

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

IN RE: St. Vincent's Medical Center of Bridgeport, Inc.
 d/b/a St. Vincent's Medical Center
 2800 Main Street
 Bridgeport, CT 06606

CONSENT AGREEMENT

WHEREAS, St. Vincent's Medical Center of Bridgeport, Inc. (hereinafter the "Licensee") doing business as St. Vincent's Medical Center (hereinafter the "Facility") has been issued License No. 0057 to operate a General Hospital under Connecticut General Statutes 19a-490 by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Department's Division of Health Systems Regulation (hereinafter the "DHSR") conducted unannounced inspections on February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004, for the purpose of conducting multiple investigations; and

WHEREAS, during the course of the aforementioned inspections, alleged violations of the Regulations of Connecticut State Agencies were identified by the DHSR in a violation letter dated June 7, 2004 (Exhibit A – copy attached); and

WHEREAS, an office conference concerning the violations identified was held between the Department and the Licensee on June 30, 2004; and

WHEREAS, the execution of this Agreement, any provision of this Agreement, any payment made by the Licensee in accordance with this Agreement, and any statements or discussions leading to the execution of this Agreement, shall not constitute or be construed to constitute any admission or adjudication of any wrongdoing, regulatory noncompliance or violation of the

Regulations of Connecticut State Agencies, the Connecticut General Statutes, the United States Code or the Code of Federal Regulations by the Licensee, its agents, servants, employees or any other person or entity; and

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

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

1. The Licensee shall within fourteen (14) days of the execution of this Agreement, review and, as applicable, revise, if it has not already done so, the following policies and procedures:
 - a. Notification of and response by attending and/or covering physicians to changes in patient conditions as reported by nursing staff;
 - b. The role of manufacturer's representatives within the surgical and post-anesthesia care units;
 - c. Monitoring and establishment of temperature ranges for all warming units within the Facility;
 - d. Methods of increasing a patient's core temperature;
 - e. Assessment and treatment of patients who experience pain during diagnostic and/or other medical procedures;
 - f. Communication between practitioners within the various departments within the Facility;
 - g. Emergency Department triage system;
 - h. Restraint assessments, orders, utilizations and documentation;

- i. Methods to assess patients' risk status for development of pressure sores, prevention and treatment of pressure sores; and
 - j. Assessment of patients' risk status related to falls and development of care plans to prevent falls for those patients assessed as high risk for falls.
2. The Licensee's medical staff and nursing staff, as applicable, shall review and revise policies and procedures specified in paragraph one (1) above, within sixty (60) days of said revisions.
3. The Licensee's medical staff, shall, if it has not already done so within sixty (60) days of the execution of this Agreement, review and revise, as applicable, its administrative practices in regard to maintenance of credentialing files for medical staff, including but not limited to, documentation of certification and credentialing for specific privileges granted to licensed independent practitioners.
4. The Licensee, acting through its Pharmacy and Therapeutics Committee, shall, if it has not already done so within thirty (30) days of the execution of this Agreement and at regular intervals thereafter, review and revise, as applicable, policies and procedures relative to:
 - a. Medication dispensing and administration including mechanisms to evaluate factors contributing to errors, remediation and systems evaluation to prevent reoccurrence of errors; and
 - b. Responsibilities of pharmacy, medical and nursing staff, as applicable, regarding ordering, monitoring and reporting laboratory values associated with the administration of specific medications.
5. The Licensee shall, within sixty (60) days of the reviews specified in paragraphs one (1) through four (4) and as applicable thereafter implement inservice programs that will address staff education and assess staff compliance with the revised policies and procedures concerning the matters specified in paragraphs one (1) and four (4) above.

6. Processes shall be developed in concert with the Licensee's Monitoring and Audit Program, whereby immediate steps toward remediation occurs for any staff failure to adhere to facility policies and procedures.
7. Any designated staff that are unable to attend inservice programs referenced in paragraph 5 above, presented by the Licensee, shall be given access to the program content in an alternate manner via written material, audiotape, videotape or computer aided instruction. A record of all staff that have attended and/or been provided with the inservice programs for review shall be maintained for a period of three (3) years and be available for Department review.
8. The Licensee, if it has not already done so, acting through its Monitoring and Audit Program, in concert with the Licensee's existing Performance Improvement (Quality Assurance) Programs, within thirty (30) days of the execution of this Agreement, shall address:
 - a. Physician response to reported changes in patients' conditions;
 - b. The role of manufacturers' representatives within surgical and/or post-anesthesia care units;
 - c. Assessment of incidents in the emergency and surgical departments which have a potential for risk of harm;
 - d. Assessment of medication errors and remedial measure(s);
 - e. Assessment of the facility's system of communication between the various departments to timely share patient information (e.g. laboratory values, x-rays and other pertinent information that influence the delivery of care/services to a patient);
 - f. Assessment and treatment of pain during diagnostic procedures;
 - g. Compliance with administrative policies regarding credentialing of the active professional staff;

- b. Recommending to the Licensee and the Department an increase in the INC's monitoring hours if unable to fulfill the responsibilities within the forty (40) hours per week;
 - c. Review of all patient care policies and procedures relative to monitoring and assessing patients; and
 - d. Assessing, monitoring and evaluating the coordination of patient care and services delivered by the various health care professional providing services within the Facility.
10. Any records maintained in accordance with any state or federal law or regulation or as required by this Agreement shall be made available to the INC and/or the Department upon request.
11. The Department shall retain the authority to extend the period of the INC functions as required, should the Department determine, after consultation with the INC and the Licensee, that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations.
12. The INC and the Licensee or a designee of the Governing Authority shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Agreement.
13. The INC shall submit weekly reports to the Department and the Licensee in accordance with his/her responsibilities identified in this Consent Agreement and the Department's general guidelines for INC (Exhibit B – copy attached).
14. The Licensee shall, within seven (7) days of the execution of this Agreement identify via written documentation, the individual designated by the Licensee who shall be responsible for the full implementation of this document. All information relevant to the requirements of this Agreement shall be directed to:

Ann Marie Montemerlo, R.N.
Supervising Nurse Consultant
Department of Public Health

Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

15. The Licensee shall made a payment to the Department in the amount of twenty thousand dollars (\$20,000.00) which shall be payable by certified check to the Treasurer of the State of Connecticut and shall be posted to the Department within two (2) weeks of the effective date of this Consent Agreement. Said check shall be directed to Ann Marie Montemerlo, at the address previously identified in this document.
16. All parties agree that this Agreement is an agreement of the Department with all of the rights and obligations pertaining thereto and attendant thereon. This Agreement reflects the Department's final actions as to the Licensee with respect to the matters set forth or referenced in the violation letter attached as Exhibit A hereto. 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.
17. Pursuant to the Memorandum of Understanding among the Department of Public Health, the Office of the Attorney General and the Division of Criminal Justice requiring the inclusion of the following text in all agreements to which the Department is a party, the Department reiterates the following. 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.

18. The provisions of this document shall remain in effect for a period of two (2) years from the effective date of this Consent Agreement.

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

ST. VINCENT'S MEDICAL CENTER OF BRIDGEPORT, CT.

October 4, 2004
Date

By: Susan Davis
Susan Davis, R.N., Ed.D., its President

State of Connecticut)
County of FAIRFIELD

ss October 4, 2004

Personally appeared the above named SUSAN DAVIS and made oath to the truth of the statements contained herein.

My Commission Expires: May 31, 2006 Robras Mule
Notary Public
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

October 13, 2004
Date

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



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 27

June 7, 2004

William Riordan, President/Administrator
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

Dear Mr. Riordan:

Unannounced visits were made to St. Vincent's Medical Center on February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations with additional information received through May 20, 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 June 23, 2004 at 10:00 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Room H, Hartford, Connecticut.

