

Stipulated Agreement

In Re: Saint Francis Hospital and Medical Center
114 Woodland Street
Hartford, CT 06105

WHEREAS, Saint Francis Hospital and Medical Center of Hartford, CT, (hereinafter the "Licensee") has been issued License No. 0054 to operate a General Hospital (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490, by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Department's Division of Health Systems Regulation conducted unannounced inspections at the Facility commencing October 21, 2003 and concluding February 2, 2004 for the purposes of conducting multiple investigations, State licensure and Federal validation surveys; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in a violation letter dated March 30, 2004 (Exhibit A – copy attached); and

WHEREAS, the Licensee responded with corrective action plans in a letter dated April 15, 2004 (Exhibit B – copy attached) and

WHEREAS, an office conference regarding the March 30, 2004 violation letter was held between the Department and the Licensee on April 15, 2004; and

WHEREAS, it is expressly understood that the execution of this Agreement, any provision of the Agreement, any monetary or educational contribution made by the Licensee in accordance with this Agreement, and any statements or discussions leading to the execution of this Agreement, shall not be construed to constitute any admission or adjudication of any violation of the Regulations of Connecticut State Agencies, the Connecticut General Statutes, the U.S. Code or the Code of Federal Regulations by the Licensee, its agents, servants, employees or any person or entity; and

WHEREAS, the Licensee without admitting wrongdoing is willing to enter into this Agreement 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 Dr. David D'Eramo, its President and Chief Executive Officer hereby stipulate and agree as follows:

1. The Licensee shall within thirty (30) days of the execution of this Agreement effect a contract with an established Medical Management Consultant Firm (MMCF) that has expertise in professional and medical health care services. Said MMCF shall be contracted to:

- a. Review the adequacy of current professional and institution mechanisms for sharing patient information when multiple disciplines are involved in the care of a patient (e.g. information sharing, coordination of services, interdisciplinary plan of care).
 - b. Review of policies/procedures and analyze via observations and interviews of staff Emergency Department (ED) functions including assessments and the communication process between ED professionals and various departments within the Facility.
 - c. Review of current Patient Safety processes, including the Patient Safety Committee and use of tools for patient safety improvement.
 - d. Review, via observations and interviews, patient safety in the Emergency Department and Operating Rooms, with specific emphasis on fire safety, and utilization of devices.
 - e. Review policies and procedures and analyze via observations and interviews of staff, the communication process between surgical and anesthesia services, with specific emphasis on how an integrated plan of care is coordinated and delivered.
2. The MMCF and the Facility shall formalize through a written contract the requirements of this document inclusive of time frames for the initial evaluation, number and credentials of individuals conducting the review, time frames for the analysis and development of recommendations. Said contract shall also specify that the MMCF shall return to the Facility seven (7) months after the issuance of its initial report to review the Facility's implementation and monitoring of recommendations. The MMCF shall have thirty (30) days post the completion of said initial onsite review and thirty (30) days post follow-up review to develop reports and provide copies to the Licensee and Department. Neither party shall be provided with the opportunity to review the draft reports and both parties shall receive copies of the documents simultaneously.
 3. The MMCF shall prepare a report which shall be provided to the Department and the Licensee. Said report shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations.
 4. The Department shall approve the MMCF selected by the Licensee and shall be provided with materials specified in paragraph #2 prior to contracting with and/or approving the MMCF.
 5. The Licensee shall provide the Department with a response to the MMCF recommendations with which the Licensee agrees and a time frame for implementation of the MMCF recommendations with which the Licensee agrees within twenty-one (21) days of receipt of the report. In the event that the Licensee disagrees with any MMCF recommendations, the Licensee, the MMCF and the Department shall meet to discuss the disagreement and develop a mutually agreeable alternative recommendation.
 6. Any record maintained by the Licensee in accordance with any state or federal law or regulation or as required by this Agreement shall be made available to the Department upon request.
 7. Within forty-five (45) days of the execution of this Agreement, the Licensee shall review and revise, as applicable, policies and procedures relative to:

- a. Patient specific interventions to be implemented prior to the utilization of mechanical and physical restraints and documentation of said interventions;
 - b. The specific types of restraints the institution shall utilize, including but not limited to, application, positioning of the patient, medical contraindications for utilization, assessment for least restrictive restraint, components of a patient assessment during the period a patient is in restraints and documentation of said assessment;
 - c. Specific delineation of professional staff who may order restraints; and
 - d. Specification of professional staff that must be present to supervise and observe the application of restraints.
 - e. Said requirements of paragraph #7 shall be subject to MMCF review.
8. The Licensee shall designate one individual who shall assume the overall responsibility for full implementation of this Agreement. The Department shall be notified as to the identity of this person within seven (7) days of the effective date of this Agreement. A report regarding facility compliance with this Agreement shall be forwarded to the Department on a monthly basis for the first six (6) months and every three (3) months thereafter, by the individual identified by the Licensee.
9. The Licensee agrees to pay twenty-five thousand (\$25,000) 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 Agreement. Said check shall be directed to Ann Marie Montemerlo, Supervising Nurse Consultant at the address identified in this document. In addition, the Licensee agrees to collaborate with the Department to develop a series of patient safety education seminars for Department staff and/or health care providers. Such seminars will be at the sole expense of the Licensee and will include topics that will be mutually agreed upon. The monetary value of the seminars shall be \$75,000.
10. Reports and meeting required by this document shall be sent to:

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

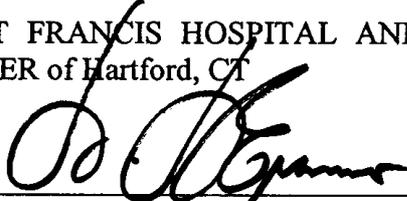
11. All parties agree that this Agreement shall have the same effect as an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this 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 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.

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

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

SAINT FRANCIS HOSPITAL AND MEDICAL
CENTER of Hartford, CT

August 18, 2004
Date

By: 
David D'Eramo, Ph.D., President and Chief
Executive Officer

State of Connecticut)
County of Hartford

ss August 18 2004

Personally appeared the above named David D'Eramo and made oath to the truth of the statements contained herein.

My Commission Expires: _____

<u>Martha E. Hartle</u>	
Notary Public	<input checked="" type="checkbox"/>
Justice of the Peace	<input type="checkbox"/>
Town Clerk	<input type="checkbox"/>
Commissioner of the Superior Court	<input type="checkbox"/>

MARTHA E. HARTLE
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2009

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

August 19, 2004
Date

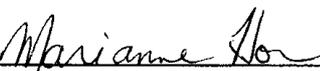
By: 
Marianne Horn, R.N., J.D., Director
Division of Health Systems Regulation

Exhibit A



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 30, 2004

David D'Eramo, President & CEO
St. Francis Hospital & Medical Center
114 Woodland Street
Hartford, CT 06105

Dear President & CEO:

Unannounced visits were made to St. Francis Hospital & Medical Center on October 31, November 17, 18, 19, 20, 21, 24, 25, December 3, 7, January 6, 22 and February 2, 2004, by representatives of the Division of Health Systems Regulation for the purposes of conducting multiple investigations, a licensure and validation survey with additional information received through March 23, 2004.

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 April 15, 2004 at 2:00 P.M. 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 violation(s) to be presented at this conference.

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

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

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Judy McDonald, R.N.
Supervising Nurse Consultant
Division of Health Systems Regulation

JFM:PMG:LAG:DSR:DMO:ESA
CAT:JCT:SHN:PJA:AMB:lsf

cc: Director of Nurses
Medical Director
President

vlstfrancishosp1sl.doc

#2002-1094, #2002-1182, #2002-1194, #2002-1195, #2002-1199, #2002-1228, #2002-1108, #2002-1108, #2002-1141, #2002-1156, #2002-1161, #2002-1206, #2002-1207, #2003-0820, #2003-1310, #2003-0256, #2003-0036, #2003-0935, #2003-1024, #2003-0950, #2003-0949, #2003-0891, #2003-0883, #2003-0405, #2003-0368, #2003-0717, #2003-1196, #2003-1339, #2003-0623, #2003-0061, #2003-0646, #2003-0951, #2003-0686, #2003-1006, #2003-0996, #2003-1311, #2003-1417, CT-2315



Phone:

Telephone Device for the Deaf (860) 509-7191

410 Capitol Avenue - MS # _____

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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1. Review of the chlorine/chloramines log for the acute care hemodialysis unit indicated that for the period of 10/1/03 through 11/18/03 evidence was lacking that the water was tested on twelve occasions (10/10, 10/16, 10/17, 10/20, 10/24, 10/25, 10/29, 11/4, 11/5, 11/6, 11/14, and 11/15). Review of Gambro policy indicated that water testing should be completed each day prior to starting the first patient.

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).

2.
 - a. Patient #4 was admitted to the hospital on 2/19/03 at 5:05 PM for induction of labor. Review of MD #40's progress note dated 2/20/03 at 11:15 PM identified that second stage labor was three plus hours with slow progression of descent and would proceed to an operative delivery. Interview with and review of the operative note with MD #39 (assisted MD #40 with delivery) identified that the first application of the Tucker Forceps was applied by MD #39, then reapplied by MD #40 with all pulls performed by MD #40. After several pulls with the Tucker Forceps, Simpson Forceps were replaced by MD #40 and Patient #4a (infant) was delivered in the occipital posterior position. At birth the infant required positive pressure ventilation, responded and was monitored in the NICU. Review of APRN #1 (NICU) and RN #23's progress notes dated 2/20/03 identified the baby was born in the anterior posterior position. MD #40's delivery note dated 2/21/03 identified a discrepancy with regards to the presenting part at the time of birth. Review of the clinical record failed to identify the presentation and the position of the fetal head prior to the application of the forceps. Review of APRN #1's (NICU) physical examination identified severe caput formation and forcep marks on the left forehead and at the right temple. Review of the NICU nursing admission data base dated 2/21/03 at 1:00 AM identified that forcep lacerations were observed on the infant's right temporal area, left frontal region and the sclera of the left eye was noted to have a small hemorrhage. Approximately three hours after delivery, the infant developed hypovolemia, coagulopathy and neurological decline with a head CT performed at 9:35 AM that identified significant intracranial hemorrhage involving the subarachnoid and subdural spaces, intracerebral hemorrhage in the left frontal lobe and diffuse brain edema. Follow-up head CT scan at 5:35 PM identified a fracture through the roof of the left orbit, with displacement of a piece of bone into the left frontal lobe and left frontal

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- hematoma. Review of the clinical record identified that the infant was transferred to another acute care hospital at 7:00 PM for further evaluation and management of care. Review of the receiving hospitals medical record identified that the infant experienced a traumatic forcep delivery and presented as hypotonic with no spontaneous activity and progressed to a flat line EEG. On 2/23/03 the infant expired. The autopsy findings support an ischemic or hypotensive event with multisystem failure.
- b. Patient #33's diagnosis included Down's Syndrome. Review of the ED report dated 06/06/03 identified that the patient arrived at the ED with complaints of left thigh pain for one week. The report further identified that a family member reported that the patient had fallen one week prior to the ED visit, that the pain now affected the patient's balance, that the leg had become increasingly weak and that the patient was having difficulty ambulating. Interview with Person #3 on 11/24/03 identified that although Patient #33's baseline ambulation status was independent, the patient required the use of a wheelchair upon arrival and discharge from the ED due to the inability to ambulate without pain. Interview with MD #4 on 11/19/03 identified that Patient #33's primary physician had sent the patient to the ED based on reports by the family of the presenting symptoms. MD #4 identified that the patient's primary physician had asked that a Doppler Scan be done to rule out a Deep Vein Thrombosis (DVT). Review of the ED record identified after an initial physical examination, blood work and a bilateral venous Doppler scan was performed and that the scan was reported as negative. No further diagnostic tests were ordered and/or performed and Patient #33 was discharged from the ED with a diagnosis of a left leg contusion. Patient #33 returned to the facility on 06/14/03 with diagnosis of a left hip fracture and subsequently underwent a left hip replacement.
- c. Patient #23 presented to the Emergency Department (ED) with diagnoses inclusive of hyperglycemia and fever. Review of the ED physical exam dated 8/7/03, 5:01 PM, identified that an assessment of the patient's systems and a physical examination was conducted. An assessment and examination of multiple systems was conducted, however an examination of endocrine, gastrointestinal, and skin systems was lacking. Review of the clinical record identified that Patient #23 was transferred to a medical floor on 8/7/03. The physician's physical examination dated 8/7/03, 9:30 PM identified a healing ulcer. On 8/8/03 pressure ulcer documentation identified a fifty cent size black area on the left heel. Review of the policy and procedure for structure and standards in the ED

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- identified that all patients will be given appropriate treatment. The physician documentation policy directed that all physical findings should be described.
- d. Patient #17 a minor child, was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in left eye. Although review of the clinical record identified that psychotropic medication changes were prescribed on 6/3/03, 6/4/03, 6/5/03, 6/6/03, 6/7/03, and 6/9/03, progress notes identified that the patient's mother was notified of the changes on 6/6/03 and 6/9/03. Review of the policy and procedure for consent of medication directed that the physician discuss with the patient and appropriate family members the medications and side effects of prescribed medications. The physician shall document that medication was discussed and patient agreed to take the medication. In the case of children and adolescents, parental or guardian consent will be documented in the medical record by the physician. MD #20 stated during an interview on 11/25/03 that although he discussed changes with the patient's parent, it was not always reflected in the medical record. In reviewing his notes outside of the clinical record, he stated that in addition to what is documented in the clinical record, he discussed changes in the patient's medication regime with the patient's parent on 6/4/03.

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)(B) and/or (d) Medical Records (3).

- 3.
- a. Patient #14 expired on 10/1/01. Hospital policy for autopsy consent referenced the General Statutes of Connecticut, section 19a-286, that identified the consent must state clearly what institution will perform the autopsy, and that the consent is to be witnessed. Review of Patient #14's clinical record revealed a post-mortem examination permission form signed by the patient's wife, dated 10/1/01. Although the post-mortem examination form had a Saint Francis Hospital and Medical Center letter head, it failed to identify where the examination was to be conducted, and was not witnessed. Interview with Patient #14's wife identified that staff at the hospital staff told her the examination was going to be done at the chief medical examiner's office in Farmington. Only later did the family realize it was done at the hospital.

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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 the Connecticut General Statutes Section 19a-286.

4.
 - a. Patient #8 underwent an endoscopy and colonoscopy on 9/3/02. Review of the endoscopy flowsheet identified that the patient was non-English speaking and that the daughter was utilized to interpret during the procedure. Review of the admission nursing assessment identified that the patient's primary language was Italian, the daughter was utilized for interpretation and that eight alcoholic drinks per day were consumed by the patient. The Withdrawal Assessment for Alcohol (CIWA) protocol identified that the CIWA scale would be used for all patients who have greater than three drink equivalents per day as assessed on the interdisciplinary Patient Admission Database. Admission physician's orders were obtained and directed that the CIWA scale be performed every one hour with a score above 12, every 2 hours with a score of 8 through 12 and every 4 hours with a score of less than 8. On 9/5/02, the Delirium Tremers protocol was instituted with a physicians order that directed Valium 5mg IV be administered every two hours PRN for breakthrough symptoms (CIWA score >8).
 - b. Patient #8 had a CIWA scale dated 9/3/02 at 6PM, 10PM and on 9/4/02 at 2AM and 6AM that indicated the patient did not understand the question pertaining to orientation and sensorium. Additionally, questions relating to nausea, auditory, tactile and visual disturbances were required to be ascertained as part of the assessment. Although scores were documented, these assessments failed to adequately reflect the patients status due a documented language barrier. Review of the clinical record with Nurse Manager #1 identified that although the patient's family had visited almost constantly, documentation was lacking that identified family members were utilized and/or other means of communication occurred with the patient to complete these assessments. Interview with the Chemical Dependency Counselor identified that on 9/5/02 a recommendation was made to utilize the DT protocol due to the patients inability to participate in these assessments.
 - c. On 9/5/02 at 1AM and 3AM the CIWA assessment identified scores of 19. Review of the clinical record from 9/5/02 (3AM) identified that a CIWA assessment was not conducted again until 9/7/02 at 9AM with a score of 11 documented.

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- d. Review of the CIWA assessment dated 9/7/02 identified that an assessment was conducted at 5PM and not again until 9/8/02 at 9AM at which time an assessment was not conducted but documented that the patient was sleeping.
- e. Review of the CIWA assessment dated 9/8/02 at 4PM identified the assessment was not completed.
- f. CIWA assessment on 9/9/02 at 12:40AM identified a score of 12 with the next assessment completed on 9/10/02 at 8:30AM with a score of 12 documented.
- g. Review of the CIWA assessments completed from 9/3/02 at 6PM through 9/10/02 at 8:30 AM failed to identify that the CIWA scores were conducted and/or completed in accordance with physicians orders.
- h. Review of Patient #15's Moderate Sedation Preprocedure Record dated 10/29/02 and interview with the Interventional Radiology Nurse Manager reflected that the Moderate Sedation Preprocedure Record lacked documentation for the patient's last oral intake to include date/time and a nurse's signature to verify that the pre-sedation checklist was completed. Review of the Moderate Sedation Policy directs that the monitoring personnel (Nurse, MD, Dentist) confirm completed history and physical, presence of informed consent for procedure and moderate sedation, completion of required preanesthetic requirements, and last oral intake.
- i. Patient #16 was admitted to the facility on 10/18/02 with a diagnosis of right lower quadrant phlegmon. On 10/29/02, the patient had a modified Barium Swallow, which identified that the patient was at a very high risk of aspiration. The patient also had a history of aspiration. Orders dated 11/6/02 at 9:52 am directed nothing by mouth. Review of facility documentation and interview with RN #2 identified that NA #1 fed the patient ice cream on 11/6/02 at 7 pm. The Nurse Aide did not receive a report from RN #2 at the beginning of her shift and review her NA worksheet prior to providing care for Patient #16. Review of the NA worksheet identified Patient #16's diet as nothing by mouth. Nurse's progress notes dated 11/6/02 identified that at 7 pm; the patient's oxygen saturation dropped to 79% on 5 liters of oxygen (was 94 % on 3 liters) and the patient had a congested cough. The patient was transferred to the intensive care unit for observation due to aspiration and was intubated at 10:30 pm.
- j. Patient #24 arrived in the emergency department on 7/20/03 at 3:52 pm with a complaint of a painful finger due to a sewing machine needle that perforated the left thumb. The patient received Tylox by mouth for pain at 6:44 pm and was discharged to home at 9:50 pm. Review of the nursing assessment lacked a pain assessment upon admission, at the time of Tylox administration, and after the

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- administration of pain medication. Review of the Pain Assessment and Management Policy directs assessment and documentation of pain on admission and after each pain management intervention once a sufficient time has elapsed for the treatment to reach effect.
- k. Review of the medical record for Patient # 45 indicated that the patient was admitted with new onset paraplegia and a history of obesity. The nurse's flow sheet dated 11/14/03 indicated that the patient had a stage II ulcer on his left buttock however documentation of the size, depth and characteristics of the wound were lacking. The flow sheet dated 11/15/03 indicated that the patient had a one and one half inch by one and one half inch breakdown. The flow sheet dated 11/16/03 failed to indicate that the patient had any skin breakdown. Review of the facility policy indicated that upon identification of a pressure ulcer a pressure ulcer assessment should be completed and then once every twenty-four hours with dressing changes.
 - l. Patient #13 was admitted to the facility on 10/23/02 for a laparoscopic appendectomy. The perioperative record identified that an indwelling foley catheter was inserted during surgery. The catheter drained sixty milliliters of clear amber colored urine and was removed prior to transfer to the Post Anesthesia Care Unit (PACU). The postoperative nursing progress notes failed to identify documentation that a genitourinary assessment was completed or post catheter voiding occurred prior to discharge. The discharge instructions identified that genitourinary instructions were not applicable. On 10/26/02 Patient #13 was readmitted to the facility with a diagnosis of acute renal failure and perforation of the bladder that was sustained during the laparoscopic appendectomy. Treatment included the placement of an indwelling catheter for ten days. Although an indwelling catheter was inserted perioperative on 10/23/02, the clinical record failed to identify documentation that a genitourinary assessment was completed or post catheter voiding occurred prior to discharge. Registered Nurse #24 stated upon interview the criteria for a laparoscopic appendectomy does not identify that a patient must void prior to discharge.
 - m. Patient #33 had diagnosis that included Down's Syndrome. Review of the ED report dated 06/06/03 identified that the patient arrived at the ED with complaints of left thigh pain for one week. The report further identified that a family member reported that the patient had fallen one week prior to the ED visit, that the pain now affected the patient's balance, and that the patient was having difficulty ambulating. Although the ED record identified that Patient #33 complained of left

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high pain on arrival to the ED at 12:23 PM and again at 7:28 PM, the record lacked documentation that Patient #33's level of pain was evaluated in accordance with the facility's policies and/or that interventions for pain relief were provided by facility staff. Review of facility policies on pain management included that pain intensity and relief is assessed in all patients and further provided assessment strategies for patients who were unable to report pain.

