

**State of Connecticut
Department of Public Health
Facility Licensing & Investigations Section**

IN RE: Natchaug Hospital, Inc.
d/b/a Natchaug Hospital
189 Storrs Road
Mansfield Center, CT 06250

STIPULATED AGREEMENT

WHEREAS, Natchaug Hospital, Inc. (hereinafter the "Licensee"), doing business as Natchaug Hospital (hereinafter the "Facility") has been issued License No. H-0003 to operate a hospital for mentally ill persons under Connecticut General Statutes § 19a-490 by the Department of Public Health (hereinafter the "Department"), and the Department's Facility Licensing & Investigations Section (hereinafter "FLIS") conducted unannounced inspections on various dates commencing on January 27, 2005 and concluding on April 29, 2005; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were alleged and described in violation letters dated May 24, 2005 (Exhibit A) and August 29, 2005 (Exhibit B); and

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

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Marianne Horn, Section Chief, and the Licensee, acting herein by and through Stephen Larcen, Ph.D., its President and CEO, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Stipulated Agreement. The INC's position shall be occupied and the duties of the INC

shall be performed by a single individual unless otherwise approved by the Department. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Stipulated Agreement. The INC shall function in accordance with FLIS's INC Guidelines (Exhibit C - copy attached).

2. The INC shall be at the Facility twenty-five (25) hours per week. The INC shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts inclusive of holidays and weekends. The INC shall serve for a minimum of three (3) months at the Facility unless the Department identifies through inspections that the continued presence of the INC is necessary to ensure substantial compliance with the applicable state and federal statutes and regulations. In the event that the Department determines that the continued presence of the INC is necessary to ensure substantial compliance with applicable state and federal statutes and regulations, the Department may, in its sole discretion, after consultation with the Licensee, extend the term of the INC contract for a period of time not to exceed an additional three (3) months. The Department may, in its discretion, at any time, reduce the hours of the INC and/or responsibilities, if, in the Department's view, the reduction is warranted.
3. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
4. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks of assumption of the position. Thereafter, the INC shall submit a weekly written report to the Department on the Facility's progress in areas identified for remediation and evaluating the care and services provided to patients. Copies of the INC's reports shall be simultaneously provided to the Director of Nurses, CEO and Medical Director.
5. The INC shall have the responsibility for:
 - a. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered

- nurses, licensed practical nurses and mental health workers and implementing prompt training and/or remediation in the area in which said staff member demonstrated a deficit. Records of such training or remediation shall be maintained by the Licensee for review by the Department;
- b. Assessing, monitoring and evaluating the coordination of patient services and implementation of master treatment plans (MTPs) by the various health care professionals providing services within the Facility;
 - c. Recommending to the Department an increase in the INC's monitoring hours if unable to fulfill the responsibilities within the stipulated hours per week; and
 - d. Monitoring the implementation of the Licensee's plans of correction submitted for the violation letters dated May 24, 2005 and June 22, 2005.
6. The INC shall confer with the Licensee's CEO, Director of Nursing Services and other staff as the INC deems appropriate concerning the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Licensee's CEO and Director of Nursing Services for improvement in the delivery of direct patient care in the Facility. The INC shall have a fiduciary responsibility to the Department. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination which, during the term of this Stipulated Agreement shall be binding on the Facility.
 7. The INC, the Licensee's CEO and the Director of Nursing Services shall meet with the Department every six (6) weeks after the effective date of this Stipulated Agreement during the duration of the contract with the INC. The meetings shall include discussions of issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.
 8. Within fourteen (14) days of the execution of this Stipulated Agreement, the Licensee shall review and revise, as necessary, to comply with applicable federal and state laws and regulations, the Licensee's current policies and procedures relative to MTPs to include, but not be limited to, identification of individual patient problems (e.g.

psychiatric, medical and social), goals and approaches based upon the comprehensive assessment. All treatment modalities and professional disciplines involved with the patient during his/her hospitalization shall specify the problems and the approaches they will utilize to attain stated goals.

9. Within fourteen (14) days of the execution of the Stipulated Agreement, the Licensee shall review and revise, as necessary, written nursing and ancillary staff policies and procedures including, but not limited to, assessments, monitoring of patients who exhibit an exacerbation of symptoms and documentation of such assessments.
10. The Licensee represents, stipulates and agrees that at all times it will ensure that each patient has a nursing assessment and treatment plan developed within twenty-four (24) hours of admission, and an MTP developed within seventy-two (72) hours of admission, which are based upon the comprehensive assessment which will commence at the time of admission. The MTP shall be reviewed and revised, as necessary to comply with applicable state and federal laws and regulations, at least every seven (7) days thereafter or promptly upon a significant change in the patient's physical, mental, or psychiatric condition(s) or behavior. The MTP reviews shall be documented.
11. The Licensee shall continue to employ sufficient personnel to monitor and meet the physical, safety and psychiatric needs of the patient population in accordance with applicable federal and state laws and regulations. The Licensee shall determine staff assignments in a manner that ensures continuity of care for the patient population.
12. The Licensee's Medical Staff shall review and approve any policy or procedure that is revised as a result of this Stipulated Agreement within thirty (30) days of said revisions.
13. Within forty-five (45) days after the revision of any policy or procedure pursuant to this Stipulated Agreement, each member of the nursing and ancillary staff shall be required to review applicable policies and procedures and acknowledge said review in writing (e.g. signature and date of review). Such policies and procedures shall be reviewed on an annual basis and revised, as necessary, to comply with applicable state and federal laws and regulations.