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

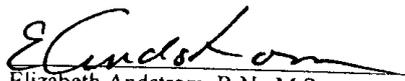
Each violation must be addressed with a prospective Plan of Correction which includes the following components:

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

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

Respectfully,


Joan Leavitt, R.N., M.S.
Public Health Services Manager
Division of Health Systems Regulation


Elizabeth Andstrom, R.N., M.S.
Supervising Nurse Consultant
Division of Health Systems Regulation

JDL:ESA:zbj

cc: Director of Nurses
Medical Director
President
vlstvmcdctr.doc
#2002-1185, #2003-0716, #2003-0172, #2003-0210, #2003-0448, #2002-1167, #2003-0731
#2003-0916, #2002-1312, #2002-1314, #2002-1211, #2003-0370, #2003-0254, #2003-0408
#2003-0457, #2003-0649, #2003-0648, #2003-0957, #2003-0995, #2003-1315, #2003-1314
#2003-2003-0874, #2003-1313, #2003-1376, #CT2495, #CT2266, #CT2569, #CT2737



Phone:

Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134

Affirmative Action / An Equal Opportunity Employer

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

1. Patient #26 had an AV node ablation and insertion of a temporary pacemaker on 7/11/03. The patient went to the operating room (OR) on 7/11/03 and underwent placement of a dual chamber permanent pacemaker by MD #5. Interview with the implanting physician, MD #5, reflected that while in the OR, he did not verify the lead and port hook up with the pacemaker representative. MD #5 further reflected that he assumed the lead connections were correct when he visually saw the pacemaker capture on the monitor. While the patient was in the post anesthesia recovery room (PACU), the patient exhibited pauses on the monitor. RN #1 called MD #5 and was directed to call the pacemaker representative. The pacemaker representative assessed the pacemaker and did not find any problems. The patient was transferred to the telemetry unit. MD #5 failed to communicate with the covering physician, MD #4, nor did he assess Patient #26 when the patient exhibited pauses on the heart monitor while in the PACU. The patient experienced episodes of dizziness and exhibited pauses on the heart monitor on 7/11/03 at 8:15 pm. The patient returned to the OR on 7/11/03 at 11:30 pm and it was found that atrial and ventricular leads had been reversed.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (4)(D) and/or (i) General (7).

2. Patient #27's diagnoses included right-sided breast cancer. The patient had an ultrasound guided needle localization by MD #1 on 7/1/03. Review of the medical record and interview with MD #1 reflected that the tip of the localization wire extended through the lesion down to the superficial portion of the pectoralis muscle. MD #1 further reflected that follow up mammogram images were obtained on 7/1/03 and he could not tell where the tip of the wire ended. MD #1 failed to determine the location of the localization wire tip and he did not notify the surgeon. On 7/2/03, the patient went to the operating room for a right partial mastectomy. Upon removal of the breast dressing by the surgeon, MD #3, the localization wire was not found. An x-ray obtained at the end of the operative procedure identified that the wire had migrated into the pleural cavity. The wire was left in the patient and the patient was monitored. Review of additional documentation dated 3/3/04 identified that the patient presented to the emergency department on 3/2/04 with a complaint of right-sided neck and back pain. The patient was admitted on 3/2/04 and went to the operating room on 3/3/04 for removal of the localization wire. The wire had migrated near the paraspinal muscles just posterior to the spinal accessory nerve. The patient was discharged home on 3/4/04.

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (4)(D) and/or (i) General (7).

3. Patient #27's diagnoses included right-sided breast cancer. The patient had an ultrasound guided needle localization by MD #1 on 7/1/03 as an outpatient in the Radiology Department. Interview with the Radiologist, MD #1, identified that Patient #27 complained of pain during the ultrasound guided needle localization procedure and local anesthetic was administered without relief of pain. MD #1 identified that he was aware that the patient complained of pain after the mammogram. MD #1 failed to address and intervene when the patient complained of pain on 7/1/03. Interview with the Chairman of Radiology, MD #31, identified that the facility policy is to address patient's pain and order appropriate medications for pain relief.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (4)(D) and/or (i) General (7).

4. Patient #24 underwent a craniectomy and partial removal of a glioma. The perioperative report identified warm bottles of fluid were attached to the patient's chest for a minute or so to warm him and were immediately removed due to the development of a first-degree burn. A review of the operating room nursing record identified the patient had a reddened area on the left chest wall, left upper right arm and right upper chest. A review of the anesthesia record identified MD #19 wanted the patient to be kept warm and MD #19 placed warm saline bottles in each axilla after induction. The bottles were removed by anesthesia and the patient's arm and side were very red as a result of the bottle placement. When the patient was moved off the OR table at the end of the case the reddened areas were noted to be blistered, treated with Bacitracin, and covered with a dressing by MD #19. A consult done on 9/8/03 identified the patient suffered a partial thickness burn with blistering to both axilla, chest wall and left arm due to contact with hot plastic bottles of normal saline solution prior to his operative procedure. During an interview, the Director of Surgical Services and Operating Room Coordinator stated saline bottles were never used to warm patients. During an interview, MD #19 stated the patient was cachectic, malnourished and very thin. The patient's temperature began to drop during preparation for surgery. MD #19 did not want the patient to develop an arrhythmia because the patient was hypothermic and he needed to warm him quickly. MD #19 removed the bottles from the warmer in the OR, wrapped the bottles in towels and

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

placed them on the patient. MD #19 stated it was not common practice to do this but did so because of his concern for the patient's losing heat quickly and was unaware of the temperature of the bottles.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (4)(D) and/or (i) General (7).

5. Based on review of facility documentation, review of facility policies, and interviews, the facility failed to ensure that one physician's credentialing file was accurate and reflective of practice. The findings include:
 - a. Review of MD #1's credentialing file identified that the physician was granted privileges for interpretation of breast localization images on 3/15/02. MD #1 performed an ultrasound guided needle localization with mammography on 7/1/03 on Patient #27. The file did not accurately reflect MD #1's current practice. Interview with the Chief Medical Director reflected that MD #1 had the training and credentialing for breast localization and had the privileges in the past. After changes in the Radiology Department in 5/03, MD #1 obtained additional experience and mentoring in this procedure. The Chief Medical Director reflected that the lack of documentation was a clerical error and since 5/1/03, MD #1 had been performing this procedure.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (3) and/or (c) Medical Staff (2)(A).

6. Patient #27's diagnoses included right-sided breast cancer. The patient had an ultrasound guided needle localization, mammogram, and sentinel node injection on 7/1/03 as an outpatient in the Radiology Department. The patient was admitted on 7/2/03 and underwent a right partial mastectomy. Interview with the Director of Outcomes Improvement identified that the patient verbally reported a complaint to the Patient Relations office on 7/2/03 about the care and services received on 7/1/03 in Radiology. The Director of Radiology, MD #31, responded and spoke to the patient's family member on 7/2/03 and perceived the patient's issues resolved. On 7/22/03, the hospital's administrative assistant received a complaint from Patient #27 and referred the complaint to MD #31. MD #31 assumed the issues were resolved from the meeting on 7/2/03 and did not pursue the concerns. The Director of Outcomes Improvement identified that Director of Patient Relations position was vacant at the time of the initial complaint and that she was not aware of the patient's

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

complaints from 7/2/03 and 7/22/03 until 8/12/03. Interview with the Director of Outcomes Improvement identified that her office received complaints from the patient and there was a two-week delay before the patient's concerns were addressed. A patient Perception of Care Form was not initiated on 7/2/03 for tracking the investigation and outcome. The facility failed to respond to patient complaints in a timely manner.

