State of Connecticut
Department of Public Health
Facility Licensing and Investigations Section

IN RE Hartford Hospital, Inc.
80 Seymour Street
Hartford, CT 06115

STIPULATED AGREEMENT

WHEREAS, Hartford Hospital of Hartford, CT (hereinafter the "Licensee"), has been issued License No. 0046 to operate a General Hospital (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490, by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Department's Facility Licensing and Investigations Section (hereinafter "FLIS") conducted unannounced inspections at the Facility on various dates commencing March 21, 2005 and concluding on May 3, 2005 for the purposes of conducting multiple investigations; and

WHEREAS, during the course of the aforementioned inspections, violations of the Regulations of Connecticut State Agencies were identified in a violation letter dated May 10, 2005 and amended June 1, 2005 (Exhibit A); and

WHEREAS, an office conference regarding the May 10, 2005 violation letter was held between the Department and the Licensee on May 23, 2005; and

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

NOW THEREFORE, the Facilities Licensing and Investigation Section of the Department of Public Health of the State of Connecticut, acting herein by and through Marianne Horn, its Section Chief, and the Licensee, acting herein by and through John Meehan, its President and Chief Executive Officer, hereby stipulate and agree as follows:

Licensee: Hartford Hospital of Hartford, Inc.

1. Within fourteen (14) days of the execution of this Stipulated Agreement, Facility staff shall review and revise, as necessary, policies and procedures regarding physician and registered nurse oversight of staff pertinent to staff's ability to perform tasks within their scope of practice; policies and procedures pertinent to coordination of medical care for all patients including those with complex medical conditions; and policies and procedures relative to the medical management, monitoring and control of hypoglycemia in patients experiencing and/or at risk for such a condition.
2. The Licensee shall provide inservice education to physicians and all direct care clinical staff within thirty (30) days of the execution of this Stipulated Agreement relative to:
    a. Scope of practice for all direct care staff;
    b. Coordination of medical care for all patients; and
    c. Monitoring and control of hypoglycemia.
3. The Licensee shall establish a mechanism, whereby the Quality Assurance Program, on an ongoing basis, reviews and evaluates the following:
    a. Protocols for monitoring staff performance, which shall include direct observation and remediation of staff who do not perform duties in accordance with facility policies and procedures.
    b. Timeliness and accuracy of interpretation of radiology studies.
    c. Coordination of medical care provided to patients.
4. The terms of the Stipulated Agreement shall remain in effect for a period of two (2) years from the effective date of this document.
5. Documents required by this Agreement shall be sent to:

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

6. The Licensee shall:
    a. make a voluntary contribution of $25,000.00 to the Public Health Foundation of CT, Inc. to be utilized for patient safety and quality improvement activities in Connecticut hospitals payable within two (2) weeks of the effective date of this Agreement by money order or bank check to the Foundation at:

        Department of Public Health
        Michael J. Purcaro
        Grants & Contracts Section
        410 Capitol Avenue, MS #13CGG
        Hartford, CT 06134 and

    b. allocate $75,000.00 to develop and provide patient safety education for the benefit of all Connecticut hospitals, which shall be provided by May 31, 2006. An accounting of these funds shall be provided to the Department.
7. All parties agree that this Stipulated Agreement is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Stipulated 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 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.
8. 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.

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Licensee: Hartford Hospital of Hartford, Inc.

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 noted below.

HARTFORD HOSPITAL OF HARTFORD, CT - LICENSEE

11/28/05
Date

By: John Meehan
John Meehan, President and Chief Executive Officer

State of Connecticut)
County of Hartford ss Hartford 2005

Personally appeared the above named John Meehan and made oath to the truth of the statements contained herein.

My Commission Expires: 11/30/2007

Diana Nino
Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

November 29, 2005
Date

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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June 1, 2005

John Meehan, President and CEO
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

Dear Mr. Meehan:

This is amended edition of the violation letter originally dated May 10, 2005.

Unannounced visits were made to Hartford Hospital on March 21, 22, 23, 24 and April 13, 2005 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations and follow up assessment implementation of Plan of Correction for violation letter dated October 11, 2004 with additional information received through May 3, 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 May 23, 2005 at 10:00 AM in the Division of Health Systems Regulation, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

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,

Elizabeth S. Andstrom, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

ESA/DSR/PMG/DJS/HC:jpf

Director of Nurses
vlhartfordhosp.doc
complaints #CT3293, #CT3319, #CT3457, #CT3533, #CT3633, #CT3697, #CT3811, #CT3915, #CT3365, #CT3459, #CT3643 and #CT3713

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

FACILITY: Hartford Hospital

DATES OF VISIT: March 21, 22, 23, 24 and April 13, 2005

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

1. Patient #2 had a history of recurrent right pleural effusions with multiple aspirations done, atrial fibrillation (AF) diabetes mellitus, hypertension, peripheral vascular disease, sleep apnea, arthritis, status post femoral-popliteal bypass, and was admitted to the facility on 11/8/04 for an elective thorascopic drainage of a right pleural effusion and pleural biopsy. A review of nurse's flow sheets dated 11/27/04, 12/6/04, and 12/7/04 identified the patient was in wrist restraints which were applied for safety. A review of progress notes identified the patient was sleepy, responded to commands, and failed to identify any behaviors for the restraints. A review of physician orders identified documentation was lacking which warranted the use of a restraint order and assessment by the physician and nursing staff. A review of the facility's restraint policy identified restraint use was based on an assessed need of the patient, must be clinically justified, used as a last resort when alternative interventions fail, and done under the direction of a physician order obtained within 12 hours of application and renewed on a daily basis.

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 (3), and/or (e) Nursing Ser vice (1), and/or (i) General (7) and (Connecticut General Statutes Section 46a-152).

