom throughout the units were the louvered type and not protected by a tamper proof material.

c. The patient bedrooms throughout the units were found to have drapery and/or metal blinds that were mechanically operable by a track and pull rope type system and not of a type that were breakaway and tamper proof.

d. There were ceramic soap dishes located in the showers of the patient bedrooms throughout the units that posed a hanging risk.
e. There was hardware throughout the patient rooms in the units not secured with tamper proof type screws.
f. There were sprinkler heads located within patient bedrooms and bathrooms throughout the units that were not of the approved tamper proof type.
g. The flush valves in the medical psychiatric unit were tall, looped and unenclosed, which posed a hanging hazard.
h. Patient electric beds in the medical psychiatric unit had electrical cords in excess of five (5) feet long and not safely secured.
i. There were patient call bell cords located in rooms throughout the units that were in excess of four (4) feet.

31. * During an interview with the Nurse Manager of Psychiatry (on 6/1/07) she stated that subsequent to Patient #1's death on 5/30/07 she observed that the shower rod located in Patient #1's room was the same shower rod utilized in other patient bathrooms on the psychiatric units. The Nurse Manager explained that these "break away" shower rods were supposed to fall down when pressure was exerted, however, in this case Patient #1 had utilized the end of the rod to tie a sheet instead of using the center of the rod resulting in a suicide hanging. The Nurse Manager further stated that the shower rods in the other patient rooms were left in place following the patient's suicide until a plan could be devised for correcting the problem. During an interview with the Director of Safety (on 6/1/07) he stated that he toured the psychiatric unit on 5/31/07 and observed the shower rods sag in the center with the weight of the shower rings and curtain and when pressure to the end of the rod was exerted, the rod didn't break away from the wall. Upon inquiry of the manufacturers directions for the use of the "break away" shower rods, the Director identified that the shower rods were made by hospital staff using PVC pipe and was unable to provide documentation that any testing on the rods were performed prior to installation. Although Patient #1 committed suicide using the "break away" rod, the hospital failed to initiate any action to ensure the safety of the patient's environment regarding utilization of the "break away" rods. On 6/1/07, the Department requested an immediate action plan to address the above noted patient safety issues in the environment on the psychiatric units.

EXHIBIT C

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

IN RE: University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT – Licensee
d/b/a John Dempsey Hospital of the University of Connecticut Health Center
263 Farmington Avenue
Farmington, CT 06032

CONSENT AGREEMENT

WHEREAS, the University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT (hereinafter the "Licensee"), has been issued License No. 0065 to operate a general hospital known as John Dempsey 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 January 26, 2006, and concluding on June 8, 2006; 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 violation letters dated May 10, 2006 and August 8, 2006 (Exhibits A and B, copies attached); and

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

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Steven L. Strongwater, its Administrator, hereby stipulate and agree and follows:

1. Within twenty-one (21) days of the execution of this Consent Agreement, the Facility shall develop and/or review and revise, as applicable, policies and procedures related to:
    a. Verification of the accuracy of diagnostic information relative to radiological services with an emphasis on the radiological services performed when the facility's radiologist is not available;
    b. Interventional Radiology clinical protocols, policies and procedures;
    c. History and physicals performed by Resident Physicians and/or review of same by Attending Physicians;
    d. Reporting changes of condition to the physician;
    e. Patient assessment prior to and post medication administration for pain control; and
    f. Operating room accounting practices for equipment and/or products.
2. Within thirty (30) days of the review and/or revision of policies and procedures identified in paragraph one (1), all residents, attending physicians and nursing staff shall, as applicable, receive education regarding said policies and procedures.
3. Within thirty (30) days of the execution of this Consent Agreement, the facility shall develop a process for the evaluation of resident medical staffs' competency in clinical areas, documentation of said competency and a process for remediation, if applicable. Documentation related to such evaluations shall be maintained by the facility and available to the Department for a period of three (3) years.
4. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator and Director of Nurses Services, shall ensure substantial compliance with the following:
    a. Patient treatments, laboratory tests, therapies and medications are performed and/or administered as prescribed by the physician and/or in accordance with the Facility's policies and procedures;

b. Physician Resident staff perform patient assessments in a timely manner and results of said assessments are communicated to the attending physician;

c. Patient care plans are reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations; and

d. The attending physician or covering physician is notified in a timely manner of any significant changes a patient's condition.

5. Within sixty (60) days of the execution of this document, the facility shall establish a mechanism whereby the Quality Assurance Program, on an ongoing basis, reviews and evaluates the following:

   a. Protocols for monitoring staff performance which shall include direct observation and remediation of staff who do not perform duties in accordance with facilities policies and procedures; and

   b. Accuracy of medical care provided to patients, to include time notification of the Attending Physicians regarding significant changes of condition.

6. Within thirty (30) days of the execution of this document, the facility shall review and revise, as necessary, mechanisms to monitor and/or supervise interns and/or residents.

7. 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 Agreement. The name of the designated individual shall be provided to the Department within said timeframe. Said individual assigned this responsibility shall submit monthly summary report which address the components of this document to the Department.

8. The individual designated as responsible for the implementation and monitoring of this Order shall meet with the Department and the designated Department's representative every three (3) months for the first year this order is in effect and then every six (6) months for the remaining duration of this Order.

9. The Licensee shall pay a monetary penalty to the Department in the amount of twenty-two thousand dollars ($22,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The monetary penalty and any reports required by this document shall be directed to:

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

10. All parties agree that this Consent Agreement 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 Consent Agreement 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 Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

11. 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.

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

13. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

*

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

UNIVERSITY OF CONNECTICUT HEALTH CENTER-JOHN DEMPSEY HOSPITAL OF FARMINGTON, CT - LICENSEE

9/22/06
Date

By: _____
Steven L. Strongwater, its Administrator

State of Connecticut
County of Hartford

ss Farmington, Sept. 22, 2006

Personally appeared the above named Steven Strongwater and made oath to the truth of the statements contained herein.

MARILYN H. GLENN
NOTARY PUBLIC
MY COMMISSION EXPIRES OCT. 31, 2008

My Commission Expires: _____

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

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

9/26/06
Date

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

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 20

May 10, 2006

Steven L. Strongwater, Administrator
John Dempsey Hospital
263 Farmington Ave
Farmington, CT 06032

Dear Mr. Strongwater:

This is amended edition of the violation letter originally ddated May 9, 2006.

Unannounced visits were made to John Dempsey Hospital on January 24, 25, 26, 27, 30, March 1 and 2, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through May 1, 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 24, 2006 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.

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

Respectfully,

Janet Williams /ESA

Janet M. Williams, RN
Public Health Services Manager
Facility Licesning and Invetigations Section

Elizabeth Andstrom

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

JMW/ESA/DH/DJS:jpf

c. Medical Director
President
Complaints #CT4718; #CT4514; #CT4419; #CT5212; #[redacted]; #CT3061 and #CT5049

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

EXHIBIT A

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) (A) and/or (B) and/or (D) and/or (d) Medical Records (3) and/or (i) General (4).