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

7. Patient #28's diagnoses included acute sepsis, dehydration, acute renal failure and diabetes mellitus. Physician's orders dated 1/7/04 included Bicitra 30 cc's four times daily. Nurses' notes dated 1/8/04 at 4:30 a.m. identified that an empty bottle of Polycitra was found at the bedside. Further review of the medical record identified that Polycitra was not a therapeutic equivalent to Bicitra and was dispensed to the nursing unit in error. Patient #28's Potassium level was 10 (normal range 3.5-5.1) and the patient required arterial blood gases, an electrocardiogram, and frequent lab monitoring as well as treatment with intravenous fluids, Kayexalate and Calcium Gluconate to treat the hyperkalemia. Pharmacist #1 stated that the physician's order read Bicitra 30 cc's four times daily, but he chose Polycitra from a list of medications on the computer screen, not realizing that it made much of a difference. Pharmacist #1 stated that the medication was dispensed in a "pint-sized" bottle which was pre-labeled by the manufacturer; however, he made a notation that said, "ordered as Bicitra", thinking that it was the equivalent. The Director of Pharmacy stated that the medication is rarely used and Pharmacist #1 should have looked up the medication but he thought that he was substituting the correct equivalent.

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

8. Patient #11 had diagnosis that included a history of severe anemia and vaginal bleeding. Patient #11 was admitted to the facility on 02/18/03 with a hemoglobin level of 5.9 (Normal 12.0 -16.0) for blood transfusions preoperatively in preparation for a Total Abdominal Hysterectomy (TAH). Review of the medical record identified that Patient #11 underwent a TAH on 02/20/03. Review of the physician's order sheet dated 02/20/03 identified orders that included Gentamycin 80 milligrams (mg.) every eight hours for six doses. Review of the physician's order sheet dated 02/22/03

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

identified another regime of Gentamycin 80 mg. every eight hours for another six doses. Review of the nursing notes dated 02/24/03 on the 11:00 PM to 7:00 AM and 7:00 AM to 3:00 PM shifts identified that Patient #11 had displayed symptoms of oliguria (a lack of urine output). Review of the medical record identified that blood work used to identify renal failure dated 02/24/03 identified that Patient #11's Blood Urea Nitrogen (BUN) was 59 (Normal 7-22) and Creatinine was 9.1 (Normal 0.7-1.1). A nephrology consult dated 02/25/03 identified that Patient #11 had developed renal failure and that Acute Tubular Necrosis (ATN) was suspected due to hypotensive episodes, gentamycin toxicity, and possible sepsis. A gentamycin trough drawn on 02/25/03 identified the trough at 15.1 (Normal <2.0). Patient #11's BUN rose to 82 and creatinine to 12.2 by 12/26/03. Review of the medical record identified that Patient #11 began hemodialysis treatments on 12/26/03, developed anasarca on 02/27/03, and that the patient continued to receive hemodialysis treatments until 03/21/03. Interview with the Pharmacy Director on 02/25/04 identified that because of the medication's nephrotoxic capabilities, the pharmacy's Gentamycin protocol included monitoring of BUN, creatinine, and Gentamycin peaks and troughs for patients whose physicians ordered single daily dosing of Gentamycin. The Pharmacy Director identified that that when doses were ordered such as the every eight hours prescribed by MD #6, the physician would have been expected to do the monitoring of the patient's blood work. Interview with MD #6 on 03/01/04 identified that he did not order any renal function testing prior to prescribing the Gentamycin for Patient #11 and that he thought that the pharmacy was monitoring the patient's blood work. Review of the medical record identified the only preoperative blood work to assess renal function was dated 8/05/00. Although Patient #11 received Gentamycin beginning 02/20/03, no monitoring of blood work to assess renal function was performed until the patient became oliguric on 02/24/03. Interview with MD #8 (nephrologist) on 03/05/04 identified that he would expect a patient's renal function to be assessed prior to beginning Gentamycin.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (g) Pharmacy (1) and/or (2).

9. Patient #20 presented to the ED on 7/27/03 with an injury to the left knee. A triage note dated 7/27/03 at 4:30 PM identified multiple abrasions to the left knee and pain at a level of 8 out of 10. A physician record dated 7/27/03 at 5:55 PM identified a contusion of the left knee and right forearm but failed to identify the length of the wound, if the wound was prepped, or if the wound was repaired. The record also

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

lacked evidence that the patient's pain was addressed. The hospital policy for pain identified to assess and address a patient's pain as needed. Interview with the nurse manager identified that there was no other nurses' note in the record because there are times that a nurse does not become involved in the patient's care, leaving the physician as the care giver. The manager identified that it is typical for a wound such as Patient #20's to be cleansed or "scrubbed," sometimes with the use of an anesthetic, due to the pain. Also, that Patient #20's record did not indicate that the patient received any treatment, such as wound care or that the patient's pain level was addressed. Interview with MD #9 identified that he did not recall specific details of the patient's care but based on documentation, he most likely did not treat the wounds.

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

10. Patient #8 was admitted on 7/17/02 following a motor vehicle accident. Facility documentation identified that on 7/21/02, Patient #8 was found sitting on the floor at 11 AM. The patient stated she fell and hit the back of her head. The patient's record was reviewed with the nurse manager and director. There was no evidence in the record that the patient's safety needs were assessed on 7/21/02 prior to the fall, there was no indication that the patient had fallen, and there was no nursing assessment of the patient following the fall. Although the patient was identified with a sitter at the bedside and on fall precautions on 7/19/02, however, on 7/21/02, there was no evidence that those measures were in place. Also, Patient #8 was identified as having pain throughout the admission for which she received medication. The patient's record was reviewed with the nurse manager and identified that 3 out of 4 times that pain medications were administered, the patient's pain was not reassessed per policy.

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. Patient #8 was admitted on 1/19/03 with nausea and vomiting, was not able to tolerate foods and fluid, and diagnosed with a Zenker diverticulum. Review of the patient's care plan identified that the patient's altered nutritional status was not addressed. Further, the patient's PO intake was not consistently documented, and the patient's IV fluids, which included the medication Potassium, were not documented consistently on 2 of 4 days. Interview with the nurse manager identified that IV solutions and IV additives such as Potassium are not documented on the medication administration

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

record, but are included in the intake and output record, which were not completed on 1/22/03 and 1/23/03.

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).

12. Patient #8 was admitted on 1/19/03 with complaints of nausea and vomiting. Interview with the unit manager identified that during that hospitalization, Patient #8 and a visitor attempted to use a "day room" on Patient #8's unit. Staff were using the room for taping their shift reports and asked them to wait a minute. This had apparently upset the patient and visitor and resulted in a conflict because the sign said it was a patient and visitor room, not a staff room. The nurse manager stated that at that time, there was a shortage of space for nurses and they frequently used the visitor's room for staff purposes. At the time, there was no other area on the unit for patients and visitors. The hospital was currently renovating the area and creating additional space for staff. Since this incident, staff no longer use that area.

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

13. Patient #4 entered the hospital's emergency department on 6/10/02 at 4:52 PM following a physician's office visit where the patient was identified as having a possible bowel obstruction. The patient arrived with written physician instructions for diagnosis and treatment of the suspected obstruction. Although the triage nurse identified the physician's suspicion of a bowel obstruction, the patient was given a Priority Level of IV and remained in the waiting room until 8:15 PM. A physician did not see Patient #4 until 9:05 PM. A priority level IV denotes a stable patient able to wait before being seen by a physician. Physicians identified the patient with possible sepsis and hypotension, and then diagnosed the small bowel obstruction. The patient experienced two episodes of cardiopulmonary arrest, the second cardiopulmonary arrest occurred on 6/11/04 at 12:26 PM, the patient expired, and an autopsy identified that 80% of the patient's bowel had been infarcted. Interviews with the triage nurse and nurse manager identified that a suspected small bowel obstruction should not have been assigned a priority level of IV.

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

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

14. Patient #27's diagnoses included right-sided breast cancer. The patient had an ultrasound guided needle localization by MD #1 on 7/1/03. Review of the medical record and interview with MD #1 reflected that the tip of the localization wire extended through the lesion down to the superficial portion of the pectoralis muscle. MD #1 further reflected that follow up mammogram images were obtained on 7/1/03 and he could not tell where the tip of the wire ended. The medical record lacked a dictated report of the mammogram performed on 7/1/03.