2. Patient #2 had a history of recurrent right pleural effusions with multiple aspirations done, atrial fibrillation (AF) Diabetes mellitus, hypertension, peripheral vascular disease, sleep apnea, arthritis, status post femoral-popliteal bypass, and was admitted to the facility on 11/8/04 for an elective thorascopic drainage of a right pleural effusion and pleural biopsy. A review of the medication administration record identified Dilaudid and/or Percocet were administered multiple times between 11/10/04 and 11/28/04. Documentation was lacking to reflect that an assessment was done regarding pain prior to and/or after administration of medication to determine the effectiveness. A review of the facility pain management policy identified pain intensity should be rated on a scale of 0 to 10 and assessed with any pain and for each pain management intervention.

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

3. Patient #2 had a history of recurrent right pleural effusions with multiple aspirations done, atrial fibrillation (AF) Diabetes mellitus, hypertension, peripheral vascular disease, sleep apnea, arthritis, status post femoral-popliteal bypass, and was admitted to the facility on 11/8/04 for an elective thorascopic drainage of a right pleural effusion and pleural biopsy. A review of the plan of care identified documentation was lacking of

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

updates to the plan that reflected the patient's changes in condition relative to the need for restraints, dressings and care for the chest wound as a result of the empyema, difficulty eating with a feeding tube inserted, generalized edema, recurrent runs of cardiac arrhytmias, refusal of physical therapy, significant respiratory difficulty and acute/chronic renal failure. A review of the facility policy of Guidelines for the Use of the Interdisciplinary Problem List and Plan of Care identified all problems must be listed, added/revised/resolved, and be re-evaluated at least weekly.

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

4. Patient #3 was admitted to the facility from an assisted living facility on 1/8/05 due to shortness of breath. During an interview the Director of Medical Claims Management stated she received a copy of a complaint sent to the Department of Public Health and reviewed the concerns in the letter regarding inadequate discharge planning, found no information to support the claim, and did not do anything more because she only received a copy of the complaint which was not directed to the facility. A review of the facility's policy, "Responding to inquiries and complaints reported by patients and/or family members", identified all complaints received would be investigated, have corrective action taken if indicated, and a response would be forwarded to the patient or family member.

The above is a violation of Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (i) General (5).

5. Patient #3 was admitted to the facility from an assisted living facility on 1/8/05 due to shortness of breath, treated for acute and chronic respiratory failure and exacerbation of COPD (chronic obstructive pulmonary disease) and discharged to return to the assisted living facility on 1/15/05. A review of the medical record identified a W10 with discharge instructions and a list of medications required for the patient. Documentation was lacking that any prescriptions or discharge instruction record were completed. A review of the facility's discharge planning policy for the care Continuum Department identified planning should include cost effective, patient specific and medically necessary services be arranged proactively, each patient must be assessed for potential discharge needs, physician orders must be confirmed, a patient centered discharge plan must be developed, and documentation of communications, plans, commitments and negotiations must be included to assure the smooth transition of the patient to the next level of care

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

needed. During an interview RN #10 stated the patient did not have any prescriptions for her medications upon arrival at the assisted living facility. During an interview the Nurse Manager of Center 12 stated a discharge to an assisted living should be treated like a discharge to home and the patient should be given prescriptions and a discharge instruction sheet.

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

6. Patient #4 had a history of COPD (chronic obstructive pulmonary disease), oxygen dependency, hypertension, anemia, and hyperthyroidism, and was admitted to the facility on 11/28/04 due to shortness of breath. Between admission and 12/1/04, progress notes and consults done identified the patient became confused, delusional, delirious, refused care, testing, and medications, was agitated and uncooperative at times, and consistently removed her oxygen. The patient was found on the floor on 12/1/04 and suffered a head laceration and broken right hip. A psychiatric consult identified the patient needed a workup for dementia and an admission nursing assessment identified the patient was agitated, irritable, incontinent of BM, had a foley, and was placed on a fall protocol with four side rails up to prevent the patient from getting out of bed. A review of the patient's plan of care identified documentation was lacking for any problems or interventions related to the patient's mental status and refusal of care, use of four side rails as a restraint, incontinence of BM, foley, and there were no updates to the care plan identified for specific interventions needed after the patient fell.
    a. Patient #15 was admitted to the facility on 3/20/05 due to a fall at home, rhabdomyolosis, alcohol abuse, pancreatitis, and gastritis. A review of the medical record identified the admission database was blank. The patient was placed on a fall protocol and identified at risk of skin breakdown but a review of the plan of care and problem list identified documentation of fall risk or skin breakdown as a problem was lacking.
    b. During a tour Patient #16 and #17 were identified as being a fall risk due to the green triangle mark on the door. A review of the medical records identified Patients #16 and #17 were not identified as fall risks and the plans of care did not reflect this as a problem. During an interview the Nurse Manager of Bliss 11 stated the nurses' put Patients #16 and #17 on the fall risk "just in case" because even though they did not trigger as a risk, their nursing judgment identified otherwise. A plan of care and implementation of the fall protocol should have been developed based on that.

FACILITY: Hartford Hospital

DATES OF VISIT: March 21, 22, 23, 24 and April 13, 2005

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

c. Patient #18 was admitted to the facility on 3/16/05 due to an altered mental status and aspiration pneumonia. A review of the admission database identified it was blank. A review of the nursing admission assessment identified the patient had a Braden score of 9 which put her at risk of skin breakdown and the safety score was above 4 which identified risk for fall. A review of the plan of care identified documentation of any problems or interventions relative to skin breakdown and falls/safety was lacking. A review of the facility policy for guidelines for the plan of care identified actual problems must be listed, problems were added, revised, at any time and must be re-evaluated at least weekly as well as a SOAP note update in progress notes to revise/resolve problems and interventions.