14. The Licensee shall develop and provide educational courses to the Licensee's staff that shall include but not be limited to:
 - a. Patient assessments including physical and mental components;
 - b. Current psychiatric standards of practice and trends; and
 - c. Development of multidisciplinary treatment planning including specific approaches and disciplines responsible for such approaches.
15. The Licensee shall maintain documentation of attendance at the educational programs set forth in this document.
16. Within fourteen (14) days of the execution of this Stipulated Agreement, the Licensee's Performance Improvement (Quality Assurance) Program shall be revised, as necessary, as determined by the Licensee to comply with applicable federal and state laws and regulations. The Licensee's Quality Assurance Program shall include, but not be limited to:
 - a. Analysis of all incidents which have occurred in the Facility, to identify all situations that have a potential for risk of harm, and what preventative measures shall be implemented by staff adopting or revising policies, to ensure that patient care practices are in compliance with applicable federal and state laws and regulations, and
 - b. Establishment of in-service education programs for licensed and unlicensed personnel which shall reflect topics pertinent to those identified by the Performance Improvement Committee.
17. Within seven (7) days of the execution of this Stipulated Agreement, the Licensee shall identify and provide in writing the name of the individual responsible for the full implementation of this document.
18. Within two (2) weeks of the effective date of this Stipulated Agreement, the Licensee shall make payment to the Department in the amount of fifteen thousand dollars (\$15,000.00), which shall be payable by money order or bank check payable to the Treasurer of the State of Connecticut and shall be posted to the Department. The monetary penalty and any reports required by this document shall be directed to:

Elizabeth Andstrom, R.N., M.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capital Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

19. In accordance with Connecticut General Statutes Section 19a-494, the Department hereby reprimands Natchaug Hospital for failure to comply with the applicable state statutes and Regulations of Connecticut State Agencies.
20. All parties agree that this Stipulated Agreement of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Stipulated Agreement or of any other statutory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Stipulated 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 otherwise retains all of its rights under applicable law.
21. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
22. The terms of this Stipulated Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
23. The Licensee had the opportunity to consult with an attorney prior to the execution of this Stipulated Agreement.

*

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

NATCHAUG HOSPITAL, INC.

9/16/05
Date

By: Stephen Larcen
Stephen Larcen, Ph.D., President and CEO

STATE OF Connecticut)

County of Tolland) ss September 16 2005

Personally appeared the above named Stephen Larcen and made oath to the truth of the statements contained herein.

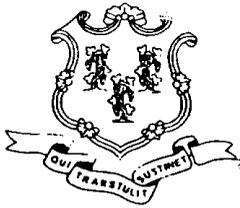
My Commission Expires: 7/31/07
(If Notary Public)

Emily A. Mecho
Notary Public []
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

September 21, 2005
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Section Chief
Facility Licensing & Investigations Section



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

May 24, 2005

Dr. Stephen Larcen, President and CEO
Natchaug Hospital
189 Storrs Road
Mansfield Center, CT 06250

Dear Dr. Larcen:

This is an amended edition of the original violation letter dated May 19, 2005.

Unannounced visits were made to Natchaug Hospital on January 27, 31; February 15; March 10 and 14, 2005 by representatives of the Health Systems Regulation Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through April 18, 2005.

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

An office conference has been scheduled for June 2, 2005 at 10:00 AM in the Health Systems Regulation Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

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

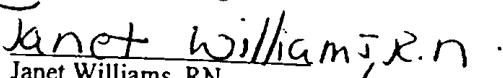
Each violation must be addressed with a prospective Plan of Correction which includes the following components:

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

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

Sincerely,


Jan Leavitt, R.N., M.S.
Public Health Services Manager
Health Systems Regulation


Janet Williams, RN
Supervising Nurse Consultant
Health Systems Regulation

JMW:zbj

- c. Director of Nurses
amd.vlnatchaug.doc
CT#3550, CT#3571, CT#3634, CT#3635



Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS #

FACILITY: Natchaug Hospital

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DATES OF VISITS: January 27, 31; February 15; March 10 and 14, 2005.