1. Based on record review and interviews for three of 11 patients, the hospital lacked a mechanism for resident supervision and competency evaluation; and/or failed to ensure that a first year resident physician notified the attending physician of an acute change in a patient's condition; and/or failed to complete a comprehensive medical plan for discharge. The findings include:

*a. Patient #5 was admitted to the Emergency Department (ED) on 6/16/04 at 5:10 PM complaining of severe epigastric abdominal pain 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the medical record revealed the patient's past medical/surgical history included hypertension and ischemic mesenteric artery bypass grafts. Record review and interview with MD #5, (a first year radiology resident at the time of the patient's admission), identified an abdominal Magnetic Resonance Angiography (MRA) was completed on 6/16/04 at 10:08 PM and he interpreted the MRA preliminary report as no evidence of mesenteric occlusion. However, interview with the Medical Director of Radiology indicated that the MRA was misread by the resident and that the following morning the Director of Radiology identified mesenteric occlusion. The patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note revealed a mesenteric graft occlusion, necrotic bowel, a portion of colon that perforated with stool in the abdomen and no viable bowel was present. The Discharge Summary dated 6/17/04 indicated the patient was pronounced dead in the Intensive Care Unit (ICU) on 6/17/04 at 5:44 PM. The Medical Director of Radiology indicated radiology resident supervision between 5 PM and 8 AM was done by consulting the on-call attending radiologist via phone only when the resident had a question. MD #5 indicated he did not have any questions when reviewing Patient #5's MRA and therefore, did not call the covering attending radiologist that night. The hospital lacked a mechanism and policy for radiology resident supervision, resident competency evaluation and radiology interpretation discrepancy. Subsequently, the hospital developed the Supervision of Radiology Residents On-Call Policy that addressed radiology resident supervision and resident competency evaluation, as well as an Abnormal Imaging Policy for radiology interpretation discrepancy.

*b. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. Review of the record identified the patient's blood pressure (BP) had decreased to 104/37 at 10:30 PM (from 162/63 at 10:15 PM) and oxygen saturation dropped to 89-90% on room air. The CSD Flowsheet noted that between 10:30 PM - 4:00 AM the patient had a urinary output of 40 cc (total) and the patient had received 150cc of IV fluid per hour and the BP range was 105/41-106/56 manually. Interview with RN #2 indicated the manual BP was higher than the automated BP and the patient's lower extremities were cyanotic and mottled. RN #2 indicated she called the physician three times during the night, however, she could not recall the times she called. Interview with MD #6, the on-call first year resident, identified he was called at 3:00 AM, indicated he saw the patient and was

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

aware of the decreased urinary output. MD #6 could not recall if the patient's BP was high or low when queried. Although a review of Physician Orders and interview with MD #6 indicated he ordered a bolus of intravenous (IV) fluid at 3:30 a.m., physician progress notes lacked documentation of a physician assessment from 6/16/04 at 8:00 p.m. to 6/17/04 at 7:45 AM. The CSD Flowsheet indicated the patient received 1000cc of IV Lactated Ringer's at 5 AM and continued to be hypotensive and oliguric. Interview with RN #2 indicated that the third time she called MD #6, possibly after 5:15 AM, she communicated the gravity of the patient's condition to MD #6 and was told to wait until "rounds" in the morning and he would speak with the attending physician. Review of the record and interviews with MD #9, the third year surgical resident and MD #11, the attending surgeon, identified they were not notified of the low BP, low urinary output or the midnight laboratory values including creatinine level of 5.0 (normal 0.6-1.2) and white blood cell count (WBC) 16.2 (normal 3.8-10.6). MD #9 indicated that, if she were aware of the laboratory results, she would have returned to the hospital to examine the patient and would have notified the attending physician. Interview with the Chief of Surgery, MD #10 identified that the patient's change in condition should have been communicated via the lines of supervision to the attending physician. Review of the medical record revealed the patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note identified Patient #5 had a mesenteric graft occlusion, necrotic bowel and a portion of colon perforated with stool present in the abdomen. The hospital lacked evidence that the patient was assessed by a physician and received medical intervention in a timely manner between 10:30 PM and 7 AM (6/16/04-6/17/04).

c. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain. The Operative Note dated 6/17/04 identified that the patient was taken emergently to the OR at 10:15 AM where it was identified Patient #5 had occluded the graft and had no viable small intestine or colon. Admission Physician Orders dated 6/16/04 directed lactate levels be drawn every six hours. However, review of the record and interview with MD #6 revealed lactate dehydrogenase (LDH) levels were completed every six hours, not serum lactate. A laboratory report dated 6/17/04 at 8:10 AM identified the patient's lactic acid level (lactate) was 19.5 (norm 0.5-1.9 mmol/L). Record review and interviews with MD #6, MD #9 and MD #11 identified lactate levels were not completed every six hours as per Admission Physician Orders.

d. Patient #1 was admitted to the hospital on 7/15/05 with complaints of urinary retention and chronic constipation. The patient's past medical history included schizophrenia, borderline IQ and chronic constipation. Review of the record identified that the patient had a psychiatric consult during hospitalization. Interview with the attending medical physician, MD #3 indicated that the patient had elimination problems due to psychiatric issues. MD #3 identified that he had to speak to Patient #1 many times concerning his refusal of enemas. A Psychiatry Attending Sign-off Progress Note dated 8/9/05 failed to address toileting issues and recommended follow-up with a psychiatrist. The Consultation Policy indicated that the consulting physician examines the patient and documents recommendations in the patient's medical record. Review of the W-10 discharge Clinical Resume Form dated 8/18/05

completed by the attending physician lacked a plan for psychiatric follow-up as per the consulting psychiatrist's recommendation.

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

2. Based on record review and interviews for one patient, the hospital failed to complete a patient's history and physical according to Medical Staff Bylaws. The findings include:
   a. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain, 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the record indicated that after completion of the MRA, Patient #5 was admitted to the Cardiac Step-Down Unit on 6/16/04 at 10:30 PM. Review of the record and interviews with two surgical residents, MD #6 (first year resident at time of admission) and MD #9 (third year resident at time of admission) indicated that they examined the patient in the ED at approximately 7 PM. MD #6 documented the admission history and physical (H & P) in the record at 8 PM. Interview with MD #9 revealed that it was not required that the senior resident co-sign the junior resident documentation. Review of the hospital's Medical Staff Rules and Regulations revealed that residents may take medical histories and perform physicals under the supervision of a qualified physician. The Medical Staff Bylaws also identified that the attending physicians shall review and approve the H & P examination. Record review and interview with MD #11, the attending physician, identified he examined the patient the following morning on 6/17/04 after reviewing the MRA in radiology. Review of the Cardiac Step-Down Unit Structure Standards identified that it was the attending physician's responsibility to see and evaluate the patient within 8 hours of admission. Interviews with hospital personnel and review of the record identified that the patient's attending physician failed to examine and evaluate Patient #5 within 8 hours of admission as per hospital policy. The hospital lacked evidence that the residency staff performed the H & P under the supervision of a qualified physician and that the attending physician authenticated the H & P as per Medical Staff Bylaws.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service and/or (d) Medical Records (B) and/or (i) General (7).

3. Based on review of the medical records, review of facility policies and procedures, and staff interviews for six patients (Patients #1, #2, #3, #5, #10, and #11), the nursing staff failed to supervise and evaluate the care of the patients per facility protocol. The findings include:
   a. Patient #1 was admitted to the hospital on 7/15/05 with complaints of urinary retention and chronic constipation. The patient's past medical history included schizophrenia, borderline IQ and chronic constipation. Physician Orders dated 8/13/05 directed to weigh the patient daily and Physician Orders dated 8/19/05, the day of discharge, at 8:10 AM directed that two soap suds enemas be administered to the patient. The Medical-Surgical Unit Flowsheets dated 8/13/05-8/19/05 lacked daily weights for 8/14/05, 8/16/05, 8/18/05 and 8/19/05. Review of the Medication Administration Record dated 8/19/05 lacked enema administration

documentation. Interview with the Nurse Manager identified that the physician orders should have been implemented prior to discharge or a note as to why the enemas were not administered.

b. Patient #2 was admitted to facility on 10/23/05 with chief complaints of suicide ideation, severely depressed and panic attacks. Review of the high risk assessment dated 10/23/05 identified that Patient #2 had a active suicidal intent and was admitted for safety and stabilization. Patient #2 was placed on fifteen-minute checks. Patient #4 was assessed with high risk behaviors including harm to self and/or others and was also on fifteen minute checks. On 10/25/05 at 11:00 PM, Patient #2 was seen talking to Patient # 4 near the medication room. At approximately 11:20 PM Patient #2 & Patient #4 were seen by mental health worker #1 outside of doorway of Room #1035 and walking to their rooms. RN #5 stated that Patient #2 seemed upset as she went to her room, shut the door and closed the curtains. Mental Health Worker (MHW) #1 stated that she went into Patient #2's room to check if she was ok however fifteen minutes later Patient #2 came out of her room and stated that Patient #4 raped her. Although Patient #4 admitted sexual contact with Patient #2, he stated that the entire act was consensual. Subsequently, both patients were placed on 1:1 observation. An arrest warrant was later issued for Patient #4 for sexual assault. Interview with MHW #1 and RN #5 indicated that they were at the nurses station when incident occurred. MHW #1 stated that one other nurse on the unit was in the medication room. MHW #1 stated that all the other patients were either in their rooms or sleeping except Patient #2 and Patient #4. Review of the staffing and assignment sheets dated 10/25/05 identified that although there were 7 patients total on the unit with 3 staff members assigned to these patients, adequate supervision of patients was lacking.