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

7. Patient #4 had a history of COPD (chronic obstructive pulmonary disease), oxygen dependency, hypertension, anemia, and hyperthyroidism, and was admitted to the facility on 11/28/04 due to shortness of breath. A review of the nurse's flow sheet and progress notes identified the patient had four side rails up between admission and 12/9/04. A review of physician orders identified documentation was lacking for an order for a restraint. A review of the facility restraint policy identified a restraint was the use of any physical device that restricted movement, controlled the patient's physical activities, and was such if the patient could not easily remove it. Restraints included devices such as side rails when the device had the effect and purpose of restricting movement and the patient couldn't easily remove the device or exit from the equipment. Each patient must be assessed for interventions and alternatives, a physician order was required and renewed daily, and based on a physician order, restraint could be applied. During an interview RN #9 stated Patient #4 was unable to lower the side rails on her own and they were raised to keep her in bed.

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

8. Patient #4 had a history of COPD (chronic obstructive pulmonary disease), oxygen dependency, hypertension, anemia, and hyperthyroidism, and was admitted to the facility on 11/28/04 due to shortness of breath. A review of the nurse's flow sheet and MAR (medication administration record) identified the patient was given Dilaudid 1 mg three

times on 12/2/04 and once on 12/19/04 for pain. Documentation was lacking that a pain assessment was done either before and/or after administration of the medication to determine the pain level and effectiveness of medication. A review of the facility pain policy identified pain must be assessed and documented by using a pain intensity scale of 1-10 before and after administration of medication.

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

9. Based on review of the medical record, review of facility documentation, and staff interviews for one patient (Patient #5), the facility failed to ensure that quality of care was maintained for a medically complex patient during admission to the geriatric psychiatric unit. The findings include:
   a. Patient #5's diagnoses included COPD, Tourette's Syndrome, depression, atrial fibrillation, and chronic renal failure. The patient was transferred from the medical unit to the geriatric psychiatric unit on 8/27/04 at 4:20 p.m. Medical Resident #4 admitted Patient #5 to the unit which included admission orders and the psychiatric intake and evaluation. The physician's examination and admission note was completed by MD #13, an attending psychiatrist. MD #13 stated that he reviewed the admission orders that were written by MD #4 and was aware of the patient's medical history. MD #13 also stated that he expected MD #4 to determine medication orders by reviewing the documentation that accompanied the patient to the unit, including a transfer summary and discharge summary. MD #4 stated that she reviewed Patient #5's previous medical record and the transfer summary and it appeared to be 10 milligrams. Although Patient #5's previous medication orders included Prednisone 40 milligrams daily and Lantus insulin 60 units subcutaneously every morning, the admission orders written by MD #4 on 8/27/04 included Prednisone 10 milligrams daily and directed that Lantus insulin 55 units be given at bedtime. In addition, the transfer summary and discharge summary identified Prednisone 40 milligrams to be tapered by 5 milligrams every four days, which did not occur. The patient received Prednisone 10 milligrams on 8/28/04. Upon interview, MD #13 stated that he "misread the number for the Prednisone". MD #13 stated that he discussed Patient #5 with MD #4, reviewed the admission orders written by MD #4, and that they interpreted the Prednisone dosage as 10 milligrams. MD #4 stated that "everything was unclear" in relation to the Prednisone dose, the transfer summary was disorganized, and she did not consult with Patient #5's previous physicians. MD #17, the attending

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

record dated 8/17/04 to 8/27/04 identified that Patient #5 was on a low potassium diet and that the Levoquin had been discontinued on 8/26/04. MD #4 stated that she was aware of Patient #5's chronic renal failure; however she did not notice the Low Potassium diet on the transfer summary as it was disorganized. MD #4 also stated that the Levoquin was included on the transfer summary and she was unaware that the Levoquin had been discontinued on 8/26/04.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B)(D), and/or (d) Medical Records (3).

10. Patient #5's diagnoses included COPD and steroid-induced hyperglycemia and the medical record identified that the patient had frequent episodes of hypoglycemia. Patient #19's diagnoses included COPD and Diabetes and the medical record identified an episode of hypoglycemia. The facility failed to follow its hypoglycemic protocol. Patient #5's diagnoses included COPD, Tourette's Syndrome, steroid-induced hyperglycemia, and chronic renal failure. Patient #5 was transferred from the medical unit to the geriatric psychiatric unit on 8/27/04. Although the patient received Lantus insulin 60 units subcutaneously at 8:00 a.m. on 8/27/04 on the medical unit, review of the medication administration record identified that another 55 units was administered at 9:30 p.m. on the geriatric psychiatric unit. RN #5 stated that she did not remember if she gave medications that night and did not recall the signature. Subsequently, the patient's blood glucose the next morning was recorded as 24. An intervention of a bedtime snack was not initiated until 8/30/04 after Patient #5 was noted to have a fasting blood glucose level of 27 at 7:30 a.m. and was transferred to the emergency department.

11. Based on review of the medical records, review of facility policies and procedures, and staff interviews for two patients (Patient #5 and Patient #19), the facility failed to ensure that hospital policies related to hypoglycemic episodes were followed. The findings include:
    a. Patient #5 was noted to be diaphoretic and not responding to nursing personnel with a blood glucose of 27 on 8/30/04 at 7:15 a.m. Instant glucose was given without response and at 7:45 a.m., intramuscular glucagon was administered resulting in a blood glucose of less than 47. Although emergency personnel was notified at 8:05 a.m. and the patient was transferred to the emergency department at 8:19 a.m., the medical record lacked documentation that the patient's blood glucose was re-checked according to facility policy.