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

1. Based on a review of medical records, interviews with facility staff, and a review of facility policies and procedures, the facility failed to ensure for Patient #1 that a Clinical Institute Withdrawal Assessment (CIWA) was done in accordance with physician orders and facility protocol and that an assessment was done for the effectiveness of medications administered.
 - a. Patient #1 had a history of drug and alcohol abuse and was admitted to the facility's adult inpatient unit on 1/18/05 on a Physician's Emergency Certificate (PEC) for chemical dependency detoxification, depression and suicidal ideations. A review of the medical record identified physician orders for a CIWA protocol on 1/18/05 that directed a CIWA and vital signs be done every hour for a CIWA score greater than 9, and every 4 hours while the CIWA was between 0-9 for 2 consecutive measures and then that vital signs be taken according to unit protocol, and that a CIWA be done each time vital signs were taken. The CIWA score was 15 on 1/19/05 at 8:00 AM and 14 on 1/22/05 at 8:00 AM. The vital signs record lacked documentation that vital signs were done at 4:00 PM on 1/21/05 and that vital signs were done hourly for the scores of 14 and 15. The CIWA score sheet lacked documentation that a CIWA was done hourly for a score greater than 9 and every four hours twice when between 0-9 and with each vital sign taken. The CIWA protocol directed Librium 50 mg be given if the patient's pulse was greater than 100 or if the CIWA score was 15 or greater. A review of the medical record identified the patient's pulse was 111 at 12 noon on 1/19/05, her CIWA score was 15 on 1/19/05 at 8:00 AM and 14 on 1/22/05 at 8:00 AM. Documentation was lacking on the MAR (medication administration record) that Librium was given on 1/19/05.

A review of the facility's protocol for taking vital signs on the adult unit identified that vital signs were done four times a day until detox monitoring (CIWA) was discontinued for chemical dependency patients.
 - b. Patient #1 had a history of drug and alcohol abuse and was admitted to the facility's adult inpatient unit on 1/18/05 on a PEC (physician's emergency certificate) for chemical dependency detoxification, depression, and suicidal ideations. A review of the MAR identified the patient received Thorazine three times between 1/22/05 and 1/23/05, Clonidine nine times between 1/18/05 and 1/23/05, and Motrin eleven times between 1/18/05 and 1/23/05. A review of progress notes identified lack of documentation of any assessments for the effectiveness of the medications.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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A review of the facility's procedure for medications identified a progress note must be entered in the patient chart stating the medication given, the reason, and the effect for all as needed (prn) medications.

The above is a violation of the Regulations of Connecticut State Agencies Section 17-227-14g Nursing (D)(1) and/or Section 17-227-14m Patient Records (B).

2. Based on a review of medical records, interviews with staff, and a review of facility policies and procedures, the facility failed to ensure for seven (7) of nine (9) patients reviewed that their multidisciplinary treatment plans identified specific individualized treatment modalities and/or approaches being utilized and that documentation accurately identified comprehensive evaluations and/or assessments, and/or physician orders for treatments for three (3) of nine (9) patients reviewed.
 - a. Patient #1 had a history of drug and alcohol abuse and was admitted to the facility's adult inpatient unit on 1/18/05 on a PEC for chemical dependency detoxification, depression, and suicidal ideations and was placed on a CIWA protocol. A review of the multidisciplinary treatment plan identified the problem of ineffective coping skills evidenced by substance abuse, anxiety and insomnia. Goals included the patient would detox within five days and verbalize decreased depression within one week, be free of opioid and alcohol withdrawal symptoms in five days, verbalize awareness to coping skills, have insomnia and anxiety decreased, write down three feelings she had difficulty expressing and three positives about herself. The facility failed to identify specific treatment modalities and specific safety approaches including the CIWA protocol that would address the problems, but instead identified non-specific treatment modalities and approaches which included therapeutic milieu: structuring, and age appropriate limits, assess affect, behavior, mood and ability to communicate, encourage medication adherence, encourage milieu involvement, evaluate client observation level, prescribe and monitor medication, and engage client in groups. A review of the progress notes identified documentation was lacking for any alternatives tried due to the patient's infrequent attendance at group therapies.
 - b. Patient #6 had a history of substance abuse and was admitted to the facility on 3/5/05 for chemical dependency detoxification and depression. A review of the multidisciplinary treatment plan identified the problem of ineffective coping due to depression and substance abuse. The patient's diagnosis also included insulin dependent diabetes mellitus (IDDM) and hypertension. The facility failed to identify specific treatment modalities and specific safety approaches that would

DATES OF VISITS: January 27, 31; February 15; March 10 and 14, 2005.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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address the problems, but instead identified non-specific treatment modalities and approaches which included assess effect/side effect of medication, encourage milieu involvement, discuss triggers for behavior and suggestion to help, assess coping skill and help develop new ones, prescribe and monitor medication, assess for discharge readiness, individual therapeutic contact, encourage group participation, meds as ordered, dietary consult, monitor blood sugars, diabetic diet, monitor blood pressure.