*c. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. Review of the record identified the patient's blood pressure (BP) had decreased to 104/37 at 10:30 PM (from 162/63 at 10:15 PM) and oxygen saturation dropped to 89-90% on room air. The CSD Flowsheet noted that between 10:30 PM - 4:00 AM the patient had a urinary output of 40 cc (total) and the patient had received 150cc of IV fluid per hour and the BP range was 105/41-106/56 manually. Although, a Nurses' Note dated 6/17/04 indicated the physician was informed of the decrease in urinary output, documentation lacked the time of notification. Interview with RN #2 indicated the manual BP was higher than the automated BP and the patient's lower extremities were cyanotic and mottled. RN #2 indicated she called the physician three times during the night, however, she could not recall the times she called. Interview with MD #6, the on-call first year resident, identified he was called at 3:00 AM, and MD orders indicated that he ordered a bolus of intravenous (IV) fluid at 3:30 AM. The CSD Flowsheet indicated that although the patient received 1000cc of IV Lactated Ringer's at 5 AM, the patient continued to be hypotensive and oliguric. Interview with RN #2 indicated that the third time she called MD #6, possibly after 5:15 AM, she communicated the gravity of the patient's condition to MD #6 and was told to wait until "rounds" later in the morning and he would speak with the attending physician. Review of the medical record revealed the patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note identified Patient #5 had a mesenteric

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graft occlusion, necrotic bowel and a portion of colon perforated with stool present in the abdomen. The hospital lacked evidence, including clinical documentation, that nursing staff communicated the patient's continuing deterioration in condition in a timely manner between 10:30 PM and 7 AM (6/16/04-6/17/04).

d. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain, 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. The hospital's Pain Policy indicated that assessment of medication effectiveness was conducted every 4 hours or more frequently with unrelieved pain. Review of the medical record and interview with RN #2 identified that the patient was extremely restless, not wanting to stay in bed and complained of abdominal pain 5/10 (12-2 AM) and 9/10 (4-6 AM) during the night on 6/17/04. Further review identified the patient received Dilaudid 2 mg at 11:45 PM (6/16/04) and 3 AM (6/17/04), however, documentation lacked reassessment for medication effectiveness. The record lacked pain documentation from 6-10 AM. The hospital failed to perform pain reassessment as per hospital protocol.

*e. Patient #3 was admitted to the facility on 7/27/05 with complaints of abdominal pain, nausea and vomiting. Patient #3 had a history of intra-abdominal ovarian carcinomatosis. Patient #3 was admitted to the oncology floor and started on nasogastric decompression with a nasogastric tube attached to low wall suction after partial resolution of a small bowel obstruction. Patient #3 had then been prepared for PEG placement by GI, however the PEG could not be placed by GI due to extensive compression of the stomach by tumor metastases. Patient #3 was then scheduled for Interventional Radiology guided PEG placement. Interview with RN #4 identified that prior to the procedure, he connected the compressed air line to Patient #3's nasogastric tube and had not realized that it was on. The patient subsequently became unresponsive, pulseless and hypotensive. Patient #3 was given CPR, intubated and sent to the ICU where she expired on 8/2/05. The autopsy report dated 8/3/05 identified that Patient #3 had expired from gastric perforation with associated pneumoperitoneum, pneumomediastinum, subcutaneous emphysema in the neck and bilateral upper extremities. Interview with MD #8 identified that he was not aware that RN #4 had connected compressed air to Patient # 3's nasogastric tube. Prior to the procedure, MD #8 stated he had discussed with team that he was going to use a 60cc syringe to inject air into stomach, however, RN #4 connected the NGT to compressed air. Interviews with staff in Interventional Radiology failed to ascertain that standard protocols for use of compressed air were in place prior to the incident or that "time outs" were done subsequent to this incident as part of planned corrective action. MD #8 stated that he never uses compressed air for PEG placements in interventional radiology. Nursing staff failed to act under medical direction and to monitor the patient when compressed air was connected to the patient's nasogastric tube.

f. Patient #10's diagnoses included depression and left shoulder pain. Physician's orders dated 2/27/06 incuded Oxycodone 5/325 millligrams every six hours as needed for pain. Nurses' notes dated 2/27/06 at 8:30 PM identified that the patient had a pain level of "7" on a scale of "1-10"; however, the medical record lacked documentation that the patient's pain level was reassessed. Review of the Pain Level Documentation with Nurse Manager #1 identified that although Patient #11 was medicated for a pain level of "5" at 10:40 AM, it lacked

documentation of Patient #11's response to the Oxycodone.

g. Patient #11's diagnoses included major depression and bipolar disorder. Patient #11 received an ECT treatment on 2/24/06 at 3:50 PM and vital signs were documented at 6:27 AM (prior to the treatement) and 6:00 PM. Patient #11 received another ECT treatment on 2/27/06 at 3:30 PM and vital signs were documented at 6:45 AM, 10:15 AM(prior to the treatment), and 8:00 PM. Review of the medical record with the Assistant Nurse Manager identified that post-ECT treatment, the medical record lacked documentation that vital signs were recorded every four hours for twelve hours according to physician's orders.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing.

4. Based on review of the medical record, review of facility policies and procedures, and staff interviews for five patients (Patients #2, #4, #5, #9, and #10), the facility failed to initiate a care plan based on the patients' diagnoses and/or current condition. The findings include:

a. Patient #9 was admitted to the acute inpatient psychiatric unit. The multidisciplinary treatment plan dated 9/20/05 identified that Patient #9 had altered health status as evidence by a fall risk, an impaired endocrine system, and an impaired cardiovascular status. Review of the medical record with Nurse Manager #1 identified that although an altered health multidisciplinary treatment plan was initiated on admission, the medical record lacked specific interventions to address Patient #9's diabetic and hypertensive status, including disease management and patient teaching related to discharge planning. Although Patient #9 was identified to be a fall risk, the medical record lacked daily assessments (per facility protocol) and specific interventions related to the patient's fall risk. The facility Treatment Planning Process identified that specific interventions, including nursing protocols, will be written in the plan. Further individualization of the treatment plan is accomplished by writing interventions for specific patient needs.

b. Patient #10's diagnoses included urinary tract infection and depression. Review of the medical record with Nurse Manager #1 identified that although a urine culture and sensitivity was completed and an antibiotic was initiated on 2/27/05, the multidiscipliary treatment plan dated 2/28/06 lacked identification and/or specific interventions to address Patient #10's genitourinary status. The facility Treatment Planning Process policy identified that when additional problems are evident, the appropriate nursing problem will be initiated and a treatment plan will be developed.

c. Patient #4 was admitted to the acute inpatient psychiatric unit on 10/23/05. Patient #4 had a history of multiple suicide attempts. Review of the high risk assessment dated 10/23/05 identified that Patient #4 had an active suicidal intent and history of assaultive behaviors. Patient #4 was placed on every fifteen-minute checks. Review of the psychiatric assessment dated 10/24/05 identified that Patient #4 wanted to hurt or cut himself and had multiple suicide and self-harming gestures. Patient #4 was placed on fifteen-minute checks, however, the multidisciplinary treatment plan and the initial nursing treatment plan dated 10/24/05 lacked specific interventions planned for Patient #4's diagnoses of suicidal and homicidal ideation.

