

**State of Connecticut
Department of Public Health
Division of Health Systems Regulation**

IN RE: MidState Medical Center of Meriden, CT.
d/b/a MidState Medical Center
453 Lewis Avenue
Meriden, CT 06451

CONSENT ORDER

WHEREAS, MidState Medical Center of Meriden, CT. ("Licensee") doing business as MidState Medical Center ("Facility") has been issued Licensee No. 0070 to operate a General Hospital under Connecticut General Statutes 19a-490 by the Department of Public Health ("DPH"); and

WHEREAS, the Department's Division of Health Systems Regulation ("DHSR") conducted unannounced inspections on April 14, June 26, August 10, 11, 12 and 14, 2003, for the purpose of conducting multiple investigations; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in an amended violation letter dated November 3, 2003 (Exhibit A); and

WHEREAS, an office conference concerning the violations identified was held between the Department and the Licensee on November 5, 2003; and

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

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut, acting herein by and through Marianne Horn, its Director, and the Licensee, acting herein by and through Lucille A. Janatka, its President, hereby stipulate and agree as follows:

1. The Licensee shall within fourteen (14) days of the execution of this Consent Order, review and revise, as applicable, policies and procedures relative to:
 - a. Emergency Department assessment and monitoring, including, but not limited to, guidelines for the physical examination assessment, monitoring of behavioral health patients, documentation of said assessments and subsequent interventions;
 - b. the specific procedure by which staff ensures timely notification of the physician regarding changes in the patient's condition;
 - c. patient specific interventions to be implemented prior to the utilization of mechanical and physical restraints and documentation of said interventions;
 - d. the specific types of restraints the institution shall utilize, including but not limited to, process for application, correct positioning of the patient, medical contraindications for utilization, assessment for recent restrictive restraints, components of a patient assessment during the period a patient is in seclusion and/or restraints and documentation of said assessment.
2. The Licensee's medical staff shall review and approve the revised written policies and procedures stipulated in paragraph one (1) above, within thirty (30) days of said revisions.
3. The Licensee shall, within sixty (60) days of the review by the medical staff as stipulated in paragraph two (2) above, implement a program that will assess staff compliance with the revised policies and procedures stipulated in paragraph one (1) above, and with standards of practices. The program shall include, but not be limited to, an ongoing process whereby retraining of staff occurs for failure to adhere to facility policies and procedures.
4. Within sixty (60) days of the execution of this Consent Order, the Licensee shall inservice all staff involved in the implementation of restraints and the reporting of patient changes in condition to the physician, regarding the institution's policies and procedures as related to the requirements of this document.

5. Within ninety (90) days of the execution of the Consent Order, all direct care staff assigned to the Emergency Department shall complete an inservice program of no less than three (3) hours. Said program shall address Emergency Department policies, procedures and practices. Said program shall include, but not limited to, recognition of and implementation of emergency interventions for behavioral health patients including diagnosis, assessment, treatment and monitoring. The curriculum developed will be reviewed by experts in the field who are not directly associated with MidState Medical Center. The Department shall have final approval of the content. Any designated staff that are unable to attend, the inservice program presented by MidState Medical Center, shall review the program content in an alternate manner: e.g. audiotaping, videotaping, computer aided instruction. A record of all staff that have attended and/or reviewed the inservice program shall be maintained for a period of three years and be available for Department review.
6. The Licensee's Performance Improvement (Quality Assurance) Program shall, within thirty (30) days of the execution of this Consent Order, be reviewed and revised as necessary, to include the following components:
 - a. The adoption of revision of policies on a periodic basis and/or as necessary to address new or revised state and federal laws and regulations;
 - b. Assessment of incidents which have occurred in the Emergency Department to identify all situations which have a potential for risk of harm;
 - c. The identification of remedial measure(s) implemented by staff in the event that staff fail to implement facility policies and procedures;
 - d. The establishment of in-service education programs for licensed and unlicensed personnel, which shall reflect topics pertinent to those identified by the Performance Improvement Committee; and
 - e. Evaluation of staffing levels in the ED and the impact upon quality of care and services.

7. The Licensee shall, within (7) days of the execution of this Consent Order identify via written documentation, the individual responsible for the full implementation of this document. All information relevant to the requirements of this Order shall be directed to:

Janet Williams, R.N.
Supervising Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

8. The Licensee shall pay a monetary fine to the Department in the amount of twenty thousand dollars (\$20,000.00) which shall be payable by certified check to the Treasurer of the State of Connecticut and shall be posted to the Department within two (2) weeks of the effective date of this Consent Order. Said check shall be directed to Janet Williams, Supervising Nurse Consultant at the address previously identified in this document.
9. All parties agree that this Consent Order is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Consent Order or of any statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
10. The Licensee is hereby reprimanded in accordance with Connecticut General Statutes Section 19a-494(4) as a result of the violations of the Regulations of Connecticut State Agencies identified in the letter issued to the Licensee on November 3, 2003.

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 DCJ's Statewide Prosecution Bureau.
12. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document.

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Licensee: MidState Medical Center of Meriden, CT.

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

MIDSTATE MEDICAL CENTER OF MERIDEN,
CT.

1/28/04
Date

By: Lucille A. Janatka
Lucille A. Janatka, its President

State of Connecticut)
County of New Haven

ss Meriden January 28, 2004

Personally appeared the above named Lucille A. Janatka and made oath to the truth of the statements contained herein.