- c. Patient #7 had a history of depression and was admitted to the facility on 11/8/04 due to suicidal ideations and attempt of an overdose of Benadryl and self-injury behavior of self inflicted burn and cut. A review of the multidisciplinary treatment plan identified the problem of potential for harm to self and/or others and a burn to wrist with infection. The facility failed to identify specific treatment modalities and specific safety approaches that would address the problems, but instead identified client observation every fifteen minutes, therapeutic milieu, assess affect, behavior, mood and ability to communicate, assess medication effects, encourage medication adherence, discuss triggers for behavior and suggestions to help, assess coping skills and help develop new ones, evaluate observation level, assess discharge readiness, weekly family group meetings, review mood, affect, mental status with psychiatrist, individual therapeutic contact to encourage verbalization of feeling, assess coping skills, facilitate/coordinate discharge planning, encourage group participation, provide instruction and help with schoolwork, and communicate home school concerns via treatment team.
- d. Patient #8 had a history of schizoaffective disorder and was admitted to the facility on 1/21/05 acutely psychotic, combative, delusional, and verbally abusive. A review of the multidisciplinary treatment plan identified the patient had altered thought, behaviors, paranoia, threatened others, abusive, labile affect, and medication non-compliance. The patient refused all care all medications. The patient had a history and physical and neurological examination, screamed at staff, was unapproachable and uninvolved in her care, refused to attend groups, and eventually required the probate court to mandate medication administration on 2/17/05. The facility failed to identify treatment modalities and safety approaches that would address the problems in the initial plan and subsequent updates. Instead the plans identified non-specific treatment modalities and approaches which included therapeutic milieu: structuring, and age appropriate limits, assess affect, behavior, mood and ability to communicate, assess effect/side effects of medications, encourage medication adherence, medication teaching, discuss trigger for behavior and suggestions to deal with them, assess

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DATES OF VISITS: January 27, 31; February 15; March 10 and 14, 2005.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- coping skills and help develop new ones, recommend and encourage attendance at groups. Weekly updates done between 1/31/05 and 3/7/05 identified interventions that were less comprehensive overall and on 1/24/05 and 2/7/05 the primary therapist identified the patient was not able to attend groups but the creative rehabilitation staff identified group interventions be done.
- e. Patient #9 was admitted to the facility on 3/1/05 due to non compliance with medications, psychosis, delusions, paranoia, and threatening behaviors. The multidisciplinary treatment plan identified the problem as alterations in thought, mood, and behaviors AEB paranoia and agitation. The facility failed to identify specific treatment modalities and specific safety approaches that would address the problems with the initial plan and all updates done, but instead identified non-specific treatment modalities and approaches which included assess affect, behavior, mood and ability to communicate, assess effect/side effects of medications, encourage medication adherence, medication teaching, discuss trigger for behavior and suggestions to deal with them, encourage milieu involvement, no specific interventions from the physician, review mood, affect, and mental status with psychiatrist, individual therapeutic contact, no direction regarding which groups to attend by therapist, and group therapy identified by the creative rehabilitation staff.
- f. Patient #2 was admitted to the facility due to suicidal ideations and gestures and depression. The patient had a history of bipolar and post traumatic stress disorder. A review of the medical record identified the patient advised staff on 12/22/04 that she cut herself on her forearm with a razor blade she found in her room. A review of the multidisciplinary treatment plan identified the problem of self mutilation and suicidal ideations. The facility failed to identify specific treatment modalities and specific safety approaches that would address problems with the initial plan and subsequent updates, but instead identified non-specific treatment modalities and approaches which included therapeutic milieu: structuring, and age appropriate limits, assess affect, behavior, mood and ability to communicate, encourage milieu involvement, evaluate observation level, prescribe and monitor medication, medication education, assess for discharge readiness, review mood, affect, and mental status with psychiatrist, individual therapeutic contact with patient to encourage verbalization of feelings and to establish rapport and trust, encourage group participation, recommend and encourage attendance at groups, and provide instruction and help with schoolwork and rules for behavior, provide safety management, encourage involvement with unit activities, perform daily mental status assessment. In addition,