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d. Patient #2 was admitted to facility on 10/23/05 with chief complaints of suicide ideation, severe depression and panic attacks. Patient #2 had a long history of suicide attempts with seven inpatient hospitalizations in the last year. Review of the high risk assessment dated 10/23/05 identified that Patient #2 had a active suicidal intent and was admitted for safety and stabilization. Patient #2 was placed on fifteen-minute checks. Review of the initial psychiatric evaluation dated 10/23/05 identified that Patient #2 had been crying since the afternoon and was suicidal. Further review identified that Patient #2 had a history of multiple suicide attempts and multiple cutting and self-mutilating episodes in the past. Although Patient #2 was placed on fifteen minute checks, review of the multidisciplinary treatment plan and the initial nursing treatment plan dated 10/24/05 lacked specific interventions planned for Patient #2's diagnoses of suicide and severe depression.

e. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. The Admission Documentation Policy indicated the RN would initiate the plan of care. Review of the clinical record and interview with hospital staff identified the record lacked a patient care plan as per hospital 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)(B), and/or (e) Nursing service (1), and/or (g) Pharmacy (1), and/or (i) General(7).

5. Based on review of the plans of correction for violation letters dated 1/21/05 and 2/1/05, review of hospital documentation and interviews, the hospital lacked evidence that the plans of correction were completed within the timeframes identified. The findings include:

a. Review of the plan of correction (POC) for the violation letter dated 1/21/05 identified that the hospital's medication administration policy was to be reviewed in the Emergency Department's Physicians and Licensed Independent Practitioners monthly meeting, February 25, 2005. Review of hospital information and interviews with hospital staff identified that the hospital lacked evidence the policy was reviewed.

b. Review of the POC for the violation letter dated 1/21/05 identified that the Pharmacy would audit Pyxis descrepancies and random chart audits with outcome evaluation would be completed in the Emergency Department. Interviews with hospital staff identified that the hospital lacked evidence the audits were completed.

c. Review of the plan of correction (POC) for the violation letter dated 2/7/05 identified that a log of the cidex OPA test strip process for daily outdate checks would be kept in the Central Sterile Department. Review of the log and interviews with hospital staff revealed that daily checks were not completed.

d. Review of the plan of correction (POC) for the violation letter dated 2/7/05 identified that chart audits would be completed to review required intravenous documentation. Review of hospital documentation and interviews with hospital staff lacked evidence that the audits were completed.

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

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

General (7), and/or (f) Infection control (1).

6. Based on observations, record review and interviews for one patient, the hospital lacked evidence that laundry personnel handled dirty linen bags according to hospital policy. The findings include:
   a. During tour of the nursery, a housekeeper was observed in the neonatal intensive care unit handling dirty linen without gloves and gown. The hospital's Linen Policy and interview with the Infection Control Nurse identified laundry personnel handling dirty linen bags shall wear moisture resistant gloves and will take appropriate precautions when handling soiled linen (i.e. gloves and gowns).

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), and/or (e) Nursing service (1), and/or (i) General (7), and/or (f) Infection control (1).

7. Based on record review and interviews for two patients (#6 and #8), the hospital lacked a physician order for isolation and/or a signed operative consent. The findings include:
   a. Physician Progress Notes dated 6/26/05 identified that Patient #6 had a post-operative wound infection and blood cultures were positive for Methicillin-resistant staphylococcus aureus (MRSA). Physician Progress Notes dated 6/26/05 recommended "gown and glove" and identified "precautions" on 6/27/05. Although interviews with nursing staff indicated isolation was implemented, the record lacked a physician order for isolation.
   b. Patient #8 was transferred to the hospital on 1/21/06 from another acute care facility for an emergency coronary artery bypass graft (CABG). Review of the discharge summary and interview with MD #12 identified the patient went to the operating room (OR) on 1/31/06 for a "second look" exploratory laparotomy status post small bowel resection on 1/30/06. Although interview with MD #12 indicated a surgical resident had obtained an operative permit, the medical record lacked a signed operative permit for the "second look" exploratory laparotomy scheduled on 1/31/06.

The following is a violation of the General Statutes of Connecticut Sections 19a-127n, as amended by section 123 of public act 03-278 and the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

8. Based on record review, interviews with hospital staff and review of hospital information, the hospital lacked a comprehensive adverse event report. The findings include:
   a. Patient #5 was admitted to the Emergency Department (ED) on 6/16/04 at 5:10 PM complaining of severe epigastric abdominal pain 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the medical record revealed the patient's past medical/surgical history included hypertension and ischemic mesenteric artery bypass grafts. Record review and hospital staff interviews revealed the patient expired the following day after bowel infarction and septic shock. Review of the hospital's adverse event report, further record review and staff interviews identified that the hospital lacked evidence of an adequate investigation of the adverse event facts. Therefore, the hospital failed to adequately identify a

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

comprehensive corrective action plan. Review of the hospital's corrective action plan failed to implement strategies that reduced the risk of similar adverse events occurring in the future, as well as, failed to develop and implement measures to evaluate the effectiveness of such strategies.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

August 8, 2006

Steven L. Strongwater, M.D., Administrator
John Dempsey Hospital
263 Farmington Avenue
Farmington, CT 06032

Dear Dr. Strongwater:

Unannounced visits were made to John Dempsey Hospital on June 5, 6, 7, 8, 19 and 20, 2006 and July 18, 19 and 20, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a Licensing Renewal Inspection, a federal survey at the request of CMS and a follow-up to a plan of correction for a statement of deficiencies dated June 19, 2006 and a violation letter dated February 1, 2005.

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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 22, 2006 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation 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, in-service 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.

Respectfully,

Ann Marie Montemerlo, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

AMM:zbj

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Affirmative Action / An Equal Opportunity Employer

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

The following are violations of the Connecticut General Statutes Section 46a-152(d) and/or (d)(2) and/or violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Service (1).

1. Based on review of the facility quality improvement/clinical operations minutes and staff interviews, the facility failed to ensure that there was a mechanism in place to evaluate the quality of each contracted service and that the contracted services were provided in a safe and effective manner. The findings include the following:
   a. Review of the quality improvement meeting minutes for the period of 1/05-5/06 indicated that there lacked documentation that contracted services e.g. hemodialysis, anestheisa, pediatric EKG readings, provided to the hospital were part of the Performance Improvement committee or were reviewed as part of the hospital wide quality assessment and performance improvement evaluation as other services provided directly by the hospital. While interviews revealed that these services are integrated into various hospital committees, there lacked documentation that the actual services were reviewed and/or evaluated by the Performance Improvement committee.

2. For Patient #20, the facility failed to ensure that the patient was monitored while in restraints. Based on review of the medical record, review of facility policy and staff interviews, the findings include the following:
   a. Review of the clinical record of Patient #20 identified that on 6/1/06 the patient had an order directing the use of a vest restraint. Review of the restraint-monitoring sheet dated 6/1/06 indicated that there lacked documentation of restraint monitoring for the period of 12:00AM-9:00AM. The 9:00AM documentation indicated that the vest restraint had been removed. Review of the facility policy indicated that while a patient is in restraints, the patient will be assessed for fluid and fluid needs, toileting needs, skin integrity, range of motion and removal and reapplication of restraints every two hours. On 6/2/06, Patient #20 had an order for bilateral wrist restraints. Review of the restraint monitoring flow sheet dated 6/2/06 indicated that the patient had bilateral wrist restraints in place from 12:00 AM-6:00 AM. The flow sheet identified that the restraints had been released and reapplied at 2:00 AM and 5:00 AM, twice in an 8 hour period. Review of the nurse's note dated 6/2/06 at 6:00AM identified that the patient was noted to have sustained a reddened area under the right wrist restraint site and that the physician had been notified of the skin breakdown. The note identified that Tegaderm had covered the area. Review of the facility policy indicated the removal and reapplication should be completed every two hours.