My Commission Expires: 12/31/06

Betsy J. DuBois
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

February 9, 2004
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Director
Division of Health Systems Regulation



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

November 3, 2003

Lucille Janatka, President and CEO
Midstate Medical Center
435 Lewis Avenue
Meriden, CT 06450

Dear Ms. Janatka:

This violation letter is hereby amended to provide as follows:

Unannounced visits were made to Midstate Medical Center on April 14, 2003; June 26, 2003; August 10, 11, 12 and 14, 2003 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations with additional information received through October 2, 2003.

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

An office conference has been scheduled for November 5, 2003 at 10:00 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

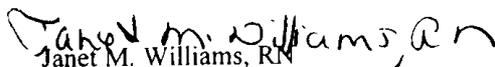
Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

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.

Respectfully,


Janet M. Williams, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JMW:DR:BC:zjb

cc: Director of Nurses
Medical Director
President
vlmidstate2.doc
#2002-1294; #2003-0046; #2003-0117
#2003-0305, #2003-0630, #2003-0875, #2003-0907



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 VISIT: April 14, 2003; June 26, 2003; August 10, 11, 12, 13 and 14, 2003

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

1. Five of thirteen medical records reviewed reflected that, the facility failed to ensure that nursing care was provided according to standards of practice and/or facility practice. The findings are based on review of the clinical records, a review of facility policy and procedures, and staff interview and include the following:
 - a. Patient #2 had a history of multiple suicide attempts the patient was admitted to the ED (Emergency Department) on 8/8/03 at 1:00 PM due to a suicidal threat after purchasing a rope to hang herself and major depression. A review of the nurse's notes identified the patient was placed on a 1:1 observation with a sitter (patient observer) at the bedside on admission. Nurse's notes written at 7:30 PM identified the sitter allowed the patient to walk to the bathroom unobserved in the GYN (gynecological) room where the patient picked up a needle and threatened to kill herself. A review of the facility Emergency Department Mental Health Patient Guidelines identified any patient actively suicidal must have constant observation. A review of the facility's Observation of Patient at Risk to Harm Themselves or Others policy identified patients who are on constant observation with a 1:1 sitter must be in constant visual contact by a staff member and when ambulatory the sitter must be within arm's reach of the patient. When the bathroom is used, the staff observer must monitor the patient by standing outside of the bathroom area. During an interview RN #5 stated the patient held a Vacutainer needle to her throat threatening to stab herself in the jugular. During a tour of the area it was identified that the sitter at the time of the incident was located at the time in a small alcove area which prohibited direct observation of the patient in the GYN room. During an interview, the Director of Clinical Services and Education stated the agency sitter assigned to watch the patient allowed the patient to go to the bathroom unescorted and unobserved, and the patient obtained a Vacutainer needle from somewhere in the GYN room where the bathroom was located.
 - b. Nurse's notes identified Patient #2 remained restrained until 4:30 AM, had a Crisis Evaluation done at 4:30 AM on 8/9/03, a PEC signed by MD #3. At 8:00 AM on 8/9/03 the patient was on every fifteen minute checks for safety. A review of the facility Emergency Department Mental Health Patient Guidelines policy identified anytime a patient is actively suicidal a PCT (Patient Care Technician) will maintain a constant observation of the patient. During an interview PCT #1 stated the patient was very agitated on transfer and verbally abusive. She was not informed of the frequency of observation required but understood the ABU patients were always on every fifteen minute checks. There was a lack of

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documentation of the assessment which reflected the change from a 1:1 constant observation to every fifteen minutes. A Crisis Evaluation done on 8/9/03 at 6:00 PM identified the patient felt like ramming her head through the wall and had poor judgment for personal safety. During an interview, the Manager of the Crisis Program stated a determination for the level of observation was usually made by the team consisting of the ED physician, RN, Crisis Team, and PCT but there was no documentation to support the decision to change the observation status or for any evaluation by Crisis Team during the patient's stay prior to the evaluation done at 4:30 AM.

- c. Nurse's notes written on 8/9/03 at 8:15 PM identified Patient #2 was given access to her belongings bag to send them home with a visitor but decided against that. At 9:35 PM the patient was anxious and requested and received Ativan 2 mg p.o. and climbed into bed. At 10:10 PM a scream was heard, an odor of smoke was noted, the patient was found in flames and ran into adjacent shower with staff in pursuit, EMT #1 pulled down the shower curtain and smothered the flames and medical personnel attended the patient. EMT #1 and Transport CNA then extinguished the flames in the patient's room. Heavy smoke permeated the ED and forced evacuation of the entire department. A review of the ED record identified the patient was unresponsive and without respirations, Patient #2 was intubated, a foley and central line were inserted, Patient #2 suffered second degree burns over 50 % of the body, and was transferred to a burn center in another facility. During an interview, PCT #2 stated she gave the patient her three bags of belongings to go thru in the ABU area adjacent to the patient's room, briefly stepped out of the ABU area, and upon return the patient gave back her belongings because she decided against sending them home with her visitor. The patient was escorted to her room, seemed anxious, and requested Ativan. PCT #2 stated she quickly reviewed the patient's belongings list but did not assure each item was accounted for. A review of the patient's belonging list identified it included a carton plus one pack of cigarettes and cigarette lighter in addition to personal items. A review of a list of items secured by the police after the fire identified a carton container of cigarettes with 8 packs inside it and no cigarette lighter. During an interview the Vice President of Patient Care stated the police found a lighter and cigarettes in the patient's room after the fire, and when housekeeping cleaned the room on 8/10/03 an additional pack of cigarettes was found under the mattress along with a cigarette butt. On 8/13/03 housekeeping cleaned the bathroom in ABU and a pack of cigarettes and matches were found inside the toilet paper dispenser.