FACILITY: Natchaug Hospital

DATES OF VISITS: January 27, 31; February 15; March 10 and 14, 2005.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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- documentation was lacking that the care plan was updated to include the patient's injury and the subsequent wound management.
- g. Patient #3 was admitted to the facility on 11/5/04 due to self injurious behaviors and non-compliance with taking medications. The patient had a history of substance abuse in the past, bipolar disorder and borderline personality disorder. A review of the multidisciplinary treatment plan identified the problem of oppositional behavior. The facility failed to identify specific treatment modalities and specific safety approaches that would address the problems, but instead identified non-specific treatment modalities and approaches which included monitor and evaluate patient status level, daily individual therapeutic contact, assess affect, behavior, mood and communication, assess milieu involvement, prescribe and monitor medication, and encourage group participation. In addition, documentation was lacking that the care plan was updated to include the patient's injury and the subsequent wound management. A review of the facility multidisciplinary treatment plan policy identified the treatment team used an interdisciplinary intervention approach to provide a consistent and planned treatment team approach to current, potential or anticipated client health problems using best practice interventions for the patient.
- h. Patient #1 had a history of drug and alcohol abuse and was admitted to the facility on 1/18/05 on a PEC (physician's emergency certificate) for chemical dependency detoxification, depression, and suicidal ideations. Progress notes written on 1/21/05 by Therapist #1 identified the patient felt suicidal, was encouraged to talk with staff, was unable to identify why she felt that way and agreed to go to staff with her feelings. Nurse's notes written at 2:15 PM identified the patient had fleeting suicidal ideations but denied plan or intent, and was encouraged to come to staff. Nurse's notes written on 1/22/05 by RN #2 identified the patient was depressed and anxious, denied suicidal ideations and was angry. Documentation was lacking relative to these events or an evaluation of the patient regarding her safety, and/or that staff were advised of the patient's suicidal ideations, and/or any follow up evaluations to assess the patient's status. Documentation written at 9:00 AM on 1/23/05 also identified the patient was depressed and anxious at a 10 out of 10 rating, denied hallucinations, returned from a courtyard break at 8:45 AM and voiced concerns regarding her medications not working. RN #2 stated the references to the depression and anxiety actually occurred at 7:45 AM when she was doing medication rounds and not at 9:00 AM. The patient was very calm and quiet at 8:45 AM despite complaints relative to the medications not working but RN #2 stated she failed to document this.

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A review of the medical record identified the patient was found by MHW #1 on 1/23/05 hanging in her room by shoelaces around her neck which were tied to the curtain rod on the window frame, CPR was begun immediately, and the patient was transferred to an acute care hospital where she died at 5:15 PM. A review of the Medical Examiner's report identified the patient died of asphyxia by neck compression from suicide. During interviews Therapist #1 and RN #2 stated comprehensive evaluations were done with each intervention but they failed to document the extent of them.

- i. Patient #2 was admitted to the facility due to suicidal ideations and gesture and depression and had a history of bipolar and post traumatic stress disorder. A review of the medical record identified the patient advised staff on 12/22/04 that she cut herself on her forearm with a razor blade she found in her room. An MD assessment identified Patient #2 had four to five superficial abrasions with no bleeding. Documentation identified the wounds were treated with Bacitracin ointment. A review of the physician orders identified documentation was lacking for an order for wound treatment or for the Bacitracin. A review of the facility policy on medications identified medications were only given based on a physician's order.
- j. Patient #3 was admitted to the facility on 11/5/04 due to self injurious behaviors and non-compliance with taking her medications and had a history of substance abuse in the past, bipolar disorder and borderline personality disorder. A review of progress notes 's right lower leg was treated with dressings and Bacitracin ointment. A review of the physicians orders identified documentation was lacking for an order for the wound care and Bacitracin. A review of the facility's policy on medications identified medication was administered only with a physician order. During an interview the Director of Nurses stated physician orders were required for wound care and medication use.
As part of a plan of correction that was to be implemented as a result of a CMS complaint validation survey concluded on 9/28/04, a revised treatment plan was to be implemented. A staff education program was also to be implemented and would review all aspects of treatment planning. This plan of correction was in response to previous issues cited by the Department relative to treatment planning.

The above are violations of the Regulations of Connecticut State Agencies Section 17-227-14f Medical Staff (B) and/or Section 17-227-14g Nursing (D)(1) and/or Section 17-227-14m Patient Records (B).

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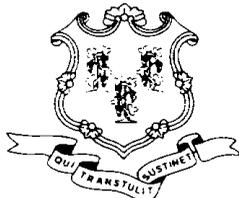
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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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3. Patient #1 had a history of drug and alcohol abuse and was admitted to the facility on 1/18/05 on a physician's emergency certificate (PEC) for chemical dependency detoxification, depression, and suicidal ideations. A review of the medical record identified the patient was found by MHW #1 on 1/23/05 hanging in her room by shoelaces around her neck and tied to the curtain rod. MHW #1 attempted to remove her, was unable to pull the rod down, was unable to untie the laces, held her body up to avoid tension on her neck while staff cut the lace from the rod and off of her neck. CPR was begun immediately, and the patient was transferred to an acute care hospital where she was pronounced dead at 5:15 PM.
A review of the hospital record identified that the patient died from an anoxic brain injury secondary to strangulation by hanging.
During an interview, Sales Representative #1 stated that curtain rods installed by them in January and February 2000 were regular rods. On 2/8/2000 the facility purchased breakaway rods. During an interview, the President, Medical Director, Vice President of Operations and Director of Plant Operations stated at the time of the incident, the curtain rods in the entire facility were regular rods and not breakaway rods that would dislodge from the wall when weight was added. They were not aware of this until the incident and could not explain why the rods had not been changed to breakaway rods.