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

15. Patient #2 had a history of congestive heart failure and received two units of packed cells on 12/16/02. The blood bank transfusion record dated 12/16/02 lacked the volume of platelets given. In addition, the discharge information was not completed RN#10 stated that she identified the second unit of packed cells as being given, but she did not identify the volume that infused. RN #10 also stated that although she gave Patient #2 a discharge instruction "hand-out, she usually documents the information in a nurses' note or in the discharge information. The facility blood transfusion policy identified that all information on the hang tag must be completed and the amount of blood product that the patient received is documented.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1) and/or (i) General (4) and/or (7).

16. Patient #2's diagnoses included congestive heart failure and anemia. Physician's orders dated 12/12/02 that were faxed to the out-patient infusion center did not include an order for Lasix. MD#17 stated that his intention for Patient #2 to receive Lasix in between transfusions was conveyed because the office faxed in two forms and the Lasix was on the first form (a booking form); however, he did not write the Lasix on the physician's order form. The booking form identified that the treatment plan was to transfuse two units of red blood cells slowly and give 40 milligrams of Lasix after the first unit. MD #17 stated that although the order sheet did not have the

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

order, he would have expected the facility to call since it was on the first form that was faxed and the facility had Patient #2's history and physical. RN #9 stated that there were two forms, one was a "booking form" that contained demographics information and the other was a physician's order form. RN #9 also stated that a nurse does not check the booking form and since the Lasix was not on the physician's order form, it was not picked up.

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

17.

- a. Patient #25 was admitted to the facility on 7/13/03 and the nursing admission assessment identified that the patient was not at risk to fall, did not have a history of falls, did not have impaired mobility, and was not confused. Physician's orders dated 7/13/03 included a waist restraint on at all times. Additional physician's orders dated 7/14/03 included the risk to fall protocol and a waist Posey. Review of the patient's medical record indicated that it lacked documentation identifying the behavior to justify the initial restraint order. The flow sheet dated 7/13/03 identified the utilization of four raised siderails; however, the medical record lacked a physician's order and assessment for the use of the siderails. In addition, the medical record lacked documentation that the patient was assessed when the restraints were utilized from 7/14/03 to 7/16/03 and/or whether least restrictive alternatives were attempted. RN #8 (the unit manager) stated that she would have expected to see four siderails documented on the restraint flow sheer. The restraint policy identified that the physician's order must include the reason for restraint and the type of restraint used, the assessment includes monitoring every two hours and whether least restrictive methods are possible.
- b. Patient #30's diagnoses included dementia and was observed on 2/24/04 in bed with a waist restraint applied. Physician's orders dated 2/14/04 included a waist Posey for safety p.r.n. (as needed). Review of the medical record dated 2/16/04 to 2/23/04 identified that it lacked complete documentation that the waist restraint was monitored and/or that least restrictive alternatives were attempted. The restraint policy identified that the physician's orders may not be written as p.r.n. and the assessment includes monitoring every two hours and whether least restrictive methods are possible.

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

- c. Patient #31 was observed on 2/24/04 in bed with wrist restraints applied and attached to the left siderail. The physician's order dated 2/19/04 directed wrist restraints per risk of invasive line protocol; however the order lacked the physician's signature. Review of the medical record dated 2/19/04 to 2/22/04 identified that it lacked complete documentation of monitoring of the restraint every two hours. The restraint policy identified that the assessment includes monitoring every two hours.
- d. Patient #5 was admitted to the facility on 11/13/02 and was identified as a risk to fall. Admission orders included an activity of out of bed with assistance. Although the care plan dated 11/13/02 identified that the patient was at risk to fall, it lacked interventions to address the problem and/or what was attempted according to the facility fall protocol. Nurses' notes dated 11/15/02 at 1:30 a.m. identified that the patient was found on the floor. The flow sheet dated 11/15/02 identified that the waist restraint was applied at 1:30 a.m. In addition, review of the flow sheets dated 11/14/02 and 11/17/02 identified that four siderails were utilized; however, the medical record lacked a physician's order and/or assessment for the siderails. The restraint policy identified physician's order must include the reason for restraint and the type of restraint used, the assessment includes monitoring every two hours that the assessment includes whether least restrictive methods are possible.
- e. Patient #39 was admitted to the hospital on 11/13/03 for altered mental status, confusion, and shortness of breath to 10 pm. Review of the Restraint Flow Sheet dated 12/1/03 identified that the patient was confused and was climbing out of bed. A waist restraint was applied on 12/1/03 at 8 pm and utilized until 10 pm and applied on 12/2/03 at 8 am until 4 pm after alternatives were tried. The medical record lacked documentation for a physician's order for the waist restraint. Interview with the Medical Surgical Director and review of the Restraint Policy directs that the nurse or other qualified, trained staff who initiates the restraint must notify a licensed independent practitioner (LIP) and obtain a verbal or written order for the restraint prior to the initiation. The LIP must write an order for the restraint after the face-to-face examination within twenty-four hours of the initial order. The order must be reviewed each calendar day after a face-to-face examination by an LIP.

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

The above are violations of the Connecticut General Statutes Section 46a-152 (c) and/or (d) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (3) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (4) and/or (7).

18. Patient #25 sustained a fall and hit her head on 7/14/02 and was assessed by the physician at 10:00 p.m. when a CT scan of the head was ordered to rule out a bleed. Although the patient's neurological exam at that time was negative, the patient was confused and Haldol was ordered. Review of the systems assessment and nurses' notes identified that the record lacked documentation that the patient was assessed between 10:00 p.m. and 3:07 a.m. (5 hours) when the CT scan was completed and read as negative. RN #8 (the unit manager) stated that if the CT scan had showed something, a neuro protocol would have been initiated. The Vice President of Patient Care Services stated that a neuro check should have been performed. The facility Neurological Observations Guidelines identified that frequent measurements of neurological status can facilitate early recognition of neurological change.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1) and/or (i) General (4) and/or (7).

19. Patient #25's diagnoses included mild mental retardation, urinary retention, and a history of falls. Review of the medical record dated 7/14/03 identified that Patient #25 utilized a waist restraint and fell on 7/14/03 at 10:00 p.m. Review of the medical record dated 7/15/03 to 7/16/03 identified that it lacked a re-assessment of the waist restraint and documentation regarding restraint monitoring and safety precautions was incomplete. In addition, although nurses' notes dated 7/16/03 identified that the patient was restless and attempting to get out of bed, the medical record lacked documentation that additional interventions were initiated for the patient's safety. Subsequently, Patient #25 fell on 7/16/03 at 9:45 p.m. and sustained a fracture of the left hip.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1) and/or (i) General (4) and/or (7).

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

20. Patient #28's diagnoses included acute sepsis, dehydration, acute renal failure, and diabetes mellitus. Physician's orders dated 1/7/04 included Bicitra 30 cc's four times daily. The Medication Administration Record dated 1/7/04 identified that the medication was administered at 10:00 p.m. Nurses' notes dated 1/8/04 at 4:30 a.m. identified that an empty bottle of Polycitra was found at the bedside. Progress notes dated 1/8/04 identified that Patient #28 was inadvertently given a bottle (1 pint, 473 ml.) of Polycitra and the patient's Potassium level was 10 (normal range 3.5-5.1). Patient #28 required arterial blood gases, an electrocardiogram, and frequent lab monitoring as well as treatment with intravenous fluids, Kayexalate and Calcium Gluconate to treat the hyperkalemia. RN #13 stated that he noted the initial order for the Polycitra and knew that the dose was 30 cc's. RN #13 stated that the label read Polycitra ordered as Bicitra, 30 cc's four times daily; however, he did not administer 30 cc's and mistakenly gave the patient the bottle. RN #13 also stated that this was the first time that he had administered that medication and he did not educate Patient #28 regarding the medication. Further review of the medical record identified that Polycitra was not a therapeutic equivalent to Bicitra and was dispensed to the nursing unit in error. The facility medication administration policy identified that the label should be read prior to pouring the medication and it is the nurse's responsibility to use the available resources to ensure proper administration.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (3) and/or (e) Nursing service (1) and/or (i) General (4) and/or (7).