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- d. Patient #12 was admitted with a diagnosis inclusive of pneumonia. A progress note dated 3/31/03, 3:00 PM identified that the patient was sitting in a cardiac chair with a table and then was found on floor. The assessment identified that the patient was complaining of head pain and right hip pain. An x-ray of the right hip dated 3/31/03 revealed a displaced intracapsular fracture of the right hip. A physician's order dated 3/31/03 prescribed Percocet, one tablet every six hours when necessary for pain. Progress notes dated 4/1/03 identified that the patient was complaining of pain at 8:00 AM, 1:30 PM, and 3:15 PM with yelling and/or moaning noted at times. Review of the Medication Administration Record (MAR) dated 4/1/03 revealed that the patient received Percocet, one tablet at 8:45 AM and 3:15 PM. Review of the policy and procedure for management of the patient experiencing pain identified that to determine pain intensity, patients will be asked to rate their pain using the numerical pain scale. All patients who report a pain rating of 4 or greater will receive an intervention to reduce the pain. Re-evaluation of the pain will be based on the intervention provided (e.g. 30 minutes after parenteral drugs and 1 hour after oral analgesic interventions). If following pharmacological interventions, the pain rating remains 4 or greater, or is unacceptable to the patient on two subsequent assessments, the attending physician must be contacted and the plan of care revised. Review of the clinical record, failed to identify that pain had been assessed in accordance with the policy and procedure.
- e. Patient #8 was admitted with a diagnosis inclusive of degenerative joint disease with a left total knee replacement completed on 1/13/03. A physician's order dated 1/13/03 prescribed Glipizide 5 milligrams (mg) in the morning at 7:30 AM and 7.5 mg at 4:30 PM. The physician's order further directed that blood glucose be monitored four times a day at 7:00 AM, 11:00 AM, 4:00 PM and 9:00 PM with sliding scale insulin coverage as needed for blood glucose greater 201. Review of the glucose flow sheet dated 1/14/03 at 4:00 PM identified the patient had a blood sugar level of 138 milligrams per deciliter (mg/dl). Review of the medication administration record dated 1/14/03 identified Glipizide 7.5 mg was administered at 4:30 PM. Review of a focus note dated 1/14/03 at 6:25 PM revealed an autologous blood transfusion was initiated with the vital signs stable. A focus note dated 1/14/03 from 6:30-7:00 PM, identified that the patient's oxygen saturation had decreased to 77-80% on room air with diaphoresis present. The clinical record failed to identify that the patient's blood glucose was assessed when diaphoresis was noted and at the scheduled time of 9:00 PM.

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- f. Patient #8 was admitted with diagnosis inclusive of degenerative joint disease with a left total knee replacement completed on 1/13/03. On 1/14/03 at 3:00 PM, Patient #8 had an oxygen saturation (O₂ sat) of 95% on room air. Physician's order sheet dated 1/14/03 directed that one unit of autologous blood be administered. Review of the medical/surgical flow sheet at 6:00 PM and interview with RN #9 identified that prior to the initiation of the blood transfusion, the patient's lungs were clear although this information was not documented in the medical record. Vital signs were: blood pressure (B/P) of 130/70, pulse of 105, and respiration's 23. At 6:25 PM, one unit of autologous blood (470cc) was started. RN #9 stated that subsequent to the initiation of the blood, the patient's O₂ saturation decreased to 77-80% on room air and nasal oxygen was administered at 4 liters which brought the O₂ sat up to 88%. The O₂ saturation remained low on the nasal O₂ therefore the patient was placed on O₂ via a non-rebreather with the O₂ saturation documented at 92%. Review of the medical/surgical flow sheet from 6:00 PM through 8:00 PM identified O₂ saturations were maintained at 92-93% on the non-rebreather O₂. At 10:00 PM, the blood transfusion was completed, vital signs were B/P 114/68, pulse 80, respiration's 16, O₂ sat 93% on the non-rebreather mask with bilateral crackles at the lung bases. Review of the medical surgical flow sheet and focus notes from 1/14/03 at 10:00 PM through 1/15/03 1:00 AM failed to identify that the patient was thoroughly monitored and/or assessed once changes from baseline were identified. Interview with RN #13 stated the physician was not notified when crackles were identified. Interview with MD #9 identified that he was not aware of the O₂ SATs of 77-80% or that the patient required the use of the non re-breather. MD #9 identified he would expect the nurse to reassess the patient within one to two hours after the non-rebreather O₂ was initiated, notify the medical physician and/or the house officer of the continued need for the non-rebreather and report bibasilar crackles following the blood transfusion. Interview with RN # 13 who was assigned to care for Patient #8 from 7:00PM to 7:00AM identified that although the patient presented with crackles at 10:00 PM, she did not notify the physician of the change in the respiratory status in accordance with policy and procedure. Focus note and the medical surgical flowsheet dated 1/15/03 at 1:00 AM through 2:35 AM identified that the patient's condition deteriorated with resuscitative efforts initiated at 2:35 AM, however, unsuccessful.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (7) and/or (j) Emergencies (2).