- n. Patient #32 had diagnosis that included Coronary Artery Disease (CAD). Review of the medical record identified that Patient #32 underwent a surgical procedure that included Coronary Artery Bypass Graft (CABG) on 03/06/03. Interview with Patient #32 on 11/24/03 identified that the patient complained of numbness of the right hand almost immediately upon awakening and stated that the hand "felt asleep." Review of the documentation in the nursing assessment record dated 03/08/03 to 03/09/03 identified that Patient #32 complained of numbness of the right hand at 4:00 PM on 03/08/03 and again at 12:00 AM on 03/09/03. At 5:30 AM on 03/09/03, Patient #32 was medicated with Toradol 30 mg. for "complaints of right hand numbness and pain." Further review of the record lacked documentation that the physician was notified at that time and/or that diagnostic tests were initiated to identify the source of the patient's complaints of numbness. Interview with MD #14 on 12/02/02 identified that he discussed Patient #32's complaints about numbness and pain of the hand on the first visit to the physician's office postoperatively, referred Patient #32 to a neurologist at that time, but did not recall being told of the problem while the patient was still in the hospital. MD #14 identified that Patient #32's symptoms of numbness were not uncommon after this type of surgery, that the problem could have been caused by opening the chest or from pressure under the elbow region, but that he would likely not have done anything about the complaints initially and pursued the complaint only if the symptoms persisted. Review of a consultation report by MD #22 and dated 07/09/03 identified that a nerve conduction study was performed and identified axonal damage within the right ulnar nerve. The consultation report further identified that by a review of the patient's history, it was the opinion of MD #22 that Patient #32's symptoms were related to compression that occurred at or subsequent to, his heart surgery. Review of the medical record of Acute Care Facility #2 identified that Patient #32 underwent a right ulnar nerve release on 11/07/03 for a diagnosis of right ulnar neuropathy.
- o. Patient #64 was admitted to the emergency department on 9/30/03 with a complaint of abdominal pain. The clinical record lacked a pain assessment on

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admission and although the patient received IV pain medication, there was no pain assessment before administration, and/or the effect of the medication was not documented. Patient #64 identified that she was discharged into the waiting room, vomiting from the effects of the pain medications. Hospital policy identified that a pain assessment was to be conducted on admission and after a pain management intervention.

- p. Patient #14 had elective abdominal surgery on 9/28/01 and received a spinal epidural for pain control. MD orders identified to assess the patient's sensory and motor function of the lower extremities and to notify anesthesiology if the patient is unable to move his thighs or legs. Although on 9/28/01 at 4 PM nurses' notes identified the patient was unable to move his left leg and complained of increasing pain, the anesthesiologist was not notified until 8 PM. At that time, the anesthesiologist identified the catheter was displaced, removed and a PCA was started. Further, there was no evidence in the clinical record that Patient #14 was assessed by a nurse between the hours of 9:30 PM on 9/29/01 and 3 AM on 9/30/01. At 3 AM on 9/30/01 Patient #14 was found slumped over in bed, pulseless and not breathing. The patient was revived, intubated, and transferred to the ICU. Further tests identified that brain death had occurred, life support was withdrawn, and the patient expired on 10/1/01 at 12 Noon. Interview with RN #11 identified that she had not seen the patient between 11 PM on 9/29/01 and 3 AM on 9/30/01. RN #11 stated that her first encounter with the patient was when he was noted to be slumped over in bed at 3 AM. RN #11 stated that although the patient's vital signs were documented at 1 AM, they were reported to her by a patient tech. Hospital policy for a patient receiving pain medications via an epidural identified to assess the patient every one hour, and if receiving pain medications via a PCA, every two hours.
- q. Patient #7 was admitted with diagnoses of chest pain. The Emergency Department (ED) records dated 4/24/03 identified allergies inclusive of Lasix. Progress notes dated 4/25/03, 8:00PM identified that the patient's blood pressure was 197/101 with the physician's assistant notified and Lasix ordered. A physician order dated 4/25/03, 20:22 prescribed Lasix 60 milligrams intravenous push, now. A subsequent progress note identified that the medication was prepared and offered at 8:45PM, however the patient refused the intravenous Lasix. The policy and procedure for drug interactions and allergies identified that an "alert" screen will appear with all drug interactions and allergies identified at the time of order entry. The Pharmacy Director on 11/25/03 stated during

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interview that although the medication administration system identifies allergies at the time of order entry, it will not prohibit dispensing the medication. She stated that the system is reliant on the individual practitioner to review the patient allergy in the system and on their computerized worksheet. RN # 5 stated during an interview on 11/20/03 that she entered the order prior to administration and could not recall if she reviewed the patient allergy.

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- i. Patient #23 presented to the Emergency Department (ED) with diagnoses inclusive of hyperglycemia and fever. Review of the clinical record identified that Patient #23 was transferred to a medical floor on 8/7/03. A Braden Scale skin assessment dated 8/7/03 identified a score of fourteen indicating that the patient was at risk for pressure ulcer development. The physician's physical examination dated 8/7/03 at 9:30PM identified a healing ulcer, however location of the healing ulcer was not identified. The patient admission database dated 8/7/03, 10:00PM identified no skin decubitus. On 8/8/03, pressure ulcer documentation identified a "fifty cent" size black area on the left heel. Further pressure ulcer documentation dated 8/9/03 and 8/10/03 identified a blackened, one-centimeter area on the left heel. Patient care flow sheets from 8/9/03 through 8/10/03 identified scant serosanguineous drainage from the blackened left heel with treatments administered in accordance with the policy and procedure. Review of an interagency patient referral report dated 8/11/03 indicated that the patient was transferred to an extended care facility and identified a reddened left heel, and to keep the foot off the bed.
- ii. An ED triage assessment dated 8/15/03 identified that the patient had been transferred back to the facility from an extended care facility for mental status changes. Nursing documentation on the

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triage assessment identified a stage two, two inch break in skin integrity on the left medial thigh and kerlix around the left heel. A Braden scale skin assessment dated 8/15/03 identified a score of nine indicating a high risk for pressure sore development. Review of progress notes and consults from 8/16/03 through 8/20/03 identified a left heel ulcer with the heel bone exposed, necrotic blisters on the lower third of the patient's calf, with a plan for a left above the knee amputation. A progress note dated 8/20/03 identified that the patient's family made a decision not to proceed with the above the knee amputation and to change the patient's plan of care to hospice care. The patient expired on 8/25/03.

- iii. Review of the policy and procedure for skin integrity identified that a nursing assessment inclusive of a Braden Scale assessment will be completed at discharge. The clinical nurse specialist will be notified of existing skin breakdown who will determine if a therapeutic bed intervention is necessary and/or dressing options, and/or need for sharp surgical debridement. In addition, in the presence of eschar, elevate the heels off the mattress using pillows.
- iv. Interview and review of the clinical record with Clinical Director #9 failed to identify that the patient's skin had been assessed utilizing the Braden Scale and that the pressure ulcer had been assessed on 8/11/03 the day of discharge in accordance with the policy and procedure. Clinical Director #9 stated during an interview that a clinical nurse specialist should have been notified of the blackened area to the left heel and a consult requested on the admission from 8/7/03 through 8/11/03. In addition, although a patient care flow

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- sheet dated 8/9/03 identified that the left heel was elevated on a pillow, review of the clinical record inclusive of the care plan failed to consistently identify that the feet were elevated on a pillow and/or that interventions had been developed to reduce pressure on the bilateral heels.
- v. RN #7 stated during interview on 11/19/03 that although she documented on the 8/11/03 interagency referral report that the left heel was reddened, she could not recall if she had assessed the wound. She stated that most often as the discharge planner she relies on the information that is communicated to her by the unit staff and generally does not assess the wound herself unless it has a very complicated treatment and/or if it has been communicated to her that it is a significant wound.
 - vi. Although the policy and procedure identified that a pressure ulcer assessment should be completed once in every twenty four hours, review of the clinical record from 8/16/03 through 8/25/03 failed to identify any assessment of the pressure ulcer subsequent to the 8/15/03 assessment.
- s. Patient #22 was admitted with a diagnosis inclusive of morbid obesity. An operative report dated 8/13/03 identified that a laparoscopic gastric bypass was completed. The operative report stated that the patient tolerated the procedure well without any complications. The Post Anesthesia Care Unit (PACU) record dated 8/13/03 from 11:03AM through 4:30PM identified Jackson Pratt drainage of 560cc, a Hemoglobin of 11.3 (normal 12.5-16.0), Hematocrit of 33.0 (normal 37-47), and a blood pressure and pulse at discharge from the PACU of 120/60 and 100 respectively. The patient was transferred to a surgical floor at 4:30PM. Review of the patient care flow sheet dated 8/13/03 from 5:45PM through 7:15PM identified a blood pressure range of 73-101/42-61 and a pulse range of 115-125. Further review of the clinical record identified that although the patient's blood pressure had decreased and the pulse increased, the physician was not notified until 7:40PM and consequently intravenous fluids were increased

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with the plan to include returning the patient to the operating room for exploration. MD #9 stated during an interview on 11/20/03 that to his recollection he had not been notified of the patient's decreased blood pressure and tachycardia on 8/13/03 from 5:45PM through 7:15PM. He further stated, had he been notified he would have ordered laboratory work, blood transfusions, and increased intravenous fluids prior to 7:40PM.

- t. Patient #17 was admitted on 6/2/03 with diagnoses of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in his left eye. A physical examination dated 6/2/03 identified a temperature of 97.6, pulse of 104, respirations of 46, blood pressure of 119/69, and a height of 46 inches. Review of the vital signs record identified that vital signs inclusive of blood pressure, pulse, respirations, and temperature were obtained on 6/3/03, 6/4/03, and 6/7/03. Further review of the clinical record inclusive of the vital sign record with Registered Nurse #8 identified that the patient's weight had not been obtained until 6/8/03 (six days subsequent to admission) with a weight of forty six pounds. RN #25 stated during an interview on 12/8/03 that the scale had been broken and during that time period they were borrowing a scale from another unit when a weight needed to be obtained, she had apparently not done it in this case. Review of the policy and procedure for vital signs and weight identified that vital signs will be obtained at admission for baseline measurement including othostatic blood pressure, pulse checks, height, and weight.
- u. Patient #31 was admitted with diagnoses inclusive of post traumatic stress disorder and bi-polar disorder. A restraint/seclusion record dated 11/3/03, 7:00PM identified that when the patient was asked to take a shower, he refused and became agitated striking Mental Health Worker (MHW) #1 in the shoulder. Patient #31 was placed in a basket hold and escorted to the patient's room. Documentation identified that the patient upon return to the room became agitated banging on the door. While the patient was in the room, the patient charged the door striking his face. The patient then wielded a wooden board and began banging on the window. The patient was placed into seclusion. Review of a nurse's progress note dated 11/3/03, 23:00 identified that the patient was in seclusion for forty five minutes with seclusion ending at 7:45PM and identified that the patient's tooth was broken in half. A physician assistant assessment dated 11/3/03, 7:45PM identified that the patient was complaining of a chipped left front tooth which was sustained during the time the patient was running into the closed door. The assessment identified that half of the left front tooth was

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missing with the pulp exposed with no active bleeding. Tylenol #3 (analgesic) one tablet was ordered every four hours when necessary. A medication administration record identified that Tylenol 325 milligrams was given on 11/4/03 at 10:10AM for complaints of dental pain. Registered Nurse (RN) #16 stated during interview on 11/19/03 at 2:30PM that when the patient got angry it was difficult to engage him. He stated that he responded to the incident immediately after MHW #1 summoned him. Upon arrival to the patient's room he observed Patient #31 in the room striking the window in the door with a large board that he had apparently obtained after breaking a piece of furniture in the room. RN #16 stated that upon his arrival the patient reported that the "tooth was broken" and was assessed as needing seclusion. Because there was no blood noted and the patient was agitated, he deferred assessment of the tooth. The patient was then walked to seclusion where he remained for forty five minutes. Subsequent to coming out of seclusion, RN #16 stated that he informed Physician Assistant (PA) #1 of the patient's report of a "broken tooth" who assessed half of the tooth as missing. Review of the clinical record identified that although the incident occurred at approximately 7:00PM and the patient reported immediately that he had broken his tooth, the patient was not assessed until forty five minutes subsequent to the incident. He further stated that he did not assess the patient's pain as these types of patients generally report physical pain right away. Review of the policy and procedure for pain assessment and management policy identified that pain intensity and relief will be assessed after any known pain-producing event. Although half of the patient's tooth had been assessed as missing with the pulp exposed and an analgesic ordered, review identified that pain assessments had not been conducted until 11/4/03 at 10:10AM and/or assessed subsequent to 11/4/03 at 10:10AM. He further stated that he did not assess the patient's pain as these types of patients generally report any physical pain right away.

- v. Review of the medication administration record (MAR) for Patient #44 indicated that the patient received Dilaudid 4mg every four hours as needed for pain. The MAR indicated that on 11/15/03 the patient received Dilaudid at 10 PM and on 11/16/03 at 9 AM, 4 PM and 9 PM for pain levels of 5-7. Review of the flow sheet and the nurse's notes failed to indicate the effectiveness of the intervention. Review of the facility policy indicated that the post assessment should be documented on the back of the nursing flow sheet.
- w. Patient #24 arrived in the emergency department on 7/20/03 at 3:52 pm with a complaint of a painful finger from a sewing machine needle through the left

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thumb. An x-ray of the left first digit identified a metallic needle type density projecting in soft tissues. The patient received Tylox by mouth for pain at 6:44 pm. Interview with MD #4 reflected that pain relief should happen as soon as possible without delay and that there was no reason that the patient did not receive pain relief earlier. Review of the Pain Assessment and Management Policy directs to respect and support the patient's right to optimal pain assessment and management.

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

5.

- a. Patient #8 underwent an endoscopy and colonoscopy on 9/3/02. Review of the endoscopy flowsheet identified that the patient was non-English speaking. Review of the admission nursing assessment identified that the patients primary language was Italian and that the daughter was utilized for interpretation. Review of CIWA assessments dated 9/3/02 at 6PM and 10PM and 9/4/02 at 2AM and 6AM indicated the patient did not understand the question pertaining to orientation and sensorium. Review of the plan of care failed to address the patients language barrier and how the CIWA assessments would be conducted based upon this information.
- b. Review of the medical record for Patient # 45 indicated that the patient was admitted with new onset paraplegia and a history of obesity. Review of the Braden Scale completed on 11/11/03 indicated a score of 15 identifying the patient as a low risk for development of pressure ulcers. The braden scale was revised on 11/12/03 and indicated a score of 13 identifying the patient as a moderate risk for skin breakdown. The nurse's flow sheet dated 11/14/03 indicated that the patient's had a stage II ulcer on his left buttock. Review of the general surgical clinical pathway indicated that the patients skin needs had not been addressed. Review of the pathway on 11/17/03 indicated that problems, preventative measures and/or interventions related to the patients new breakdown were not addressed. Review of facility policy indicated that on admission each patient should have completed an individualized care plan addressing there needs completed.

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- c. Patient #10 was identified on admission on 9/30/03 with intact skin and at minimal risk for pressure sores. Following an emergency re-vascularization of the right femoral artery on 10/2/03, the patient was transferred to the ICU where an ecchymotic stage one pressure sore was noted on the coccyx. Although a care plan was initiated that identified skin integrity, only the IV line site and surgical wounds were addressed. The wound tracking flow sheets identified that the pressure sore progressed to a stage two on 10/3/03 and treatment and/or pressure relieving measures were not initiated until 10/11/03. The patient was discharged on 11/22/03 with the stage II pressure sore.

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).

6.

- a. During a tour of 8-1 on 11/17/03 at 11:35 AM, an intravenous bag containing a Magnesium Sulfate solution mixture and two tablets of medication, Diflucan 100 milligrams (mg) and Oxycodone 5 mg. were observed to be left unattended on the counter of the open nourishment room. Interview with the Nurse Manager of 8-1 on 11/19/03 identified that RN #1 had carried the medications into the nourishment room to obtain ice cream for a patient and had inadvertently left the medications on the counter.

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).

7.

- a. Patient #14 had elective abdominal surgery on 9/28/01 and had a spinal epidural for pain control. On 9/29/01 between 4 PM and 8 PM the epidural flow sheet failed to identify the amount of epidural pain medication, if any, the patient received. The facility policy for use of an epidural flow sheet identified to document the milligrams of medication administered in an 8 hour period. In addition, at 7 PM on 9/29/01 Patient #14 was given 30 mg of IV Toradol for complaints of increasing pain, followed by two (2) doses of IV Dilaudid at 8 PM and 9 PM. A patient controlled anesthesia PCA pump was started at 9:30 PM. The PCA order identified two different Basal Rates, 0.5 mg and 1 mg per hour. The nurse failed to question the order and the PCA was set at the higher dose of 1

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mg per hour. Further, the documented amount of PCA pain medications the patient received between 9:30 PM on 9/29/01 and 3 AM on 9/30/01 was obliterated and re-written. The facility policy for correcting documentation errors identified that entries may not be obliterated. The facility policy for use of an epidural flow sheet identified to document the milligrams of medication administered in an 8 hour period. Interview with MD #23 identified that PCA orders should include only one basal rate, and in this instance, the basal rate was intended to be 1 mg.

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.

- a. Review of Patient #15's medical record and interview with the Nursing Director of Surgery reflected that multiple blood product Transfusion Records lacked complete documentation, which included transfusion checklist and transfusion reaction. Review of the Blood Component Therapy Protocol directs to complete the Transfusion Checklist on the blood component bag.

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

9. During tour of the multiple clinics at the 1000 Asylum building, the following was observed:
 - a. Three (3) of four (4) records (Patient #57, 58, 59, 60) reviewed in the Pediatric/Adolescent Clinic lacked a signed consent to treat form.
 - b. One (1) of four (4) records (Patient #49) reviewed in the Medical/Surgical Clinic lacked information of past medical history, current medications and/or a problem list.

The above is a violation of the Regulations of Connecticut State Agencies (d) Medical Records (3).

10. Based on review of the medical record and review of facility policy, the facility failed to ensure that documentation was complete for Patient #8 and/or failed to ensure that Patient

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#15's codesheet identified signatures for the recorder and the physician in charge. The findings include:

- a. Patient #8 had alcohol withdrawal assessments that lacked dates and times the assessments were conducted. Review of a CIWA assessment with LPN #1 who conducted the assessment identified that the date of this assessment was lacking (located on the same sheet as the 9/4/02 assessment) the time was not legible and the sum of the score incorrect.
- b. Patient #15 had a liver biopsy on 10/29/02 and had a cardiac arrest on 10/29/02 at 5:15 pm. Review of the Cardiopulmonary Arrest Flowsheet and interview with the 7-1 Nurse Manager reflected that the codesheet lacked signatures for the recorder and the physician in charge. Review of the Codes Policy directs that the physician team captain will sign the code record and the caregiver nurse on the area of the arrest will prepare medications, equipment, and record events.

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).

11. Based on a review of medical records and facility policy and procedure, the facility failed to ensure for two patients that the admission database was complete.
 - a. Patient #18 underwent an anterior cervical discectomy and fusion. The patient developed a hematoma and pulmonary edema in the recovery room that required a return to the OR drainage of the incisional hematoma. A review of the patient's admission database identified it was incomplete. The admission data bases for Patient's #18 and 19 lacked information that included abuse and/or substance use, nutrition, fall risk and/or speech, occupational or physical therapy and lacked an RN signature, title and date done.
 - b. Patient #19 underwent a right thyroidectomy and isthmusectomy with postoperative bleeding that required a return to the OR for ligation of bleeding from the left inferior thyroid artery. A review of the patient's admission database identified it was incomplete. A review of the facility policy for guidelines for use of interdisciplinary patient admission database identified the database must be completed within twenty-four hours of admission. If unable to obtain information from the patient, documentation in the Progress Notes should reflect this and be completed when the assessment is completed.

