

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
FACILITY LICENSING AND INVESTIGATIONS SECTION**

IN RE: University of Connecticut Health Center – John Dempsey Hospital of  
Farmington, CT – Licensee  
d/b/a John Dempsey Hospital of the University of Connecticut Health Center  
263 Farmington Avenue  
Farmington, CT 06032

CONSENT AGREEMENT

WHEREAS, the University of Connecticut Health Center – John Dempsey Hospital of Farmington, CT (hereinafter the “Licensee”), has been issued License No. 0065 to operate a general hospital known as John Dempsey Hospital, (hereinafter the “Facility”) under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the “Department”); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter “FLIS”) of the Department conducted unannounced inspections on various dates commencing on January 26, 2006, and concluding on June 8, 2006; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated May 10, 2006 and August 8, 2006 (Exhibits A and B, copies attached); and

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

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Steven L. Strongwater, its Administrator, hereby stipulate and agree and follows:

1. Within twenty-one (21) days of the execution of this Consent Agreement, the Facility shall develop and/or review and revise, as applicable, policies and procedures related to:
  - a. Verification of the accuracy of diagnostic information relative to radiological services with an emphasis on the radiological services performed when the facility's radiologist is not available;
  - b. Interventional Radiology clinical protocols, policies and procedures;
  - c. History and physicals performed by Resident Physicians and/or review of same by Attending Physicians;
  - d. Reporting changes of condition to the physician;
  - e. Patient assessment prior to and post medication administration for pain control; and
  - f. Operating room accounting practices for equipment and/or products.
2. Within thirty (30) days of the review and/or revision of policies and procedures identified in paragraph one (1), all residents, attending physicians and nursing staff shall, as applicable, receive education regarding said policies and procedures.
3. Within thirty (30) days of the execution of this Consent Agreement, the facility shall develop a process for the evaluation of resident medical staffs' competency in clinical areas, documentation of said competency and a process for remediation, if applicable. Documentation related to such evaluations shall be maintained by the facility and available to the Department for a period of three (3) years.
4. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator and Director of Nurses Services, shall ensure substantial compliance with the following:
  - a. Patient treatments, laboratory tests, therapies and medications are performed and/or administered as prescribed by the physician and/or in accordance with the Facility's policies and procedures;

- b. Physician Resident staff perform patient assessments in a timely manner and results of said assessments are communicated to the attending physician;
  - c. Patient care plans are reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations; and
  - d. The attending physician or covering physician is notified in a timely manner of any significant changes a patient's condition.
5. Within sixty (60) days of the execution of this document, the facility 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 facilities policies and procedures; and
  - b. Accuracy of medical care provided to patients, to include time notification of the Attending Physicians regarding significant changes of condition.
6. Within thirty (30) days of the execution of this document, the facility shall review and revise, as necessary, mechanisms to monitor and/or supervise interns and/or residents.
7. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department within said timeframe. Said individual assigned this responsibility shall submit monthly summary report which address the components of this document to the Department.
8. The individual designated as responsible for the implementation and monitoring of this Order shall meet with the Department and the designated Department's representative every three (3) months for the first year this order is in effect and then every six (6) months for the remaining duration of this Order.

9. The Licensee shall pay a monetary penalty to the Department in the amount of twenty-two thousand dollars (\$22,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The monetary penalty and any reports required by this document shall be directed to:

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

10. All parties agree that this Consent Agreement is an agreement with 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 Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
11. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
12. The terms of this Consent 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.
13. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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

UNIVERSITY OF CONNECTICUT HEALTH  
CENTER-JOHN DEMPSEY HOSPITAL OF  
FARMINGTON, CT - LICENSEE

9/22/06  
Date

By: Steven L. Strongwater  
Steven L. Strongwater, its Administrator

State of Connecticut  
County of Hartford

ss Farmington, Sept. 22, 2006

Personally appeared the above named Steven Strongwater and made oath to the truth of the statements contained herein.