2. For one medical record reviewed the facility failed to implement care planning interventions and/or safety interventions to reduce the risk of falls. The findings are based on review of the clinical record and staff interview and include the following:
 - a. Patient #12 was admitted with a diagnosis inclusive of pneumonia. Review of the ED flow sheet dated 3/30/03, 7:40 AM identified that the patient was admitted to the holding unit awaiting availability of a room. A safety screen dated 3/30/03 identified a history of falls, poor safety awareness, and attempts to get out of bed. The safety plan of care interventions included 4 side rails up and call light in reach. Progress notes from 3/30/03, 8:30 PM through 3/31/03, 12:00 AM identified that the patient was confused and required assistance with transfers, the patient was found attempting to get out of bed on to the commode on two occasions. A progress note dated 3/31/03, 3:00 PM identified that the patient was at an increased risk for falls and that the staff were unable to obtain a safety monitor when requested earlier in the day. Further review of the 3/31/03, 3:00 PM progress note identified that the patient was sitting in a cardiac chair with a table and subsequently was found on the floor. The patient was complaining of head pain and right hip pain. An x-ray of the right hip dated 3/31/03 revealed a displaced intracapsular fracture of the right hip. During an interview with RN #11 on 5/6/03 at 10:30 AM, she stated that when she received report at the beginning of her shift she was informed that the patient was a fall risk. She made an inquiry to all of the units soliciting a device however learned that none were available. RN #11 further identified that she was attempting to locate a monitor as it would have alerted staff of any attempts made by the patient to get out of the chair, however was unsuccessful in her efforts and consequently utilized a cardiac chair with a table across her lap, which the patient could remove independently. Although the nurse was unable to obtain a safety device, review of the clinical record failed to identify any further interventions to address the patient's increased risk for falls.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (7).

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3. Based on review of the clinical record, review of policy and procedures and staff interviews the facility failed to accurately and consistently document intake and output for one Patient (Patient #8) and includes the following:
 - a. Patient #8 had preoperative orders dated 1/13/03 that identified an order for Lactated Ringers IV at 100cc per hour (time initiated not documented). Postoperative physician's orders directed that Lactated Ringers IV be administered at 80cc's per hour (initiated per medical surgical flow sheet at 4:00 PM) and Ancef 1 gram IV every eight hours for 48 hours. Medical surgical flow sheet dated 1/13/03 at 4:00 PM through 1/14/03 at 6:00 PM (26 hours: 2,080cc IV fluid) identified the Lactated Ringers solution infused at 80cc per hour. Review of the intake and output flow sheet dated 1/13/03 through 1/14/03 identified discrepancies when compared to the medical surgical flow sheet. Clinical record failed to identify that the patient's intake and output was accurately documented consistently. In addition, on 1/14/03, Patient #8 had Autologous blood, 470cc administered from 6:25 PM through 10:00 PM with the lactated ringers solution restarted at 80cc per hour. Review of the procedure for administration of blood products directed that normal saline 250cc would infuse at a keep vein open rate (KVO) flush the IV tubing once the transfusion was completed and document the amount of normal saline and blood product given. Review of the medical surgical flow sheet and intake and output (I&O) sheet failed to identify the amount of the normal saline solution infused. Review of the I&O sheet failed to accurately document the amount of blood administered (blood 500cc).

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

4. Based on a review of the medical record and facility policies and procedures, and interviews, the facility failed to ensure for five of thirteen patients that assessments were done after administration of medications, and/or respiratory assessments were documented, and/or the medical records contained sufficient information for Patients #2, #3, #4, #8 and #9. The findings include:
 - a. Patient #2 was admitted to the ED due to a suicidal threat after purchasing a rope to hang herself and depression. A review of the medical record identified the patient was given Ativan 2 mg p.o. on 8/8/03 at 2:20 p. m. and Ativan 2 mg IM at 7:55 p.m., on 8/9/03 Ativan 2 mg. IM at 4:30 a.m. and at 9:35 p.m. Documentation was lacking to reflect that an assessment of medication