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12. The facility failed to ensure that the clinical record for Patient #6 contained documentation of all physician orders and/or that the record of Patient #11 included documentation during a Code Blue. The findings include.
 - a. Patient #6, a Department of Mental Retardation client and group home resident, was admitted to the Emergency Department on 11/8/02 at approximately 9:00 p.m. after it was determined that his jejunostomy tube had become displaced. The patient's J-tube was replaced the following morning and the patient was discharged back to the group home at approximately 2:30 pm. The clinical record indicated that a Foley catheter was placed for incontinence without documentation of physician orders.
 - b. Patient #11 presented to the Emergency Department (ED) on 12/28/02 at 11:20pm complaining of an asthma attack with an inability to speak. MD #31's examination identified a diagnosis of extremis, status asthmaticus with an oxygen saturation of sixty-six percent (normal greater than 96%) on ambient air. A nurse progress note revealed that subsequent to pulseless electrical activity cardiopulmonary resuscitation was initiated. Although a Code Blue was called, a review of the clinical record failed to identify documentation that a recording of the events was maintained. Hospital "Code Blue" Policy identified that the events of a code are recorded on the "Code Blue" record, signed by the Physician and placed in the medical record.

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).

13. During a tour of the acute hemodialysis unit on 11/18/03, the following was identified:
 - a. The storeroom lacked a lock and contained syringes, needles and some medications.
 - b. The door to the medication room was wedged open.
 - c. The medication refrigerator was observed to contain food items.

14. During a tour of the acute hemodialysis unit on 11/18/03, the following was identified:

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- a. Blood collection tubes (green tops) in the storeroom were noted to have expired in September 2002.
- b. Pre mixed bags of heparin in the storeroom were noted to have expired on September 2002.
- c. During a tour of the acute hemodialysis unit on 11/18/03, intravenous bags of 100cc and 250cc of normal saline had been removed from their protective covering and were being stored in a box.

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).

15. The facility failed to ensure that the appropriate dishwasher temperatures were achieved.
 - a. A review of the facility documentation for 11/1/03 through 11/19/03 indicated that on twelve occasions (evening meal) the dishwasher failed to reach the 150-degree threshold required. The flow sheet indicated temperatures of 142, 145 and 140 degrees on ten (10) occasions. Interview with the supervisor indicated she was unaware of the issue and that although there is a policy the policy does not indicate how long after the dishwasher is started the temperature should be monitored. The policy indicated that if a temperature is below the acceptable range the supervisor should notify engineering immediately.

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

16. Based on observations, medical record reviews and review of facility policies the facility failed to ensure an infection control officer or officers implemented policies governing control of infections. The findings include:
 - a. Patient #42 had diagnosis that included cancer of the breast. During a tour of unit 8-1 on 11/17/03 at 11:25 AM, an intravenous (IV) solution was observed to be infusing via a pump into Patient #42. The IV tubing that delivered the solution was observed to be dated as initiated on 11/12/03 and due to be changed on 11/15/03. Review of the facility's policy on changing of intravenous tubing identified that IV tubing would be changed every seventy two hours.

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) and/or (l) Infection Control (1).

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17. During tour of the Endoscopy area on 11/17/03, the facility failed to show documented evidence that the Cidex OPA was changed according to facility policy. Review of the monitoring logs documented that Cidex changes occurred intermittently, in some instances after 28 days of use, specifically on 7/24/03, 9/3/03 and 10/28/03. Review of the facility policy for Cidex OPA Solution Change revealed that the solution should be changed every 14 days. Scopes hanging in the cabinet between treatment rooms #5 & #6 were observed to be coiled and with tips of scopes lying on the base of the cabinet.
18. During tour of the Operating Suite the following was observed:
 - a. A rack for the sterilizer in the Ambulatory Surgical Unit was observed to be lying on the floor propped against the wall.
 - b. Disinfectant coverage spray was observed to be stocked in the same bin/cubicle as the patient care solutions such as Hibiclens and Betadine.
 - c. The main operating room steris failed to have consistent daily biological monitoring.
 - d. Throughout the Operating Suite head coverings of personnel, including some directly involved at the surgical site were observed to not cover the entire head of hair.
19. The St. Francis Campus Ambulatory Surgical Unit biological monitoring of the flash autoclaves was incomplete for incubation and results of test and control on several days including 8/25/03, 8/26/03 and 8/30/03.
20. During tour of the Mt. Sinai Campus Central Sterile on 11/19/03, the following was observed:
 - a. One (1) of two (2) washers for the central sterile area was located in the midst of the "clean area" necessitating staff to travel through the clean wrapping area with soiled equipment. The facility failed to monitor the temperatures reached during the cleaning cycle of the unit and the unit lacked an automatic printout. Additionally, this washer was wrapped on one side with layers of cellophane tape.
 - b. The storage for sterilized case packs was separated from the "soiled area" by a curtain.
 - c. Wrapped, non-sterile packs are stored on shelves in the staff lounge and locker area.

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- d. Soiled heavy equipment (Baxter pumps, wall suction, venodynes, etc.) are cleaned in the "clean area" and the cleaned equipment was observed to be recharging next to the open trash can.
 - e. The facility failed to show evidence that the sterilizers are on a cleaning schedule.
 - f. The floor of the Central Sterile area was soiled.
21. Review of the biological monitoring of the autoclaves in the Burgdorf Dental Clinic, kept at the Mt. Sinai campus, revealed no evidence that a control test was utilized during the biological testing monitor.
22. During tour of the multiple clinics at the 1000 Asylum building the following was observed:
- a. Review of the Dental Clinic monitoring logs revealed inconsistent monitoring of the biological testing of the six autoclaves (five functional) in the clinic. Review of the monitoring logs on 11/18/03 revealed multiple styles of recording test results rendering it impossible to tell which test was completed for which autoclave. In addition, 11/5/03 lacked any recorded test results. Suction canisters, sani-wipes and miscellaneous items were observed to be stored beneath the sink in the Dental Clinic.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (7) and/or (l) Infection Control (1).

- 23.
- a. Patient #27 underwent a laparoscopy and due to severe endometriosis and adhesions and an open laparotomy was required. Perioperative notes written by RN #3 identified during the change over from laparoscopic to open laparotomy, MD #11 placed the laparoscope with the light cord attached and on, on the patient's upper body. When the cord shifted the end of the scope rested on the drape and scorched through the drape and burned the patient's left shoulder. A review of the manufacturer's warnings and precautions identified that prolonged contact of the scope tip with flammable materials should be avoided due to high intensity light transmission that results in high temperatures. A review of the 2002 AORN Standards, Recommended Practices, and Guidelines identified that illuminated endoscopic light cords should not be allowed to remain in contact with drapes, patient's skin or any flammable material as the heat from the light

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ords may cause drapes to burn. During interviews the Director of Surgical Services, RN #3, and the CST all stated the laparoscope should have been handed to the CST so the light source could be shut off and handed off the surgical field to RN #3 but MD #11 placed it on the patient's chest with the light source on.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2)(B) and/or (4)(A).

24. For Patient #12 the facility failed to ensure that the medical record contained a complete history and physical prior to surgery. The findings include:
- a. Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. Although the laparoscopic inguinal hernia repair was performed on 11/15/02, the preoperative History and Physical was dated 9/11/02. The hospital Medical Staff Rules and Regulations detailing the requirements for History and Physical prior to surgery identified that a history and physical is valid for thirty days only if an update is documented on the History and Physical within seven days of surgery.

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

25. For Patients (#9, #12 and #13) in the survey sample, the facility failed to ensure that physician services were provided in accordance with hospital policies and procedures. The findings are based on a review of the clinical records, staff interviews, review of facility policies and procedures and include the following.
- a. Patient # 13 was admitted to the hospital on 10/23/02 for a laparoscopic appendectomy. Although the informed consent identified a physician signature, it failed to indicate the date the physician signed the form. Facility Consent Policy identified that signed inform consents are valid for thirty days from signature.
 - b. Patient # 9 was admitted on 5/21/02 for a laparoscopic gastric banding procedure. An informed consent dated 5/2/02 identified the original procedure/operation indicated on the informed consent was crossed through several times and a laparoscopic gastric banding procedure added. The consent form failed to identify documentation of the date the type of procedure/operation was changed or the person who initiated the change. MD #19 stated upon interview that the informed consent forms are pre-printed with operations/procedures and are signed in the

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physician's office prior to surgery. MD #19 further stated the change in procedure was initiated on 5/2/02 when the Patients signature was obtained. The facility Standards of Documentation identified that errors are corrected by writing the word "error" above the error and drawing a single line through it, adding the correct information and writing signature and status.

- c. Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. The informed consent for the procedure was signed by Patient #12 and MD#7 on 9/11/02 . Review of the hospital Consent Policy identified that signed informed consent forms shall be valid for thirty days. MD # 7 stated the informed consent was signed in September 2002, with the surgery scheduled electively at the convenience of the patient.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (8).

26. Based on a review of the medical records, review of facility policies and procedures, and interviews, the facility failed to ensure for two patients (Patient #27 and Patient #12) that the operative report accurately reflected all complications that occurred during surgery were documented. The findings include:

- a. Patient #27 underwent a laparoscopy and due to severe endometriosis and adhesions an open laparotomy was required. Perioperative notes written by RN #3 that identified during the change over from laparoscopic to open laparotomy, MD #11 placed the laparoscope with the light cord attached and on, on the patient's upper body. When the cord shifted the end of the scope rested on the drape and scorched through the drape and burned the patient's left shoulder. During interviews the Director of Surgical Services, RN #3, and the CST all stated the laparoscope should have been handed to the CST so the light source could be shut off and handed off the surgical field to RN #3 but MD #11 placed it on the patient's chest with the light source on. Saline gauze, bacitracin, and a Band-Aid were applied in the OR on verbal orders from the physician. A review of the operative report written by MD #11 identified documentation was lacking that any burn injury occurred during the surgery.
- b. Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. An intraoperative injury to the bladder occurred and a Urology Service consultation was conducted to repair the injury to the bladder. A conversion to an open procedure was required to perform the repair. The clinical record failed to

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identify documentation that the Urology Service completed a dictated or written Operative Report detailing the surgical repair of the bladder. Upon request, a dictated operative report dated 11/24/03 was provided by the facility. The hospital Medical Staff Rules and Regulations detailing the requirements for Operative Notes (15.e.) identified that the Operative Report is documented in the medical record immediately after surgery.

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

27.

- a. Patient #28 was admitted on 7/28/03 for operative procedures that included transanal pull through secondary to Hirshsprungs disease and a circumcision. Pre-procedure vital signs at 6:40 AM identified a blood pressure of 94/40, pulse rate was 168 beats per minute and respirations of 60 per minute. Review of the admission database identified that the patient was last fed pedialyte at midnight on 7/28/03. Review of the Anesthesia Record dated 7/28/03 identified that Patient #28 arrived in the OR at 7:28 AM, underwent mask induction and was intubated. Review of the operative report with MD #36 (surgeon) identified that a right broviac catheter (central line) was inserted secondary to lack of a peripheral site. Interview with MD #36 identified that the right internal jugular vein was tied after the broviac catheter was inserted and that this procedure is routinely performed and has no bearing on blood flow to and/or from the brain. Further review of the operative report identified that the patient was placed in the lithotomy position. Interview with MD #36 and MD #47, indicated that Patient #28 was positioned supine, bilateral legs were folded up onto the abdomen, taped lightly, a small towel was placed under the patients buttocks and that the Trendelenberg position was not utilized. Review of the perioperative record and interview with RN #19 (circulating nurse) indicated that MD #36 and MD #47 positioned the patient for surgery. RN #19 documented that the position of the patient was lithotomy and described this as, "arms by the side, legs in fetal position on abdomen wrapped in kerlix with abdominal pad in-between legs and secured with two-inch adhesive tape." Interview stated that the patient's head was in good alignment and that the patient was not placed in Trendelenberg. Review of the vital signs while in the operating room identified that the blood pressures ranged from 70/22 to 40/15 from 7:45 AM through 12:19 PM. At 12:46 PM, the patient arrived in the PACU

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with a blood pressure of 114/52, pulse of 155 and respiratory rate of 20. Review of the PACU record identified that the patient was observed with a weak cry, cyanotic, with some periodic desaturations to the mid 80's, with tonic/clonic type movements, became apneic and required re-intubation and transfer to another hospital for further care. Review of the receiving hospitals medical record identified Patient #28 had diffuse cerebral edema related to an ischemic event and identified low blood pressures intraoperatively. Interview with MD #48 (neurologist) at the receiving hospital indicated that low perfusion and intraoperatively blood pressures contributed to the above mentioned diagnoses. Interview with MD #36 identified that he was not informed of the blood pressures intraoperatively, stated that central venous pressure could have been assessed to explore reasons for low pressures and would have been discussed with anesthesia staff in order to make a determination whether the elective circumcision should have been done. Interview with MD #35 (anesthesiologist), MD #37 (anesthesiologist) and Nurse Anesthetist #1 identified that they were not concerned with the above mentioned blood pressures therefore did not communicate this information to the surgeon. The anesthesia staff expressed concern in regarding to the right internal jugular vein being tied following the insertion of the Broviac catheter and position of the baby which they described as "steep Trendelenberg", "extreme lithotomy" and "virtually standing on head" which possibly contributed to the cerebral edema. In addition, prior to the surgical procedure, a urinary catheter was inserted by MD #36. Review of the Intake and Urinary output record with Nurse Anesthetist #1 identified that 220 cc's of Ringers lactate intravenous solution had infused during surgery and no urinary output was recorded. Interview with Nurse Anesthetist #1 attributed the lack of urinary output to the steep Trendelenberg and Lithotomy; position the patient maintained intraoperatively. MD #36 (surgeon) stated during interview that positioning was not a factor contributing to lack of urinary output and that a dialogue should have occurred between anesthesia staff and himself in relation to lack of urinary output. Review of the perioperative record identified that the Foley catheter was removed postoperatively. Review of the post anesthesia care unit (PACU) record identified that Patient #28 arrived in the PACU at 12:46 PM with Ringers Lactate solution infusing via the central intravenous line. At 5:50 PM, an indwelling Foley catheter was reinserted prior to the transfer to another hospital. Review of the PACU record failed to identify urinary output.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (4)(A).

28.

- a. Patient #11 presented to the Emergency Department (ED) on 12/28/02 at 11:20pm complaining of an asthma attack with an inability to speak. MD #31's (ED Physician) examination identified a diagnosis of extremis, status asthmaticus and an oxygen saturation of 66% (normal greater than 96%). Combivent nebulizer treatments were administered at 11:20pm and 11:25pm. Intravenous solumedrol and epinephrine were administered at 11:45pm. At 11:50pm and 12:00am oxygen saturation levels while receiving 100% oxygen were recorded at 90%. A nurse progress note identified that beginning at 12:00am, MD #31 made multiple unsuccessful attempts to insert an endotracheal tube. Additionally, Paramedic #1 made several unsuccessful attempts to pass the endotracheal tube. At 12:40am continued attempts at intubation were unsuccessful and cyanosis of the face and upper trunk was identified. At 12:56am pulseless electrical activity was identified and cardiopulmonary resuscitation was initiated. A cricothyroidotomy was performed at 1:15am to provide an airway. Resuscitation efforts were unsuccessful and Patient #11 expired at 1:30am. According to ambulance dispatch documentation, the request to transport Patient #11 to the acute care hospital was received on 12/29/02 at 12:14am. Although Patient #11 was diagnosed with status asthmaticus (defined as an emergent condition in the hospital Triage Guidelines) and a high potentiality to require treatment at a higher level of care, the Emergency Department Physician failed to request ambulance transportation for 54 minutes after presentation to the Emergency Department. Furthermore after multiple intubation attempts were unsuccessful and cyanosis was identified at 12:40am, a cricothyroidotomy was not performed until 1:15am (thirty-five minutes after the identified respiratory distress). MD # 4 (Director of the ED) stated that a cricothyroidotomy is performed when the patients' oxygen saturation is 90% or lower and a "couple" of attempts to insert an endotracheal tube are unsuccessful. Additionally MD #4 stated the condition of the airway also determines the necessity to perform a cricothyroidotomy. MD #31 stated the airway was visualized as edematous with no opening realized. At least seven or eight attempts were made to insert the endotracheal tube prior to the decision to perform a cricothyroidotomy. MD # 31 further stated that under his direction, Paramedic #1 performed the cricothyroidotomy because he had prior experience

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in performing the procedure. Upon interview, Paramedic #1 stated he performed three separate intubations with proper placement confirmed by MD #31.

Paramedic #1 stated that although clinical signs, (elevation in oxygen saturation, audible breathe sounds and improvement in color) indicated successful intubation had been accomplished, MD #31 ordered extubation of the three endotracheal tubes inserted. Although x-ray was available, it was not utilized to confirm placement prior to extubation. Paramedic #1 further stated that MD #31 instructed him to perform the cricothyroidotomy even though he was aware that although trained, he had never performed the procedure.

- b. Patient #24 arrived in the emergency department on 7/20/03 at 3:52 pm with a complaint of a painful finger from a sewing machine needle which penetrated the left thumb. An x-ray of the left first digit identified a metallic needle type density projecting in soft tissues. The patient received Tylox by mouth for pain at 6:44 pm. Review of the medical record and interview with the Director of the Emergency Department, MD #4, reflected that an orthopedic physician, MD #19, was unable to come to the hospital to evaluate the patient. The record further identified that the patient's plan was discussed with MD #19 by telephone and the patient was instructed to call MD #19's office on 7/21/03 for follow up. The embedded sewing machine needle was left in the patient and the patient was discharged home at 9:50 pm with instructions for pain medication and antibiotics. The facility failed to provide adequate medical care and treatment while in the emergency department on 7/20/03.

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)(B) and/or (i) General (7) and/or (j) Emergencies (2).

29. The facility failed to ensure that necessary medical information was provided upon transfer of two patients (patients #6 and #66) from the Emergency Department and/or inpatient unit to another facility.
 - a. Patient #6, a Department of Mental Retardation client and group home resident, was admitted to the Emergency Department on 11/8/02 at approximately 9:00 p.m. after it was determined that his jejunostomy tube had become displaced. The patient took nothing by mouth and was dependent on J-tube feedings and medication administration. The patient's J-tube was replaced the following morning and the patient was discharged back to the group home at approximately

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2:30 pm. ED documentation indicated that the patient received intravenous fluids and that oxygen was administered at 6:25 am following an oxygen saturation reading of 93 percent. Although nursing documentation indicated that discharge instructions were given, the clinical record lacked a completed interagency referral form and/or written discharge instructions upon the patient's discharge back to the group home.

- b. Patient #66 was admitted to the facility from a nursing home on 11/13/03 with symptoms that included a new onset of jaundice, elevated temperature, and change in level of alertness. Review of the medical record identified that on 11/15/03, Patient #66 had blood work reported as positive for the Hepatitis B Surface Antigen. Review of the progress note dated 11/18/03 identified that Patient #66 had an unclear presentation, that the patient was positive for Hepatitis B, and that the physician questioned whether the Hepatitis B was acute or chronic. Review of the Interagency Referral Form dated 11/20/03 lacked documentation of the positive Hepatitis B finding. In addition, review of the dictated discharge summary dated 11/13/03 lacked documentation of the positive Hepatitis B finding. Interview with the Infection Control Nurse (ICN) at the nursing home identified that the nursing home was not aware of the new diagnosis for five days when additional blood work drawn at the extended care facility identified the virus.

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).

30. Based on record review and interviews, the hospital failed to address Patient #64's complaint in a timely manner. The findings include:
 - a. Patient #64 filed a written complaint, dated 10/4/03, with the facility regarding care and services in the emergency department on 9/30/03. The hospital failed to address the patient's complaint within ten (10) business days, per their policy. Interview with the Chief of Emergency Services identified that there was a breakdown in communication that prevented him from receiving the complaint in a timely manner. Once he received the complaint, he addressed the complaint with Person #64. Interview with Person #64 identified that it took repeated calls to the facility before the complaint was addressed.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administrator (2).

31. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that a comprehensive assessment was performed that identified the need for restraints for one Patient (#8) and includes the following:
 - a. Patient #8 had a physician's order dated 9/4/02 at 7:37 PM that identified an order for soft wrist, ankle and a vest restraint to prevent falling. Review of the restraint/constant observation flowsheet dated 9/4/02 at 11:00PM identified that a vest restraint and 4-point restraints were applied at 11:00PM. Review of the clinical record with the Nurse Manager identified that a nursing assessment and observed behaviors were lacking prior to the institution of these restraints. Review of facility policy for restraint use identified that an assessment by a RN would be conducted and documented to identify potential behavioral and environmental risk factors so as to reduce and/or limit the use of restraints.

32. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that a plan of care for restraint usage was implemented for one patient (#8) and includes the following:
 - a. Patient #8 was admitted on 9/3/02 with a documented language barrier, history of alcohol use with the fall risk assessment not completed. On 9/4/02 an order to utilize soft wrist, ankle and a vest restraint was obtained to prevent falling. Review of the clinical pathways and/or plan of care with the Director of Quality failed to identify that restraint use was addressed.