21. Patient #1 was admitted to the facility on 12/9/02 for a laparoscopic ventral hernia repair and suffered bowel perforations subsequently identified on surgery done on 12/12/02. The patient expired on 12/14/02. A review of the discharge summary identified it was dictated and typed on 10/22/03. During an interview, the Director of HIS stated her reviewers had identified an initial but incomplete discharge summary that was written before the patient had a change in condition and this was identified as the discharge summary for the hospitalization. The Director also stated all discharge summaries must be done within thirty days of discharge or death of the patient and this criteria was not met.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (4)(A) and/or (d) Medical Records (3).

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

22. Patient #24 was admitted to the facility on 9/8/03 and underwent a right post midline suboccipital craniotomy and partial removal of an intra-cerebellar bi-lobulated glioma. A review of the operative report identified warm bottles of fluid were attached to the patient's chest for a minute or so to warm him and were immediately removed due to the development of a first degree burn from them. A review of the discharge summary identified a lack of documentation relative to any burn injury. A review of the facility medical staff by-laws identified discharge summaries must contain significant changes, pertinent diagnostic findings, treatment rendered, and any additional diagnoses. During an interview, MD #19 stated the discharge summary was dictated by his assistant and he failed to include the information relative to the burn injury.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (4)(A) and/or (d) Medical Records (3).

23.

- a. Patient #1 was admitted to the facility on 12/9/02 for a laparoscopic ventral hernia repair and suffered bowel perforations subsequently identified on surgery done on 12/12/02. A review of the pain flow sheet identified documentation was lacking that an assessment of medication effectiveness for all doses administered on 12/9/02 and 12/10/02 was done.
- b. Patient #6 was admitted to the facility and underwent a Hysteroscopy and D&C and developed post obstructive pulmonary edema (POPE). A review of the pain flow sheet identified documentation was lacking to reflect that an assessment of medication effectiveness for pain medications administered on 3/18, 3/19 and 3/20/2004 was done.
- c. Patient #10 was admitted to the facility and underwent a hysteroscopy, D&C, laparoscopic lysis of omental uterine adhesions as well as puncture and aspiration of right ovarian cyst and returned to the OR immediately postoperatively due to bleeding which was controlled. A review of the pain flow sheet identified documentation was lacking to reflect that an assessment of medication effectiveness for pain medications administered on 2/13, 2/14, 2/15 and 2/16/03 was done.
- d. Patient #16 was admitted to the facility on 6/5/03 and underwent an abdominal hysterectomy with right salpingectomy/oophorectomy and lysis of pelvic and bladder adhesions. A review of the operative record identified the patient had multiple bladder adhesions and a ruptured right ovarian cyst with the right ovary

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

and tube adhered to the lateral wall. The patient voided well post op and was discharged on 6/7/03. On 6/9/03 the patient was evaluated in the facility's ED for abdominal pain and decreased urine output. During a cystogram a bladder laceration was identified. The patient had a surgical repair of a laceration dome of the bladder and recovered and was discharged on 6/13/03. A review of the pain flow sheet identified documentation was lacking to reflect that an assessment of medication effectiveness was done for pain medication administered on 6/5, 6/6, 6/7, 6/10, 6/11, 6/12 and 6/13/03. A review of the facility pain management policy identified anytime an intervention to relieve pain is employed a reassessment of pain levels will be made within one hour of medication administration by using the pain rating or Wong-Baker rating scales.

- e. Patient #39 was admitted to the hospital on 11/13/03 for altered mental status, confusion, and shortness of breath. The patient attempted to climb out of bed while utilizing a waist restraint and sustained left-sided rib fractures. Review of the Pain Flow Sheet identified that the patient received Tylenol for rib/back pain intermittently from 12/3/03 at 7 pm to 12/25/03 at 9 pm. The Pain Flow Sheet lacked consistent documentation of pain reassessment within one hour of the intervention. Interview with the Medical Surgical Director identified that the facility policy is to reassess the pain level within one hour of any intervention.
- f. Patient #27's diagnoses included right-sided breast cancer. The patient had an ultrasound guided needle localization, mammogram, and sentinel node injection on 7/1/03 as an outpatient in the Radiology Department. The Ambulatory Post Procedure Nursing Assessment identified that the patient received morphine sulfate four milligrams intravenously at 2:50 PM. The assessment form lacked a pain assessment after the medication administration. Interview with the Director of Outcomes Improvement identified that the facility policy is to document a pain assessment one hour after each dose of analgesic administered.

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) and/or (i) General (7).

24.

- a. Patient #1 was admitted to the facility on 12/9/02 for a laparoscopic ventral hernia repair and suffered bowel perforations subsequently identified on surgery done on 12/12/02. A review of the restraint flow sheet dated 12/13/02 and 12/14/02 identified the patient was in wrist restraints due to attempts to pull out his lines. A review of the physician orders failed to identify any physician order for the

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

restraint. A review of the facility restraint use policy identified clinical restraint protocols must have a physician one time order to initiate the specific protocol. During an interview, the Director of 6N/6S stated a physician order was necessary for the restraint use based on the protocols.

- b. Patient #24 was admitted to the facility on 9/8/03 and underwent a right post midline suboccipital craniectomy and partial removal of an intra-cerebellar bi-lobulated glioma. A review of physician orders identified an order was written on 9/8/03 for soft restraints prn for safety and mitts prn. A review of the facility physical restraint and seclusion policy identified orders cannot be written as "prn". During an interview, MD #19 stated it was routine for the Neurology service to write a prn order just in case it was needed postoperatively so patients do not dislodge lines and tubes.

The above is a violation of the Connecticut General Statutes Section 46a-152 (a) and/or (c) and/or a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2) and/or (d) Medical records (3) and/or (7) and/or (e) Nursing service (1) and/or (i) General.

25.

- a. Patient #29 had an expected delivery date of 7/28/03 and presented to the hospital on 8/4/03 in active labor. Review of a nursing flow sheet at 1:16 am identified that pain was assessed as a 10 on a 0 (no pain) to 10 (worst possible pain) scale. Physician's order at 1:35 AM directed that Demerol 75 mg and Phenergan 25 mg may be administered intramuscularly for one dose. Review of the flow sheet identified that these medications were administered but lacked the time they were given and staff failed to subsequently reassess the patient's pain level.
- b. Review of Patient #29's labor record reflected that at 4 AM on 8/4/03 a liter bag (1000cc) of Ringers lactate solution was started but lacked documentation of the amount of IV solution that had infused. In addition at 7:45 AM, Ringers lactate with Pitocin 10 units was started and there was no documentation to identify the amount of IV solution and/or medication that had infused. In addition at 10:30 am, a one-liter bag of Ringers lactate IV solution was started and the medical record lacked the amount of IV solution that had infused.
- c. Review of the Anesthesia analgesia record with RN #20 identified that Patient #29 had an epidural catheter inserted at 4:30 AM on 8/4/03 by the anesthesiologist with a basal rate of 8 cc/hour running continuously (Bupivacaine 0.125% with Fentanyl 2 micrograms per cc). Review of a physicians order dated