The above is a violation of the Regulations of Connecticut State Agencies Section 17-227-14c Management (C) and/or Section 17-227-14d Environment (G) and/or Section 17-227-14e Safety (A).



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

August 29, 2005

Stephen W. Larcen, President
Natchaug Hospital
189 Storrs Road
Mansfield Center, CT 06250

Dear Mr. Larcen:

The violation letter originally dated June 22, 2005 is hereby amended to provide as follows:

Unannounced visits were made to Natchaug Hospital on May 31, June 1 and 2, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a follow-up to violation letters dated December 14, 2004 and April 29, 2005.

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

An office conference has been scheduled for at 10:00 AM on July 7, 2005 in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

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

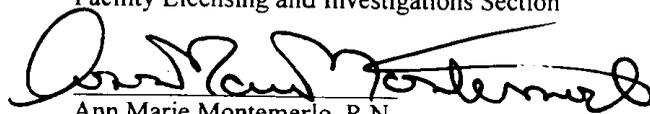
Each violation must be addressed with a prospective Plan of Correction which includes the following components:

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

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

Respectfully,


Joan D. Leavitt, R.N., M.S.
Public Health Services Manager
Facility Licensing and Investigations Section


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

JDL:AMM:zsj

c. Director of Nurses
vlnatchaug.doc



Phone:

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

FACILITY: Natchaug Hospital

DATES OF VISITS: May 31, June 1 and 2, 2005

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

The following is a violation of the Regulation of Connecticut State Agencies Section 17-227-14m Patient rights (B).

1. Based on a tour of the medical records storage area and staff interview, the facility failed to ensure that medical records were stored securely. The findings include:
 - a. During a tour of the medical records storage area on 6/1/05, two (2) file cabinets in an unattended office were noted with keys engaged in the locks in an "open" position. The medical records were not being maintained in a secure manner and the Director of Medical Records acknowledged that the cabinets should have been locked.

The following are violations of the Connecticut General Statutes Section 17a-542 and/or violations of the Regulations of Connecticut State Agencies Section 17-227-14c Management (C) and/or Section 17-227-14f Medical staff (B) and/or Section 17-227-14g Nursing and/or Section 17-227-14m Patient Records (B).

2. Based on a review of medical records, review of facility policies and procedures, and interviews with facility personnel, the facility failed to ensure for thirteen (13) patients reviewed that medical records were complete and/or comprehensive and/or contained complete and/or comprehensive multidisciplinary treatment plans.
 - a. Patient #14 was admitted to the facility's satellite PHP program on 4/26/05 for poly-substance dependence and abuse. A review of the medical record on 6/1/05 identified the patient had repeated, positive, random drug screen results that indicated the patient was still using drugs. The MTP lacked documentation of problems, goals, and interventions to address this problem. During an interview on 6/1/05 Primary Therapist #1 stated the patient was on a 3 strikes and you're out contract and if he had one more positive drug test he would be referred to a detox or inpatient hospitalization program. A review of the medical record on 6/1/05 identified weekly progress notes were not documented by the physician and primary therapist.
 - b. Patient #16 was admitted to the facility's PHP on 3/16/05 after discharge from inpatient treatment. A review of the medical record on 6/1/05 identified weekly progress notes were not documented by the physician and documentation for multiple group sessions were written once a week in a synopsis format that summarized the patient's participation and behaviors and did not identify individual session results.

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- c. Patient #17 was admitted to the one of the facility's satellite PHP's on 4/15/05. A review of the medical record on 6/1/05 identified weekly physician progress notes were not documented and group notes were documented once a week in a synopsis format that generically described the patient's participation and behaviors overall.
- d. Patient #18 was admitted to the facility's satellite PHP (partial hospital program) on 3/2/05 due to out of control behaviors and depression. A review of the medical record on 6/1/05 identified that the patient had written a note in school that reflected suicidal ideations. A review of the MTP on 6/1/05 identified updates or specific interventions regarding the patient's suicidal ideations were not documented. Weekly progress notes were not documented by the primary therapist.
- e. Patient #19 was admitted to the facility's satellite PHP program on 4/25/05 due to behavioral problems. A review of the medical record on 6/1/05 identified the patient was obese but the MTP failed to identify the medical problems and interventions for obesity. The patient had ongoing defiant behaviors and was being evaluated for dismissal from the program. A review of the MTP on 6/1/05 identified updates for interventions relative to the behavioral changes and primary therapist's weekly progress notes were not documented.
A review of the facility's MTP policy identified the team used a consistent and planned team approach to current, potential or anticipated client health problems using best practice interventions for the patient.
A review of the facility policy on documentation requirements for PHP (partial hospitalization programs) and IOP (Intensive outpatient programs) programs identified the MTP was to be reviewed every seven days and updated as needed and handwritten progress notes were required once weekly that reflected one individual contact by the primary therapist and psychiatrist. As a standard group notes must consist of the name of the group, the number of times the patient participated, the level of participation, and progress toward defined goals. All progress/group notes should contain the problem #/name from the Master Problem List.
- f. Patient #27 was admitted to the facility's PHP on 4/28/05 with diagnoses that included alcohol dependence. A review of the medical record on 5/31/05 identified that weekly progress notes had not been documented since 5/18/05.
- g. Patient #29 was admitted to the facility's PHP on 4/13/05 with diagnoses that included bipolar disorder and depression. A review of the medical record on 5/31/05 failed to reflect that weekly progress notes had been entered since