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

33. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that restraints were utilized in the least restrictive manner for Patient #8 and includes the following:
 - a. Patient #8 had a physician's order dated 9/4/02 at 7:37 PM that identified an order for soft wrist, ankle and a vest restraint to prevent falling. Review of the restraint/constant observation flowsheet dated 9/4/02 at 11:00 PM through 9/5/03 at 5:45 AM with the nurse manager failed to identify what alternative measures were attempted prior to the initiation of a vest restraint and 4-point restraints.

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Review of the clinical record from 9/5/02 through 9/10/02 identified the patient continued to utilize restraints without the benefit of alternative measures tried. Review of the facility policy for restraint use identified that alternatives or less restrictive interventions must be determined by the patient's assessed needs, tried and clearly documented. Restraint use must be limited to those situations with adequate and appropriate clinical justification and selected only when other less restrictive measures have been found ineffective.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1).

34. Based on review of the clinical record and review of facility policy, the facility failed to ensure that for Patients #8 and 65 that staff continually assessed, monitored restraint use and/or re-evaluated in accordance with facility policy and includes the following:
- a. Review of the restraint/constant observation flowsheet dated 9/6/02 at 2:45 PM identified that Patient #8 utilized 4-point restraints and was observed to be physically aggressive towards others. During the 3:00 PM through 11:45 PM shift the facility failed to identify that an assessment was conducted. Review of the policy for restraint use identified that the patient's condition would be monitored and documented at least every two hours.
 - b. Patient #65 presented to the Emergency Department (ED) with an altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19 AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's noted dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the restraint/seclusion policy for behavior management in a non-behavioral health unit identified restraint or seclusion may be used in response to emergent, dangerous behavior, as a protective intervention to planned medical-surgical care or as a component of an approved protocol. An assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary.

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Patient care includes offering food and fluid, opportunity to eliminate, range of motion and repositioning with skin integrity checks and circulation every two hours, patient monitoring and condition is completed every fifteen minutes and an assessment is conducted by the RN every hour to determine mental status, cognitive functioning, and readiness to release the restraint. The patient's condition is monitored and documented by a trained individual every fifteen minutes and assessed/documentated by an RN every thirty minutes. Review identified that although restraints were utilized in the ED, the clinical record lacked an assessment which indicated that the patient was a danger to self and/or others, any efforts to release the restraints, and patient care relative to restraint utilization in accordance with the policy and procedure.

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).

35. Based on review of the clinical record, a review of facility policy and procedures, and staff interviews, the facility failed to implement seclusion in accordance with the policy and procedure. The findings include:
 - a. Patient #65 presented to the Emergency Department (ED) with an altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19 AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's noted dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the behavioral health physical examination dated 11/25/03 at 3:50 PM identified that the patient was admitted subsequent to a physician emergency certificate with paranoid delusions and a diagnosis inclusive of bipolar disorder. Admission orders included monitoring every fifteen minutes. A nurse's note dated 11/25/03 identified that at 4:00 PM the patient was delusional stating that he wanted to go downstairs and walked towards the exit door (secured door). The patient complied with verbal redirection to walk to the seclusion/monitoring room and the physician was notified at 5:00 PM. Intra-muscular psychotropic medications and seclusion were ordered and the patient was compliant with the administration

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and implementation of such. A restraint/seclusion record dated 11/25/03, 5:00 PM identified that the patient was placed in locked seclusion from 5:00 PM to 6:00 PM with assessments completed at 5:30 PM, 5:45 PM, and 6:00 PM. RN #18 stated during interview on 12/3/03 at 4:30 PM that she was assigned to care for Patient #65 subsequent to admission to the secured behavioral health unit. Shortly before 5:00 PM the patient was delusional and expressed a desire to leave the unit. She stated that the patient was verbally redirected to the seclusion and/or monitoring room to err on the side of caution and "to prevent something from happening", however could not identify any dangerous behaviors. Once in the seclusion/monitoring room the patient continued to insist upon leaving the secured unit. She stated that because the patient would not agree to stay in the room and insisted on leaving the secured unit, locked seclusion was implemented from 5:00 PM to 6:00 PM. Although the policy and procedure for seclusion identified that restraint or seclusion may be used in response to emergent, dangerous behavior as a protective intervention, review of the clinical record and staff interview failed to identify the patient's behaviors as such when seclusion was implemented on 11/25/03 from 5:00 PM to 6:00 PM.

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).

36. Based on review of the clinical record, a review of policy and procedures, and staff interview, the facility failed to obtain an order for the implementation of restraints for two patients (Patients #17 and #65) in accordance with the policy and procedure. The findings include:
- a. Patient #17 was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in his left eye. A nursing progress note dated 6/5/03 identified that the patient's peer made a comment and the patient lost control. The patient was verbally abusive in a time out, became assaultive to staff, and was placed in a two minute therapeutic hold. Review of the policy and procedure for restraint and/or seclusion use for behavior management on the behavioral health unit identified an assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary. Review of the clinical record with RN #8 failed to identify that an assessment

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- and/or physician order for the therapeutic hold was completed and/or obtained in accordance with the policy and procedure.
- b. Patient #65 presented to the Emergency Department (ED) with an altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19 AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's noted dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the restraint/seclusion policy for behavior management in a non-behavioral health unit identified restraint or seclusion may be used in response to emergent, dangerous behavior, as a protective intervention to planned medical-surgical care or as a component of an approved protocol. An assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary. Patient care includes offering food and fluid, opportunity to eliminate, range of motion and repositioning with skin integrity checks and circulation every two hours, patient monitoring and condition is completed every fifteen minutes and an assessment is conducted by the RN every hour to determine mental status, cognitive functioning, and readiness to release the restraint. The patient's condition is monitored and documented by a trained individual every fifteen minutes and assessed/documentated by an RN every thirty minutes. Review identified that although restraints were utilized in the ED, the clinical record lacked a physician order directing the use of the restraints.

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).

37. Based on observation, the facility failed to provide recreation and/or activity equipment in a good state of repair. The findings include:
- a. Observation of the activity room on 11/18/03 identified floor mats utilized for a recreation activity to be in poor condition. Mats were noted to have torn areas with the foam padding exposed with one mat noted to be worn to the threading.

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The Behavioral Health Director stated during interview on 11/18/03 stated that the mats were in poor condition and replacement mats had been ordered. Subsequent to interview, the Behavioral Health Director, directed the unit staff to remove the thread worn mat from the activity room.

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

38. Based on review of the clinical record and staff interview, the facility failed to ascertain current medications for Patient #17 when admitted to a behavioral health unit. The findings include:
- a. Patient #17, a minor patient, was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in his left eye. A bio-psychosocial assessment dated 6/2/03 identified current medications of Topomax 25 milligrams (mg) at hour of sleep and Risperdal .25mg twice a day. A physician's order dated 6/4/03 prescribed Atropine 1%, one drop in the left eye starting at 7:00AM on 6/5/03. A physician's progress note dated 6/10/03 identified that the patient's mother expressed concerns over the patient's medications with a plan to administer the eye drops as directed by the ophthalmologist. MD #20 stated during an interview on 11/25/03 that he met with the patient's mother to discuss concerns that she had regarding a delay in ordering the patient's Atropine eye drops that had been routinely administered prior to admission to the unit. He stated that he maintains and/or manages the psychotropic medications and it is the responsibility of the clinical team to manage the patient's medical needs. He further stated that although he is not sure why they didn't get ordered on admission, he "didn't blame her for being upset". Interview with the Clinical Director of the Behavioral Health Unit on 12/16/03 identified that a pre-admission assessment is done prior to the patient's arrival to the unit through the Clinical Assessment Center (CAC). An inquiry is made regarding current medications and medical history at that time and then again shortly after arriving when the physical examination is done. She stated that often the minor patients come unaccompanied and they have to rely on the pre-admission bio-psychosocial assessment that is completed. During an interview with CAC Intake Coordinator #1 on 12/11/03, she stated most often the information for the bio-psychosocial assessment is obtained from a crisis worker at the transferring facility who in many cases is not aware of current medications

DATES OF VISIT: October 31, November 17, 18, 19, 20, 21, 24, 25, December 3, 7, January 6, 22 and February 2, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

or medical history. She further stated that an inquiry or follow up with the patient's family and/or guardian is not generally made to ascertain a current medical history of the patient or current medications. RN #25 stated during an interview on 12/8/03 that she admitted Patient #17 and during the admission process she typically makes an inquiry and reviews the bio-psychosocial assessment with whomever has accompanied the patient as to current medications and medical history. She further stated that if the patient's mother had mentioned the Atropine eye drops she has to assume she would note it, but could not recall in this case. Review and interview failed to identify a mechanism and/or system to attempt to obtain accurate medical history and/or current medications when a minor patient was admitted to the behavioral health unit unaccompanied.

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

39. A clinical record review identified that Patient's #67, #68, #70 and #71 did not receive clinician biopsychosocial assessments within 24 hours per hospital policy. Also, there were no clinician notes on Patients #67 and #68 for two (2) days and on Patient #70 for four (4) days. The hospital policy identified that clinicians would document daily, on each patient Monday through Friday and as needed. Interview with staff identified that a Licensed Alcohol and Drug Counselor, LADC #1, was out sick on 1/15/04 and 1/16/04. During the absence, other social workers or counselors were to pick up LADC #1's 5 patients. Interview with the Clinician Manager identified that the remaining clinicians should have split up LADC #1's patients on 1/15/04 and 1/16/04 and provide care the patient's may have needed, including biopsychosocial assessments and daily documentation. Interviews with Clinician Managers also identified that clinician led group meetings scheduled on 1/15/04 and 1/16/04 did not occur, as they should have. These groups were to be attended by all patients on the unit deemed capable of attending.

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

40. The facility did not assure that width of aisles or corridors (clear and unobstructed) serving as exit access was at least (select the proper width depending upon use of either Existing or New, ie. 4 or 8) feet as required by the referenced LSC. On 11/18/03 at

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1:15PM, the surveyor observed that the Seventh and Eighth floors had clutter throughout the full length of the corridor.

41. The facility did not assure that width of aisles or corridors (clear and unobstructed) serving as exit access was at least (select the proper width depending upon use of either Existing or New, ie. 4 or 8) feet as required by the referenced LSC. On 11/18/03 at 2:00PM, the surveyor observed that the full length of the nursing corridor was cluttered with nursing equipment.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2).

Exhibit B



April 15, 2004

Judy McDonald, RN
Supervising Nurse Consultant
Division of Health Systems Regulation
State of Connecticut
Department of Public Health
410 Capitol Avenue - MS #12HSR
P. O. Box 340308
Hartford, Connecticut 06134

Re: Unannounced Visits of October 31, 2003 through February 2, 2004

Dear Ms. McDonald:

In response to the violations cited as a result of the unannounced visits of October 31, November, 17, 18, 19, 20, 21, 24, 25, December 3, 7, January 6, 22, and February 2, 2004, please note the following:

1. *Review of the chlorine/chloramines log for the acute care hemodialysis unit indicated that for the period of 10/1/03 through 11/18/03 evidence was lacking that the water was tested on twelve occasions (10/10, 10/16, 10/17, 10/20, 10/24, 10/25, 10/29, 11/4, 11/5, 11/6, 11/14, and 11/15). Review of Gambro policy indicated that water testing should be completed each day prior to starting the first patient.*

Response: The technician responsible for water testing has returned from a Leave of Absence, and the Gambro dialysis nurses are reviewing the testing log regularly. Oversight of the dialysis contractor (Gambro) activities on the St. Francis campus has been transferred to the Sr. Vice President for Patient Care Services. Policy expectations have been reviewed with the contractor and periodic auditing is being done by the Hospital's Safety Committee and Patient Care Services.

The Sr. Vice President for Patient Care Services is responsible for compliance, which was achieved by March 15, 2004.

2.
 - a. *Patient #4 was admitted to the hospital on 2/19/03 at 5:05 PM for induction of labor. Review of MD #40's progress note dated 2/20/03 at 11:15 PM identified that second stage labor was three plus hours with slow progression of descent and would proceed to an operative delivery. Interview with and review of the operative note with MD #39 (assisted MD #40 with delivery) identified that the first application of the Tucker Forceps was applied by MD #39, then reapplied by MD #40 with all pulls performed by MD#40. After*

several pulls with the Tucker Forceps, Simpson Forceps were replaced by MD #40 and Patient #4a (infant) was delivered in the occipital posterior position. At birth the infant required positive pressure ventilation, responded and was monitored in the NICU. Review of APRN #1 (NICU) and RN #23's progress notes dated 2/20/03 identified the baby was born in the anterior posterior position. MD #40's delivery note dated 2/21/03 identified a discrepancy with regards to the presenting part at the time of birth. Review of the clinical record failed to identify the presentation and the position of the fetal head prior to the application of the forceps. Review of APRN #1's (NICU) physical examination identified severe caput formation and forceps marks on the left forehead and at the right temple. Review of the NICU nursing admission data base dated 2/21/03 at 1:00 AM identified the forceps lacerations were observed on the infant's right temporal area, left frontal region and the sclera of the left eye was noted to have a small hemorrhage. Approximately three hours after delivery, the infant developed hypovolemia, coagulopathy and neurological decline with a head CT performed at 9:35 AM that identified significant intracranial hemorrhage involving the subarachnoid and subdural spaces, intracerebral hemorrhage in the left frontal lobe and diffuse brain edema. Follow-up head CT scan at 5:35 PM identified a fracture through the roof of the left orbit, with displacement of a piece of bone into the left frontal lobe and left frontal hematoma. Review of the clinical record identified that the infant was transferred to another acute care hospital at 7:00 PM for further evaluation and management of care. Review of the receiving hospitals medical record identified that the infant experienced a traumatic forcep delivery and presented as hypotonic with no spontaneous activity and progressed to a flat line EEG. On 2/23/03 the infant expired. The autopsy findings support an ischemic or hypotensive event with multisystem failures.

Response: This case was reviewed with all OB/GYNs in the May 2003 Morbidity and Mortality Conference of the Department of Obstetrics and Gynecology and served as a teaching tool for all obstetricians. In addition, all forceps deliveries were monitored for 6 months following this delivery – through August 31, 2003. No unusual forceps deliveries were noted.

The physician involved (Physician #40) has since retired from obstetrics, so no corrective action with respect to him is planned. The Department of Obstetrics and Gynecology continues to review cases through its monthly Morbidity and Mortality Conference under the overall supervision of the Interim Chairman/Director of Obstetrics and Gynecology.

- b. Patient #33's diagnosis included Down's Syndrome. Review of the ED report dated 6/06/03 identified that the patient arrived at the ED with complaints of left thigh pain for one week. The report further identified that a family member reported that the patient had fallen one week prior to the ED visit, that the pain now affected the patient's balance, that the leg had become increasingly weak and that the patient was having difficulty ambulating. Interview with Person #3 on 11/24/03 identified that although Patient #33's baseline ambulation status was independent, the patient required use of a wheelchair upon*

arrival and discharge from the ED due to the inability to ambulate with out pain. Interview with MD #4 on 11/19/03 identified that Patient #33's primary physician had sent the patient to the ED based on reports by the family of the presenting symptoms. MD #4 identified that the patient's primary physician had asked that a Doppler Scan be done to rule out a Deep Vein Thrombosis (DVT). Review of the ED record identified after an initial physical examination, blood work and a bilateral venous Doppler scan was performed and that the scan was reported as negative. No further diagnostic tests were ordered and/or performed and Patient #33 was discharged from the ED with a diagnosis of a left leg contusion. Patient #33 returned to the facility on 06/14/03 with diagnosis of a left hip fracture and subsequently underwent a left hip replacement.

Response: This case was included in the Emergency Department monthly Morbidity and Mortality conference in August 2003. The need to consider the referring physician's suggestion in the context of conducting a thorough and comprehensive evaluation of the patient was re-emphasized.

In addition, for three months following the incident, the Chairman of Emergency Services reviewed the practice of this particular physician as part of the Department's regular Quality Improvement activities, with special emphasis on fractures. No further problems were identified. The Chairman of Emergency Services is responsible for assuring ongoing compliance.

- c. *Patient #23 presented to the Emergency Department (ED) with diagnoses inclusive of hyperglycemia and fever. Review of the ED physical exam dated 8/7/03, 5:01 PM, identified that an assessment of the patient's systems and a physical examination was conducted. An assessment and examination of multiple systems was conducted, however an examination of endocrine, gastrointestinal, and skin systems was lacking. Review of the clinical record identified that Patient #23 was transferred to a medical floor on 8/7/03. The physician's physical examination dated 8/7/03, 9:30 PM identified a healing ulcer. On 8/8/03 pressure ulcer documentation identified a fifty cent size black area on the left heel. Review of the policy and procedure for structure and standards in the ED identified that all patients will be given appropriate treatment. The physician documented policy directed that all physical findings should be described*

Response: The review of systems customary in any Emergency Department is generally focused on the chief complaint and related elements and is not intended to be exhaustive. When the decision is made to admit the patient – based on the principal diagnosis or condition – the admitting physician then conducts a detailed history and physical examination. This was the case with Patient #23, whose principal diagnoses were recurrent psychosis with bipolar disorder, fever and hyperglycemia. The attending physician conducted a detailed H&P – identifying the heel ulcer – while she was still in the Emergency Department.

Notwithstanding the above, the issue of assuring documentation of all physical findings will be discussed at the April 2004 Emergency Department physician staff meeting. As part of

ongoing quality assessment, the Chairman of Emergency Services reviews approximately ten charts per day, and will review for adequacy of documentation.

- d. *Patient #17 a minor child, was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in the left eye. Although review of the clinical records identified that psychotropic medication changes were prescribed on 6/3/03, 6/4/03, 6/5/03, 6/6/03, 6/7/03, and 6/9/03, progress notes identified that the patient's mother was notified of the changes on 6/6/03 and 6/9/03. Review of the policy and procedure for consent of medication directed that the physician discuss with the patient and appropriate family members the medications and side effects of prescribed medications. The physician shall document that medication was discussed and patient agreed to take the medication. In the case of children and adolescents, parental or guardian consent will be documented in the medical record by the physician. MD #20 stated during an interview on 11/25/03 that although he discussed changes with the patient's parent, it was not always reflected in the medical record. In reviewing his notes outside of the clinical record, he states that in addition to what is documented in the clinical records, he discussed changes in the patient's medication regime with the patient's parent on 6/4/03.*

Response: The policy on consent for medication was reviewed with Physician #20 in December 2003 and the Behavioral Health Auditing Team will review one of this physician's charts each week for the next three months. The Interim Chairman of Behavioral Health is responsible for monitoring compliance with this requirement.

3.

- a. *Patient #14 expired on 10/1/01. Hospital policy for autopsy consent referenced the General Statutes of Connecticut, section 19A-286, that identified the consent must state clearly what institution will perform the autopsy, and that the consent is to be witnessed. Review of Patient #14's clinical record revealed a post-mortem examination permission form signed by the patient's wife, dated 10/1/01. Although the post-mortem examination form had a Saint Francis Hospital and Medical center letterhead, it failed to identify where the examination was going to be conducted, and was not witnessed. Interview with Patient #14's wife identified that staff at the hospital staff told her the examination was going to be done at the chief medical examiner's office in Farmington. Only later did the family realize it was done at the hospital.*

Response: Connecticut General Statute §19a-286(c), which enumerates the minimum requirement for an autopsy form (including a statement on which institution will perform the autopsy) did not become effective until January 1, 2002, therefore did not apply to the form in question, which was completed three months earlier, on October 1, 2002. The Hospital's current form does meet the requirements.

4.

- a. *Patient #8 underwent an endoscopy and colonoscopy on 9/3/02. Review of the endoscopy flowsheet identified that the patient was non-English speaking and that the daughter was utilized to interpret during the procedure. Review of the admission nursing assessment identified that the patient's primary language was Italian, the daughter was utilized for interpretation and that eight alcoholic drinks per day were consumed by the patient. The Withdrawal Assessment for Alcohol (CIWA) protocol identified that the CIWA scale would be used for all patients who have greater than three drink equivalents per day as assessed on the interdisciplinary Patient Admission Database. Admission physician's orders were obtained and directed that the CIWA scale be performed every one hour with a score above 12, every 2 hours with a score of 8 through 12 and every 4 hours with a score of less than 8. On 9/5/02, the Delirium Tremors protocol was instituted with a physicians order that directed Valium 5mg IV be administered every two hours PRN for breakthrough symptoms (CIWA score >8).*

Response: This section states the facts of the admission of Patient #8, but does not identify any violation.