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

- 8/4/03 at 5:00 am directed that motor function of the lower extremities would be documented every hour (0= no movement, 1= moderate or severe weakness, 2= slight weakness and 3=full motor function). Review of the nursing flowsheets with RN # 20 identified that although motor function was documented at 5:00 am, 5:03 am, 5:06 am, and 6:45 am, there lacked documentation of motor function from 6:45 am to 12:08 PM when the epidural analgesia was turned off. Interview with RN #20 stated that although assessments should be documented every hour, she was with the patient continuously.
- d. Review of Patient #29's labor record and fetal monitoring strips with RN #20 identified that membranes were artificially ruptured at 8:08 AM on 8/4/03, the patient began to push at approximately 11:45 AM with the birth of Patient #19 at 2:50 PM. Review of recorded vital signs at 12:45 PM with RN #20 identified a blood pressure (B/P) of 141/92 and respirations of 20 and at 1:19 PM a pulse rate of 133 and oxygen saturation of 92 % on 8 liters of masked oxygen. From 12:45 PM through 2:50 PM, the facility failed to identify that vital signs were monitored and/or assessed in accordance with the vital sign policy. The facility's vital sign policy directed that B/P, pulse and respiration's be taken every one (1) hour once membranes were ruptured.
- e. Patient #19 was born on 8/4/03 at 2:50 pm. Review of MD #23's (neonatologist) progress note dated 8/4/03 at 3 pm described the infant with decreased tone, required positive pressure ventilation for 30 seconds and was observed to be grunting. Apgar Rating at one minute of birth was five (5), eight (8) at 5 minutes of birth and eight (8) at 10 minutes of birth. Subsequently the infant was transferred to the Special Care Nursery with a diagnosis of metabolic acidosis. Review of admission orders written by MD #23 directed that continuous positive airway pressure (CPAP) is implemented to maintain oxygen saturation between 92% through 95%. Special Care Nursery flowsheet identified the infant was started on continuous positive airway pressure (CPAP) at 3:45 pm with an oxygen saturation documented at 100%. Review of the flowsheet with RN #22 identified that a trial off CPAP was implemented at 8:30 pm with a progress note that stated the infant had a decrease in oxygen saturation and was subsequently placed back on CPAP. Interview with RN #22 stated that although she could not recall how long the patient was off of CPAP and/or when CPAP was reapplied, documentation reflected that the O2 saturation decreased to 91% at 10 pm. Review of the clinical record with RN #22 failed to identify that a physician's order was obtained to trial the patient off of CPAP and stated a physician's order is required to trial such. Additionally, Special Care Nursery Flowsheets reflected

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

that the infant was removed from CPAP on 8/5/03 at 1:30 am for fifteen (15) minutes and noted the Patient had tachypnea (respirations in the 80's). Flowsheet dated 8/5/03 at 9am identified Patient #19 was trialed off CPAP with mild tachypnea noted. Nurse's note from 3:30 pm through 5pm identified the patient had increased respiration's (80's to 100), oxygen saturation of 82% and MD #23 was present. Subsequently, the infant was placed back on CPAP.

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

26. Patient #13 arrived at the Emergency Department (ED) on 03/10/03 and sought treatment for complaints of chest and back pain. Review of the medical record identified that diagnostic tests that included multiple blood tests, a chest x-ray, and an electrocardiogram were provided. In addition, while at the ED, Patient #13 complained of left leg pain and a Duplex scan of the left lower extremity was ordered. Review of the medical record failed to identify that the scan was provided. Interview with MD #7 on 02/25/04 identified that he was "almost sure" that the reason for not doing the Duplex scan was that there was a long wait and that the patient's clinical examination did not identify any classic symptoms of a thrombus. MD #7 identified that after a discussion with a cardiologist, a decision was made that the test wasn't needed. The record failed to reflect documentation of the consult with the cardiologist and/or why the scan was not provided to Patient #13. Patient #13's discharge diagnosis was documented as "chest wall pain, muscular skeletal."

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

27.

a. Patient #21 had diagnosis that included a pancreatic cyst. Review of the admission assessment dated 04/07/03 identified Patient #21 was at low risk for pressure ulcers. On 04/07/03, Patient #21 underwent an exploratory laparotomy and creation of a cyst gastrostomy and a nasogastric tube was placed preoperatively. Review of the medical record identified twenty four hour flow sheets dated 04/09/03 through 04/13/03 that provided a daily assessment of eyes, ears, nose, and throat and described Patient #21's mucous membranes as dry. Review of the narrative nursing notes dated 04/14/03 identified that Patient #21 had developed a "small ulcer" of the (right) nares. Subsequent flow sheets dated

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

04/15 and 04/16/03 identified Patient #21's left nares as red, irritated, sore, and scabbed. RN #8 identified that the average time for a nasogastric tube to be in place is three days but that removal depended on patient progress. RN #8 identified that when medical necessity requires that a patient continue use of a nasogastric tube beyond the average length of time, options to prevent irritation to the nares included removal and reinsertion of the tube through the opposite nares and/or a readjustment of placement of the tube and tape. Interview with RN #8 on 02/26/04 identified that staff is directed to assess the nares of patients with nasogastric tubes daily. Review of facility policy identified that staff should keep the nostrils well lubricated with a water soluble lubricant. Review of the medical record lacked documentation that reflected a comprehensive plan of care to address the potential for skin breakdown/tissue irritation due to the medical need for an extended time frame of Patient #21's nasogastric tube placement and/or to address the ongoing assessments of dry mucous membranes that included use of a lubricant. Review of facility documentation dated 04/14/03 identified that Patient #21 developed a Stage II ulcer of the left nares.

- b. Patient #22 had diagnoses that included complete small bowel obstruction, respiratory failure, Diabetes, and Peripheral Vascular Disease (PVD). An admission assessment dated 06/16/03 identified the patient was at low risk for pressure ulcers with a Braden Scale of 26 and the patient's skin was assessed as clean, dry and intact. Review of the medical record dated 06/19/03 identified that Patient #22 experienced a fall on the way to the bathroom. Although diagnostic tests that included x-rays and a CT Scan were reported as negative, subsequent to the fall, Patient #22 complained of being "too weak" to ambulate, became incontinent of urine and of loose stools, was more lethargic, and developed an elevated temperature to 102.3 (Normal 98.6). Review of the medical record lacked documentation that reflected that an additional assessment for risk for skin integrity impairment was completed at that time. On 06/21/03, Patient #22 underwent abdominal surgery for a small bowel obstruction. Review of the nursing note dated 06/25/03, identified that Patient #22's buttocks and coccyx area were reddened. Review of the nursing note dated 06/28/03 identified a two by one centimeter necrotic area on the left buttocks and redness, excoriation with bleeding on the right buttocks. Although the nursing note on that date identified that the patient remained on a zone air bed, was being turned every two hours, and had a duoderm in place, the record lacked documentation of a comprehensive plan of care that included consistent documentation of wound appearance, size, and location and consistent documentation that the facility's skin care protocol was

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

- being followed or that licensed staff were utilizing a consistent approach to the wound care.
- c. Patient #32 had diagnosis that included a small bowel obstruction and was admitted on 02/24/04. Review of the admission assessment dated 02/24/04 identified Patient #32 was at low risk for pressure ulcers. A nasogastric tube was placed on 02/25/04. Observation of Patient #32 on 02/26/04 identified that the patient had a nasogastric tube heavily taped in place in the left nares. Review of the medical record lacked documentation of a comprehensive plan of care to address the potential for skin breakdown and or tissue trauma as a result of the nasogastric tube placement.
 - d. Patient #33 had diagnosis that included acute diverticulosis and was admitted on 02/19/04. Review of the admission assessment dated 02/19/04 identified Patient #33 was at low risk for pressure ulcers. A nasogastric tube was placed on 02/24/04. Observation of Patient #33 on 02/26/04 identified that the patient had a nasogastric tube taped in place in the left nares. Review of the medical record lacked documentation of a comprehensive plan of care to address the potential for skin breakdown and or tissue trauma as a result of the nasogastric tube placement.
 - e. Patient #35 had diagnosis that included aortic stenosis. Patient #35 was admitted to the facility on 12/10/03. An admission assessment dated 12/10/03 identified the patient was at low risk for pressure ulcers with a Braden Scale of 17. Observation of the patient on 02/26/04 identified that Patient #35 was on isolation precautions for Vancomycin Resistant Enterococcus (VRE), had a tracheotomy and feeding tube, and that respiratory support was provided with a ventilator. Review of the medical record lacked documentation that reflected that an additional assessment for risk for skin integrity impairment was completed as Patient #35's medical condition declined. Review of the daily skin assessment flow sheet dated 02/12/04 identified that Patient #35's skin was intact. On 02/13/04, the documentation identified that "comfeel" was placed on the patient's coccyx but lacked documentation of size and/or appearance of the wound. On 02/14/04, the documentation identified that a "large decubitus" was identified, that a wet to dry dressing was applied. On 02/16/04, the documentation identified that "safegel" was applied to the coccyx. Review of the medical record dated 02/24/04 identified that a wound care consult was completed. Patient #35 underwent an excisional debridement of a six by six centimeter necrotic decubitus. Review of the medical record lacked documentation of a comprehensive plan of care that included consistent documentation of wound appearance, size, and location and consistent documentation that the facility's skin care protocol was being followed, or that