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- effectiveness for all doses was conducted and an evaluation was not done until 7:00 a.m. for the 4:30 a.m. dose given on 8/9/03.
- b. Patient #3 was admitted to the facility with a self inflicted stab wound, underwent a surgical repair and placed on 1:1 observation postoperatively. On 8/12/03 Ativan 1 mg p.o. was given. Documentation was lacking to reflect the rationale for administration of Ativan and subsequent effectiveness.
 - c. Patient #4 was admitted to the ED due to homicidal ideations. A review of the medical record identified Motrin 800 mg was given on 8/14/03 at 8:15 a.m. for pain. There was a lack of any pain assessment prior to or after administration of the medication. A review of the facility drug administration standard identified the patient's reaction to the drugs should be documented. During an interview the Director of Clinical Services and Education stated the expectation is to assess the need for and effectiveness of the medication administered and that had not been done.
 - d. Patient #8 was admitted on 1/13/03 for elective left total knee replacement surgery. Clinical record review identified that preoperatively, Ancef 1 gram was administered intravenously (IV) as well as Lactated Ringers solution IV 1000cc at 100cc per hour. Review of the clinical record failed to identify how much intravenous solution was administered (Lactated Ringers and Ancef) and the amount of urinary output prior to the surgery.
 - e. Patient # 9 had a nursing focus note dated 11/5/02 that identified on 11/2/02, the patient inadvertently received a radioisotope injection intended for another patient. Interview with RN # 4 identified that the physician's order was entered into the computer for Patient #9, however intended for another patient. The requisition is then electronically transmitted to the radiology department and administered by the radiology staff. Review of the diagnostic procedure for injection of a radioisotope identified that the radiopharmaceutical injected including the dose, time, where it was injected, and route of injection would be documented on the venipuncture/medication log. Review and interview with the Director of Clinical Services on 4/14/03 identified that documentation could not be located regarding the administration of the radioisotope.
 - f. Review of Patient #8's medical/surgical flowsheet dated 11/14/02 at 7:00 AM with RN #9 identified that the patient's lungs were clear. At 3:00 PM, Patient #8 had an O2 Sat of 95% on room air, at 6:00 PM the O2 Sat was documented as 88% on four liters of nasal oxygen. Review of the flowsheet and focus note dated 1/14/03 with RN #9 identified at 6:25 PM, 470cc of autologous blood was hung per physician's orders. Interview with RN #9 stated the patient's breath sounds

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were clear prior to the initiation of the blood transfusion although that was not documented in the clinical record. Review of the procedure for administration of blood products identified a baseline assessment would be conducted including auscultation of the lungs.

The above is a violation 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).

5. Based on a review of the medical record and interviews, the facility failed to ensure for three of thirteen patients (Patients #1, #2, and #10) that medical record documentation was signed and/or dated and/or timed.
 - a. Patient #1, an adolescent, was admitted to the ED on 8/11/03 due to suicidal threat and ideations. A review of the medical record identified a one time dose of Ativan 2 mg IM was given at 2:30 a.m. on 8/12/03 but physician orders for it were not dated and were written on an ER record dated 8/11/03. A review of an observation and restraint record failed to identify a date on the record and a restraint order sheet lacked a date and time the RN signed off the order.
 - b. Patient #2 was admitted to the ED on 8/8/03 and treated for a suicidal threat after purchasing a rope to hang herself and major depression. A review of the medical record identified a physician order sheet dated 8/8/03 with orders for Ativan 2 mg. p.o. and Ativan 2 mg. IM that lacked a physician signature. During an interview, MD #4 stated he neglected to sign the orders. Nurse's notes written on 8/8/03 between 7:20 p.m. and 8:40 p.m. lacked a signature. During an interview RN #2 stated she did not sign her documentation and should have.
 - c. Review of the observation and restraint records for Patient #10 with the Director of Clinical Services failed to identify that these forms were dated (pages 1, 2, 3, 4, 6, 8 and 10).

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

6. Based on clinical record review, review of facility policy and procedure and staff interviews, the facility failed to ensure that the restraint order was authenticated for one patient (Patient #10) and included the following:
 - a. Review of the physician restraint/seclusion order form dated 3/17/03 at 8:00 AM for Patient #10 with the Director of Clinical Services failed to identify that the physician had signed the order for restraint use.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

7. Based on a review of the medical record, review of facility policies and procedures and interviews, the facility failed to ensure for one patient (Patient #2) that an assessment, monitoring, and identified interventions were documented.
 - a. Patient #2 was treated in the facility's ED on 8/8/03 due to suicidal threats after purchasing a rope to hang herself and major depression. A review of the medical record identified at 4:00 p.m. the patient was increasingly agitated and kept getting off of the stretcher and that RN #4 spoke with the patient to calm her down. During an interview RN #1 stated Crisis spoke with the patient shortly after arrival, knew the patient by history, and spoke with the ED physician about the patient. During an interview RN #5, who was the charge nurse, stated the patient got very agitated, was yelling, got off the stretcher, ran out the ambulance entrance in her stocking feet and had to be brought back by security personnel. The Crisis Counselor spoke with her, calmed her down, assisted with getting her to change out of her clothes into a hospital gown with a 1:1 sitter at her bedside. Documentation was lacking to reflect the patient's agitated state and subsequent intervention with Crisis.
 - b. At 7:30 p.m. the Patient #2 threatened to stab herself with a needle she obtained while using the bathroom unattended in the GYN room. Nurse's notes identified the patient was talked down with promises of seeing Crisis immediately and assurances of no harm to her. After the patient agreed, she was searched for other contraband, medicated with Ativan 2 mg IM with her approval, seen by Crisis, and placed in two point restraints. During an interview RN #4 stated she was able to calm the hysterical patient down and get her undressed but did not document her interactions with the patient. Documentation was lacking to reflect the incident, assessment, or interventions by Crisis.

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

8. The facility failed to ensure that all medical records reviewed contained physician orders which were explicit to the care of the patients and based on a review of the medical record and facility policies and procedures, and interviews.