**MARILYN H. GLENN**  
**NOTARY PUBLIC**  
MY COMMISSION EXPIRES OCT. 31, 2008

My Commission Expires: \_\_\_\_\_ Marilyn H. Glenn

- Notary Public
- Justice of the Peace
- Town Clerk
- Commissioner of the Superior Court

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

9/26/06  
Date

By: Joan Leavitt  
Joan Leavitt R.N., M.S., Section Chief  
Facility Licensing and Investigations Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A  
PAGE 1 OF 20

May 10, 2006

Steven L. Strongwater, Administrator  
John Dempsey Hospital  
263 Farmington Ave  
Farmington, CT 06032

Dear Mr. Strongwater:

**This is amended edition of the violation letter originally ddated May 9, 2006.**

Unannounced visits were made to John Dempsey Hospital on January 24, 25, 26, 27, 30, March 1 and 2, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through May 1, 2006.

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 24, 2006 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

It will not be necessary for you to bring a plan of correction to this meeting as Department staff will be discussing alternative remedies to address the non-compliance issues identified during the course of the inspection/investigation.

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

Respectfully,

  
Janet M. Williams, RN  
Public Health Services Manager  
Facility Licesning and Invetigations Section

  
Elizabeth S. Andstrom, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

JMW/ESA/DH/DJS:jpf

c. Medical Director  
President  
Complaints #CT4718; #CT4514; #CT4419; #CT5212; #~~CT4431~~; #CT3061 and #CT5049



Phone: (860) 509-7400  
Telephone Device for the Deaf (860) 509-7191  
410 Capitol Avenue - MS # 12HSR  
P.O. Box 340308 Hartford, CT 06134  
An Equal Opportunity Employer

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Hospital  
DATES OF VISIT: January 24, 25, 26, 27, 39, March 1 and 2, 2006

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) (A) and/or (B) and/or (D) and/or (d) Medical Records (3) and/or (i) General (4).

1. Based on record review and interviews for three of 11 patients, the hospital lacked a mechanism for resident supervision and competency evaluation; and/or failed to ensure that a first year resident physician notified the attending physician of an acute change in a patient's condition; and/or failed to complete a comprehensive medical plan for discharge. The findings include:
  - \*a. Patient #5 was admitted to the Emergency Department (ED) on 6/16/04 at 5:10 PM complaining of severe epigastric abdominal pain 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the medical record revealed the patient's past medical/surgical history included hypertension and ischemic mesenteric artery bypass grafts. Record review and interview with MD #5, (a first year radiology resident at the time of the patient's admission), identified an abdominal Magnetic Resonance Angiography (MRA) was completed on 6/16/04 at 10:08 PM and he interpreted the MRA preliminary report as no evidence of mesenteric occlusion. However, interview with the Medical Director of Radiology indicated that the MRA was misread by the resident and that the following morning the Director of Radiology identified mesenteric occlusion. The patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note revealed a mesenteric graft occlusion, necrotic bowel, a portion of colon that perforated with stool in the abdomen and no viable bowel was present. The Discharge Summary dated 6/17/04 indicated the patient was pronounced dead in the Intensive Care Unit (ICU) on 6/17/04 at 5:44 PM. The Medical Director of Radiology indicated radiology resident supervision between 5 PM and 8 AM was done by consulting the on-call attending radiologist via phone only when the resident had a question. MD #5 indicated he did not have any questions when reviewing Patient #5's MRA and therefore, did not call the covering attending radiologist that night. The hospital lacked a mechanism and policy for radiology resident supervision, resident competency evaluation and radiology interpretation discrepancy. Subsequently, the hospital developed the Supervision of Radiology Residents On-Call Policy that addressed radiology resident supervision and resident competency evaluation, as well as an Abnormal Imaging Policy for radiology interpretation discrepancy.
  - \*b. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. Review of the record identified the patient's blood pressure (BP) had decreased to 104/37 at 10:30 PM (from 162/63 at 10:15 PM) and oxygen saturation dropped to 89-90% on room air. The CSD Flowsheet noted that between 10:30 PM - 4:00 AM the patient had a urinary output of 40 cc (total) and the patient had received 150cc of IV fluid per hour and the BP range was 105/41-106/56 manually. Interview with RN #2 indicated the manual BP was higher than the automated BP and the patient's lower extremities were cyanotic and mottled. RN #2 indicated she called the physician three times during the night, however, she could not recall the times she called. Interview with MD #6, the on-call first year resident, identified he was called at 3:00 AM, indicated he saw the patient and was