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- 5/16/05. The facility's documentation requirements for the PHP programs identified that the MTP is reviewed by the team every seven days and signed by all present and that handwritten progress notes were required once weekly, reflecting one individual contact by the primary therapist and psychiatrist.
- h. Review of the medical record for Patient #33 indicated that the patient was admitted on 5/27/05 after an attempted overdose. The patient had a history of bipolar disorder and cutting. Review of the Multidisciplinary Treatment Plan (MTP) initiated on 5/28/05 and reviewed on 6/1/05 indicated that the nursing section of the MTP had not been completed. Review of the facility indicated that the MTP would be completed within 72 hours of admission. Further review of the Multidisciplinary Treatment Plan (MTP) initiated on 5/28/05 indicated that the patient's interdisciplinary medical problem was identified as obesity. Although the MTP identified interventions of monitoring and education, the MTP failed to identify specific methods of implementation. Review of the physician's orders indicated that the patient was on a regular diet and had no restrictions. Interview with the nurse manager indicated that she was unaware of the problem, that a nutritional consult had not been done and that a physician's order would be needed.
- i. Review of the medical record for Patient #34 indicated that the patient had been admitted to the facility on 5/27/05 with post traumatic stress disorder (PTSD), depression, suicidal ideation and cutting behaviors. Review of the initial plan of care identified a lack of specific measures to be implemented. The initial plan of care included interventions of daily observation and documentation of participation in the milieu, interactions with family, peers and staff and every fifteen minute observation. The plan of care also included the intervention to maintain status for safety and observation by encouraging patient to express feelings and issues which required explanation on how this would be accomplished, however, this information was not included. Review of the facility policy indicated that the RN should complete the initial plan that addressed the problems identified, goals, interventions, aftercare planning and recommendations from the treatment team. Review of the Multidisciplinary Treatment Plan (MTP) initiated on 5/28/05 and reviewed on 6/1/05 indicated that the nursing section of the MTP had not been completed. Review of the facility policy indicated that the MTP would be completed within 72 hours of admission.
- j. Patient #44, an adolescent, was admitted to the hospital on 5/27/05 with diagnoses of psychosis and PTSD (Post Traumatic stress Disorder). The patient was admitted following an episode of hearing demons which were telling him to harm

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himself. Axis IV problems included problems related to social environment, educational problems and psychosocial issues. A psychosocial assessment dated 5/28/05 identified a need for individual therapy to focus on anger management and family therapy with a focus of increasing communication.

A review of the initial plan of care dated 5/27/05 identified a problem of alteration in thought and mood. Interventions included were non-specific to the problem but instead identified vague modalities such as daily observation and documentation of interactions with staff, family and peers. Although a description of these interactions was required as part of the plan, this information was left blank. An additional intervention included every fifteen checks however a purpose for conducting these checks was lacking.

An additional problem on this plan included medical issues as demonstrated by developmental delays with learning disabilities. Interventions had not been identified to address this problem.

The subsequent multidisciplinary treatment plan dated 5/28/05 and 5/29/05 identified problems in the areas of alteration in thought mood, and behavior as exhibited by auditory hallucinations. The long term goal identified that the patient would be safe with self and others. Specific interventions to address this problem were lacking but instead included non-specific modalities such as group therapy five times a week, goals group seven times a week, therapeutic milieu; structuring and age appropriate limits, encourage milieu involvement and assess presence of coping skills and help clients develop new or other coping skills. Also identified were individual therapeutic contacts with the patient however specificity for these interventions was lacking, e.g. frequency of contact, etc. Although, the psychosocial assessment conducted on admission identified a need for family therapy with specific goals, family therapy was not identified on the MTP as an intervention but was left blank.

A review of the Mental Health Worker's Assignment sheets did not include specific information regarding the care of the patients. Interview with the (Nurse manager) identified that instead of providing specific assignments, the facility utilized a Nursing Report Sheet. A review of the information provided for Patients #44, #45 and #46 did not include information specific to caring for the patient but instead included descriptives of either the patient's personality and/or behaviors, e.g. Pregnancy test negative, pushes limits, constant demands, upset regarding clothes, good sleep, Risperdal hs prn.

- k. Patient #45, an adolescent, was admitted to the hospital on 5/27/05 with diagnoses which included mood disorder. Axis IV problems included problems with primary

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support group, problems relative to the social environment, school expulsion, and problems with the legal system. The patient had overdosed on multiple medications and had threatened to harm others in her household and was subsequently admitted to the hospital.