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

b. Patient #5 was found unresponsive on 8/31/04 at 6:13 a.m. with a blood glucose level of less than 21. Although nurses' notes identified that glucagon was administered and the ambulance was called for transfer to the emergency department, the medical record lacked documentation of the patient's response to the glucagon or that the patient's blood glucose was re-checked. RN #4 stated that she notified the on-call physician who responded; however, the medical record lacked documentation of a physician assessment and/or physician' orders at that time. The ambulance "run" sheet identified that upon their arrival, Patient #5 was unresponsive with periods of apnea and pinpoint pupils.
c. Patient #19's diagnoses included COPD and diabetes. Nurses' notes dated 3/18/05 identified that at 9:00 p.m., the patient was diaphoretic with a blood glucose level of 33. Although the patient was able to ingest a high carbohydrate snack, the medical record lacked documentation that the blood glucose had been re-checked per facility protocol. At 10:00 p.m., the patient was slightly diaphoretic with a blood glucose of 97 and the on-call physician was notified. Orders were obtained to hold the morning insulin and monitor the patient's blood glucose through the night; however, the medical record lacked documentation of the blood glucose levels.

The facility protocol for the treatment of hypoglycemia identified that for blood glucose levels under 30, the blood glucose is repeated in 5-10 minutes after glucagon and for blood glucose levels under 60, the blood glucose is re-checked 15–20 minutes after a carbohydrate snack. Documentation should include the date and time of all blood glucose tests and treatment.

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

12. Based on review of the medical record, review of facility policies and procedures, and staff interviews for one patient (Patient #5), the facility failed to ensure that the medical record contained accurate medication orders in order to provide appropriate care when the patient was transferred. The findings include:
    a. Patient #5's diagnoses included COPD, Tourette's Syndrome, steroid-induced hyperglycemia, and chronic renal failure. Patient #5 was transferred from the medical unit to the geriatric psychiatric unit on 8/27/04. Although Patient #5's previous medication orders included Prednisone 40 milligrams daily and Lantus insulin 60 units subcutaneously every morning, the admission orders written by

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

MD #4 on 8/27/04 included Prednisone 10 milligrams daily and directed that Lantus insulin 55 units be given at bedtime. MD #4 stated that she reviewed Patient #5's previous medical record and the transfer summary and it appeared to be 10 milligrams. MD #4 also stated that "everything was unclear" in relation to the Prednisone dose, the transfer summary was disorganized. The transfer summary and discharge summary identified Prednisone 40 milligrams to be tapered by 5 milligrams every four days, which did not occur. MD #13 stated that he expected MD #4 to determine medication orders by reviewing the documentation that accompanied the patient to the unit, including a transfer summary and discharge summary. The Director of Risk Management stated that a transfer summary is not required when a patient is transferred from a medical unit to the geriatric psychiatric unit. MD #6 stated that when a patient is transferred from a medical unit to the geriatric psychiatric unit, the expectation is that the discharge summary, the medication administration record, and the facility computer system are reviewed. The facility lacked a mechanism to ensure that medications are continued as intended by the attending physician.

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

13. During a review of the facility's Corrective Action Plan concerning an adverse event that occurred on August 31, 2004, the facility failed to submit all information related to the plan. The event was represented as a medication transcription error; however, the investigation ascertained that the adverse event encompassed systemic problems including unit to unit communication, nursing and medical staff documentation, hypoglycemic protocol, and medical oversight. After the substantial findings were presented to the facility on 4/25/05, the facility indicated that they had not offered the entire Corrective Action Plan during the investigation, which had concluded on 3/24/05. On 4/27/05, the facility was forthcoming with additional information that pertained to the original action plan.

The above is a violation of Regulation of Connecticut State Statutes Section 19a-127n.

14. Patient #7 was admitted on 07-03-2004 for a cardiac workup, including the need for an implantable cardioverter defibrillator. The patient had a history of status post ventricular fibrillation arrest, ischemic cardiomyopathy, congestive heart failure, atrial fibrillation/flutter, coronary disease, and multiple system organ failure. Facility

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

documentation, dated 07-03-2004, identified that Patient #7 was confused, unable to follow directions was irritable, had strong bilateral hand grasps and weak bilateral leg movements. Facility documentation, dated 07-13-2004, identified that Patient #7 required minimum staff assistance for supine to sitting in bed, for sitting to standing, and for ambulating. Facility documentation, dated 07-31-2004 at 12:00 noon, identified that RN #7 inserted a Peripherally Inserted Central Catheter (PICC) with ultrasound guidance, into Patient #7's right arm with a positive blood return. Facility policy, titled "PICC/Midclavicular/Midline Policies", identified that a PICC is inserted into a vein and the tip resides in the superior vena cava (SVC). Interview with RN #7, on 03-29-2005, identified that there was a blood return after the insertion of the 07-31-2004 PICC for Patient #7. Upon inquiry of RN #7 as to the color of the patient's blood upon catheter insertion, RN #7 replied there was "nothing remarkable". Upon further inquiry as to whether the RN noted any pulsation of the blood RN #7 responded "no". Facility documentation, dated 07-31-2004 at 09:23 p.m., identified that "PICC line 15 in place with its tip in the region of the subclavian SVC junction" and was interpreted by MD #12. Interview with MD #12, on 03-31-2005, identified on Patient #7's 07-31-2004 X-Ray, that the tip of the PICC line was a bulbous rounded area and was in the region of the SVC junction and the subclavian. Facility documentation, dated 08-03-2004 at 02:15 p.m., identified that Patient # 7 was not responsive to verbal commands, exhibited a right sided facial droop and was unable to move the left side of his body-including no left hand grasp, and no push or pull of left leg. Computed Tomography (CT) Scan, dated 08-03-2004 at 03:00 p.m., identified a catheter located in the right common carotid artery and chest X-Ray, dated 08-03-2004 at 04:00 p.m., identified a right sided PICC line going into the neck. Facility documentation, dated 08-03-2004 at 2:30 p.m., identified Patient #7 had an acute Cerebrovascular Accident (CVA) from line placement in the right common carotid. Facility documentation, dated 08-04-2004, identified Patient #7 was lethargic and oriented to person, place and time, had gross movement and sensation of the left arm and full strength and sensation of the left leg. Facility documentation, therapy evaluation dated 08-06-2004, identified that Patient #7 was alert and oriented to person, place, and time, required staff assistance for supine to sitting in bed, and had decreased upper extremity strength and coordination. Interview with MD #7, on 03-29-2005, identified that the cause of Patient #7's CVA was related to the PICC. Interview with MD #16, on 04-01-2005, identified that on Patient #7's 07-31-2004 X-Ray the tip of the PICC was identified lying cephalad to the thoracic inlet in a vertical position in the neck.