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

licensed staff were utilizing a consistent approach to the wound care. Subsequent to surveyor observation of wound care by RN #16, RN #16 documented the appearance of Patient #35's sacral area as four by five cm., three cm. deep, with some necrotic tissue, the skin around the wound was macerated, and that the Skin Care Clinician was notified. Interview with the facility's Skin Care Clinician on 02/27/04 identified that the facility's skin protocol is implemented when a patient is at risk to develop pressure areas, that initialing every shift on the flow record would identify documentation of the implementation, and that a care plan would be in place. The Skin Care Clinician identified that as part of her responsibilities, she provides assessment of wound care when nursing staff refers patients to her. Review of facility policy directed documentation of nursing process included documentation of ongoing assessment at least every eight hours, defining goals or outcomes for problems listed, that problems specific to patient needs must be identified on every patient and followed daily. In addition, facility policy directed that pressure ulcers should include accurate measurement and documentation that included the stage, size, and location in order to allow for evaluations of nursing interventions designed to improve skin integrity.

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

28.

- a. Patient #21 had diagnosis that included a pancreatic cyst. Review of the admission assessment dated 04/07/03 identified Patient #21 at low risk for pressure ulcers. On 04/07/03, a nasogastric tube was placed. Review of the narrative nursing notes dated 04/14/03 identified that Patient #21 had developed a "small ulcer of the right nares." Subsequent flow sheets dated 04/15 and 04/16/03 identified Patient #21's left nares as red, irritated, sore, and scabbed. Review of the medical record lacked documentation that reflected an assessment of the size and stage of the ulcer and the correct location of the nares involved. Review of facility documentation dated 04/14/03 identified that Patient #21 developed a Stage II ulcer of the left nares.
- b. Patient #22 had diagnosis that included complete small bowel obstruction, respiratory failure, Diabetes, and Peripheral Vascular Disease (PVD). An admission assessment dated 06/16/03 identified the patient was at low risk for pressure ulcers. Review of a wound care consult dated 08/21/03 identified that Patient #22 had "multiple skin ulcerations" that now included the left heel. Patient

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

- #22 was discharged to Skilled Nursing Facility #1 (SNF #1) on 09/06/03. Although review of the interagency referral form dated 09/06/03 from the acute care facility to SNF #1 identified "two small open areas coccyx," a review of Patient #22's skilled nursing facility record identified that a skin assessment was completed on the day of admission to the facility. Patient #22 was admitted to the SNF with multiple ulcerated areas that included a Stage II area on the left buttocks measuring, 3 by 1.5 cm. that was reddened with a yellow center, a 6 by 3.5 cm. by 05 cm. in depth Stage III area on the right buttocks that was "pinkish" with yellowish and necrotic center as well as Stage I areas on the scrotum and left heel. Interview with LPN #3 on 3/18/04 identified that she had been responsible for completing the interagency referral form for Patient #2 on 9/6/03. LPN #3 identified that although she usually measured open areas, she could not recall what the measurements were as they were not documented. Review of the nursing notes and flow records from the facility dated 9/10/03 through 9/6/03 lacked documentation to reflect that Patient #22's open areas were measured.
- c. Patient #35 had diagnosis that included aortic stenosis. An admission assessment dated 12/10/03 identified the patient was at low risk for pressure ulcers. Review of the daily skin assessment flow sheets on 02/13/04 identified that "comfeel" was placed on the patient's coccyx but lacked further documentation of the appearance of the wound. On 02/14/04, the documentation identified that a "large decubitus" was identified, that a wet to dry dressing was applied, but lacked documentation of location and/or appearance of the wound. On 02/16/04, the documentation identified that "safegel" was applied to the coccyx but continued to lack documentation of size and/or appearance of the wound. Review of the medical record dated 02/24/04 identified that Patient #35 had developed a six by six centimeter necrotic decubitus. Review of facility policy directed documentation of pressure ulcers should include accurate measurement and documentation that included the stage, size, and location in order to allow for evaluations of nursing interventions designed to improve skin integrity.

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

29. Patient #17 had diagnosis that included End Stage Renal Disease (ESRD), Diabetes, and an infection of a dialysis shunt. An admission assessment dated 01/10/03 identified the patient was at low risk for pressure ulcers with a Braden Scale of 17.

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

Review of the medical record identified that Patient #17 was placed on isolation precautions for Methicillin Resistant Staphylococcus Aureus (MRSA), developed elevated temperatures to 104.0 degrees, was very restless, required bilateral wrist restraints to prevent removal of oxygen and other tubing.

- a. Review of the flow sheet dated 01/13/03 identified that Patient #17 was on a pressure relief mattress. Although the record identified that on 01/14/03, Patient #17's buttocks were pink but intact, the record lacked documentation to reflect consistent assessments of Patient #17's buttocks from 1/17 through 02/08/03. Review of the medical record identified that on 2/9/03, Patient #17 was identified with a Stage II area to the coccyx.
- b. Review of the flow sheet dated 01/13/03 identified that Patient #17 was to wear "bilateral heel relief". Review of the medical record lacked documentation to reflect ongoing assessments of Patient #17's heels from 1/17 through 1/27/03. On 1/28/03, the documentation identified that the patient had developed a necrotic area on the right heel though lacked documentation to reflect the size of the necrotic area. In addition, the medical record lacked documentation to reflect that an assessment of Patient #17's heels was completed from 2/14 through 2/22/03 and inconsistent assessments of the patient's heels through 3/6/03. Review of the consultation report dated 03/07/03 identified that Patient #17 had developed a Stage II ulcer of the heel that required debridment.
- c. Further review of the medical record identified that on 2/9/03, Patient #17 was identified with a Stage II area to the coccyx. On 2/15/03 the documentation reflected that Patient #17's wound had progressed to a Stage III. Review of the record lacked documentation that consistent assessments that included measurements of Patient #17's coccyx wounds were completed. In addition, the record lacked documentation of a consistent method of treatment and instead reflected that nurses chose various treatment options based on the facility's skin care protocol. On 3/11/03, the documentation identified that a "large Stage IV decubiti was observed. On 3/12/03, the documentation identified that Patient #17 now had Stages I, II and IV decubiti to sacral area.
- d. Review of the medical record dated 2/24/03 identified that Patient #17 had developed "decubitus to ears." The record lacked documentation to reflect the size or extent of the ear wounds or new interventions to heal or prevent further decline of the areas. Review of facility policy directed documentation of nursing process included documentation of ongoing assessment at least every eight hours, defining goals or outcomes for problems listed, that problems specific to patient needs must be identified on every patient and followed daily. In addition, facility

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

policy directed that pressure ulcers should include accurate measurement and documentation that included the stage, size, and location in order to allow for evaluations of nursing interventions designed to improve skin integrity. In addition, the facility policy identified that if the patient has a pressure ulcer, that a description of the ulcer is to be in the form of a "SOAP note" on admission, every Wednesday, and day of discharge. Review of Patient #17's medical record lacked documentation of a comprehensive plan of care that included consistent documentation of wound appearance, size, location, and treatment plan. The record lacked consistent documentation to reflect that the facility's skin care protocol was being followed or that licensed staff was utilizing a consistent approach to Patient #17's wound care. Review of facility documentation from the Skilled Nursing Facility #2 (SNF#2) dated 03/15/03 identified an admission skin assessment completed upon Patient #17's arrival to the SNF. The assessment identified that Patient #17 had a 3 by 2 centimeter (cm.) on the right upper buttocks, a 3 by 3 cm. open area on the right lower buttocks, a 9 by 6 cm. Stage IV area on the left buttocks, excoriations on both the right and left ears, a 2 ½ by 1 cm. black scab on the left outer heel, a 0.5 by 0.5 cm on the left outer foot, and blisters on the left buttocks.