Documentation in the medical record on 6/2/05 did not include a complete psychiatric evaluation upon admission in that the attending physician's evaluation summary was left blank. Also not included were Axis I through IV diagnoses. A review of the initial plan of care dated 5/28/05 identified problems in the area of ineffective individual coping as exhibited by out of control behaviors, sexual acting out and overdose on meds.

The MTP dated 5/31/05 identified a problem of potential for harm to self. Specific interventions to address this problem were lacking but instead included non-specific modalities such as client observation will be performed using one to one staffing or at intervals of 5", 15" or one hour to maintain safety. A specific time frame for patient monitoring had not been chosen based upon the patient's status. Interventions also included therapeutic milieu: structuring with age appropriate limits, encourage milieu involvement, and assess affect, behavior, mood and ability to communicate, etc.

1. Review of the medical record for Patient #47 indicated that the patient had been admitted on 6/1/05 with psychotic disorder, schizophrenia, PTSD and rule out major depression. Review of the initial plan of care indicated that the patient had an identified medical issue of Encopresis, however, there lacked designated interventions for this problem.

3. Based on review of the medical record, interview with facility personnel and review of the facility medical bylaw Rules and Regulations, the facility failed to ensure that a history and physical was completed for Patient #41. The findings include the following:
 - a. Patient #41 was admitted on 5/25/05 secondary to substance abuse and exhibited paranoia, belligerence and was uncooperative. Documentation in the medical record identified that the patient refused a history and physical on 5/26/05 and 5/27/05. Additional reference to Patient #41's cooperativeness in subsequent days was lacking. The patient experienced chest pain on 5/28/05, was seen by the attending psychiatrist and sent to the Emergency Room for evaluation. Although the patient had no chest pains while in the Emergency Room, the patient was diagnosed with an abnormal electrocardiogram secondary to a past myocardial infarct of unknown age. The patient experienced nausea, vomiting and weakness through 5/31/05 as identified in the progress narratives. Subsequently on 5/31/05,

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a history and physical was completed by the covering medical service and did not reference the Emergency Room evaluation completed three (3) days earlier. A review of the medical bylaw rules for record documentation identified that the history and physical would be completed within twenty-four hours.

The following are violations of the Regulations of Connecticut State Agencies Section 17-227-14d Environment (A) and/or (G).

4. During a tour of Joshua Center in Brooklyn on 5/31/05, the refrigerator freezer used for storage of patient food and drink was observed to have four to five inches of ice buildup and the refrigerator temperature registered at 56 degrees.
5. During a tour of the Joshua Center in Enfield on 6/1/05, the following was identified:
 - a. The patient refrigerator was observed to contain numerous 46 fluid oz. containers of juices that had expiration dates of 3/16/05, 4/28/05 and 5/25/05. Interview with the Program Director noted he had been aware of this and was waiting for a current supply.
 - b. A small refrigerator noted to be on the floor in the kitchen was observed to be stocked with fruit and lacked a thermometer and the documentation of the monitoring of it.

The following are violations of the Regulations of Connecticut State Agencies Section 17-227-14d Environment (B) and/or (G).

During tour of the facility between 5/31/05 through 6/2/05, the following items were noted:

6. Main Campus:
 - a. Dust and debris was observed on ventilation grills in the Adult patient care area.
 - b. The Laundry Room on the Adult Wing was not provided with any mechanical ventilation i.e., the room was very warm while the machines were in use.
7. Joshua Center – Brooklyn:
 - a. The exit door in the rear stairway was blocked with chairs and tables.
 - b. There were books and magazines being stored in the front stairway.
 - c. The exit signs on the second floor were not properly located and giving false direction.

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8. Joshua Center – Enfield:
 - a. The pull-down stair cases were not provided with the required vertical protection i.e., no sheetrock on the hatch door.
 - b. There was a refrigerator on the floor with fruits and drinks in it.

9. Joshua Center – Montville:
 - a. The Janitor Closet/Storage area has voids around penetration through the ceiling, which were not sealed with the required fire resistive material.
 - b. The door to the Janitor Closet/Storage Area on the far side was marred and damaged.

10. River East Day Treatment Center – Vernon:
 - a. The rear door was marked as an exit, which was locked and had a deadbolt lock which needed a key to be opened.

11. Care plus PHP – Groton:
 - a. The flooring in the bathrooms and at the base of the rear stairs was worn marred and damaged.
 - b. The exhaust fans and diffusers grills had large amounts of dust and debris.
 - c. A telephone cable wad duct taped to the floor in the Office Area.

12. Thames Valley PHP – Norwich:
 - a. There were areas of the ceiling in the Common Room that were water damaged due to roof leaks.

FLIS Independent Nurse Consultant Guidelines

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

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

Relationship between INC and the Institution:

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