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aware of the decreased urinary output. MD #6 could not recall if the patient's BP was high or low when queried. Although a review of Physician Orders and interview with MD #6 indicated he ordered a bolus of intravenous (IV) fluid at 3:30 a.m., physician progress notes lacked documentation of a physician assessment from 6/16/04 at 8:00 p.m. to 6/17/04 at 7:45 AM. The CSD Flowsheet indicated the patient received 1000cc of IV Lactated Ringer's at 5 AM and continued to be hypotensive and oliguric. Interview with RN #2 indicated that the third time she called MD #6, possibly after 5:15 AM, she communicated the gravity of the patient's condition to MD #6 and was told to wait until "rounds" in the morning and he would speak with the attending physician. Review of the record and interviews with MD #9, the third year surgical resident and MD #11, the attending surgeon, identified they were not notified of the low BP, low urinary output or the midnight laboratory values including creatinine level of 5.0 (normal 0.6-1.2) and white blood cell count (WBC) 16.2 (normal 3.8-10.6). MD #9 indicated that, if she were aware of the laboratory results, she would have returned to the hospital to examine the patient and would have notified the attending physician. Interview with the Chief of Surgery, MD #10 identified that the patient's change in condition should have been communicated via the lines of supervision to the attending physician. Review of the medical record revealed the patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note identified Patient #5 had a mesenteric graft occlusion, necrotic bowel and a portion of colon perforated with stool present in the abdomen. The hospital lacked evidence that the patient was assessed by a physician and received medical intervention in a timely manner between 10:30 PM and 7 AM (6/16/04-6/17/04).

- c. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain. The Operative Note dated 6/17/04 identified that the patient was taken emergently to the OR at 10:15 AM where it was identified Patient #5 had occluded the graft and had no viable small intestine or colon. Admission Physician Orders dated 6/16/04 directed lactate levels be drawn every six hours. However, review of the record and interview with MD #6 revealed lactate dehydrogenase (LDH) levels were completed every six hours, not serum lactate. A laboratory report dated 6/17/04 at 8:10 AM identified the patient's lactic acid level (lactate) was 19.5 (norm 0.5-1.9 mmol/L). Record review and interviews with MD #6, MD #9 and MD #11 identified lactate levels were not completed every six hours as per Admission Physician Orders.
- d. Patient #1 was admitted to the hospital on 7/15/05 with complaints of urinary retention and chronic constipation. The patient's past medical history included schizophrenia, borderline IQ and chronic constipation. Review of the record identified that the patient had a psychiatric consult during hospitalization. Interview with the attending medical physician, MD #3 indicated that the patient had elimination problems due to psychiatric issues. MD #3 identified that he had to speak to Patient #1 many times concerning his refusal of enemas. A Psychiatry Attending Sign-off Progress Note dated 8/9/05 failed to address toileting issues and recommended follow-up with a psychiatrist. The Consultation Policy indicated that the consulting physician examines the patient and documents recommendations in the patient's medical record. Review of the W-10 discharge Clinical Resume Form dated 8/18/05

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completed by the attending physician lacked a plan for psychiatric follow-up as per the consulting psychiatrist's recommendation.