- b. *Patient #8 had a CIWA scale dated 9/3/02 at 6PM, 10PM and on 9/4/02 at 2AM and 6AM that indicated the patient did not understand the question pertaining to orientation and sensorium. Additionally, questions relating to nausea, auditory, tactile and visual disturbances were required to be ascertained as part of the assessment. Although scores were documented, these assessments failed to adequately reflect the patients status due a documented language barrier. Review of the clinical record with Nurse Manager #1 identified that although the patient's family had visited almost constantly, documentation was lacking that identified family members were utilized and/or other means of communication occurred with the patient to complete these assessments. Interview with the Chemical Dependency Counselor identified that on 9/5/02 a recommendation was made to utilize DT protocol due to the patients inability to participate in these assessments.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale and implementation of the translator services, as well as documentation of same. Monitoring of CIWA scale and interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- c. *On 9/5/02 at 1AM and 3AM the CIWA assessment identified scores of 19. Review of the clinical record from 9/5/02 (3AM) identified that a CIWA assessment was not conducted again until 9/7/02 at 9AM with a score of 11 documented.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale, as well as documentation of same. Monitoring of CIWA scale and

interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- d. Review of the CIWA assessment dated 9/7/02 identified that an assessment was conducted at 5PM and not again until 9/8/02 at 9AM at which time an assessment was not conducted but documented that the patient was sleeping.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale, as well as documentation of same. Monitoring of CIWA scale and interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- e. Review of the CIWA assessment dated 9/8/02 at 4PM identified the assessment was not completed.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale, as well as documentation of same. Monitoring of CIWA scale and interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- f. CIWA assessment on 9/9/02 at 12:40 AM identified a score of 12 with the next assessment completed on 9/10/02 at 8:30AM with a score of 12 documented.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale, as well as documentation of same. Monitoring of CIWA scale and interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- g. Review of the CIWA assessments completed from 9/3/02 at 6PM through 9/10/02 at 8:30AM failed to identify that the CIWA scores were conducted and/or completed in accordance with physicians orders.*

Response: Staff from the unit on which Patient #8 was admitted are being reeducated about use of the CIWA scale, as well as documentation of same. Monitoring of CIWA scale and interpreter service use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well. The Senior Vice President for Patient Care Services is responsible for compliance.

- h. Review of Patient #15's Moderate Sedation Procedure Record dated 10/29/02 and interview with the Interventional Radiology Nurse Manager reflected that the Moderate Sedation Preprocedure Record lacked documentation for the patient's last oral intake to include date/time and a nurse's signature to verify that the pre-sedation checklist was completed. Review of the Moderate Sedation Policy directs that the monitoring personnel (Nurse, MD, Dentist) confirm completed history and physical, presence of informed consent for procedure and moderate sedation, completion of required pre-anesthetic requirements, and last oral intake.*

Response: Documentation of the patient's last oral intake and verification of the checklist by a nurse were addressed in staff meetings in December 2003. Compliance with these requirements has been added as a component of the quarterly moderate sedation audits. Compliance is being monitored by the Nursing Team Leader in Radiology.

- i. Patient #16 was admitted to the facility on 10/18/02 with a diagnosis of right lower quadrant phlegmon. On 10/29/02, the patient had a modified Barium Swallow, which identified that the patient was at a very high risk of aspiration. The patient also had a history of aspiration. Orders dated 11/6/02 at 9:52 AM directed nothing by mouth. Review of facility documentation and interview with RN#2 identified that NA #1 fed the patient ice cream on 11/6/02 at 7PM. The Nurse Aide did not receive a report from RN #2 at the beginning of her shift and review her NA worksheet prior to providing care for Patient #16. Review of the NA worksheet identified Patient #16's diet as nothing by mouth. Nurse's progress notes dated 11/6/02 identified that at 7PM; the patient's oxygen saturation dropped to 79% on 5 liters of oxygen (was 94% on 3 liters) and the patient had a congested cough. The patient was transferred to the intensive care unit for observation due to aspiration and was intubated at 10:30PM.*

Response: The Nursing Assistant responsible for this event was suspended at the time and has since been terminated. In addition, care of NPO patients was reviewed with all staff on the unit in November 2002. The Nurse Manager of the unit is responsible for monitoring continued compliance.

- j. Patient #24 arrived in the emergency department on 7/20/03 at 3:52 PM with a complaint of painful finger due to a sewing machine needle that perforated the left thumb. The patient received Tylox by mouth for pain at 6:44PM and was discharged to home at 9:50 pm. Review of the nursing assessment lacked a pain assessment upon admission, at the time of Tylox administration, and after the administration of pain medication. Review of the Pain Assessment and Management Policy directs assessment and documentation of pain on admission and after each pain management intervention once a sufficient time has elapsed for the treatment to reach effect.*

Response: The policy regarding pain assessment for ED patients will be reviewed with all ED staff by April 30, 2004. Monitoring for compliance with the policy will be done via review of 15

ED charts per day by the Emergency Department Manager and Assistant Managers. The Emergency Department Manager is responsible for overall compliance.

- k. Review of the medical record for Patient #45 indicated that the patient was admitted with a new onset paraplegia and a history of obesity. The nurse's flow sheet dated 11/14/03 indicated that the patient had a stage II ulcer on his left buttock however documentation of the size, depth and characteristics of the wound were lacking. The flow sheet dated 11/15/03 indicated that the patient had a one and one half inch by one and one half inch breakdown. The flow sheet dated 11/16/03 failed to indicate that the patient had any skin breakdown. Review of the facility policy indicated that upon identification of a pressure ulcer a pressure ulcer assessment should be completed and then once every twenty-four hours with dressing changes.*

Response: The Nurse Manager of the unit on which Pt. #45 was admitted reviewed the requirements for documentation of pressure ulcers with staff in November and December 2003. It has been made a standing item for subsequent staff meetings.

Screening for pressure ulcers and review of Braden Scale documentation are done quarterly by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- l. Patient #13 was admitted to the facility on 10/23/02 for a laparoscopic appendectomy. The perioperative records identified that an indwelling foley catheter was inserted during surgery. The catheter drained sixty milliliters of clear amber colored urine and was removed prior to transfer to the Post Anesthesia Care Unit (PACU). The postoperative nursing progress notes failed to identify documentation that a genitourinary assessment was completed or post catheter voiding occurred prior to discharge. The discharge instructions identified that genitourinary instructions were not applicable. On 10/26/02 Patient #13 was readmitted to the facility with a diagnosis of acute renal failure and perforation of the bladder that was sustained during the laparoscopic appendectomy. Treatment included the placement of an indwelling catheter for ten days. Although an indwelling catheter was inserted perioperative on 10/23/02, the clinical record failed to identify documentation that a genitourinary assessment was completed or post catheter voiding occurred prior to discharge. Registered Nurse #24 stated upon interview the criteria for a laparoscopic appendectomy does not identify that a patient must void prior to discharge.*

Response: The current Clinical Pathway for ambulatory surgery does not require pre-discharge GU assessment and/or voiding, unless it is specifically ordered by the physician. The Pathway does require that all patients be assessed for the need to void, but if there is no need, nothing further is required. In this case, the RN checked "N/A" at the section on voiding, indicating that

the patient had no need to void. The physician who operated on Patient #13 has indicated that the fact that a peri-operative catheter was in place should have no bearing on whether there is a need for special GU and/or voiding assessment postoperatively.

Notwithstanding the above, the OR Clinical Nurse Specialist will review evidence-based clinical practice to determine whether the post-procedure voiding aspect of the pathway continues to be appropriate, and make changes as necessary.

- m. Patient #33 had diagnosis that included Down's Syndrome. Review of the ED report dated 6/6/03 identified that the patient arrived at the ED with complaints of left thigh pain for one week. The report further identified that a family member reported that the patient had fallen one week prior to the Ed visit, that the pain now affected the patient's balance, and that the patient was having difficulty ambulating. Although the ED record identified that Patient #33 complained of left thigh pain on arrival to the ED at 12:23 PM and again at 7:28 PM, the record lacked documentation that Patient #33's level of pain was evaluated in accordance with the facility's policies and/or that interventions for pain relief were provided by facility staff. Review of facility policies on pain management included that pain intensity and relief is assessed in all patients and further provided assessment strategies for patients who were unable to report pain.*

Response: The policy regarding pain assessment for ED patients will be reviewed with all ED staff, beginning immediately and completed by 4/30/04.

Monitoring for compliance will be done via review of 15 charts daily by the Emergency Department Manager and Assistant Managers. The Emergency Department Nurse Manager is responsible for compliance.

- n. Patient #32 had diagnosis that included Coronary Artery Disease (CAD). Review of the medical record identified that Patient #32 underwent a surgical procedure that included Coronary Artery Bypass Graft (CABG) on 3/6/03. Interview with Patient #32 on 11/24/03 identified that the patient complained of numbness of the right hand almost immediately upon awakening and stated that the hand "felt asleep." Review of the documentation in the nursing assessment record dated 3/8/03 to 3/9/03 identified that Patient #32 complained of numbness of the right hand at 4:00 PM on 3/8/03 and again at 12:00 AM on 3/9/03. At 5:30AM on 3/9/03, Patient #32 was medicated with Toradol 30 mg. for "complaints of right hand numbness and pain.". Further review of the record lacked documentation that the physician was notified at that time and/or that diagnostic tests were initiated to identify the source of the patient's complaints of numbness. Interview with MD #14 on 12/2/02 identified that he discussed Patient #32's complaints about numbness and pain of the hand on the first visit to the physician's office postoperatively, referred Patient #32 to a neurologist at that time, but did not recall being told of the problem while the patient was still in the hospital. MD #14 identified that Patient #32's symptoms of numbness were not uncommon after this type of surgery, that the problem*

could have been caused by opening the chest or from pressure under the elbow region, but that he would likely not have done anything about the complaints initially and pursued the complaint only if the symptoms persisted. Review of a consultation report by MD #22 and dated 7/9/03 identified that a nerve conduction study was performed and identified axonal damage within the right ulnar nerve. The consultation report further identified that by a review of the patient's history, it was the opinion of MD #22 that Patient #32's symptoms were related to compression that occurred at or subsequent to, his heart surgery. Review of the medical record of Acute Care Facility #2 identified that Patient #32 underwent a right ulnar nerve release on 11/7/03 for a diagnosis of right ulnar neuropathy.

Response: The record for Patient #32 has been reviewed and it is noted that the patient did complain of numbness in his right hand intermittently on the second and third post-op days, but did not complain again to either nurses or physicians during the remainder of his eight day stay. The nursing staff did not report this symptom to the physician as it appeared to be transient in nature.

The nursing staff in the CICU have been counseled and instructed to document and report any identified symptoms of this nature, no matter how transient.

The Nursing Director, Patient Care Services, who is also Manager of this unit is responsible for monitoring compliance with this requirement. At least two charts per month will be audited to identify whether the physician was notified when the patient had specific complaints.

- o. Patient #64 was admitted to the emergency department on 9/30/03 with a complaint of abdominal pain. The clinical record lacked a pain assessment on admission and although the patient received IV pain medication, there was no pain assessment before administration, and/or the effect of the medication was not documented. Patient #64 identified that she was discharged into the waiting room, vomiting from the effects of the pain medications. Hospital policy identified that a pain assessment was to be conducted on admission and after a pain management intervention.*

Response: The policy regarding pain assessment for ED patients will be reviewed with all ED staff, beginning immediately and completed by 4/30/04.

Monitoring for compliance will be done via review of 15 charts daily by the Emergency Department Manager and Assistant Managers. The Emergency Department Nurse Manager is responsible for compliance.

- p. Patient #14 had elective abdominal surgery on 9/28/01 and received a spinal epidural for pain control. MD orders identified to assess the patient's sensory and motor function of the lower extremities and to notify anesthesiology if the patient is unable to move his thighs or legs. Although on 9/28/01 at 4 PM nurses' notes identified the patient was unable to move his left leg and complaints of increasing pain, the anesthesiologist was not*

notified until 8 PM. At that time, the anesthesiologist identified the catheter was displaced, removed and a PCA was started. Further, there was no evidence in the clinical record that Patient #14 was assessed by a nurse between the hours of 9:30 PM on 9/29/01 and 3 AM on 9/30/01. At 3 AM on 9/30/01 Patient #14 was found slumped over in bed, pulseless and not breathing. The patient was revived, intubated, and transferred to the ICU. Further tests identified that brain death had occurred, life support was withdrawn, and the patient expired on 10/1/01 at 12 Noon. Interview with RN #11 identified that she had not seen the patient between 11PM on 9/29/01 and 3 AM on 9/30/01. RN #11 stated that her first encounter with the patient was when he was noted to be slumped over in bed at 3 AM. RN #11 stated that although the patient's vital signs were documented at 1 AM, they were reported to her by a patient tech. Hospital policy for a patient receiving pain medications via an epidural identified to assess the patient every one hour, and if receiving pain medications via a PCA, every two hours

Response: The 9/28/01 nursing note also documents that the patient later regained his ability to move his left leg and by 7:00 p.m. had verbalized his ability to do so. It is understood that some transient weakness in or inability to move one or both legs while receiving epidural medication is not uncommon. The subsequent notification of the anesthesiologist was due to lack of pain control, not lack of movement. As for the order to notify an anesthesiologist if the patient develops an inability to move thighs/legs, it is understood that an anesthesiologist would be notified in cases of prolonged inability to move both legs, but not necessarily in a situation like this where there is a transient weakness or inability to move one leg.

Notwithstanding the above, the nursing documentation should clearly reflect the events of the shift. The nurse responsible for the entry is no longer employed by the Hospital, but in October and November 2002 – after this incident occurred – a hospital-wide training initiative was done on a number of issues, including completeness of documentation. Each unit reviews 14 charts monthly, for a variety of factors, including documentation.

With regard to the lack of nursing assessments of Patient #14, the nurse responsible has been counseled, and all nurses on the unit reminded of the need to document assessments. Assessments are also audited in the above noted reviews.

With regard to the MD order, the Nurse Manager of the unit will review two epidural patient records per week during April and May to assure compliance with physician orders. The Nurse Manager is responsible.

- q. Patient #7 was admitted with diagnoses of chest pain. The Emergency Department (ED) records dated 4/24/03 identified allergies inclusive of Lasix. Progress notes dated 4/25/03, 8:00 PM identified that the patient's blood pressure was 197/101 with the physician's assistant notified and Lasix ordered. A physician order dated 4/25/03, 20:22 prescribed Lasix 60 milligrams intravenous push, now. A subsequent progress note identified that the medication was prepared and offered at 8:45 PM, however the patient refused the*

intravenous Lasix. The policy and procedure for drug interactions and allergies identified that an "alert" screen will appear with all drug interactions and allergies identified at the time of order entry. The Pharmacy Director on 11/25/03 stated during interview that although the medication administration system identified allergies at the time of order entry, it will not prohibit dispensing the medication. She stated that the system is reliant on the individual practitioner to review the patient allergy in the system and on their computerized worksheet. RN #5 stated during an interview on 11/20/3 that she entered the order prior to administration and could not recall if she reviewed the patient allergy.

Response: Documentation of medication allergies is required within the ED. Information regarding allergies must be entered at the time the patient's assessment is being entered into the Emergency Department Information System (EDIS). Each patient reporting an allergy also receives a red wristband indicating the name of the allergic medication(s).

ED nursing staff education on allergy procedures and documentation is beginning immediately and will be completed by 4/30/04. Monitoring for compliance will be done via review of 15 charts daily by the Emergency Department Manager and Assistant Managers. The Emergency Department Nurse Manager is responsible for compliance.

r.

- i. *Patient #23 presented to the Emergency Department (ED) with diagnoses inclusive of hyperglycemia and fever. Review of the clinical record identified that Patient #23 was transferred to a medical floor on 8/7/03. A Braden Scale skin assessment dated 8/7/03 identified a score of fourteen indicating that the patient was at risk for pressure ulcer development. The physician's physical examination dated 8/7/03 at 9:30PM identified a healing ulcer, however location of the healing ulcer was not identified. The patient admission database dated 8/7/03, 10:00 PM identified no skin decubitus. On 8/8/03, pressure ulcer documentation identified a "fifty cent" size black area on the left heel. Further pressure ulcer documentation dated 8/9/03 and 8/10/03 identified a blackened, one-centimeter area on the left heel. Patient care flow sheets from 8/9/03 through 8/10/03 identified scant serosanguinous drainage from the blackened left heel with treatments administered in accordance with the policy and procedure. Review of an interagency patient referral report dated 8/11/03 indicated that the patient was transferred to an extended care facility and identified a reddened left heel, and to keep the foot off the bed.*

Response: The Nurse Manager of the unit on which Pt. #23 was admitted reviewed the requirements for documentation of pressure ulcers with staff in January and February 2004.

Screening for pressure ulcers and review of Braden Scale documentation are done quarterly by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement

- ii. *An ED triage assessment dated 8/15/03 identified that the patient had been transferred back to the facility from an extended care facility for mental status changes. Nursing documentation on the triage assessment identified a stage two, two inch break in skin integrity on the left medial thigh and kerlix around the left heel. A Braden scale skin assessment dated 8/15/03 identified a score of nine indicating a high risk for pressure sore development. Review of progress notes and consults from 8/16/03 through 8/20/03 identified a left heel ulcer with a heel bone exposed, necrotic blisters on the lower third of the patient's calf, with a plan for a left above the knee amputation. A progress note dated 8/25/03, identified that the patient's family made a decision not to proceed with the above the knee amputation and to change the patient's plan of care to hospice care. The patient expired on 8/25/03.*

Response: Staff on the unit on which Patient #23 was admitted on 8/15/03 are being re-educated regarding Braden Scale protocol and skin care. Two additional RNs have been added to the unit's Skin Care Performance Improvement Team for additional monitoring and education.

Screening for pressure ulcers and review of Braden Scale documentation are done quarterly by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- iii. *Review of the policy and procedure for skin integrity identified that a nursing assessment inclusive of a Braden Scale assessment will be completed at discharge. The clinical nurse specialist will be notified of existing skin breakdown who will determine if a therapeutic bed intervention is necessary and/or dressing options, and/or need for sharp surgical debridement. In addition, in the presence of eschar, elevate the heels off the mattress using pillows.*

Response: The Nurse Manager of the unit from which Pt. #23 was discharged on 8/11/03 reviewed the requirements for documentation of pressure ulcers – including discharge assessment and indications for calling in the Clinical Nurse Specialist – with the nurse who discharged the patient as well as all staff in January and February 2004.

Screening for pressure ulcers and review of Braden Scale documentation are done quarterly by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- iv. *Interview and review of the clinical record with Clinical Director #9 failed to identify that the patient's skin had been assessed utilizing the Braden Scale and that the pressure ulcer had been assessed on 8/11/03 the day of discharge in accordance with the policy and procedure. Clinical Director #9 stated during an interview that a clinical nurse specialist should have been notified of the blackened area to the left heel and a consult requested on the admission from 8/7/03 through 8/11/03. In addition, although a patient care flow sheet dated 8/9/03 identified that the left heel was elevated on a pillow, review of the clinical record inclusive of the care plan failed to consistently identify that the feet were elevated on a pillow and/or that interventions had been developed to reduce pressure on the bilateral heels.*

Response: The Nurse Manager of the unit from which Pt. #23 was discharged on 8/11/03 reviewed the requirements for documentation of pressure ulcers – including discharge assessment and indications for calling in the Clinical Nurse Specialist – with the nurse who discharged the patient as well as all staff in January and February 2004.

Screening for pressure ulcers and review of Braden Scale documentation are done quarterly by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- v. *RN #7 stated during interview on 11/19/03 that although she documented on the 8/11/03 interagency referral report that the left heel was reddened, she could not recall if she had assessed the wound. She stated that most often as the discharge planner she relies on the information that is communicated to her by the unit staff and generally does not assess the wound herself unless it has a very complicated treatment and/or if it has been communicated to her that it is a significant wound.*

Response: The Case Manager who was responsible for Patient #23 was counseled regarding thorough review of the patient record and assessment, communication and documentation. The standards for assessment, communication and documentation were also reviewed with all staff.

Case Management Managers interact daily with all Case Managers and review documentation weekly.

The Manager of Continuum of Care is responsible for monitoring compliance.

- vi. *Although the policy and procedure identified that a pressure ulcer assessment should be completed once in every twenty four hours, review of the clinical record from 8/16/03 through 8/25/03 failed to identify any assessment of the pressure ulcer subsequent to the 8/15/03 assessment.*

Response: Staff on the floor on which Patient #23 was admitted on 8/15/03 are being re-educated regarding Braden Scale protocol and skin care. Two additional RNs have been added to the floor's Skin Care Performance Improvement Team for additional monitoring and education.