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

30.

- a. Patient #17 had diagnoses that included Down's Syndrome a recent diagnosis of Methicillin Resistant Staph Aureus (MRSA), and End Stage Renal Disease (ESRD) for which the patient received regular hemodialysis treatments. Review of the medical record identified that Patient #17 was transferred from the hemodialysis center to the hospital due to high fever and generalized weakness. Review of the physician order sheet dated 1/11/03 identified an order for bilateral wrist restraints in accordance with the facility's invasive line protocol. Review of nursing documentation dated 1/13/03 identified that Patient #17 was observed to continue to remove oxygen delivery tubing and attempt to pull out intravenous lines when released from the bilateral wrist restraints. Review of the facility's policy for restraints included documentation in a patient's record for each episode of restraint use to include reassessment and results of patient monitoring every two hours. Review of the flow records dated 1/11/03 through 1/29/03, lacked

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

- documentation to reflect that consistent monitoring at least every two hours was provided during the times that Patient #17 required bilateral wrist restraints.
- b. Patient #17 had a shunt in the left arm through which the patient received regular hemodialysis treatments. Review of the medical record dated 1/15/03 identified Patient #17's left arm was "swollen." The record lacked documentation to reflect that the swelling of the patient's left arm was consistently monitored. On 1/21/03, the documentation identified Patient #17's left arm was as "swollen but without redness." The record again lacked documentation to reflect that the swelling of the patient's left arm was consistently monitored through 1/27/03. On 1/28/03, the documentation identified that Patient #17 had a Doppler study that identified a Deep Vein Thrombosis (DVT) in the left arm.

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

31. Patient #17 had diagnoses that included Down's Syndrome and End Stage Renal Disease (ESRD) for which the patient received regular hemodialysis treatments. Review of the medical record identified that Patient #17 was admitted to the facility on 1/10/03 due to high fever and generalized weakness. Review of the physician order sheet dated 1/24/03 identified an order for Haldol one milligram (mg.), Intramuscularly (IM), "on call to dialysis." Interview with MD #30 on 3/18/04 identified that his intention of the 1/24/03 order was that the patient receive the Haldol prior to each dialysis treatment. Review of the MAR dated 1/29/03 identified that Patient #17 received Haldol one mg. IM at 2:00 AM by LPN #2. Review of the medical record lacked documentation that Patient #17 was scheduled to be treated in the dialysis unit in the middle of the night or documentation of a physician's order for the 2:00AM Haldol.

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

32.

- a. Patient #36 arrived at the Emergency Department (ED) via ambulance at 4:49 PM on 04/12/02. Review of the medical record identified that Patient #36 was triaged at the ED at 5:00 PM at a Priority III. An assessment of Patient #36's vital signs that included a pain assessment, were completed at 5:05 PM. MD #18 examined Patient #36 at 5:30 PM and identified that the patient had a contusion of the right knee. Review the medical record identified that MD #18 had documented an order

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

for a right knee x-ray but that a line through the order and the word "cancel" was written. Interview with MD #18 on 03/04/04 identified that although there could have been multiple reasons as to why he might have cancelled the x-ray, there was no documentation to reflect the reason for his decision.

- b. Review of the ED medical record identified that Patient #36 received sixty milligrams of Toradol (an anti-inflammatory medication) intramuscularly at 6:00 PM. Review of the documentation failed to reflect the signature and/or initials of the administrating nurse.
- c. Review of Patient #36's pain assessment on admission identified that the patient complained of knee pain at a four out of ten, ten being the most pain. In addition, Patient #36 complained of chest pain at an eight out of ten. Review of the medical record lacked documentation to reflect that the chest pain was addressed by the examining physician and/or that the patient's chest and knee pain had subsided prior to discharge.

The above are violations of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

33. Review of Patient #26's medical record identified twelve lead electrocardiograms (ECG) dated 7/11/03 at 3:24 PM and 7/11/03 at 8:31 PM which identified readings of AV sequential or dual chamber electronic pacemaker and Electronic ventricular pacemaker. A cardiologist, MD #29, interpreted the ECG's dated 7/11/03. Review of the ECG's with the cardiologist, MD #5, reflected that the ECG's dated 7/11/03 showed the atrial pacemaker lead paced the ventricle and the ventricular lead paced the atrium and that the EKG's were misread with incorrect interpretations.

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

34. Patient #39 was admitted to the hospital on 11/13/03 for altered mental status, confusion, and shortness or breath. The patient was diagnosed with respiratory failure due to pneumonia. The patient had a history of confusion and three falls two weeks prior to admission. The Nursing Admission Assessment was incomplete. Review of the policy on Documentation of Nursing Process and interview with the Director of Medical Surgical Services on 5/5/04 identified that the Admission Assessment must be completed within eight hours on the receiving unit. In unusual situations, it can be completed within twenty-fours. Review of the Falls Prevention

FACILITY: St. Vincent's Medical Center

EXHIBIT **A**
Page 27 of 27

DATES OF VISITS: February 23, 24, 25, 26, 27; March 3, 4 and May 5, 2004

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

Protocol directs that an assessment on admission for risk to fall is done using the parameters on the Admission Assessment Form. In addition, the Plan of Care record lacked documentation of a problem for high risk to fall prior to the patient falling on 12/2/03. Interview with the Medical Surgical Director identified that, based on the patient's history and presentation, if the Nursing Admission Assessment was completed the patient would be identified as high risk to fall with identification of high risk to fall in the Plan of Care.

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

35. Patient #39 was admitted to the hospital on 11/13/03 for altered mental status, confusion, and shortness of breath. Review of the Restraint Flow Sheet dated 12/1/03 identified that the patient was confused and was climbing out of bed. A waist restraint was applied on 12/1/03 at 8 pm after alternatives were tried. Further review identified the patient utilized a waist restraint on 12/2/03 from 8 am to 4 pm. Interview with RN #24 identified that the patient was confused and always tried to climb out of bed. The progress notes dated 12/2/03 at 3:15 pm identified that the patient was found attempting to get out of bed between the side rails. Subsequently, the patient sustained left-sided rib fractures at rib numbers ten and eleven. Although the patient utilized a waist restraint, the facility failed to protect the patient from injury.

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)

DHSR Independent Nurse Consultant Guidelines

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

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

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution.
- The INC's responsibilities include:
 - Assessment of staff in carrying out their roles of administration, supervision and education.
 - Assessment of institution's compliance with federal/state laws and regulations.
 - Recommendations to institutional administration regarding staff performance.
 - Monitoring of care/services being provided.
 - Assists staff with plans of action to enhance care and services within the institution.
 - Recommendation of staff changes based on observations and regulatory issues.
 - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
 - Promotes staff growth and accountability.
 - May present some inservices but primary function is to develop facility resources to function independently.
 - Educates staff regarding federal/state laws and regulations.