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

2. Based on record review and interviews for one patient, the hospital failed to complete a patient's history and physical according to Medical Staff Bylaws. The findings include:
  - a. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain, 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the record indicated that after completion of the MRA, Patient #5 was admitted to the Cardiac Step-Down Unit on 6/16/04 at 10:30 PM. Review of the record and interviews with two surgical residents, MD #6 (first year resident at time of admission) and MD #9 (third year resident at time of admission) indicated that they examined the patient in the ED at approximately 7 PM. MD #6 documented the admission history and physical (H & P) in the record at 8 PM. Interview with MD #9 revealed that it was not required that the senior resident co-sign the junior resident documentation. Review of the hospital's Medical Staff Rules and Regulations revealed that residents may take medical histories and perform physicals under the supervision of a qualified physician. The Medical Staff Bylaws also identified that the attending physicians shall review and approve the H & P examination. Record review and interview with MD #11, the attending physician, identified he examined the patient the following morning on 6/17/04 after reviewing the MRA in radiology. Review of the Cardiac Step-Down Unit Structure Standards identified that it was the attending physician's responsibility to see and evaluate the patient within 8 hours of admission. Interviews with hospital personnel and review of the record identified that the patient's attending physician failed to examine and evaluate Patient #5 within 8 hours of admission as per hospital policy. The hospital lacked evidence that the residency staff performed the H & P under the supervision of a qualified physician and that the attending physician authenticated the H & P as per Medical Staff Bylaws.

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

3. Based on review of the medical records, review of facility policies and procedures, and staff interviews for six patients (Patients #1, #2, #3, #5, #10, and #11), the nursing staff failed to supervise and evaluate the care of the patients per facility protocol. The findings include:
  - a. Patient #1 was admitted to the hospital on 7/15/05 with complaints of urinary retention and chronic constipation. The patient's past medical history included schizophrenia, borderline IQ and chronic constipation. Physician Orders dated 8/13/05 directed to weigh the patient daily and Physician Orders dated 8/19/05, the day of discharge, at 8:10 AM directed that two soap suds enemas be administered to the patient. The Medical-Surgical Unit Flowsheets dated 8/13/05-8/19/05 lacked daily weights for 8/14/05, 8/16/05, 8/18/05 and 8/19/05. Review of the Medication Administration Record dated 8/19/05 lacked enema administration

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documentation. Interview with the Nurse Manager identified that the physician orders should have been implemented prior to discharge or a note as to why the enemas were not administered.

- b. Patient #2 was admitted to facility on 10/23/05 with chief complaints of suicide ideation, severely depressed and panic attacks. Review of the high risk assessment dated 10/23/05 identified that Patient #2 had a active suicidal intent and was admitted for safety and stabilization. Patient #2 was placed on fifteen-minute checks. Patient #4 was assessed with high risk behaviors including harm to self and/or others and was also on fifteen minute checks. On 10/25/05 at 11:00 PM, Patient #2 was seen talking to Patient # 4 near the medication room. At approximately 11:20 PM Patient #2 & Patient #4 were seen by mental health worker #1 outside of doorway of Room #1035 and walking to their rooms. RN #5 stated that Patient #2 seemed upset as she went to her room, shut the door and closed the curtains. Mental Health Worker (MHW) #1 stated that she went into Patient #2's room to check if she was ok however fifteen minutes later Patient #2 came out of her room and stated that Patient #4 raped her. Although Patient #4 admitted sexual contact with Patient #2, he stated that the entire act was consensual. Subsequently, both patients were placed on 1:1 observation. An arrest warrant was later issued for Patient #4 for sexual assault. Interview with MHW #1 and RN #5 indicated that they were at the nurses station when incident occurred. MHW #1 stated that one other nurse on the unit was in the medication room. MHW #1 stated that all the other patients were either in their rooms or sleeping except Patient #2 and Patient #4. Review of the staffing and assignment sheets dated 10/25/05 identified that although there were 7 patients total on the unit with 3 staff members assigned to these patients, adequate supervision of patients was lacking.
- \*c. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. Review of the record identified the patient's blood pressure (BP) had decreased to 104/37 at 10:30 PM (from 162/63 at 10:15 PM) and oxygen saturation dropped to 89-90% on room air. The CSD Flowsheet noted that between 10:30 PM - 4:00 AM the patient had a urinary output of 40 cc (total) and the patient had received 150cc of IV fluid per hour and the BP range was 105/41-106/56 manually. Although, a Nurses' Note dated 6/17/04 indicated the physician was informed of the decrease in urinary output, documentation lacked the time of notification. Interview with RN #2 indicated the manual BP was higher than the automated BP and the patient's lower extremities were cyanotic and mottled. RN #2 indicated she called the physician three times during the night, however, she could not recall the times she called. Interview with MD #6, the on-call first year resident, identified he was called at 3:00 AM, and MD orders indicated that he ordered a bolus of intravenous (IV) fluid at 3:30 AM. The CSD Flowsheet indicated that although the patient received 1000cc of IV Lactated Ringer's at 5 AM, the patient continued to be hypotensive and oliguric. Interview with RN #2 indicated that the third time she called MD #6, possibly after 5:15 AM, she communicated the gravity of the patient's condition to MD #6 and was told to wait until "rounds" later in the morning and he would speak with the attending physician. Review of the medical record revealed the patient was taken emergently to the Operating Room (OR) on 6/17/04 at 10:15 AM for an exploratory laparotomy. The Operative Note identified Patient #5 had a mesenteric