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- a. Patient #1 was admitted to the ED on 8/11/03 due to suicidal threat and ideations. Physician orders written on an order sheet dated 8/11/03 that directed that Ativan 2 mg IM be administered lacked an administration timeframe.
- b. Patient #2 was admitted to the ED on 8/8/03 and treated for a suicidal threat after purchasing a rope to hang herself and major depression. A review of the medical record identified a physician order sheet dated 8/8/03 with orders for Ativan 2 mg. p.o. and Ativan 2 mg. IM lacked a timeframe for administration.
- c. Patient #3 was admitted to the ED on 8/12/03 after a self inflicted stab wound from a knife. The med-surg flowsheet for 8/12/03 on the 7 p.m. to 7 a.m. shift and 8/13/03 on the 7 a.m. shift identified the patient was on constant observation. A review of the medical record identified an observation record was not started until 7:00 a.m. on 8/13/03. A review of the facility's sitter (patient observer) responsibilities for the patient observer program identified documentation for 1:1 observation was required every fifteen minutes.
- d. Patient #4 was admitted to the ED due to homicidal ideations. A review of the medical record failed to identify any physician orders for the level of observation needed. A review of the facility's Observation of Patient at Risk to Harm Themselves or Others policy identified the physician must be notified and an increased observation order for constant or frequent observation must be obtained and renewed every twenty-four hours. During an interview the Director of Clinical Services and Education stated the multidisciplinary staff determined the level of observation based on their assessment but in practice no orders were written.

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

9. The facility failed to meet the emergency needs of patients in accordance with acceptable standards of practice. The findings are based on a review of clinical records, a review of facility policy and procedures, and staff interviews and include the following:
 - a. Patient #13 was evaluated in the ED on 1/4/03 at 11:40 AM for complaints of blood in the urine and back pain. Review of the Physician Assistant's (PA) ED assessment identified a body diagram which noted that in evaluating the patient's abdomen, moderate abdominal tenderness and a mass were noted extending from the lower abdomen to the umbilicus. The assessment was negative for vaginal bleeding. Although the initial nursing examination indicated that the patient denied pregnancy, a urine pregnancy test revealed a positive result. Further

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assessment identified a fetal heart rate of 148. The patient was discharged on 1/4/03 with diagnoses inclusive of abdominal pain secondary to pregnancy and a urinary tract infection with orders for Macrobid, one, by mouth twice a day for five days and with instructions that the patient should follow up with the obstetrician in two days. Further review of the clinical record identified that the patient returned to the facility on 1/8/03. An obstetric admitting record dated 1/8/03, 5:14 AM identified vaginal bleeding with a cervical exam that indicated that the caput was crowning. The record further identified foul odor, meconium stained fluid with no fetal heart rate heard. Psychosocial data included that the patient's mother related that the patient "is slow". A progress note dated 1/8/03 identified that a stillborn female infant was delivered with a birth weight of seven (7) pounds and six (6) ounces. During an interview with the ED Medical Director on 4/14/03 at 3:30 PM, he stated that the PA's assessment on 1/4/03 was not as thorough as it should have, as this was the first time the patient was being evaluated subsequent to learning that she was pregnant. He additionally stated that the PA should have transferred the case to the level of a physician once it was determined that the patient was pregnant and absent of any prenatal care.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (i) General (7) and/or (j) Emergencies (2).

10. Based on a review of the medical record and facility policies and procedures, and interviews, the facility failed to ensure for two patients that a psychiatrist evaluated the patients according to facility policy and that Crisis evaluations were documented.
 - a. Patient #2 who had a history of multiple suicide attempts was admitted to the ED on 8/8/03 at 1:00 p.m. due to a suicidal threat after purchasing a rope to hang herself and major depression and transferred to another facility on 8/10/03 at 12:30 a.m. A review of the medical record failed to identify any psychiatrist's evaluation of the patient. During an interview RN #1 stated Crisis spoke with the patient shortly after arrival, knew the patient by history, and spoke with the ED physician about the patient. During an interview RN #5, who was the charge nurse, stated the patient got very agitated, was yelling, got off the stretcher, ran out the ambulance entrance in her stocking feet and had to be brought back by security personnel. The Crisis counselor spoke with her, calmed her down, assisted with getting her to change out of her clothes into a hospital gown with a 1:1 sitter at her bedside. There was a lack of documentation to identify this

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incident or any interaction with Crisis. At 7:30 p.m. the patient threatened to stab herself with a needle she obtained while using the bathroom unattended in the GYN room. Nurse's notes identified the patient was talked down with promises of seeing Crisis immediately and assurances of no harm to her. After the patient agreed, she was searched for other contraband, medicated with Ativan 2 mg IM with her approval, and placed in two point restraints and spoke with Crisis. During an interview RN #4 stated she was able to calm the hysterical patient down and get her undressed but did not document her interactions with the patient. There was a lack of documentation of the incident, assessment, or interventions by RN #4 or Crisis or any physician evaluation other than an addendum on the admission physical examination record that the patient grabbed a needle, threatened to stab her jugular, was talked down, and sedated. During an interview, the Manager of the Crisis Program stated there was no documentation for any evaluation by Crisis during her stay prior to the evaluation done at 4:30 a.m. During an interview MD #4 stated the ED physicians usually do not interact with any psychiatric patients being held unless there is an issue.

- b. Patient #4 was admitted to the ED due to homicidal ideations on 8/12/03 at 1:00 p.m. and a crisis progress note written on 8/14/03 at 8:45 a.m. identified the patient was waiting to be seen by a psychiatrist. A review of the medical record failed to identify any evaluation done by a psychiatrist. A review of the facility's Emergency Department Mental Health Patient Guidelines policy identified if a patient is held in the ED more than 24 hours the patient should be seen once a day by a psychiatrist until a disposition is made. During an interview the VP of Patient Care stated the hospital practice was unclear as to when the 24 hour timeframe began and no psychiatrist saw the patients.