FACILITY: Hartford Hospital

DATES OF VISIT: March 21, 22, 23, 24 and April 13, 2005

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

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2) (B) and/or (e) Nursing Service (1) and/or (f) Diagnostic and Therapeutic Facilities.

15. Patient #7 was admitted on 07-03-2004 for a cardiac workup, including the need for an implantable cardioverter defibrillator. The patient had a history of status post ventricular fibrillation arrest, ischemic cardiomyopathy, congestive heart failure, atrial fibrillation/flutter, coronary disease, and multiple system organ failure. Facility documentation, dated 07-31-2004 at 12:00 noon, identified a physician order for a Chest X-Ray (CXR) for PICC line placement, (stat 3) which was received in the Radiology department at 12:30 p.m., and the test was completed at 7:55 p.m. Interview with Radiology department coordinator, on 04-05-2005, identified that a routine x-ray, Stat 3, would be completed within the shift. Facility policy, titled "Ordering procedure for stat and routine radiologic examinations for inpatients" identified that a STAT 3 test would be completed within the shift.

The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and Therapeutic Facilities.

16. Based on review of the medical record, review of facility policy, review of facility documentation and interviews, the facility failed to ensure that a medically complex patient who required treatment within a hyperbaric chamber, received medical supervision and/or received medical interventions by qualified staff. The findings included:
    a. Patient #9 had diagnoses that included Insulin Dependent Diabetes (IDDM), a history of Cerebral Vascular Accident (CVA), esophageal strictures, and a recent (1/13/05) cardiac arrest. Review of the medical record identified that Patient #9 was admitted to the facility on 12/29/04 for treatment to an infected left thigh wound that included antibiotics and surgical debridement of the wound. Review of the medical record identified that on 1/6/05, Patient #9 was found unresponsive with a fingerstick of less than twenty (Normal 90-120). Review of the Magnetic Resonance Imaging (MRI) and the neurology note both dated 1/6/05, identified that Patient #9 had sustained a new left posterior/ parietal stroke. On 1/12/05, a Peripheral Intravenous Catheter (PICC) line was inserted into Patient #9's left arm. Patient #9's plan of care for the thigh wound was revised to include hyperbaric therapy at the facility's Center for Wound Healing and Hyperbaric Medicine and treatments at the center began on 1/19/05. Although Patient #9

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initially had a nasogastric tube in place for liquid feedings due to dysphagia, on 1/20/05, the patient underwent surgery for the placement of a gastrostomy tube (G-Tube). Liquid feedings through the G-Tube began on 1/22/05. Review of the medical record identified that Patient #9 was brought into the hyperbaric chamber on 2/1/05 at 10:00 AM. Hyperbaric Technician #1 (HBT #1) was in the role of the inside observer and remained in the chamber with Patient #9. HBT #2 was identified as the Chamber Operator (C.O.) and remained outside the chamber. At 11:16 AM, Patient #9's fingerstick was checked and reported to MD #10 as 82. Interview with MD #10 on 3/24/05 at 3:10 PM identified that he was the supervising physician in the hyperbaric unit on 2/1/05. MD #10 stated that based on the patient's fingerstick, he ordered that Patient #9 received juice but that he was told by the technician that the patient was to have nothing by mouth. MD #10 stated that he then gave orders for Patient #9 to receive fifty percent dextrose and believed he instructed HBT #1 to give the dextrose through the patient's G-Tube. MD #10 gave the order to HBT #1 without affirming the scope of the technician's practice and/or the technician's ability to perform the administration of dextrose. MD #10 stated that he asked HBT #1 if he wanted him to "lock in" (to enter the chamber) but that HBT #1 responded, "No." Interview with HBT #1 on 3/24/05 at 3:45 PM identified that the glass syringe filled with dextrose had been drawn up the previous week because of concerns relating to Patient #9's blood sugars and was already in the chamber. HBT #1 stated that he administered the fifty percent dextrose intravenously (IV) to Patient #9. HBT #1 stated that he removed the cap of the syringe and connected it to the needless connection of Patient #9's PICC line in the left arm. HBT #1 stated that he did not check or flush the IV line prior to pushing the dextrose nor did he flush the IV line after the administration. Review of facility policy directed that PICC lines must be flushed with ten cc. of normal saline and two cc. of Heplock before and after each use. HBT #1 stated that although he had experience in starting IV lines from a previous job, he had never administered IV medication to a patient prior to 2/1/05. HBT #1 stated that he felt comfortable administering the dextrose and that he had refused MD #10's offer to come into the chamber. In addition, further interview with MD #10 on 3/24/05 identified that after the dextrose was admininstered, he requested that the patient's liquid feeding be brought from the nursing unit to the Hyperbaric Medicine Unit for infusion during therapy. MD #10 stated that the feeding materials were placed into the hatch, that he observed HBT #1 connect the feeding, but that based on the angle of Patient #9's body, he could not actually see where HBT #1 connected the feeding and thought HBT #1 had connected the