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 (1)(A) and/or (c) Medical staff (2) and/or (d) Medical records (3).

3. Based on medical record review for Patient #30 and staff interview, the facility failed to ensure there was a mechanism in place for medical resident supervision. The findings include:
   a. Review of the clinical record for Patient #30 identified that the patient was initially seen at the outpatient psychiatry clinic in 8/03 for medication management. Review of the record indicated that the patient was being seen every three months by the resident staff. Review of the record indicated that MD #15 who is a PGY 4 had been seeing the patient since 12/04. Review of the progress notes dated 12/2/04, 8/3/05, 12/21/05 and 3/15/06 identified that there lacked documentation that an attending physician oversaw the care provided by the Resident (PGY4). Interview with the Medical Director and the Chief of Psychiatry indicated that PGY 3's see patients in conjunction with the Attendings and the progress notes are co-signed, however PGY 4's see the patients independently and the cases are discussed with the attending physician after the visit but there is not always documentation in the record to reflect this. The facility lacked a policy that addressed resident supervision.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (7).

4. Based on medical record review, review of facility policy and procedure, staff interview and observations, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for each patient e.g. Patients #5, #16, #21, #23 and #34. The findings include:
   a. Patient #15 was admitted to the hospital on 4/22/05 with diagnoses of lumbar disc displacement and spondylisthesis and underwent multiple surgical procedures of the spinal column. Following the surgical procedures and post-operative recovery period, Patient #15 was admitted to a hospital unit on 4/22/06 at approximately 10 PM with a PCA pump (patient controlled analgesia). Review of Patient #15's clinical record identified that vital signs were obtained shortly after the patient's arrival on the unit at 10 PM and were not obtained again until 1:45 AM, when the patient was found unresponsive, approximately 3 1/2 hours later. Interviews with the Director of Performance Improvement & Patient Safety on 6/7/06 and again on 6/14/06 identified that, per the hospital's patient controlled analgesia pain policy, a patient's vital signs were to be assessed every 2 hours.

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

b. Patient #16, with diagnosis that included Diabetes Mellitus and was on hemodialysis, was admitted on 6/2/06 with chest pain. Review of the medical record identified that the initial nursing database assessment on 6/2/06 lacked completion.

c. For one (1) of two (2) patients on hemodialysis, the facility failed to ensure that the patients weight had been obtained after the hemodialysis treatment. Review of Patient #21's dialysis treatment flow sheets dated 5/29/06 and 6/2/06, indicated that there lacked documentation that the patient had been weighed at the end of the dialysis treatments. Review of the facility policy indicated that at the end of the treatment, the patient should be assessed and the assessment should include comparing the pre and post dialysis weights to determine the amount of fluid removed.

d. Patient #23 had a history of breast cancer and was admitted to the facility on 6/1/06 due to dehydration, malignant ascites, nausea and vomiting. A review of physician orders identified vital signs and pulse oximetry were to be done every four hours, weights were to be done daily, and the physician was to be notified if designated vital sign parameters were not met. A review of the daily nursing flow sheets and progress notes identified documentation was lacking that vital signs and pulse oximetry were done every four hours and that daily weights were done. In addition, physician orders directed he be notified if the systolic blood pressure was less than 90. A review of the nurse's flow sheet identified on 6/3/06 that the blood pressure was 89/67. Documentation was lacking of physician notification.

e. A review of Patient #23's and Patient #34's IV lines identified they were labeled with a piece of tape and had the date 6/5/06 written on them. A review of facility policy and interview with the Nurse Manager identified that a standard label with the start date/time and expiration date/time should be used because it was not possible to determine whether the 6/5/06 date was a start date or end date.

5. Based on medical record review and review of facility policy and procedure, the facility failed to ensure for five (5) of six (6) care plans reviewed that nursing staff developed and/or kept current a nursing care plan for Patients #20, #21, #22, #23 and #27. The findings include:

a. Review of the medical record for Patient #20 indicated that the patient had been admitted on 5/31/06 with expressive aphasia and to rule out a cerebral vascular accident (CVA). Review of the clinical record on 6/5/06 identified that there lacked a current care plan.

b. Review of the medical record for Patient #21 identified that the patient had been admitted on 4/26/06 with diagnoses of aspiration pneumonia, diabetes, acute renal failure and respiratory failure. During the patient's hospitalization, the patient had a tracheostomy, permacath placement and received hemodialysis, developed a small bowel obstruction and was started on parenteral nutrition. Review of the care plan on 6/5/06 indicated that the patient's active

problems were alteration in gas exchange and alteration in nutrition. The care plan failed to address the patients other issues related to dialysis or diabetes. Review of the care plan policy indicated that the RN or LPN is responsible for initiating; reviewing, updating and/or revising the care plan for each assigned patient.

c. Patient #22, who was status post a fall, was admitted on 6/4/06 with complaints of syncope. Review of the medical record identified that the patient was identified as a high risk for falls. Review of the facility protocol for falls directed that an individualized fall prevention treatment plan would be developed for each patient based on the patient's risk for falls. Review of the patients Nursing outcomes/plan of care for falls, failed to identify individualized interventions.

d. Patient #23 with a history of breast cancer was admitted to the facility on 6/1/06 due to malignant ascites, dehydration, nausea and vomiting. Physician orders directed the need for daily weights, vital signs and pulse oximetry every four hours. The patient underwent a paracentesis during which 2100 cc's of fluids was removed, received Dilaudid for pain as needed, was not able to take nourishment by mouth, was nauseaus and vomited, required parenteral nutrition, and the insertion of a PICC line. A review of the patient's care plan identified Problem #1 as discharge planning and identified the intervention of "discharge planning protocol" but lacked identification of patient specific needs. Problem #2 identified educational needs regarding hospitalization and illness and identified the intervention of "admission protocol" but lacked specifics of what the patient needed education for or how to approach it. Problem #3 identified alteration in fluid volume with interventions that included IVF, labs, antiemetics, and to replace electrolytes as ordered. Problems, interventions, and goals were lacking regarding the nausea and vomiting, nutrition needs, post paracentesis monitoring, pain control, and fluid retention monitoring.

e. Patient #27 was admitted to the facility on 6/1/06 with meningococcemia. The patient was placed on respiratory isolation, had episodes of chest and musculo-skeletal pain, had a rash from the menigococcemia, and required pain medication. A review of the patient's care plan identified problems of pain control, IV's, pulse oximetry with desired outcomes but lacked any patient specific interventions. Problems, interventions, and outcomes relative to respiratory isolation, the rash, and any educational needs were lacking.
A review of the facility's policy on Nursing outcomes/plan of care identified there were a list of categories of actual or potential problems as well as nursing standards (protocols, procedures) that staff must consider for each patient and identify if it was an active problem or not. Outcomes were identified but there were not references to what interventions were required for the patient problems

identified. Where a protocol was identified, specific interventions within the protocol relative to the patient needs were not identified.