Screening for pressure ulcers and review of Braden Scale documentation is done quarterly on all inpatients by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- a. *Patient #22 was admitted with a diagnosis inclusive of morbid obesity. An operative report dated 8/13/03 identified that a laparoscopic gastric bypass was completed. The operative report states that the patient tolerated the procedure well without any complication. The Post Anesthesia Care Unit (PACU) record dated 8/13/03 from 11:03 AM through 4:30 PM identified Jackson Pratt drainage of 560cc, a Hemoglobin of 11.3 (normal 12.5-16.0), Hematocrit of 33.0 (normal 37-47), and a blood pressure and pulse at discharge from the PACU of 120/60 and 100 respectively. The patient was transferred to a surgical floor at 4:30 PM. Review of the patient care flow sheet dated 8/13/03 from 5:45 PM through 7:15 PM identified a blood pressure range of 73-101/42-61 and a pulse range of 115-125. Further review of the clinical record identified that although the patient's blood pressure had decreased and the pulse increase, the physician was not notified until 7:40 PM and consequently intravenous fluids were increased with the plan to include returning the patient to the operating room for exploration. MD #9 stated during an interview on 11/20/03 that to his recollection he had not been notified of the patient's decreased blood pressure and tachycardia on 8/13/03 from 5:45 PM through 7:15 PM. He further stated, had he been notified he would have ordered laboratory work, blood transfusions, and increased intravenous fluids prior to 7:40 PM.*

Response: The Nurse Manager for the floor to which Patient #22 was admitted re-viewed this record. The 5:45 p.m. blood pressure was 94/61, which was low, but it was within reason for the nurse to wait for a subsequent check before notifying a physician. The 6:00 p.m. reading was higher, at 101/58, so it was again reasonable for the nurse not to notify the physician. At 6:15 p.m. the BP was down to 74/42, and at this point the nurse would notify a physician. The general practice for this floor would be to notify the resident, who would give orders and then notify the attending physician, as appropriate.

The record shows that at 7:00 p.m. the patient was given a bolus of Lactated Ringers, pursuant to a telephone order given by a resident. The nurse did notify the resident between 6:15 and 7:00, and received that order as well as laboratory and transfusion orders.

Notwithstanding the above, the nurse should have documented the time at which the resident was notified. The Nurse Manager will review documentation expectations with all staff on the floor.

The Nurse Manger is responsible for monitoring compliance with documentation standards.

- b. *Patient #17 was admitted on 6/2/03 with diagnoses of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in his left eye. A physical examination dated 6/2/03 identified a temperature of 97.6, pulse of 104, respirations of 46, blood pressure of 119/69, and a height of 46 inches. Review of the vital signs record identified that vital signs inclusive of blood pressure, pulse, respirations, and temperature were obtained on 6/3/03, 6/4/03, and 6/7/03. Further review of the clinical record inclusive of the vital sign record with Registered Nurse #8 identified that the patient's weight had not been obtained until 6/8/03 (six day subsequent to admission) with a weight of forty six pounds. RN #25 stated during an interview on 12/8/03 that the scale had been broken and during that time period they were borrowing a scale from another unit when a weight needed to be obtained, she had apparently not done it in this case. Review of the policy and procedure for vital signs and weight identified that vital signs will be obtained at admission for baseline measurement including orthostatic blood pressure, pulse check, height, and weight.*

Response: The requirement for documenting admission weights was reinforced with nursing staff in December 2003. In addition, a daily audit is being done to assure compliance with the various admission requirements, with each chart audited 24 hours after the patient was admitted.

The Director of Nursing for Behavioral Health is responsible for compliance with this requirement.

- c. *Patient #31 was admitted with diagnoses inclusive of post traumatic stress disorder and bi-polar disorder. A restraint/seclusion record dated 11/3/03, 7:00 PM identified that when the patient was asked to take a shower, he refused and became agitated striking Mental Health Worker (MHW) #1 in the shoulder. Patient #31 was placed in a basket hold and escorted to the patient's room. Documentation identified that the patient upon return to the room became agitated banging on the door. While the patient was in the room, the patient charged the door striking his face. The patient then wielded a wooden board and began banging on the window. The patient was placed into seclusion. Review of a nurse's progress note dated 11/3/03, 23:00 identified that the patient was in seclusion for forty five minutes with seclusion ending at 7:45 PM and identified that the patient's tooth was broken in half. A physician assistant assessment dated 11/3/03, 7:45 PM identified that the patient was complaining of a chipped left front tooth which was sustained during the time the patient was running into the closed door. The assessment identified that half of the left front tooth was missing with the pulp exposed and no active bleeding. Tylenol #3 (analgesic) one tablet was ordered every four hours when necessary. A medication*

administration record identified that Tylenol 325 milligrams was given on 11/4/03 at 10:10 AM for complaints of dental pain. Registered Nurse (RN) #16 stated during interview on 11/19/03 at 2:30 PM that when the patient got angry it was difficult to engage him. He stated that he responded to the incident immediately after MHW #1 summoned him. Upon arrival to the patient's room he observed Patient #31 in the room striking the window in the door with a large board that he had apparently obtained after breaking a piece of furniture in the room. RN #16 stated that upon his arrival the patient reported that the "tooth was broken" and was assessed as needing seclusion. Because there was no blood noted and the patient was agitated, he deferred assessment of the tooth. The patient was then walked to seclusion where he remained for forty five minutes. Subsequent to coming out of seclusion, RN #16 stated that he informed Physician Assistant (PA) #1 of the patient's report of a "broken tooth" who assessed half of the tooth as missing. Review of the clinical record identified that although the incident occurred at approximately 7:00 PM and the patient reported immediately that he had broken his tooth, the patient was not assessed until forty five minutes subsequent to the incident. He further stated that he did not assess the patient's pain as these types of patients generally report physical pain right away. Review of the policy and procedure for pain assessment and management policy identified the pain intensity and relief will be assessed after any known pain-producing event. Although half of the patient's tooth had been assessed as missing with the pulp exposed and an analgesic ordered, review identified that pain assessments had not been conducted until 11/4/03 at 10:10 AM and/or assessed subsequent to 11/4/03 at 10:10 AM. He further stated that he did not assess the patient's pain as these types of patients generally report any physical pain right away.

Response: In February 2004 a flow sheet with a detailed pain assessment was implemented in Behavioral Health, and staff was re-educated on the pain assessment policy. In addition, for any patient with pain identified as greater than 4 on a scale of 10, a separate problem sheet is initiated.

The Behavioral Health Auditing Team reviews 21 charts per week for compliance with a variety of factors, including use of the flow sheet.

The Director of Nursing for Behavioral Health is responsible for monitoring compliance with use of the flow sheet.

- d. Review of the medication administration record (MAR) for Patient #44 indicated that the patient received Dilaudid 4mg every four hours as needed for pain. The MAR indicated that on 11/15/03 the patient received Dilaudid at 10 PM and on 11/16/03 at 9 AM, 4 PM and 9 PM for pain levels of 5-7. Review of the flow sheet and the nurse's notes failed to indicate the effectiveness of the intervention. Review of the facility policy indicated that the post assessment should be documented on the back of the nursing flow sheet.*

Response: The requirement for documenting the effectiveness of pain medication was reviewed with staff on the floor on which Patient #44 was admitted in January and February 2004.

The assessment of effectiveness of pain medication is part of the ongoing audit of 14 charts per unit per month. The Nurse Manager continues to monitor compliance.

- e. *Patient #24 arrived in the emergency department on 7/20/03 at 3:52 PM with a complaint of painful finger from a sewing machine needle through the left thumb. An x-ray of the left first digit identified a metallic needle type density projecting in soft tissues. The patient received Tylox by mouth for pain at 6:44pm. Interview with MD#4 reflected that pain relief should happen as soon as possible without delay and that there was no reason that the patient did not receive pain relief earlier. Review of the Pain Assessment and Management Policy directs to respect and support of the patient's right to optimal pain assessment and management.*

Response: The policy regarding pain assessment for ED patients – which includes timeliness of pain interventions - will be reviewed with all ED staff, beginning immediately and continuing through 4/30/04.

Monitoring for compliance will be done via review of 15 charts daily by the Emergency Department Manager and Assistant Managers. The Emergency Department Nurse Manager is responsible for compliance.

5.

- a. *Patient #8 underwent an endoscopy and colonoscopy on 9/3/02. Review of the endoscopy flowsheet identified that the patient was non-English speaking. Review of the admission nursing assessment identified that the patients primary language was Italian and that the daughter was utilized for interpretation. Review of the CIWA assessment dated 9/3/02 at 6 PM and 10 PM and 9/4/04 at 2AM and 6 AM indicated the patient did not understand the question pertaining to orientation and sensorium. Review of the plan of care failed to address the patients language barrier and how the CIWA assessments would be conducted based upon this information.*

Response: The requirement for documentation of language needs and CIWA scale requirements in the care plan will be reviewed with unit staff by the Nurse Manager of the unit on which Patient #8 was hospitalized.

Monitoring of CIWA scale use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well.

The Senior Vice President for Patient Care Services is responsible for compliance.

- b. Review of the medical record for Patient #45 indicated that the patient was admitted with new onset paraplegia and a history of obesity. Review of the Braden Scale completed on 11/11/03 indicated a score of 15 identifying the patient as a low risk for development of pressure ulcers. The Braden scale was revised on 11/12/03 and indicated a score of 13 identifying the patient as a moderate risk for skin breakdown. The nurse's flow sheet dated 11/14/03 indicated that the patient's had a stage II ulcer on his left buttock. Review of the general surgical clinical pathway indicated that the patients skin needs had not been addressed. Review of the pathway on 11/17/03 indicated that problems, preventative measures and/or interventions related to the patients new breakdown were not addressed. Review of facility policy indicated that on admission each patient should have completed an individualized care plan addressing there needs completed.*

Response: The Nurse Manager for the floor on which Patient #45 was admitted reviewed the care plan requirements – including the need to change or add elements when the Braden Scale indicates risk of skin breakdown – with staff in January and February 2004.

Screening for pressure ulcers and review of Braden Scale documentation is done quarterly on all inpatients by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

- c. Patient #10 was identified on admission on 9/30/03 with intact skin and at minimal risk for pressure sores. Following an emergency re-vascularization of the right femoral artery no 10/2/03, the patient was transferred to the ICU where an ecchymotic stage one pressure sore was noted on the coccyx. Although a care plan was initiated that identified skin integrity, only the IV line site and surgical wounds were addressed. The wound tracking flow sheets identified that the pressure sore progressed to a stage two on 10/3/03 and treatment and/or pressure relieving measures were not initiated until 10/11/03. The patient was discharged on 11/22/03 with the stage II pressure sore.*

Response: There is no specific documentation regarding the institution of pressure-relieving measures between 10/3 and 10/11 because all of the beds in the MS ICU are specialized beds designed to reduce risk of pressure sores. On 10/11/03, when the patient was transferred to a step-down unit, there was a need to address the need for pressure relieving measures because the use of the specialized beds is not standard on that unit.

The Clinical Nurse Specialist for the MSICU will review the Skin Care Protocol documentation requirements with staff. Screening for pressure ulcers and review of Braden Scale documentation is done quarterly on all inpatients by the Clinical Nurse Specialists.

The Sr. Vice President for Patient Care Services is responsible for monitoring compliance with this requirement.

6.

- a. *During a tour of 8-1 on 11/7/03 at 11:35 AM, an intravenous bag containing a Magnesium Sulfate solution mixture and two tablets of medicine, Diflucan 100 milligrams (mg) and Oxycodone 5 mg. were observed to be left unattended on the counter of the open nourishment room. Interview with the Nurse Manger of 8-1 on 11/19/03 identified that RN #1 had carried the medications into the nourishment room to obtain ice cream for a patient and had inadvertently left the medications on the counter.*

Response: The responsible nurse was counseled and disciplined according to policy. Medication safety protocols were discussed with all staff at a staff meeting in December 2003.

Random compliance audits are being conducted by the Nurse Manager.

7.

- a. *Patient #14 had elective abdominal surgery on 9/28/01 and had a spinal epidural for pain control. On 9/29/01 between 4 PM and 8PM the epidural flow sheet failed to identify the amount of epidural pain medication, if any, the patient received. The facility policy for use of an epidural flow sheet identified to document the milligrams of medication administered in an 8 hour period. In addition, at 7 PM on 9/29/01 Patient #14 was given 30 mg of IV Toradol for complaints of increasing pain, followed by two (2) doses of IV Dilaudid at 8PM and 9 PM. A patient controlled anesthesia PCA pump was started at 9:30 PM. The PCA order identified two different Basal Rates, 0.5mg and 1 mg per hour. The nurse failed to question the order and the PCA was set at the higher dose of 1 mg per hour. Further, the documented amount of PCA pain medications the patient received between 9:30 PM on 9/19/02 and 3 AM on 9/30/01 was obliterated and re-written. The facility policy for correcting documentation errors identified that entries may not be obliterated. The facility policy for use of an epidural flow sheet identified to document the milligrams of medication administered in an 8 hour period. Interview with MD#23 identified that PCA orders should include only on basal rate, and in this instance, the basal rate as intended to be 1 mg.*

Response: The nurse caring for Patient #14 did not fill in the "administered" column of the epidural flow sheet between 4:00 p.m. and 8:00 p.m. on 9/29/01, however the record indicates that the rate of 16 cc/hr. continued during those hours. The RN in question no longer works for the Hospital, but all staff on the unit on which Patient #14 was admitted have been counseled regarding completion of flow sheets.

The nurse responsible for crossing out and re-writing documentation has been counseled by the Nurse Manger of the unit on the proper procedure for making corrections in the record.

In October and November 2002 – after this incident occurred – a hospital-wide training initiative was done on a number of issues, including complete-ness of documentation and proper corrections. Each unit reviews 14 charts per month, for a variety of factors, including documentation.

The double basal rate appears to have been a “computer glitch” and one which Pharmacy and HIS staff have been unable to duplicate. The nurse who did not question the rate no longer works for the Hospital, but all staff on the unit have been reminded of the need to question unclear orders.

The Nurse Manager of the unit is responsible for monitoring compliance with these requirements.

8.

- a. *Review of Patient #15's medical record and interview with the Nursing Director of Surgery reflected that multiple blood product Transfusion Records lacked complete documentation, which included transfusion checklist and transfusion reaction. Review of the Blood Component Therapy Protocol directs to complete the Transfusion Checklist on the blood component bag.*

Response: The blood transfusions in question were intraoperative blood transfusions, which are handled by the Department of Anesthesia. All anesthesia staff will be asked to re-review the Blood Component Therapy Protocol.

The Director of Anesthesiology will be responsible for monitoring compliance with these requirements.

9. *During tour of the multiple clinics at 1000 Asylum building, the following was observed:*

- a. *Three (3) of four (4) records (Patient #57, 58, 59, 60) reviewed in the Pediatric/Adolescent Clinic lacked a signed consent to treat form.*

Response: All clinic staff are being re-educated about consent requirements.

The Nurse Manager for the clinics is reviewing one day's worth of charts for a specific clinic each month to assure compliance.

- b. *One (1) of four (4) records (Patient #49) reviewed in the Medical/Surgical Clinic lacked information of past medical history, current medications and/or a problem list.*

Response: Patient #49 was a patient returning for a follow-up visit after being hospitalized, and not expected to be a regular clinic patient. A policy is being developed to address this category of patients and the appropriate charting expectations.

The Nurse Manager for the clinics is reviewing one day's worth of charts for a specific clinic each month to assure compliance.

10. *Based on review of the medical record and review of facility policy, the facility failed to ensure that documentation was complete for Patient #8 and/or failed to ensure that Patient #15's code sheet identified signatures for the recorder and the physician in charge. The findings include:*

- a. *Patient #8 had alcohol withdrawal assessments that lacked dates and times the assessments were conducted. Review of the CIWA assessment with LPN #1 who conducted the assessment identified that the date of this assessment was lacking (located on the same sheet as the 9/4/02 assessment) the time was not legible and the sum of the score incorrect.*

Response: Staff from the unit on which patient #8 was admitted are being re-educated about use of the CIWA scale, as well as documentation of same.

Monitoring of CIWA scale use will be added to our ongoing review of 14 charts per unit per month. If problems are identified on other units, education will be expanded to those units as well.

The Senior Vice President for Patient Care Services is responsible for compliance.

- b. *Patient #15 had a liver biopsy on 10/29/02 and had a cardiac arrest on 10/29/02 at 5:15 PM. Review of the Cardiopulmonary Arrest Flowsheet and interview with the 7-1 Nurse Manager reflected that the code sheet lacked signatures for the recorder and the physician in charge. Review of the Codes Policy directs that the physician team captain will sign the code record and the caregiver nurse on the area of the arrest will prepare medications, equipment, and record events.*

Response: The Cardiopulmonary Arrest Flowsheet was reviewed with the staff who conducted the code, who were counseled on documentation requirements. Code documentation requirements will be included in unit education inservices over the next two months.

The Cardiac Arrest Committee monitors all code documentation.

11. *Based on review of medical records and facility policy and procedure, the facility failed to ensure for two patients that the admission database was complete.*

- a. *Patient #18 underwent an anterior cervical discectomy and fusion. The patient developed a hematoma and pulmonary edema in the recovery room that required a return to the OR drainage of the incisional hematoma. A review of the patient's admission database identified it was incomplete. The admission data bases for Patient's #18 and 19 lacked information that included abuse and/or substance use, nutrition, fall risk and or speech, occupational or physical therapy and lacked an RN signature, title and date done.*

Response: The Nurse Manager of the MSICU (the unit to which Patients #18 and 19 were admitted) reviewed admission database requirements with staff at a Staff Meeting in February 2004.

Completion of the admission database within 24 hours is part of the ongoing audit of 14 charts per unit per month. The Nurse Manager continues to monitor compliance.

- b. Patient #19 underwent a right thyroidectomy and isthmusectomy with postoperative bleeding that required a return to the OR for ligation of bleeding from the left inferior thyroid artery. A review of the patient's admission database identified it was incomplete. A review of the facility policy for guidelines for use of interdisciplinary patient admission database identified the database must be completed within twenty-four hours of admission. If unable to obtain information from the patient, documentation in the Progress Notes should reflect this and be completed when the assessment is completed.*

Response: The Nurse Manager of the MSICU (the unit to which Patient #19 was admitted) reviewed admission database requirements with staff at a Staff Meeting in February 2004.

Completion of the admission database within 24 hours is part of the ongoing audit of 14 charts per unit per month. The Nurse Manager continues to monitor compliance.

12. The facility failed to ensure that the clinical record for Patient #6 contained documentation of all physician orders and/or that the record of Patient #11 included documentation during a Code Blue. The findings include.

- a. Patient #6, a Department of Mental Retardation client and group home resident, was admitted to the Emergency Department on 11/8/02 at approximately 9:00 p.m. after it was determined that his jejunostomy tube had become displaced. The patient's J-tube was replaced the following morning and the patient was discharged back to the group home at approximately 2:30 pm. The clinical record indicated that Foley catheter was placed for incontinence without documentation of physician orders.*

Response: On 3/20/04, the Hospital will be installing a new computerized Physician Order Entry system that will include a series of protocol orders for Emergency Department nurses. These protocols, which have been approved by the ED medical staff, will address frequently instituted measures such as a Foley catheter.

Significant education has been done in preparation for implementation of the new computer system, however the specific protocols and oversight of ED compliance will be done by the Chairman of Emergency Services and the ED Nurse Manger.

- b. Patient #11 presented to the Emergency Department (ED) on 12/28/02 at 11:20 pm complaining of an asthma attack with an inability to speak. MD #31's examination identified a diagnosis of extremis, status asthmaticus with an oxygen saturation of sixty-six percent (normal greater than 96%) on ambient air. A nurse progress note revealed that subsequent to pulseless electrical activity cardiopulmonary resuscitation was initiated. Although a Code Blue was called, a review of the clinical record failed to identify documentation that a recording of the event was maintained. Hospital "Code Blue" Policy identified that the events of a code are recorded on the "Code Blue" record, signed by the Physician and placed in the medical record.*

Response: All Emergency Department Nursing and Physician staff will be reeducated about the need for proper completion of the "Code Blue" record.

Code charts are reviewed by the ED Management, and the Cardiac Arrest Committee monitors all code documentation. The Chairman of Emergency Services and the ED Nurse Manager will be responsible for overseeing compliance.

- 13. During a tour of the acute hemodialysis unit on 11/18/03, the following was identified:*
- a. The storeroom lacked a lock and contained syringes, needles and some medications.*
 - b. The door to the medication room was wedged open.*
 - c. The medication refrigerator was observed to contain food items.*

Response:

- a.** A lock has been ordered for the storeroom door.
- b.** The policy regarding locking of the medication room door has been reviewed with staff.
- c.** Food items have been moved to a separate refrigerator.