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feeding to Patient #9's G-Tube. MD #10 gave instructions to HBT #1 without affirming the scope of the technician's practice and/or the technician's ability to connect the feeding appropriately. Further interview with HBT #1 on 3/24/05 identified that the liquid feeding was passed to him through the hatch and that he connected the feeding to the same IV line (PICC line) he had used to administer the dextrose. HBT #1 stated that at the time, he was not aware of the difference between a G-Tube and an IV line. HBT #1 stated that he had never initiated a feeding prior to the 2/1/05 incident, that he did it because the physician ordered it, that he did not ask for assistance, nor did he tell anyone he had never done it before. Although review of MD #10's progress note dated 2/1/05 identified that Patient #9 had received the dextrose and liquid feeding through the G-Tube, review of the hyperbaric flow record identified that Patient #9 was connected to the tube feeding via IV at 11:44 AM with a drip rate of thirty cubic centimeters (cc.) per hour. Review of the HBT job description lacked direction for responsibilities that included the administration of any medications and/or the performance of any skilled procedures. Review of facility documentation identified that HBTa are employed by a contracted service and would be supervised for any patient care duties in the Hyperbaric Program by the Medical Director. Although the facility had a system in place for adult Intensive Care Unit (ICU) and Pediatric ICU patients to be accompanied into the chamber by a qualified hyperbaric nurse, the facility lacked a system to address direct nursing supervision for medically complex patients from the regular inpatient units. Interview with the Nurse Manager of the Hyperbaric Medicine Unit identified that although nursing staff was available in the wound clinic area, that at the time of the incident on 2/1/05, there was no nurse assigned specifically to oversee the chamber room. The Nurse Manager stated that the physician on duty provided the supervision and oversight of the operation of the chamber and of the hyperbaric technicians. The record identified that Patient #9's treatment ended at 12:21 PM. Review of the nursing note dated 2/1/05 identified that Patient #9 returned to the nursing unit at 1:10 PM. The documentation identified that RN #8 observed that the feeding was connected to the patient's PICC line, stopped the infusion, and notified the physician. Review of the progress note dated 2/1/05 identified that the physician discussed the incident with Patient #9's spouse and that a decision was made to continue the current course of Comfort Measures Only (CMO) due to the patient's expected demise as a result of chemically induced respiratory failure. Patient #9 expired at 4:33 PM on 2/1/05.

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The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (C) Medical Staff (B) and/or (D) and/or (e) Nursing service (1).

17. Based on review of the medical record, review of facility policies, and interviews, the facility failed to provide a complete assessment by a qualified professional after one patient experienced changes that required medical intervention during a hyperbaric treatment. The findings included:
    a. Patient #9 had diagnosis that included Insulin Dependent Diabetes (IDDM), a history of Cerebral Vascular Accident (CVA,) and End Stage Renal Disease (ESRD) that required peritoneal dialysis. Review of the medical record identified that Patient #9 was admitted to the facility on 12/29/04 for treatment to an infected left thigh wound. Treatment for the wound included antibiotics, and surgical debridement of the wound. On 1/19/05, Patient #9 began treatments of hyperbaric therapy at the facility's Center for Wound Healing and Hyperbaric Medicine. Interview with Hyperbaric Technician #1 (HBT #1) on 3/24/05 at 3:45 PM identified that he performed an "assessment" of Patient #9's status on 2/1/05 prior to entry into the hyperbaric chamber. HBT #1 stated that the "assessment" included a check and documentation of the patient's vital signs that included blood pressure, pulse, respirations, and blood sugar. HBT #1 stated that he was the inside observer in the chamber, the staff member who remained inside the chamber with the patient during the treatment. During the treatment process on 2/1/05 from 10:21 AM to 12:21 PM, Patient #9 experienced a low blood sugar that required physician directed intervention. In addition, Patient #9's tube feeding was inadvertently connected to the patient's a Peripheral Intravenous Catheter (PICC) line rather than her gastric tube by HBT #1. Although the facility had a system in place for adult Intensive Care Unit (ICU) and Pediatric ICU patients to be accompanied into the chamber by a qualified hyperbaric nurse, the facility lacked a system to address direct nursing supervision for medically complex patients from the regular inpatient units. HBT #1 stated that during the treatment, he continued to monitor Patient #9's vital signs and that he did not observe any symptoms as a result of the inadvertent connection of the tube feeding. The record identified that the treatment ended at 12:21 PM. Although Patient #9 had multiple invasive lines and had required medical interventions during the hyperbaric treatment, review of the flow sheet lacked documentation to reflect that a complete assessment by a physician and/or registered nurse prior to the patient's return to the inpatient unit that included verification of appropriate

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placement of a feeding line connected by HBT #1. Review of the nursing note dated 2/1/05 identified that Patient #9 returned to the nursing unit at 1:10 PM. The documentation identified that RN #8 observed that Patient #9's liquid feeding was connected to the PICC line instead the gastric tube, that she stopped the infusion, attempted to aspirate the liquid feeding from the line, notified the physician, and that the PICC line was removed. Review of the progress note dated 2/1/05 identified that Patient #9 experienced respiratory distress most likely directly related to the administration of tube feeding through the PICC line.

The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (C) Medical Staff (B) and/or (D) and/or (e) Nursing Service (1).