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

6. Based on medical record review and review of facility policy for one (1) of one (1) hemodialysis patient reviewed, the facility failed to ensure that Patient #21 had a valid physicians order in place for an administered treatment. The findings include:
   a. Review of Patient #21's hemodialysis treatment flow sheet dated 6/2/06 identified that the patient was being dialyzed with a 2.0 Potassium and 2.5 Calcium bath. The flow sheet further indicated that at 3:35 PM, the patient had a potassium level of 2.9 and was placed on a 4.0 Potassium bath. Review of the physician's orders indicated that there lacked a physician's order directing the administration of a 2.0 Potassium bath or the subsequent change to the 4.0 Potassium bath. Review of the corresponding physician order's indicated an order for a 3.0 Potassium and 2.5 Calcium bath however, the orders while signed by an RN had not been authenticated by a Licensed Independent Practitioner. Review of the facility policy identified that the physician's order should be checked prior to the start of the hemodialysis treatment to verify the orders.

7. Based on clinical record review and staff interviews, the hospital failed to ensure that patient clinical records were accurately written and promptly completed for five (5) patients, Patients #12, #13, #14, #15 and #30. The findings include:
   a. Patient #12 was admitted into the Partial Hospital Program on Friday, June 2, 2006, and was to attend the program 5 days a week. The patient was identified with severe depression, had feelings of being overwhelmed and having feelings of killing herself but would not carry them out. Although the clinical record identified the patient participated in a safety plan, the content of the safety plan was not documented. In addition, a progress note dated Monday, June 5, 2006, identified that Patient #12 called and stated that she would not be coming to the program that day, but would return the next day. Interview with the Licensed Professional Counselor on 6/5/06 at 1:45 PM identified that a safety plan was discussed with Patient #12 at the time of the call, but not documented.
   b. Patient #13 was admitted to the psychiatric unit on 5/31/06 with a diagnosis of dementia and a major depressive disorder. Patient #14 was admitted to the psychiatric unit on 5/19/06 with a diagnosis of schizophrenia with a history of threatening behaviors.

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

The master treatment plans for Patients #13 and #14 were reviewed with the Nurse Manager on 6/5/06. The plans for both patients identified a problem related to an altered thought process but failed to identify specific interventions appropriate to the patients. The plans referred to a hospital protocol related to an altered thought process, but staff failed to identify which aspects of the protocol applied to the patients.

c. Patient #15 was admitted to the hospital on 4/22/05 with diagnoses of lumbar disc displacement and spondylisthesis and underwent multiple surgical procedures of the spinal column. Following completion of the surgical procedures, the patient was placed in the post anesthesia care unit (PACU) at 8 PM. The PACU records were reviewed with RN #11 and identified that although the PACU clinical record reflected that admitting, interim and discharge assessments were completed and the patient assessments were within normal limits, the printed computerized clinical record documentation did not reflect dates and times that the assessments were performed. RN #11 identified that some dates and times related to specific aspects of the assessment could be found elsewhere in the record, but the printed record did not allow for each assessment to be dated and timed.
In addition, following the PACU, Patient #15 was admitted to a hospital unit on 4/22/06 at approximately 10 PM. On 4/23/05 at 1:45 AM, NA #1 entered Patient #15's room to obtain routine vital signs. The patient was identified as snoring, had no obtainable blood pressure and her lips were blue. An emergency code was called, the patient was resuscitated, intubated and transferred to ICU. On 4/23/05, a neurological consult was obtained that identified the patient had suffered a cardiopulmonary arrest of unknown duration, occurring sometime within a 40 minute time period. The patient was identified as experiencing a severe ischemic anoxic brain injury with a lack of brain stem function. On 4/24/05, the patient was extubated with family present, and death was pronounced at 11:53 AM.
Interview on 6/13/06 at 9:30 AM with MD #20, the pathologist, identified that the patient died from a massive saddle-type pulmonary embolism that completely blocked the patient's airway. The pathologist identified that pulmonary embolisms of this type are fatal and death is instant. The clinical record was reviewed with RN #10, RN #11 and the Risk Manager and failed to identify specific dates and/or times that care was provided to Patient #15 between 4/22/05 at 10 PM and 4/23/05 at 1:45 AM.
Interviews with the Director of Performance Improvement & Patient Safety on 6/7/06 and again on 6/14/06 identified that, per the hospital's patient controlled analgesia pain policy, a patient's vital signs were to be assessed every 2 hours. Review of Patient #15's clinical record identified that vital signs were obtained

shortly after the patient's arrival on the unit at 10 PM and were not obtained again until 1:45 AM, when the patient was found unresponsive, approximately 3 1/2 hours later.

d. Review of the clinical record for Patient #30 identified that the patient had been seen initially on 8/13/03. The clinical record indicated that the current treatment plan had been completed on 4/21/05. Interview with the Program Director indicated that the treatment plans are to be updated every six months.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (g) Pharmacy (4) and/or (i) General (7).

8. Based on observation, staff interview and review of facility policy, the facility failed to ensure that medications that required refrigeration were appropriately stored. The findings include:
   a. During a tour of Surgery 7 on 6/6/06, observation identified the Pyxus medication refrigerator temperature, that contained medications, was fifty degrees and warm inside. Documentation was lacking that temperature monitoring had been performed and the freezer was a solid block of ice. A review of the policy for management of the unit medication refrigerator identified the temperature range should be between thirty-six and forty-six degrees, checked at least every twenty-four hours by authorized unit staff and that a temperature log would be maintained. If the temperature was outside the acceptable range, a call would be placed to Facilities for repair and to Pharmacy for disposition of the medications. During interviews with Surgery 7 staff, no one was able to identify whose responsibility it was to monitor the temperature and defrost the freezer.
   b. During tour of the Labor and Delivery unit on 6/7/06, the medication refrigerator freezer that contained Cervidil suppositories, was observed compacted with ice build-up. Interview with the Pharmacist on 6/7/06 identified that nursing is responsible for the defrosting of the refrigerators/freezers.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (4).

9. Based on observation, staff interview and review of facility policy, the facility failed to ensure that drugs and/or biologicals were kept in a locked storage area. The findings include:
   a. During tour of the pre-testing area of the Operating Suite on 6/5/06, the medication refrigerator was observed unlocked. Review of the facility policy on

the management of the medication refrigerator directed that all drugs requiring refrigeration shall be kept locked.

b. An anesthesia cart in the outer core hallway of the OR suite was observed unattended and unlocked with the key hanging in the lock. Additionally, an unlocked difficult airway cart containing medications was observed in this same area.

c. During tour of OR #9, an unattended and unlocked anesthesia cart was observed. Additionally, an unlocked Latex box containing medications was observed on the floor of this OR.

d. During tour of the unattended Procedure Room 1, the key to the medication cabinet was observed stored in the unlocked drawer below the cabinet. Interview with the RN of that area identified the key should be on the nurse, not in the drawer.

e. During tour of the Cesarean Section OR on 6/7/06, an unlocked and unattended anesthesia cart was observed. Interview with the Chief of Anesthesia identified that the anesthesia carts should be locked at the conclusion of a case.

10. Based on observation and staff interviews, the facility failed to ensure that outdated drugs and/or biologicals were not available for patient use. The findings include:

a. Anesthesia carts in the holding area of the Operating room suite contained expired medications vials of Romazicon that had expired on 4/05, and Naloxone HCl that had expired on 1/03 and 11/05, mixed in with regular medications.

b. Anesthesia carts in OR #7 contained expired medication vials of Metoprolol that had expired on 10/05, Benadryl that had expired on 4/05, and Dopamine that had expired on 9/04, mixed in with the regular medications.

c. A medication room in the OR suite was observed to contained tackle boxes with medications in them, piled on the floor. The one inspected contained expired Lidocaine medication dated '05. Interview with the Chief of Anesthesia on 6-8-06 identified that the OR anesthesia techs had the responsibility of checking the anesthesia carts for expired medications and to restock them. Additionally, he noted that the individual tackle boxes belonged to individual licensed staff who should check for out dated medications.

d. During a review made on 6/5/06 and 6/6/06 of medications in Interventional Radiology, sterile water, Urikinase, and Barium sulfate had expiration dates of 12/05, 6/1/06, and 4/06.

e. A review of medications in the Cancer Clinic identified Coumadin, Jantiva, Mag Ox, Amoxicillin, Lidocaine, Alamag plus, and normal saline that had expirations dates of 1/06, 5/06, 12/05, 8/05, 9/05, 7/05, and 2/13/06 respectively.