Compliance the above items will be the responsibility of the Vice President for Patient Care Services.

- 14. During a tour of the acute hemodialysis unit on 11/18/03, the following was identified:*
- a. Blood collection tubes (green tops) in the storeroom were noted to have expired in September 2002.*
 - b. Pre mixed bags of heparin in the storeroom were noted to have expired on September 2002.*
 - c. During a tour of the acute hemodialysis unit on 11/18/903, intravenous bags of 100cc and 250cc of normal saline had been removed from their protective covering and were being stored in a box.*

Response:

- a.** The outdated blood collection tubes have been removed.
- b.** The outdated heparin has been removed.

The Hospital Safety Committee is responsible for monitoring compliance with this requirement through its periodic safety rounds.

15. *The facility failed to ensure that the appropriate dishwasher temperatures were achieved.*
- a. *A review of the facility documentation for 11/1/03 through 11/19/03 indicated that on twelve occasions (evening meal) the dishwasher failed to reach the 150-degree threshold required. The flow sheet indicated temperatures of 142, 145, and 140 degrees on ten (10) occasions. Interview with the supervisor indicated she was unaware of the issue and that although there is a policy the policy does not indicate how long after the dishwasher is started the temperature should be monitored. The policy indicated that if a temperature is below the acceptable range the supervisor should notify engineering immediately.*

Response: The Food & Nutrition Operations Manager reviewed temperature logs, minimum temperature requirements and actions to be taken in the event of failure to meet minimums with Operations staff on 11/25/03. The temperature log format was updated to more clearly indicate minimums and actions to be taken.

The Operations Manager is responsible for assuring compliance.

16. *Based on observations, medical record reviews and review of facility policies the facility failed to ensure an infection control officer or officers implemented policies governing control of infections. The findings include:*
- a. *Patient #42 had diagnosis that included cancer of the breast. During our tour of unit 8-1 on 11/7/03 at 11:25 AM, an intravenous (IV) solution was observed to be infusing via a pump into Patient #42. The IV tubing that delivered the solution was observed to be dated as initiated on 11/12/03 and due to be changed on 11/15/03. Review of the facility's policy on changing of intravenous tubing identified that IV tubing would be changed every seventy two hours.*

Response: Policies for labeling IV tubing were reviewed with staff on 8-1 in December 2003. Random audits are being conducted to assure compliance.

The Nurse Manager of 8-1 is responsible for assuring compliance.

17. *During tour of the Endoscopy area on 11/17/03, the facility failed to show documented evidence that the Cidex OPA was changed according to facility policy. Review of the monitoring logs documented that Cidex changes occurred intermittently, in some instances after 28 days of use, specifically on 7/24/03, 9/3/03 and 10/28/03. Review of the facility policy for Cidex OPA Solution Change revealed that the solution should be changed every 14 days. Scopes hanging in the cabinet between treatment rooms #5 and #6 were observed to be coiled and with tips of scopes lying on the base of the cabinet.*

Response: An inservice on Cidex OPA changes was provided by the manufacturer on 12/10/03.

The Assistant Nurse Manager is responsible for ongoing compliance audits

18. *During tour of the Operating Suite the following was observed:*

- a. *A rack for the sterilizer in the Ambulatory Surgical Unit was observed to be lying on the floor propped against the wall.*
- b. *Disinfectant coverage spray was observed to be stocked in the same bin/cubicle as the patient care solutions such as Hibiclens and Betadine.*
- c. *The main operating room steris failed to have consistent daily biological monitoring.*
- d. *Throughout the Operating Suite head coverings of personnel, including some directly involved at the surgical site were observed to not cover the entire head of hair.*

Response:

- a. The rack was moved at the time it was identified.
- b. The disinfectant spray has been moved.
- c. A Central Sterile group leader has been designated to do testing on weekends and holidays, which were the days not previously done.
- d. Staff were reminded to wear head coverings appropriately.

Monitoring of 18 a, b and d will be done by the Director of Nursing for Surgical Services. 18 c will be monitored by the Central Services Director.

19. *The St. Francis Campus Ambulatory Surgical Unit biological monitoring of the flash autoclaves was incomplete for incubation and results of test and control on several days including 8/25/03, 8/26/03, and 8/30/03.*

Response: The tests had been performed, but the technician had kept the log sheets on a clipboard, and neglected to move them into the binder with other log sheets. The clipboard has been eliminated and all sheets are in the log book.

20. *During tour of the Mt. Sinai Campus Central Sterile on 11/19/03, the following was observed:*

- a. *One (1) of two (2) washers for the central sterile area was located in the midst of a "clean area" necessitating staff to travel through the clean wrapping area with soiled equipment. The facility failed to monitor the temperatures reached during the cleaning cycle of the unit and the unit lacked an automatic printout. Additionally, this washer was wrapped on one side with layers of cellophane tape.*
- b. *The storage for sterilized case packs was separated from the "soiled area" by a curtain.*
- c. *Wrapped, non-sterile packs are stored on shelves in the staff lounge and locker area.*
- d. *Soiled heavy equipment (Baxter pumps, wall suction, venodynes, etc.) are cleaned in the "clean area" and the cleaned equipment was observed to be recharging next to the open trash can.*

- e. The facility failed to show evidence that the sterilizers are on a cleaning schedule.*
- f. The floor of the Central Sterile area was soiled.*

Response:

- a. The washer in question has been replaced and the new washer relocated.
- b. A wall has been erected in place of the curtain.
- c. The sterile storage area has been enhanced and completely separated from the locker area.
- d. Soiled heavy equipment is now being cleaned in a new wash area. Recharging of equipment has been relocated to a clean storage area.
- e. Cleaning has been incorporated with the regular preventive maintenance.
- f. Floor cleaning has been done.

Monitoring of 20 a-f is the responsibility of the Central Services Director.

21. *Review of the biological monitoring of the autoclaves in the Burdorf Dental Clinic, kept at the Mt. Sinai campus, revealed no evidence that a control test was utilized during the biological testing monitor.*

Response: A new log has been created for use by the Dental Clinic, with space added for entries related to the control tests. In addition evidence of biologic monitoring has been added to the quarterly Infection Control reports.

The Central Services Director is responsible for monitoring compliance.

22. *During tour of the multiple clinics at the 1000 Asylum building the following was observed:*
- a. Review of the dental Clinic monitoring logs revealed inconsistent monitoring of the biological testing of the six autoclaves (five functional) in the clinic. Review of the monitoring logs on 11/18/03 revealed multiple styles of recording test results rendering it impossible to tell which test was completed for which autoclave. In addition, 11/5/03 lacked any recorded test results. Suction canisters, sani-wipes and miscellaneous items were observed to be stored beneath the sink in the Dental Clinic.*

Response: The Central Services Director worked with Dental Clinic staff to implement the same log system used in the rest of the facility, and evidence of it is part of the quarterly Infection Control report. In addition, items stored under the sink were moved.

The Director of Dentistry is responsible for monitoring compliance.

- 23.
- a. Patient #27 underwent a laparoscopy and due to severe endometriosis and adhesions and an open laparotomy was required. Perioperative notes written by RN #3 identified during the change over from laparoscopic to open laparotomy, MD #11 placed the*

laparoscope with the light cord attached and on, on the patient's upper body. When the cord shifted the end of the scope rested on the drape and scorched through the drape and burned the patient's left shoulder. A review of the manufacturer's warnings and precautions identified that prolonged contact of the scope tip with flammable materials should be avoided due to high intensity light transmission that results in high temperatures. A review of the 2002 AORN Standards, Recommended Practices, and Guidelines identified that illuminated endoscopic light cords should not be allowed to remain in contact with drapes, patient's skin or any flammable materials as the heat from the light cords may cause drapes to burn. During interviews the Director of Surgical Services, RN #3, and the CST all stated the laparoscope should have been handed to the CST so the light source could be shut off and handed off the surgical field to RN #3 but MD #11 placed it on the patient's chest with the light source on.

Response: The incident was reviewed with staff at the time of occurrence. Changes made include:

- a new policy which states that when a case is converted from laparoscopic to open, the new procedure will not begin until ALL laparoscopic equipment has been removed; and
- a tray was obtained for the scope, so that it will not touch drapes during a procedure.

In addition, the Fire Safety Plan was re-reviewed with all staff in April 2003 and again in December 2003. Special fire drills are done in the OR/PACU two times per year.

The Director of Nursing for Surgical Services is responsible for compliance with the OR Fire Safety Plan.

24. *For Patient #12 the facility failed to ensure that the medical record contained a complete history and physical prior to surgery. The findings include:*
- a. *Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. Although the laparoscopic inguinal hernia repair was performed on 11/15/02, the preoperative History and Physical was dated 9/11/02. The hospital Medical Staff Rules and Regulations detailing the requirements for History and Physical prior to surgery identified that a history and physical is valid for thirty days only if an update is documented on the History and Physical within seven days of surgery.*

Response: The pre-operative history and physical requirements will be reviewed with all surgeons at the Department of Surgery business meeting on 3/17/04.

The Pre-admission Testing staff review charts prior to surgery and have been instructed to cancel any surgery where the H&P is not current.

The Chairman of Surgical Services is responsible for overseeing compliance with this requirement.

25. *For Patients (#9, #12, and #13) in the survey sample, the facility failed to ensure that physician services were provided in accordance with hospital policies and procedures. The findings are based on a review of the clinical records, staff interviews, review of facility policies and procedures and include the following:*
- a. *Patient #13 was admitted to the hospital on 10/23/02 for a laparoscopic appendectomy. Although the informed consent identified a physician signature, it failed to indicate the date the physician signed the form. Facility Consent Policy identified that signed inform consents are valid for thirty days from signature.*
 - b. *Patient #9 was admitted on 5/21/02 for a laparoscopic gastric banding procedure. An informed consent dated 5/2/02 identified the original procedure/operation indicated on the informed consent was crossed through several times and a laparoscopic gastric banding procedure added. The consent form failed to identify documentation of the date the type of procedure/operation was changed or the person who initiated the change. MD #19 stated upon interview that the informed consent forms are pre-printed with operations/procedures and are signed in the physician's office prior to surgery. MD #19 further stated the change in procedure was initiated on 5/2/02 when the Patients signatures was obtained. The facility Standards of Documentation identified that errors are corrected by writing the word "Error" above the error and drawing a single line through it, adding the correct information and writing signature and status.*
 - c. *Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. The informed consent for the procedure was signed by Patient #12 and MD #7 on 9/11/02. Review of the hospital Consent Policy identified that signed informed consent forms shall be valid for thirty days. MD #7 stated the informed consent was signed in September 2002, with the surgery scheduled electively at the convenience of the patient.*

Response:

- a. The informed consent requirements were reviewed with all surgeons at the Department of Surgery business meeting on 3/17/04. The Pre-admission Testing staff review charts prior to surgery and have been instructed to cancel any surgery where the informed consent is not correct.
- b. The Chairman of Surgical Services will review with the requirements for properly amending documents with Physician #19. The Pre-admission Testing staff review charts prior to surgery and have been instructed to cancel any surgery where the informed consent is not correct.
- c. The informed consent requirements were reviewed with all surgeons at the Department of Surgery business meeting on 3/17/04. The Pre-admission Testing staff review charts prior to surgery and have been instructed to cancel any surgery where the informed consent is not correct.

The Chairman of Surgical Services is responsible for overseeing compliance with items 25a. through 25c.

26. *Based on a review of the medical records, review of facility policies and procedures, and interviews, the facility failed to ensure for two patients (Patient #27 and Patient #12) that*

the operative report accurately reflected all complications that occurred during surgery were documented. The findings include:

- a. Patient #27 underwent a laparoscopy and due to severe endometriosis and adhesions an open laparotomy was required. Perioperative notes written by RN #3 that identified during the change over from laparoscopic to open laparotomy, MD #11 placed the laparoscope with the light cord attached and on, on the patient's upper body. When the cord shifted the end of the scope rested on the drape and scorched through the drape and burned the patient's left shoulder. During interviews the Director of Surgical Services, RN #3, and the CST all stated the laparoscope should have been handed to the CST so the light source could be shut off and handed off the surgical field to RN #3 but MD #11 placed it on the patient's chest with the light source on. Saline gauze, bacitracin, and a Band-Aid were applied in the OR on verbal orders from the physician. A review of the operative report written by MD #11 identified documentation was lacking that any burn injury occurred during the surgery.*
- b. Patient #12 underwent an outpatient laparoscopic inguinal hernia repair on 11/15/02. An intraoperative injury to the bladder occurred and a Urology Service consultation was conducted to repair the injury to the bladder. A conversion to an open procedure was required to perform the repair. The clinical record failed to identify documentation that the Urology Service completed a dictated or written Operative Report detailing the surgical repair of the bladder. Upon request, a dictated operative report dated 11/24/03 was provided by the facility. The hospital Medical Staff Rules and Regulation detailing the requirements for Operative Notes (15.3.) identified that the Operative Report is documented in the medical record immediately after surgery.*

Response:

- a.** The Interim Chairman/Director of Obstetrics and Gynecology reviewed the lack of information regarding the burn injury in the operative note with Physician #11.
- b.** The Chairman of Surgical Services reviewed with the Operative Note requirements with the surgeon involved.

The Medical Records Committee is responsible for monitoring compliance with Operative Note requirements.

27.

- a. Patient #28 was admitted on 7/28/03 for operative procedures that included transanal pull through secondary to Hirshsprungs disease and a circumcision. Preprocedure vital signs at 6:40 AM identified a blood pressure of 94/40, pulse rate was 168 beats per minute and respirations of 60 per minute. Review of the admission database identified that the patient was last fed pedialyte at midnight on 7/28/03. Review of the Anesthesia Record dated 7/28/03 identified that Patient #28 arrived in the OR at 7:28 AM, underwent mask induction and was intubated. Review of the operative report with MD #36 (surgeon) identified that a right broviac catheter (central line) was inserted*

secondary to lack of a peripheral site. Interview with MD #36 identified that the right internal jugular vein was tied after the Broviac catheter was inserted and that this procedure is routinely performed and has no bearing on blood flow to and/or from the brain. Further review of the operative report identified that the patient was placed in the lithotomy position. Interview with MD #36 and MD #47, indicated that Patient #28 was positioned supine, bilateral legs were folded up onto the abdomen, taped lightly, a small towel was placed under the patients buttocks and that the Trendelenberg position was not utilized. Review of the perioperative record and interview with RN #19 (circulating nurse) indicated that MD #36 and MD #47 positioned the patient for surgery. RN #19 documented that the position of the patient was lithotomy and described this as, "arms by the side, legs in fetal position on abdomen wrapped in kerlix with abdominal pad in-between legs and secured with two-inch adhesive tape". Interview stated that the patient's head was in good alignment and that the patient was not placed in Trendelenberg. Review of the vital signs while in the operating room identified that the blood pressures ranged from 7/22 to 40/15 from 7:45 AM through 12:19 PM. At 12:46 PM, the patient arrived in the PACU with a blood pressure of 114/52, pulse of 155 and respiratory rate of 20. Review of the PACU record identified that the patient was observed with a weak cry, cyanotic, with some periodic desaturations to the mid 80's, with tonic/clonic type movements, became apneic and required re-intubation and transfer to another hospital for further care. Review of the receiving hospitals medical record identified Patient #28 had diffuse cerebral edema related to an ischemic event and identified low blood pressures intraoperatively. Interview with MD #48 (neurologist) at the receiving hospital indicated that low perfusion and intraoperatively blood pressures contributed to the above mentioned diagnoses. Interview with MD #36 identified that he was not informed of the blood pressures intraoperatively, stated that central venous pressure could have been assessed to explore reasons for low pressures and would have been discussed with anesthesia staff in order to make a determination whether the elective circumcision should have been done. Interview with MD #35 (anesthesiologist), MD #37 (anesthesiologist) and Nurse Anesthetist #1 identified that they were not concerned with the above mentioned blood pressures therefore did not communicate this information to the surgeon. The anesthesia staff expressed concern in regarding tot the right internal jugular vein being tied following the insertion of the Broviac catheter and position of the baby which they described as "steep Trendelenberg", "extreme lithotomy" and "virtually standing on head" which possibly contributed to the cerebral edema. In addition, prior to the surgical procedure, a urinary catheter was inserted by MD #36. Review of the Intake and Urinary output record with Nurse Anesthetist #1 identified that 220 cc's of Ringers lactate intravenous solution had infused during surgery and no urinary output was recorded. Interview with Nurse Anesthetist #1 attributed the lack of urinary output to the steep Trendelenberg and Lithotomy position the patient maintained intraoperatively. MD #36 (surgeon) stated during interview that positioning was not a factor contributing to lack of urinary output and that a dialogue should have occurred between anesthesia staff and himself in relation to the lack of

urinary output. Review of the perioperative record identified that the Foley catheter was removed postoperatively. Review of the post anesthesia care unit (PACU) record identified that Patient #28 arrived in the PACU at 12:46 PM with Ringers Lactate solution infusion via the central intravenous line. At 5:50 PM, an indwelling Foley catheter was reinserted prior to the transfer to another hospital. Review of the PACU record failed to identify urinary output.

Response: The Hospital's Department of Anesthesiology strongly disagrees with the conclusion that condition(s)/ standard(s) are not met as delineated in prefix tags A263 and A270, but at the requirement of the State of Connecticut Department of Public Health to submit a plan of correction, will implement the following procedure in response to those conclusions: In patients of the age and status of patient #28, the attending anesthesiologist(s) will jointly discuss and determine with the attending surgeon and any necessary specialty consultants, the range of blood pressure and volume of urinary output to be targeted during each such surgical procedure, and will report any deviation from those targets to the surgeon in a clinically timely and appropriate manner.

The Chairman of Anesthesiology will review two such charts every month through September 2004 to assure compliance.

28.

- a. *Patient #11 presented to the Emergency Department (ED) on 12/28/02 at 11:30 pm complaining of an asthma attack with an inability to speak. MD #31's (ED physician) examination identified a diagnosis of extremis, status asthmaticus and an oxygen saturation of 66% (normal greater than 96%). Combivent nebulizer treatments were administered at 11:20pm and 11:25 pm. Intravenous solumedrol and epinephrine were administered at 11:45pm. At 11:50pm and 12:am oxygen saturation levels while receiving 100% oxygen were recorded at 90%. A nurse progress note identified that beginning at 12:00am, MD #31 made multiple unsuccessful attempts to insert an endotracheal tube. Additionally, Paramedic #1 made several unsuccessful attempts to pass the endotracheal tube. At 12:40am continued attempts at intubation were unsuccessful and cyanosis of the face and upper trunk was identified. At 12:56am pulseless electrical activity was identified and cardiopulmonary resuscitation was initiated. A cricothyroidotomy was performed at 1:15am to provide an airway. Resuscitation efforts were unsuccessful and Patient #11 expired at 1:30am. According to ambulance dispatch documentation, the request to transport Patient #11 to the acute care hospital was received on 12/29/02 at 11:14am. Although Patient #11 was diagnosed with status asthmaticus (defined as an emergent condition in the hospital Triage Guidelines) and a high potentiality to require treatment at a higher level of care, the Emergency Department Physician failed to request ambulance transportation for 54 minutes after presentation to the Emergency Department. Furthermore after multiple intubation attempts were unsuccessful and cyanosis was identified at 12:40am,*

a cricothyroidotomy was not performed until 1:15am (thirty-five minutes after the identified respiratory distress). MD #4 (Director of the ED) stated that a cricothyroidotomy is performed when the patients' oxygen saturation is 90% or lower and a "couple" of attempts to insert an endotracheal tube are unsuccessful. Additionally MD #4 stated the condition of the airway also determines the necessity to perform a cricothyroidotomy. MD #31 stated the airway was visualized as edematous with no opening realized. At least seven or eight attempts were made to insert the endotracheal tube prior to the decision to perform a cricothyroidotomy. MD #31 further stated that under his direction, Paramedic #1 performed the cricothyroidotomy because he had prior experience in performing the procedure. Upon interview, Paramedic #1 stated he performed three separate intubations with proper placement confirmed by MD #31. Paramedic #1 stated that although clinical signs, (elevation in oxygen saturation, audible breathe sounds and improvement in color) indicated successful intubation had been accomplished, MD #31 ordered extubation of the three endotracheal tubes inserted. Although x-ray was available, it was not utilized to confirm placement prior to extubation. Paramedic #1 further stated that MD #31 instructed him to perform the cricothyroidotomy even though he was aware that although trained, he had never performed the procedure.