18. Patient #11 was admitted to the facility on 1/4/04 with diagnoses that included liver failure. Patient #11 expired on 1/22/04 from complications related to multiple co-morbidities. Review of the medical record identified a signed but incomplete discharge summary. Interview with MD #18 on 4/6/05 identified that although he began the dictation for the discharge summary, he realized that he was not the physician of record responsible for the dictation and returned the responsibility to the medical record department to notify the appropriate physician. MD #18 stated that he must have inadvertently signed the discharge summary along with many others and did not realized that the summary was still incomplete.

The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (7).

19. Patient #12 was admitted to the facility on 10-26-2004 for the removal of an implantable cardioverter defibrillator and placement of an implantable cardioverter defibrillator/biventricular pacemaker. The patient had a history of congestive heart failure, coronary artery disease, cardiomyopathy, atrial fibrillation, atrial flutter, chronic ischemic heart disease, hypercholestrolemia, chronic renal failure, and Diabetes Mellitus with retinopathy, polyneuropathy, and gangrene of the foot. Facility documentation, dated 10-26-2004, identified that Patient #12's genitourinary system was normal. Facility documentation, dated 10-26-2004 and 10-27-2004, identified that Patient #12 was voiding without difficulty. Facility document, dated 10-28-2004, identified that RN #6 inserted a urinary catheter intra-procedure for Patient #12. Interview with RN #6, on 03-31-2005, identified that there was no documentation with regards to difficulty inserting Patient #12's urinary catheter, that the color of the urine upon catheter insertion and when

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the patient left the Interventional Electrophysiology (EPS) Laboratory was clear yellow. Facility documentation, dated 10-28-2004 identified that Patient #12 arrived to the Post Anesthesia Care Unit (PACU) with hematuria, rose colored, and a urology consult was ordered. Facility documentation, dated 10-28-2004 at 06:00p.m., identified Patient #12 experienced catheter trauma with hematuria while transferring from the procedure table to a bed. Facility documentation, dated 10-29-2004, identified Patient #12 had a urinary catheter placed on 10-28-2004 which was tugged on with resultant hematuria with blood clots and a diagnosis of benign prostatic hypertrophy (BPH). Facility documentation, dated 10-31-2004, 11-01-2004, and 11-02-2004, identified that the indwelling urinary catheter was removed on 10-31-2004 and subsequently Patient #12 was intermittently catheterized by the facility staff, voided on his own on 11-01-2004 once and on 11-02-2004 six times and was discharged to home with an indwelling urinary catheter.

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

20. Patient #14 walked into to the Emergency Department (ED) on 08-02-2004 at 7:18 p.m. for complaints of weakness, sleepiness, fatigue, nausea, bloating, decreased appetite, and diarrhea for the past month and an elevated blood urea nitrogen (BUN) identified on 08-02-2004. Facility documentation identified that Patient #14 was assessed by the triage nurse upon arrival to the ED and was a priority 3 level. Facility Triage Policy identified a patient triaged to a priority 3 level should be assigned to a treatment area or be observed, by a care provider, in the waiting area until placed in a treatment area. Facility documentation identified that the physician examined Patient #14 at 03:40 a.m., more than eight hours after arrival in the ED, and subsequently Patient #14 was admitted for renal failure. Interview with the Nursing Director of the ED, on 03-29-2005, identified that the ED time interval goal-from ED triage to physician examination- is 90 minutes for a patient who was triaged to a priority 3 level and would expect the patient to be examined by a physician sooner than the time interval that Patient #14 experienced on 08-02-2004. Facility documentation titled "Audit Report-August 9, 2004 –Intervals to Events" identified that the average time interval from ED Triage to physician examination for priority 3 patients, for the week ending 08-08-2004, was one hour and 41 minutes.

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

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21. Based on review of the medical record, review of facility policies, and interviews, the facility failed to provide a private setting during a psychiatric evaluation for one patient, Patient #26, and to ensure that a complaint related to the lack of privacy expressed by a family member of the patient, was investigated and responded to in accordance with facility policy. The findings included:
    a. Patient # 26 was brought to the Emergency Department (ED) on 12/8/04 with mental status changes. Review of the ED record identified that a family member, Person #4, reported that Patient #26 had increased agitation and confusion. The ED record identified orders that included a psychiatric evaluation. Based on written information submitted by Person #4 on 1/16/05, Person #4 stated that Patient #26's psychiatric evaluation took place in the hallway of the ED and felt that Patient #26's right to privacy had been violated. Interview with Physician's Assistant #1 (PA #1) on 3/23/05 at 11:10 AM identified that he recalled that Patient #26 was placed in the hallway of the ED where the blue and red corridors meet due to high census in the ED, the unavailability of a room, and Patient #26's lack of need for specialized monitoring. PA #1stated that if a patient was waiting in a hallway and that patient required privacy during an interview, that options included a temporary use of the trauma room and/or to delay the interview. PA #1 stated that the consultant could initiate that response. PA #1 stated that the ED was very busy and that there were many people moving about the hallways. PA #1 stated that although he was unable to recall the family's exact words, that the family expressed general concerns related to privacy but that he did not report the concerns to Patient Relations or the Privacy Officer. Interview with Advance Practice Registered Nurse #3 (APRN #3) on 3/23/05 at 11:30 AM identified that she did perform Patient #26's psychiatric intake evaluation while the patient remained in the ED corridor. APRN #3 stated that alternatives to performing the evaluation in the hallway would have been to transfer the patient to the psychatric area of the ED (the Purple Pod) or to delay the interview. APRN #3 stated that although it was possible that the family complained about privacy issues, she did not recall the complaint. Review of facility policy identified that patients and/or their family may initiate a complaint with any member of the health care team. The policy directed that any complaints concerning patient privacy with respect to protected information would be referred to Patient Relations and the Privacy Officer.