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

f. A review of medications on Oncology 6 identified multiple vials of depotassium, a study drug that had expired on 5/15/06.

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 (g) Pharmacy (1).

11. Based on review of facility documentation, observation and staff interview, the facility failed to ensure controlled drugs were accounted for and/or failed to follow facility policy for drug discrepancies. The findings include:

a. Review of the Oncology unit controlled drug discrepancy report on 6/5/06 identified a discrepancy for epidural Hydromorphone 2.5mg/250cc solution bags. The Pyxis machine that dispenses medication, reflected that three (3) IV bags of the epidural Hydromorphone 2.5mg/250cc bags were listed as being available in the machine, yet were not observed inside of the Pyxis drawer. Review of facility documentation and/or interview with the Director of Pharmacy on 6/8/06 at 12:45 PM identified the following: 1. On 5/2/06, a pharmacy technician actually delivered three bags of Hydromorphone 20mg/100cc IV bags to the Pyxis machine and entered the bags as epidural Hydromorphone 250cc into the Pyxis system. 2. A Pharmacist tried to correct the error on 5/2/06, placed the Hydromorphone 20mg/100cc bags into the correct drawer, and added the three bags into the Pyxis tracking system. 3. The Pharmacist failed to delete the error entry for the three bags of Hydromorphone 2.5mg/250cc. 4. The discrepancy continued from 5/2/06 to 6/7/06 until it was brought to the attention of the Pharmacy Director. Further interview with the Director of Pharmacy at this time identified that when nursing could not resolve the discrepancy they should have entered this into the Pyxis system, this would have generated a report in the Pharmacy department and in turn, an investigation by the Director of Pharmacy would have been conducted. The Director of Pharmacy indicated that she did not always receive the weekly, controlled substance inventory audit which nursing was responsible to complete nor were the monthly pharmacist reviews done for approximately the last six months. Review of the Automated Dispensing System policy on 6/8/06 noted all nursing units must perform a weekly inventory audit of all controlled substances in the Pyxis machine. Assigned pharmacy personnel will perform a monthly physical inventory of controlled substances. For any discrepancy that cannot be resolved by nursing, " unresolved " must be entered into the Pyxis system.

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 (h) Dietary Service (3) and/or (i) General (7).

12. Based on observation and staff interview, the facility failed to ensure consistent oversight of the daily management of dietary services. The findings include:
    a. Observation on 6/7/06 at 10:15 AM identified a dietary aide clearing food debris and kitchenware from soiled trays with disposable gloves donned. The dietary aide removed the soiled gloves and proceeded to don clean gloves to empty the cleaned kitchenware from the dish machine. Subsequently, the Director of Food Services indicated the dietary aide should have washed his hands between glove changes. Subsequent to surveyor inquiry, the Dietary Aide was educated to wash his hands prior to donning clean gloves.
    b. During a review of patient food storage refrigerators on Surgery 7 and in the Emergency Department, sandwiches were identified stored in individual plastic baggies with no date identified on the bags. During an interview the Director of Food Services identified the food should be labeled with the expiration date.

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 (2) and/or (7) and/or (l) Infection control (6).

13. Based on tours of the facility, staff interview and review of facility policy, the facility failed to ensure that supplies and/or equipment was maintained to ensure an acceptable level of safety and quality. The findings include:
    a. During tour of the pre-testing area in the holding area of the OR's, multiple outdated blood tubes dated from 10-05 to 1-06 were observed in Exam room 2.
    b. The medication refrigerator in the OR med room lacked consistent temperature monitoring for the months of April '06, May '06 and June '06. Interview with the RN Clinical Manager on 6-5-06 identified that this is assigned to a nurse.
    c. The refrigerator in the Anesthesia storage room of the Labor & Delivery OR suite contained vials of Zemuron and Succinylcholine medication and lacked the monitoring of the temperature. Interview with the Unit Manager identified that anesthesia noted there has been no log for the monitoring of the temperatures on that refrigerator.
    d. The closets in the outer core of the OR's were observed with patient positioning devices and pillows on the floor. The floor was observed to have large amounts of dirt and dust on them. Interview with the RN Clinical Manager identified that the cleaning of these closets were the OR techs responsibility.

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

e. Observation of the breast milk freezer on 6/7/06 in the newborn area identified an excessive build up of ice with a bottle of breast milk covered in frost.

f. During a review of Interventional Radiology on 6/6/06, multiple blood collection tubes were observed with expiration dates of May 2006.

g. During tour of Oncology 6 on 6/5/06, clean chemotherapy spill kits were identified stored in the soiled utility room.

h. In the Emergency Department (ED) on 6/5/06, clean supplies that included betadine, handsoap, alcohol and hand lotion were stored in the soiled utility room. Additionally, a large, glass bottle of 95% Ethyl Alcohol was observed stored in the soiled utility room on the counter. During an interview, staff identified a physician poured the Ethyl Alcohol into a small container that contained a wick and lit it with a lighter in a treatment room to defog instruments before they were used. The facility lacked a policy or procedure for this. Based on surveyor inquiry, the facility removed the Ethyl Alcohol and will no longer allow this practice to be performed.

i. During tour in the ED, a patient was observed seated in a treatment room without staff in attendance, with a bag of insulin syringes in a drawer in the room. During interview, the Nurse Manager stated they should not have been stored there.

j. Tour of the adult and geriatric psychiatry units with the Nurse Manager on 6/5/06 identified that the specimen and nourishment refrigerators and/or freezers contained ice build-up several inches thick, rendering the freezers unusable. Interview with the Nurse Manager on 6/5/06 identified that the dietary staff were responsible for maintaining the nourishment refrigerators and nursing staff were responsible for the maintenance of the specimen refrigerators.

14. Based on observation, review of manufacturers recommendations and staff interview, the following was identified:

a. Observation on 6/5/06 in the G.I. suite identified 2 (two) scopes in the storage closets that were observed touching the bottom of the closet.

b. During tour of the OR suite on 6/5/06, OR # 8 was observed having the door opened to the substerile room while surgery was in progress.

c. Review of the Central Sterile Supply biological log monitoring for the Sterrad sterilizer on 6/5/06 identified that the facility was checking biologicals on this equipment on a weekly basis. Review of the manufacturer's recommendation identified testing was to be done on a daily basis. Interview with the Manager of the Department identified that the facility lacked a policy for this practice. Additionally, review of the spore testing readout facility logs, lacked consistent 48-hour reading documentation per the manufacturer's recommendation.

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

d. During tour of the Central Sterile Supply wrapping area, an employee's duffle bag was observed underneath the counter.

e. During tour of Medical/Surgical 4 on 6-6-06, the storage room was observed to contain patient's wound vac supplies in a box on the floor as well as sterile wrapped trach supplies dated between '03, '04, and '05. These supplies were mixed in with piles of patient clothing in plastic bags on the floor.

f. A review of the monthly attendance for the members of the Infection Control Committee meetings for 2004, 2005 and 2006 to date identified the required department representatives from Faculty Practice, Neonatal, Infectious Disease, Pharmacy, Surgery, Administration, Facilities Management, Laboratory, OB/GYN, and Employee Health attended between 20% and 92% of the time. A review of the facility Infection Control Committee policy identified appointed departmental representatives were required to attend monthly meetings or send an alternate.

The following are violations of the Regulations of Connecticut State Agencies Section 19a-36-D35(c) Responsibilities of Director.