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graft occlusion, necrotic bowel and a portion of colon perforated with stool present in the abdomen. The hospital lacked evidence, including clinical documentation, that nursing staff communicated the patient's continuing deterioration in condition in a timely manner between 10:30 PM and 7 AM (6/16/04-6/17/04).

- d. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the hospital on 6/16/04 at 4:46 PM complaining of severe abdominal pain, 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. The hospital's Pain Policy indicated that assessment of medication effectiveness was conducted every 4 hours or more frequently with unrelieved pain. Review of the medical record and interview with RN #2 identified that the patient was extremely restless, not wanting to stay in bed and complained of abdominal pain 5/10 (12-2 AM) and 9/10 (4-6 AM) during the night on 6/17/04. Further review identified the patient received Dilaudid 2 mg at 11:45 PM (6/16/04) and 3 AM (6/17/04), however, documentation lacked reassessment for medication effectiveness. The record lacked pain documentation from 6-10 AM. The hospital failed to perform pain reassessment as per hospital protocol.
- \*e. Patient #3 was admitted to the facility on 7/27/05 with complaints of abdominal pain, nausea and vomiting. Patient #3 had a history of intra-abdominal ovarian carcinomatosis. Patient #3 was admitted to the oncology floor and started on nasogastric decompression with a nasogastric tube attached to low wall suction after partial resolution of a small bowel obstruction. Patient #3 had then been prepared for PEG placement by GI, however the PEG could not be placed by GI due to extensive compression of the stomach by tumor metastases. Patient #3 was then scheduled for Interventional Radiology guided PEG placement. Interview with RN #4 identified that prior to the procedure, he connected the compressed air line to Patient #3's nasogastric tube and had not realized that it was on. The patient subsequently became unresponsive, pulseless and hypotensive. Patient #3 was given CPR, intubated and sent to the ICU where she expired on 8/2/05. The autopsy report dated 8/3/05 identified that Patient #3 had expired from gastric perforation with associated pneumoperitoneum, pneumomediastinum, subcutaneous emphysema in the neck and bilateral upper extremities. Interview with MD #8 identified that he was not aware that RN #4 had connected compressed air to Patient #3's nasogastric tube. Prior to the procedure, MD #8 stated he had discussed with team that he was going to use a 60cc syringe to inject air into stomach, however, RN #4 connected the NGT to compressed air. Interviews with staff in Interventional Radiology failed to ascertain that standard protocols for use of compressed air were in place prior to the incident or that "time outs" were done subsequent to this incident as part of planned corrective action. MD #8 stated that he never uses compressed air for PEG placements in interventional radiology. Nursing staff failed to act under medical direction and to monitor the patient when compressed air was connected to the patient's nasogastric tube.
- f. Patient #10's diagnoses included depression and left shoulder pain. Physician's orders dated 2/27/06 included Oxycodone 5/325 milligrams every six hours as needed for pain. Nurses' notes dated 2/27/06 at 8:30 PM identified that the patient had a pain level of "7" on a scale of "1-10"; however, the medical record lacked documentation that the patient's pain level was reassessed. Review of the Pain Level Documentation with Nurse Manager #1 identified that although Patient #11 was medicated for a pain level of "5" at 10:40 AM, it lacked

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documentation of Patient #11's response to the Oxycodone.