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The above is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (C) Medical Staff (F).

22. Based on review of the medical record, review of facility policies, and interviews, the facility failed to ensure that pain assessments/reassessments for two patients identified with ongoing pain issues. Patients #27 and #28 were consistently documented. The findings included:
    a. Patient #27 was admitted to the facility on 3/4/05 with diagnoses that included an infected amputation site. Review of care plan dated 3/22/05 identified the patient's need for pain management with interventions that included use of the pain scale. Review of the medical record identified physician orders dated 3/22/05 for renewal of Dilaudid one to two milligrams (mg.) intravenously (IV) every two hours as needed for pain. Review of the daily nursing assessments/flow sheets from 3/4/05 through 3/23/05 with facility staff lacked documentation to reflect that Patient #27's pain assessments and reassessments were consistently monitored in accordance with facility policy.
    b. Patient #28 was admitted to the facility on 2/18/05 with diagnoses that included End Stage Renal Disease (ESRD) and a decubitus ulcer on the coccyx. An admission assessment described Patient #28 to "moan(s) a lot" and identified that the patient had a history of chronic pain. Review of care plan dated 3/22/05 identified the patient's need for pain management with interventions that included use of the pain scale and using the most appropriate scale for cognitive level. Review of the medical record identified physician orders dated 3/22/05 for renewal of a Duragesic Patch fifty micrograms (mcg.) to be changed every seventy-two hours for pain management. Review of the daily nursing assessments/flow sheets from 3/17/05 through 3/21/05 with facility staff lacked documentation to reflect that Patient #28's pain assessments/reassessments were consistently monitored in accordance with facility policy.

    Review of facility policies on pain management directed that pain intensity would be assessed and documented at regular intervals, after any known pain-producing event (at least every shift) and after each pain management intervention once sufficient time had elapsed for the intervention to reach peak effect.

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

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

23. Patient #29 had a history of alcohol use of three beers a day, COPD, and asthma and was admitted to the facility on 3/10/05 for a left total knee replacement. A review of progress notes and nurse's flow sheets identified the patient became confused and agitated on 3/11/05 and was identified as having alcohol withdrawal symptoms. The patient was placed in bed with four side rails up between 3/11/05 and 3/14/05. Documentation was lacking of any physician order for the restraint use of four side rails or monitoring done. During an interview the Nurse Manager of CB6 stated the side rails were used to keep the patient in bed for safety and he was not able to put them down himself.
    a. Patient #29 was admitted to the facility on 3/15/05 due to alcohol withdrawal and agitation and was status post left knee replacement. A review of the medical record identified nurse's flow sheets and progress notes dated between 3/16/05 and 3/25/05 and on 3/27/05 documented the patient was placed in bilateral wrist restraints due to agitation, pulling off his oxygen, pulling at lines and tubes, and hitting the staff. A review of physician orders and nurse's flow sheets identified documentation was lacking for a physician order for restraint use, physician notification of the need for restraints, for any interventions tried, and for restraint monitoring done on 3/16/05, 3/20/05, 3/21/05,and 3/23/05.
    b. A review of Patient #29's plan of care for the 3/10/05 and 3/15/05 admissions identified documentation was lacking for any problem or interventions related to the need for restraint.

A review of the facility's restraint policy identified a device such as a side rail that restricts movement that the patient couldn't easily remove or exit from was a restraint. Medical restraint documentation should include alternative interventions considered or tried, a physician or other Licensed Independent Practitioner (LIP) notification and a written or verbal order obtained within 12 hours of restraint application and renewed daily, and the patient's plan of care should reflect the restraint use.

The above are violations of Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (c) Medical staff (2), and/or (4) (D), and/or (d), Medical records (3), and/or (e) Nursing service (1), and/or (i) General (7) and/or Section 46a-152.

24. Patient #29 had a history of alcohol use of three beers a day, COPD, and asthma and was admitted to the facility on 3/10/05 for a left total knee replacement, developed alcohol withdrawal, and was discharged on 3/14/05. A review of physician orders identified documentation was lacking for a discharge order for the patient.
    a. Patient #29 was triaged in the facility's ED on 3/15/05 at 10:10 a.m. due to agitation and shortness of breath, evaluated by the physician at 11:15 a.m.,

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had respiratory treatments and lab work done, and was admitted to the facility at 7:40 p.m. due to alcohol withdrawal. A review of the ED record identified the patient was placed on oxygen, had vital signs done at 11:15, 12:20, 1:20 and 7:00 p.m., had a foley, IV, and lab work done at 1:15 p.m., and had respiratory treatments at 11:20 a.m. and 12:10 p.m. Documentation was lacking for a triage assignment, respiratory rate, assessments for pain, mental status, respiratory status, discharge disposition and condition, and for any interaction with the patient between 1:20 p.m. and 7:10 p.m. During an interview the Nurse Manager of the ED stated their standard for reassessing the patient should be at least every two hours and documentation was lacking to reflect any assessments or discharge disposition.

b. A review of physician orders for Patient #29 identified orders for Dilaudid 1mg IV, Ativan 1 mg IV, and Ativan 2 mg IV lacked a frequency of administration. The medication administration record identified the patient was given Ativan 1 mg IV and Dilaudid 1mg IV at 1:15 p.m. and Ativan 2 mg IV at 7:10 p.m. Documentation was lacking for any assessment regarding the reason for medications or their effectiveness. A review of the facility's Unit Dose Medication Administration policy identified all orders must include the frequency of administration. A review of the facility pain policy identified pain must be assessed utilizing the pain scale rating and done for each episode of pain and after any pain management intervention.

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