Chemistry

15. Based on a review of the clinical chemistry procedure manual, patient test reports, and interview with the supervisor, it was determined that the director failed to ensure that the normal ranges on the patient test report correlate with the normal ranges in the procedure manual. Findings include:

Test	Proc. Manual	Pt. Test Report
Glucose	74-106 mg/dl	75-115 mg/dl
BUN	6-20 mg/dl	8-24 mg/dl
Creatinine	M-0.9 mg/dl F-0.6-1.1 mg/dl	0.6-1.2 mg/dl
Chloride	98-107 meq/L	100-111 meq/L
Calcium (Total)	8.6-10.0 mg/dl	8.9-10.4 mg/dl
Bilirubin (Total)	0.4-1.4 mg/dl	0.3-1.2 mg/dl
Protein (Total)	6.2-8.1 g/dl	6.4-8.3 g/dl
FSH - Mid Follicular Phase	3.85-8.78 mIU/mL	3.83-8.78 mIU/mL

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 (4)(A) and/or (d) Medical records (3) and/or (i) General (7).

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

16. Based on review of the clinical record and interviews, the facility failed to ensure that all items utilized during surgery were accounted for at the completion of surgery. The findings include the following:
    a. Review of the clinical record for the hospital stay dated 1/10/06 indicated that Patient #19 was admitted for surgical repair of a ventral hernia. Review of the operation note dated 1/11/06 indicated that after the initial laporotomy was performed a retained foreign body was noted within the abdominal cavity. The foreign body was identified, as a large surgical visceral retained known as a "FISH." Interview with MD #16, the assistant surgeon for the 1/11/06 surgery for a large incisional hernia repair identified that during the surgery, the "FISH" was observed to be laying in the abdominal cavity. MD #16 stated that the "FISH" was not adhered and was lying unattached in the abdominal cavity. Interview with the Director of Performance Improvement indicated that on investigation it was determined the patient had a ventral hernia repair in February of 2004 and the "FISH" had been left in at that time. The Director of Performance Improvement indicated that MD #17 who performed the initial surgery is no longer at the facility but was involved in the review of the case and felt he always removed the "FISH" and was unsure how it could have happened.

17. Based on review of the clinical record, review of policies and interviews, the facility failed to have a mechanism in place to ensure that all items utilized during surgery were accounted for at the completion of surgery. The findings include the following:
    a. Review of the clinical record for the hospital stay dated 1/10/06 indicated that Patient #19 was admitted for surgical repair of a ventral hernia. Review of the operation note dated 1/11/06 indicated that after the initial laporotomy was performed a retained foreign body was noted within the abdominal cavity. The foreign body was identified as a large surgical visceral retainer known as a "FISH". Review of the clinical record dated 2/10/04 indicated that the patient was admitted for an incisional hernia repair. Interview with RN #9 indicated that she was the circulating nurse for the February 2004 incisional hernia repair surgery and that she remembered seeing a "FISH" on the equipment table but does not recall the time of this observation. Interview with RN #9 indicated that at the time of the February 2004 surgery, the "FISH" was not included in the sponge/equipment count. Review of the facility policy in place in 2004 identified that the "FISH" was not included in the final count.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (7).

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

18. The facility did not assure that electrical devices in-patient areas were being inspected as required in NFPA 99 "Health Care Facilities."
    a. On 6/20/06 at 10:30 AM, the surveyor observed a component of the anesthesia monitoring equipment in OR #19, item number A00481, with a Clinical Engineering inspection date of 2/22/05 and failure to provide documentation that this patient care electrical device was inspected/tested as required in NFPA 99, Section 7-5.1.3, 7-5.2.2.1 and 7-6.2.1.2. Upon inquiry and through a review of the preventative maintenance records for this unit, it was determined that this required a Clinical Engineering PM and was removed from the Operating Room.

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

19. Patient #101 was admitted to the facility on 7-18-06 for an angiogram with croplasty procedure. Although review of the medical record identified a history and physical (H & P) dated 4/14/06, it lacked a current H & P.

20. Patient #116 was admitted to the facility on 7/17/06 for an ultrasound guided liver biopsy. Although the record contained a gastroenterology progress note dated 5/18/06, the medical record lacked a history and physical.

21. Patient #117 was admitted to the facility on 7/17/06 for a renal angiogram procedure. Although the record contained a hypertension/vascular note dated 6/22/06, the medical record lacked a history and physical.

22. Patient #123 was admitted to the facility on 7/19/06 for repair of the eyelid. Although the record through a consultation dated 7/5/06 identified that the patient had an extensive and complex medical history, the medical record lacked a history and physical.

23. Patient #102 who underwent a lung biopsy in Interventional Radiology on 7/18/06 failed to have documentation (vital sign monitoring and progress note) in the medical record post procedure that identified the whereabouts and condition of the patient from 9:10 AM, when the last vital signs were taken, until 10:05 AM when the patient was admitted to PACU for recovery. Review of the Conscious Sedation/Analgesia Flow Sheet identified that the patient received Xanax 1 mg at 8:20 AM, a time out was completed at 9 AM and the specimen was sent to Cytology at 9:15 AM. During interview the patient's nurse stated that after the procedure she accompanied the patient to x-ray for a chest x-

ray to rule out pneumothorax and then took the patient to PACU. Review of the facility policy for documentation identified that a progress narrative should be written following a procedure.

24. For Patients #103 and 105, the facility failed to ensure that a history and physical was completed and in the record prior to surgery. The findings include:
    a. Patient #103 underwent radical neck surgery on 7/12/06. Review of the surgical record failed to provide evidence that a history and physical was completed and/or updated within seven days of surgery.
    b. Patient # 105 underwent a cardiac valve replacement surgery on 7/12/06. Although the patient was seen for a cardiac review on 6/20/06 and a pulmonary review on 6/28/06 there failed to be an update notation of the patient's condition prior to the actual surgery on 7/12/06. Review of the facility's Medical Bylaws identified a failure to address the requirements of a surgical history and physical.

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

25. For Patient #108 with a known history of Alzheimer's Disease who was restrained during a hospitalization from 3/15/06 through 3/17/06, the following was identified:
    a. Review of the medical record for Patient #108 failed to identify that on the evening of 3/16/06 through the morning of 3/17/06 attempts were made to utilize the least restrictive manner of restraint. Although a nurse's narrative for that shift identified that the patient was confused and walking from room to room, the narrative failed to identify least restrictive interventions utilized prior to restraining the patient with a posey vest in a recliner with a tray in place. The narrative identified that the patient's attending physician was aware of the restlessness and the patient was given Ativan without noticeable effect. The medical record lacked an assessment for use of restraints and a flow record identifying interventions and patient response for the restraint period. During review of the physician's narrative dated 3/17/06 and interview on 7/20/06, the attending physician stated that she was aware of the patient's restlessness on the evening of 3/16/06. She requested the nurse give one dose of Ativan and if the Ativan was not helpful the nurse should utilize a 1:1 sitter. The physician stated that she was not notified of the use of vests and wrist restraint nor would she approve it. Review of the physician's orders identified that on 3/16/06 at 7:30 PM the patient's nurse initiated use of a posey vest and/or bilateral wrist

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

restraints. Although the orders reflected that the attending directed the order, the order was not signed until 3/17/06 at 7:10 AM by the geriatric fellow. Additionally, a nursing narrative reflecting patient response while receiving constant observation on 3/15/06 through 3/16/06 was lacking. Review of the facility policy for Restraints: Acute Medical/Surgical directs that a progress narrative and assessment and care of the patient while in restraints must be documented on the restraint flow sheet. The progress narrative should reflect any attempts to reduce and/or eliminate restraints, patient reaction and plan of action.

FLIS Independent Nurse Consultant Guidelines

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

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

Relationship between INC and the Institution:

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