Response: The issues raised in this violation have been fully addressed. Patient #11 was admitted to the Emergency Department at the Mt. Sinai campus of Saint Francis Hospital and Medical Center. While that campus had a fully equipped Emergency Department, it was staffed for a significantly lower patient volume and acuity and did not have rapid access to additional specialists.

On March 31, 2003 the Emergency Department was closed. All emergency patients are now treated at the Saint Francis campus of Saint Francis Hospital and Medical Center, which is a Level II Trauma Center with in-house anesthesia and on-call attending level consultations services in every specialty. There are at least two board-certified emergency physicians on-site at all times. Physician #31 is no longer employed at Saint Francis Hospital and Medical Center.

The Chairman of Emergency Services is responsible for quality assurance for the Emergency Department and does daily chart reviews and quarterly chart audits as part of the Department's Quality Assurance plan.

- b. Patient #24 arrived in the emergency department on 7/20/03 at 3:52 pm with a complaint of painful finger from a sewing machine needle which penetrated the left thumb. An x-ray of the left first digit identified a metallic needle type density projecting in soft tissues. The patient received Tylox by mouth for at 6:44 pm. Review of the medical record and interview with the Director of pain the Emergency Department, MD #4, reflected that an orthopedic physician, MD #19, was unable to come to the hospital to evaluate the patient. The record further identified that the patient's plan was discussed with MD #19 by telephone and the patient was instructed to call MD #19's*

office on 7/21/03 for follow up. The embedded sewing machine needle was left in the patient and the patient was discharged home at 9:50pm with instructions for pain medication and antibiotics. The facility failed to provide adequate medical care and treatment while in the emergency department on 7/20/03.

Response: The removal of a foreign body from a finger is not necessarily an emergent procedure, provided there is appropriate consultation, infection prophylaxis, pain management and follow up arrangements, all of which were provided in the case of Patient #24. In fact, such a procedure is often done on a scheduled basis. Nevertheless, ED staff could do a better job of explaining this information to the patient and assuring the patient of the safety of the plan of care.

The Chairman of Emergency Services will review this case with ED physicians at their April 2004 meeting.

29. *The Facility failed to ensure that necessary medical information was provided upon transfer of two patients (patients #6 and #66) from the Emergency Department and/or inpatient unit to another facility.*

- a. *Patient #6, a Department of Mental Retardation client and group home resident, was admitted to the Emergency Department on 11/8/02 at approximately 9:00 p.m. after it was determined that his jejunostomy tube had become displaced. The patient took nothing by mouth and was dependent on J-tube feedings and medication administration. The patient's J-tube was replaced the following morning and the patient was discharged back to the group home at approximately 2:30 pm. ED documentation indicated that the patient received intravenous fluids and that oxygen was administered at 6:25 am following an oxygen saturation reading of 93 percent. Although nursing documentation indicated that discharge instructions were given, the clinical record lacked a completed interagency referral form and/or written discharge instructions upon the patient's discharge back to the group home.*

Response: The Emergency Department Information System (EDIS) has the capacity to print copies of the interagency referral form (W-10). Physicians will be re-educated on completing the W-10 in the EDIS system, and nurses will be counseled on their responsibility to assure that the W-10 is completed and sent to the patient's next provider.

Monitoring for compliance will be done via review of 15 charts daily by the Emergency Department Manager and Assistant Managers.

The Chairman of Emergency Services and the Nurse Manager of the Emergency Department will be responsible for assuring compliance

- b. *Patient #66 was admitted to the facility from a nursing home on 11/13/03 with symptoms that included a new onset of jaundice, elevated temperature, and change in*

level of alertness. Review of the medical record identified that on 11/15/03, Patient #66 had blood work reported as positive for the Hepatitis B Surface Antigen. Review of the progress note dated 11/18/03 identified that Patient #66 had an unclear presentation, that the patient was positive for Hepatitis B, and that the physician questions whether the Hepatitis B was acute or chronic. Review of the Interagency Referral Form dated 11/20/03 lacked documentation of the positive Hepatitis B finding. In addition, review of the dictated discharge summary dated 11/13/03 lacked documentation of the positive Hepatitis B finding. Interview with the Infection Control Nurse (ICN) at the nursing home identified that the nursing home was not aware of the new diagnosis for five days when additional blood work drawn at the extended care facility identified the virus.

Response: A Case Management Manager reviewed the omission of the Hepatitis B status on the Interagency Referral Form with the staff involved in December 2003. Staff were counseled regarding the standards for thorough chart review and documentation.

Case Management Managers interact daily with all Case Managers and review documentation weekly.

Case Management Managers review documentation on a regular basis and are responsible for compliance with these standards.

30. *Based on record review and interviews, the hospital failed to address Patient #64's complaint in a timely manner. The findings include:*
- a. *Patient #64 filed a written complaint, dated 10/4/03, with the facility regarding care and services in the emergency department on 9/30/03. The hospital failed to address the patient's complaint within ten (10) business days, per their policy. Interview with the Chief of Emergency Services identified that there was a breakdown in communication that prevented him from receiving the complaint in a timely manner. Once he received the complaint, he addressed the complaint with Person #64. Interview with Person #64 identified that it took repeated calls to the facility before the complaint was addressed.*

Response: The policy regarding complaints was reviewed with the Administrative Secretary who initially spoke with Person #64.

All complaints are monitored and reviewed quarterly. The Director of Compliance and Risk Management is responsible for monitoring compliance with this policy.

31. *Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that a comprehensive assessment was performed that identified the need for restraints for one Patient (#8) and includes the following:*

- a. *Patient #8 had a physician's order dated 9/4/02 at 7:37 PM that identified an order for soft wrist, ankle and a vest restraint to prevent falling. Review of the restraint/constant observation flowsheet dated 9/4/02 at 11:00 PM identified that a vest restraint and 4-point restraints were applied at 11:00PM. Review of the clinical record with the Nurse Manager identified that a nursing assessment and observed behaviors were lacking prior to the institution of these restraints. Review of facility policy for restraint use identified that an assessment by a RN would be conducted and documented to identify potential behavioral and environmental risk factors so as to reduce and/or limit the use of restraints.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be assessment of the patient and documentation of behavioral and environmental risk factors.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

32. *Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that a plan of care for restraint usage was implemented for one patient (8) and includes the following:*
 - a. *Patient #8 was admitted on 9/3/02 with a documented language barrier, history of alcohol use with a fall risk assessment not completed. On 9/4/02 an order to utilize soft wrist, ankle and a vest restraint was obtained to prevent falling. Review of the clinical pathways and/or plan of care with the Director of Quality failed to identify that restraint use was addressed.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be inclusion of use of restraints in the care plan.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

33. *Based on review of the clinical record, review of the facility policies, and interviews, the facility failed to ensure that restraints were utilized in the least restrictive manner for Patient #8 includes the following:*
- a. *Patient #8 had a physician's order dated 9/4/02 at 7:37 PM that identified an order for soft wrist, ankle and a vest restraint to prevent falling. Review of the restraint/constant observation flowsheet dated 9/4/03 at 11:00 PM through 9/5/03 at 5:45 AM with a nurse manager failed to identify what alternative measures were attempted prior to the initiation of a vest restraint and 4-point restraints. Review of the clinical record from 9/5/02 through 9/10/02 identified the patient continued to utilize restraints without the benefit of alternative measures tried. Review of the facility policy for restraints used identified that alternatives or less restrictive interventions must be determined by the patient's assessed needs, tried and clearly documented. Restraint use must be limited to those situations with adequate and appropriate clinical justification and selected only when other less restrictive measures have been found ineffective.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be documentation of use of alternative or less restrictive measures tried prior to initiation of restraints.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

34. *Based on review of the clinical record and review of facility policy, the facility failed to ensure that for patient #8 and 65 that staff continually assessed, monitored restraint use and/or re-evaluated in accordance with facility policy and includes the following:*
- a. *Review of the restraint/constant observation flowsheet dated 9/6/02 at 2:45 PM identified that Patient #8 utilized 4-point restraints and was observed to be physically aggressive towards others. During the 3:00 PM through 11:45 PM shift the facility failed to identify that an assessment was conducted. Review of the policy for restraint use identified that the patient's condition would be monitored and documented at least every two hours*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be the requirements for documentation of ongoing assessments.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

- b. *Patient #65 presented to the Emergency Department (ED) with altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's noted dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the restraint/seclusion policy for behavior management in a non-behavioral health unit identified restraint or seclusion may be used in response to emergent, dangerous behavior, as a protective intervention to planned medical-surgical care or as a component of an approved protocol. An assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary. Patient care includes offering food and fluid, opportunity to eliminate, range of motion and repositioning with skin integrity checks and circulation every two hours, patient monitoring and condition is completed every fifteen minutes and an assessment is conducted by the RN every hour to determine mental status, cognitive functioning, and readiness to release the restraint. The patient's condition is monitored and documented by a trained individual every fifteen minutes and assessed/documented by an RN every thirty minutes. Review identified that although restraints were utilized in the ED, the clinical record lacked an assessment which indicated that the patient was a danger to self and/or others, any efforts to release the restraints, and patient care relative to restraint utilization in accordance with the policy and procedure.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be the requirements for documentation that the patient is a danger to self and/or others, efforts to release the restraints and patient care relative to restraint utilization in accordance with policy and procedures.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the emergency Department Nurse Manager and Nursing Director, Patient Care Services are responsible for compliance.

35. *Based on review of the clinical record, a review of facility policy and procedures, and staff interviews, the facility failed to implement seclusion in accordance with the policy and procedure. The findings include:*

- a. *Patient #65 presented to the Emergency Department (ED) with an altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19 AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's note dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the behavioral health physical examination dated 11/25/03 at 3:50 PM identified that the patient was admitted subsequent to a physician emergency certificate with paranoid delusions and a diagnosis inclusive of bipolar disorder. Admission orders included monitoring every fifteen minutes. A nurse's note dated 11/25/03 identified that at 4:00 PM the patient was delusional stating that he wanted to go downstairs and walked towards the exit door (secured door). The patient complied with verbal redirection to walk to the seclusion/monitoring room and the physician was notified at 5:00 PM. Intra-muscular psychotropic medications and seclusion were ordered and the patient was compliant with the administration and implementation of such. A restraint/seclusion record dated 11/25/03, 5:00 PM identified that the patient was placed in locked seclusion from 5:00 PM to 6:00 PM with assessments completed at 5:30 PM, 5:45 PM, and 6:00 PM. RN #18 stated during interview on 12/3/03 at 4:30 PM that she was assigned to care for Patient #65 subsequent to admission to the secured behavioral health unit. Shortly before 5:00 PM the patient was delusional and expressed a desire to leave the unit. She stated that the patient was verbally redirected to the seclusion and/or monitoring room to err on the side of caution and "to prevent something from happening", however could not identify any dangerous behaviors. Once in the seclusion/monitoring room the patient continued to insist upon leaving the secured unit, unit locked seclusion was implemented from 5:00 PM to 6:00 PM. Although the policy and procedure for seclusion identified that restraint or seclusion may be used in response to emergent, dangerous behavior as a protective intervention, review of the clinical record and staff interview failed to identify the patient's behaviors as such when seclusion was implemented on 11/25/03 from 5:00 PM to 6:00 PM.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be identification of the specific patient behaviors that led to the need for restraints.

In addition, a "Behavioral Health Restraint Resources Team" has been established to oversee the use of restraints in Behavioral Health.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance

36. *Based on review of the clinical record, a review of policy and procedures, and staff interview, the facility failed to obtain an order for the implementation of restraints for two patients (Patient #17 and #65) in accordance with the policy and procedure. The findings include:*
- a. *Patient #17 was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in his left eye. A nursing progress note dated 6/5/03 identified that the patient's peer made a comment and the patient lost control. The patient was verbally abusive in a time out, became assaultive to staff, and was placed in a two minute therapeutic hold. Review of the policy and procedure for restraint and/or seclusion use for behavior management on the behavioral health unit identified an assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary. Review of the clinical record with RN #8 failed to identify that an assessment and/or physician order for the therapeutic hold was completed and/or obtained in accordance with the policy and procedure.*

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be the requirements for orders and assessments.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Services Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

- b. *Patient #65 presented to the Emergency Department (ED) with an altered mental status. An ED nurse's note dated 11/25/03, 3:10 AM through 3:19 AM identified combativeness and that the patient continues to escalate with two point restraints applied at 3:19 AM. Review of nurse's notes dated 11/25/03 from 3:19 AM through 9:30 AM (six hours and eleven minutes) identified that two point restraints were utilized with a nurse's noted dated 11/25/03, 4:34 AM identifying that the patient is beginning to settle down and resting quietly on the stretcher. Patient #65 was cleared medically and was transferred to the secured behavioral health unit located at a satellite campus on 11/25/03 at 1:00 PM. Review of the restraint/seclusion policy for*

behavior management is a non-behavioral health unit identified restraint or seclusion may be used in response to emergent, dangerous behavior, as a protective intervention to planned medical-surgical care or as a component of an approved protocol. An assessment by a Registered Nurse, Physician, or Licensed Independent Practitioner is conducted and documented to identify potential behavior and environmental risk factors to reduce and/or limit the use of the restraint. An order for a restraint is necessary. Patient care includes offering food and fluid, opportunity to eliminate, range of motion and repositioning with skin integrity checks and circulation every two hours, patient monitoring and condition is completed every fifteen minutes and an assessment is conducted by the RN every hour to determine mental status, cognitive functioning, and readiness to release the restraint. The patient's condition is monitored and documented by a trained individual every fifteen minutes and assessed/documentated by an RN every thirty minutes. Review identified that although restraints were utilized in the ED, the clinical record lacked physician order directing the use of the restraints.

Response: A Hospital-wide initiative on restraint use and documentation is underway. Daily monitoring of use of restraints has begun, and an educational packet for nurses is complete and educational sessions are being conducted with all licensed staff. Among the components of the education packet will be the requirements for securing a physician order prior to or within 15 minutes of the initiation of restraints.

Upon completion of the education, audits will be done of all restraint use for three months.

The Patient Care Service Performance Improvement Council is overseeing the restraints initiative, and the Nursing Director, Patient Care Services is responsible for compliance.

37. *Based on observation, the facility failed to provide recreation and/or activity equipment in a good state of repair. The findings include:*
- a. *Observation of activity room on 11/18/03 identified floor mats utilized for a recreation activity to be in poor condition. Mats were noted to have torn areas with the foam padding exposed with one mat noted to be worn to the threading. The Behavioral Health Director stated during interview on 11/18/03 stated that the mats were in poor condition and replacement mats had been ordered. Subsequent to interview, the Behavioral Health Director, directed the unit staff to remove the thread worn mat from the activity room.*

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

38. *Based on review of the clinical record and staff interview, the facility failed to ascertain current medications for Patient #17 when admitted to the behavioral health unit. The findings include:*

- a. *Patient #17, a minor patient, was admitted with diagnoses inclusive of oppositional defiance disorder, attention deficit hyperactivity disorder, and legally blind in this left eye. A bio-psychosocial assessment dated 6/3/03 identified current medications of Topomax 25 milligrams (mg) at hour of sleep and Risperdal .25mg twice a day. A physician's order dated 6/4/03 prescribed Atropine 1%, one drop in the left eye starting at 7:00 AM on 6/5/03. A physician's progress note dated 6/10/03 identified that the patient's mother expressed concerns over the patient's medications with a plan to administer the eye drops as directed by the ophthalmologist. MD #20 stated during an interview on 11/25/03 that he met with the patient's mother to discuss concerns that she had regarding a delay in ordering the patient's Atropine eye drops that had been routinely administered prior to admission to the unit. He stated that he maintains and/or manages the psychotropic medications and it is the responsibility of the clinical team to manage the patient's medical needs. He further stated that although he is not sure why they didn't get ordered on admission, he "didn't blame her for being upset". Interview with the Clinical Director of the Behavioral Health Unit on 12/16/03 identified that a pre-admission assessment is done prior to the patient's arrival to the unit through the Clinical Assessment Center (CAC). An inquiry is made regarding current medications and medical history at that time and then again shortly after arriving when the physical examination is done. She stated that often the minor patients come accompanied and they have to rely on the pre-admission bio-psychosocial assessment that is completed. During an interview with CAC Intake Coordinator #1 on 12/11/03, she stated most often the information for the bio-psychosocial assessment is obtained from a crisis worker at the transferring facility who in many cases is not aware of current medications or medical history. She further stated that an inquiry or follow up with the patient's family and/or guardian is not generally made to ascertain a current medical history of the patient to current medications. RN #25 stated during an interview on 12/8/03 that she admitted Patient #17 and during the admission process she typically makes an inquiry and reviews the bio-psychosocial assessment with whomever has accompanied the patient to current medications and medical history. She further stated that if the patient's mother had mentioned the Atropine eye drops she has to assume she would note it, but could not recall in this case. Review and interview failed to identify a mechanism and/or system to attempt to obtain accurate medical history and/or current medications when a minor patient was admitted to the behavioral health unit unaccompanied.*

Response: The Hospital has contracted with a Family Practice Physician to follow children on both the ABC and CAPS units. This physician reviews all admissions, history and physicals and follows the children through the course of their hospitalization. He works 3 days a week.

Oversight of this physician's activities is done by the Interim Chairman of Behavioral Health Services.

39. *A clinical record review identified that Patient's #67, #68, #70 and #71 did not receive clinician biopsychosocial assessments within 24 hours per hospital policy. Also, there were no clinician notes on Patients #67 and #68 for two (2) days and on Patient #70 for four (4) days. The hospital policy identified that clinicians would document daily, on each patient Monday through Friday and as needed. Interview with staff identified that a Licensed Alcohol and Drug Counselor, LADC #1, was out sick on 1/15/04 and 1/16/04. During the absence, other social workers or counselors were to pick LADC #1's 5 patients. Interview with the Clinician Manager identified that the remaining clinicians should have split up LADC #1's patients on 1/15/04 and 1/16/04 and provide care the patient's may have needed, including biopsychosocial assessments and daily documentation. Interviews with Clinician Managers also identified that clinician led group meetings scheduled on 1/15/04 and 1/16/04 did not occur, as they should have. These groups were to be attended by all patients on the unit deemed capable of attending.*

Response: All clinicians have been reminded of the time frame requirement to complete the biopsychosocial. This will continue to be monitored on the monitor form and individual clinicians will be spoken with in any cases of deficiencies. Documentation of this reminder will be in the form of a memo that each clinician will be asked to read and sign that it has been read.

If a clinician calls out the program manager for that unit will re-assign his/her cases. The re-assignment will be listed in order for all the staff, not just clinicians, to read. Other clinicians had seen the patients in question during this period, but no notes had been written. Each clinician has been reminded of the requirement to write a note on each patient, Monday through Friday. In addition, clinical groups have been re-organized and the schedules reflect the correct days and times of the groups. In order to provide flexibility for urgent needs of patients, clinicians are encouraged to combine groups when necessary.

Ten charts per week will be audited by the Director of Social Services to ensure that the standard continues to be met.

40. *The facility did not assure that width of aisles or corridors (clear and unobstructed) serving as an exit access was at least (select the proper width depending upon use of either Existing or New, ie. 4 or 8) feet as required by the referenced LSC. On 11/18/03 at 1:15 PM, the surveyor observed that the Seventh and Eighth floors had clutter throughout the full length of the corridor.*

Response: All Nurse Managers have been reminded to assure that floors remain clutter free. Any equipment in the hallways should be on wheels and placed on one side of the hallway only. The Hospital Safety Committee is responsible for monitoring compliance with this requirement through its periodic safety rounds.

41. *The facility did not assure that width of aisles or corridors (clear and unobstructed) serving as exit access was at least (select the proper width depending upon use of either Existing or New, ie, 4 or 8) feet as required by the referenced LSC. On 11/18/03 at 2:00 PM, the surveyor observed that the full length of the nursing corridor was cluttered with nursing equipment.*

Response: All Nurse Managers have been reminded to assure that floors remain clutter free. Any equipment in the hallways should be on wheels and placed on one side of the hallway only. The Hospital Safety Committee is responsible for monitoring compliance with this requirement through its periodic safety rounds.

We take the responsibility of maintaining a safe and violation-free institution very seriously and thank you for the opportunity to respond to the deficiencies you identified. If you have any specific questions regarding any of the responses above, please feel free to contact Nancy J. Budds, Director of Compliance and Risk Management at (860) 714-5181.

Sincerely,



Richard Moed
Executive Vice President

RM:NJB:n

cc: David D'Eramo, Ph.D., President and Chief Executive Officer
Robert J. Falaguerra, Vice President Support Services and Construction
Susan L. Freeman, MD, MS, Senior Vice President, Medical Affairs
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