The above 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 (i) General (7).

11. Based on a review of a facility video tape, the facility failed to ensure for one patient (Patient #2) that confidentiality of medical records was maintained.
 - a. Patient #2 was treated in the facility's ED on 8/8/03 due to suicidal threats after purchasing a rope to hang herself and major depression. A review of a facility video tape identified the patient was periodically videotaped while under care and observation in ABU (Acute Behavioral Unit) #4 in the ED. A review of the medical record failed to identify any documentation of permission from the

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patient regarding the use of the video tape. A review of the facility policy for patient rights and responsibilities identified that patients have the right to privacy concerning medical care and to expect that all communications and records pertaining to care be treated as confidential. A review of the facility notice of privacy practices identified protected health information would be communicated only to those directly relevant to the person's involvement in the patient's care or payment for care. All other uses or disclosures would only be made with the patient's specific written authorization. During an interview the Security Manager stated video periodically was recorded from fourteen cameras throughout the facility and included patients in the ABU rooms in the ED. The video recording was kept in security with for 40 to 60 days for security purposes and the Security Manager and his assistant could view the tape.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (7).

12. Based on a review of the medical record, review of facility policies and procedures, and interviews, the facility failed to ensure for two patients that restraint orders were signed within one hour after restraints were initiated and/or signed by the physician that performed the face to face evaluation.
- a. Patient #4 was admitted to the ED due to homicidal ideations and placed in 4 point restraints on admission due to risk of injury to others. A review of the restraint order sheet identified the start time for restraint application was 10:15 a.m. on 8/12/03 and the physician and RN signed the order at 1:25 p.m.
 - b. Patient #2 was admitted to the ED due to a suicidal threat after purchasing a rope to hang herself and major depression and placed in 4 point restraint due to risk of injury to self. A review of the restraint order sheet dated 8/9/03 7:30 p.m. identified it was signed by MD # 1. During an interview MD #1 stated she signed the order sheet even though MD #4 did the evaluation. During an interview RN #5 stated the restraint order was obtained from MD #1 who had not seen the patient because MD #4 was busy. A review of the facility restraint policy identified the LIP (Licensed Independent Practitioner) or his/her designee must order the restraint within one hour after doing a face to face evaluation of the patient.
 - c. Patient #10 was admitted to the facility on 3/11/03 with severe right hip pain and was subsequently admitted to the medical floor. Admission assessment dated 3/11/03 identified the patient was alert, oriented and ambulated independently

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with a cane. Nurse's notes dated 3/14/03 at 1:55 PM through 3/15/03 at 8:00 PM identified that the patient was confused related to pain medication, required frequent reorientation and a personal alarm was implemented. Nurse's note dated 3/15/03 at 11:30 PM identified that the patient left his room against staff advice and security was called to help return the patient to bed safely. A nurse's note dated 3/16/03 at 12:15 AM identified that the patient was aggressive, security was called and two (2) point soft restraints were applied to the patient for safety. Nurse's note at 1:00 AM identified that the patient's left arm and right leg had the 2 point soft restraints intact. At 2:35 AM, RN #6's nurse's note identified that the patient had ripped off the restraints, ambulated out into the hall with his cane, struck a staff member over the head with the cane and while doing so lost his balance and fell. Review of a physician's progress note dated 3/16/03 at 3:50 AM identified the patient required four point restraints. Facility policy for the use of restraints identified that the RN may implement restraints in an emergency and must notify the MD immediately. Review of the clinical record with the Director of Clinical Services on 7/8/03 failed to identify that the physician was notified when restraints were implemented at 12:15 AM on 3/16/03 as directed by policy.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (i) General (7).

13. Based on a review of the medical record, review of facility policies and procedures, and interviews, the facility failed to ensure for three patients that restraints were ordered with a stop time and for no longer than two hours for an adolescent.
 - a. Patient #1, an adolescent, was admitted to the ED due to suicidal threat and ideations, and placed in 4 point restraints due to risk of injury to self and others. A review of the restraint order sheet date 8/12/03 identified the physician ordered restraints for behavioral health reasons for twenty-four hours and authorized continuation of the order if needed by an RN.
 - b. Patient #2 was admitted to the ED due to a suicidal threat after purchasing a rope to hang herself and major depression and placed in 4 point restraint due to risk of injury to self. A review of the restraint order sheet dated 8/9/03 at 7:30 p.m. identified it was signed by MD # 1, and the end time limit had been changed three times. During an interview MD #1 stated she signed the order sheet even though MD #4 did the evaluation and the nurses usually fill in the end time when the restraints are taken off. During an interview RN #5 stated the restraint order was obtained from MD #1 who had not seen the patient because MD #4 was busy.

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- c. Patient #4 was admitted to the ED due to homicidal ideations and placed in 4 point restraints on admission due to risk of injury to others. The restraint order sheet dated 8/13/03 at 10:15 a.m. had one end time crossed out and an end time of 2 p.m. written in when the restraints were actually discontinued. A review of the facility restraint policy identified each order was time limited to two hours for adolescents, four hours for adults, and orders could be renewed by the RN if designated to do so by the LIP. During an interview the VP of Patient Care Services stated the physician's initial order should have been for two hours, the RN typically fills in the time when the restraints are discontinued, and the physician usually doesn't complete the order time.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (i) General (7).

14. Based on a review of the medical record, review of facility policies and procedures, and interviews, the facility failed to ensure for two patients that restraint monitoring, and vital signs were done in accordance with facility policy.
 - a. Patient #1 was admitted to the ED due to suicidal threat and ideations, and placed in 4 point restraints due to risk of injury to self and others. A review of the observation and restraint records dated 8/12/03 and 8/13/03 identified a lack of documentation that offer of food/fluids and bathroom use, check of circulation/skin, range of motion/limb release, and removal and reapplication of restraints were done.
 - b. Patient #2 was admitted to the ED due to a suicidal threat after purchasing a rope to hang herself and major depression and placed in 4 point restraint due to risk of injury to self. There was a lack of any observation sheet for the timeframe the patient was in restraints.
 - c. Patient #4 was admitted to the ED due to homicidal ideations and placed in 4 point restraints on admission due to risk of injury to others. The restraint observation record failed to identify that monitoring of food/fluid offers, bathroom use, skin/circulation checks, release/ROM/reapplication of restraints, and vital signs were done.
 - d. Patient #10 had restraint orders dated 3/16/03 at 12:15 AM through 3/19/03 at 3:00 PM that identified the use of 1, 2, 3 or 4 point locked restraints. Facility policy for restraints identified that all patients in locked restraints must be on close observation with documentation completed at least every 15 minutes. Additionally the policy for the use of restraints identified that monitoring was

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inclusive of circulation checks, range of motion exercise, elimination, hygiene, repositioning, skin integrity checks and maintenance of patient dignity and comfort. Review of the observation and restraint records with the Director of Clinical Services identified that the patient was inconsistently monitored while in locked restraints as evidenced by review of the observation and restraint records pages 2-10. In addition, review of the observation and restraint records dated 3/16/03 through 3/19/03 identified that Patient #10 was observed to be talking and/or lying down and/or quiet and/or sleeping and/or resting on the bed. Review of the medical record identified that the patient remained in two (2) and/or four (4) point restraints for periods greater than 4 hours despite the above observations. A review of the facility restraint policy identified monitoring should be documented every two hours. During an interview the VP of Patient Care Services stated monitoring was not done in accordance with facility policy, and the observation sheet was missing for Patient #2.

The above is a violation of the Connecticut General Statutes Section 46a-152 and/or a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (7).

15. Review of the restraint utilization and/or seclusion log from 2/19/03 through 4/1/03 identified that restraints had been utilized on two occasions, however, lacked documentation indicating the specific behaviors that necessitated its use.

The above is a violation of the Connecticut General Statutes Section 46a-153.

16. Review of the daily patient census, dated 4/13/03 identified that although the facility is licensed for 94 General Hospital beds and 12 Bassinets, the daily census was 117 inclusive of 9 nursery bassinets.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (7).

17. For one medical record reviewed, the facility failed to re-assess an abnormal laboratory value in a timely manner. The findings are based on a review of the clinical record and staff interview and include the following:

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- a. Patient #14 was evaluated in the Emergency Department (ED) on 12/13/02 at 2:52PM with diagnoses of diabetic ketoacidosis and hypothyroidism. Review of the cardiac chemistry laboratory results identified a Potassium (K+) level of 6.3 (normal 3.4-4.5) on 12/13/02 at 3:28PM. Review of the Emergency Department (ED) record identified that Sodium Bicarbonate, one ampule Intravenously (IV) was administered at 3:45PM and Potassium Chloride (KCL) 40meq by mouth was administered at 4:00PM. Further review of the ED record identified that the patient was transferred to the Intensive Care Unit (ICU) on 12/13/02 at 9:55PM. Review of the physician orders dated 12/13/02 prescribed laboratory testing which included a K+ level every eight hours for twenty-four hours, then daily. A nurse's progress note dated 12/14/02, 12:00AM identified that the K+ was drawn with a result of 6.8 (8 hours 36 minutes since last obtained). The physician evaluated the patient at approximately 1:45AM subsequent to patient agitation, moaning, and tachycardia with 2 ampules of Sodium Bicarbonate administered. Review of a physician progress note dated 12/14/02, 2:45AM identified that the patient experienced ventricular tachycardia with the blood pressure absent. Resuscitative efforts were initiated with the patient stabilized and arrangements made to transfer to another facility. In a written interview with MD #7 on 7/11/03, he stated that the facility requested an endocrinology consult relative to the management of diabetic ketoacidosis. He further indicated that in reference to Patient #10's care relative to the diagnosis of diabetic ketoacidosis, the frequency of the prescribed laboratory testing was more than sufficient. During an interview with MD #6 (attending physician) on 5/14/03 at 11:00AM and MD #10 on 9/9/03 at 2:00PM they identified subsequent to identifying an elevated potassium and initiating aggressive therapy a re-evaluation of labs including a potassium level should be drawn two to three hours later. Although the patient had an elevated potassium level on 12/13/02 at 3:28PM with potassium administered at 4:00PM, the potassium level was not re-assessed until 8 hours and 36 minutes later.

The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (7).