- g. Patient #11's diagnoses included major depression and bipolar disorder. Patient #11 received an ECT treatment on 2/24/06 at 3:50 PM and vital signs were documented at 6:27 AM (prior to the treatment) and 6:00 PM. Patient #11 received another ECT treatment on 2/27/06 at 3:30 PM and vital signs were documented at 6:45 AM, 10:15 AM (prior to the treatment), and 8:00 PM. Review of the medical record with the Assistant Nurse Manager identified that post-ECT treatment, the medical record lacked documentation that vital signs were recorded every four hours for twelve hours according to physician's orders.

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

4. Based on review of the medical record, review of facility policies and procedures, and staff interviews for five patients (Patients #2, #4, #5, #9, and #10), the facility failed to initiate a care plan based on the patients' diagnoses and/or current condition. The findings include:
- a. Patient #9 was admitted to the acute inpatient psychiatric unit. The multidisciplinary treatment plan dated 9/20/05 identified that Patient #9 had altered health status as evidence by a fall risk, an impaired endocrine system, and an impaired cardiovascular status. Review of the medical record with Nurse Manager #1 identified that although an altered health multidisciplinary treatment plan was initiated on admission, the medical record lacked specific interventions to address Patient #9's diabetic and hypertensive status, including disease management and patient teaching related to discharge planning. Although Patient #9 was identified to be a fall risk, the medical record lacked daily assessments (per facility protocol) and specific interventions related to the patient's fall risk. The facility Treatment Planning Process identified that specific interventions, including nursing protocols, will be written in the plan. Further individualization of the treatment plan is accomplished by writing interventions for specific patient needs.
- b. Patient #10's diagnoses included urinary tract infection and depression. Review of the medical record with Nurse Manager #1 identified that although a urine culture and sensitivity was completed and an antibiotic was initiated on 2/27/05, the multidisciplinary treatment plan dated 2/28/06 lacked identification and/or specific interventions to address Patient #10's genitourinary status. The facility Treatment Planning Process policy identified that when additional problems are evident, the appropriate nursing problem will be initiated and a treatment plan will be developed.
- c. Patient #4 was admitted to the acute inpatient psychiatric unit on 10/23/05. Patient #4 had a history of multiple suicide attempts. Review of the high risk assessment dated 10/23/05 identified that Patient #4 had an active suicidal intent and history of assaultive behaviors. Patient #4 was placed on every fifteen-minute checks. Review of the psychiatric assessment dated 10/24/05 identified that Patient #4 wanted to hurt or cut himself and had multiple suicide and self-harming gestures. Patient #4 was placed on fifteen-minute checks, however, the multidisciplinary treatment plan and the initial nursing treatment plan dated 10/24/05 lacked specific interventions planned for Patient #4's diagnoses of suicidal and homicidal ideation.

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- d. Patient #2 was admitted to facility on 10/23/05 with chief complaints of suicide ideation, severe depression and panic attacks. Patient #2 had a long history of suicide attempts with seven inpatient hospitalizations in the last year. Review of the high risk assessment dated 10/23/05 identified that Patient #2 had a active suicidal intent and was admitted for safety and stabilization. Patient #2 was placed on fifteen-minute checks. Review of the initial psychiatric evaluation dated 10/23/05 identified that Patient #2 had been crying since the afternoon and was suicidal. Further review identified that Patient #2 had a history of multiple suicide attempts and multiple cutting and self-mutilating episodes in the past. Although Patient #2 was placed on fifteen minute checks, review of the multidisciplinary treatment plan and the initial nursing treatment plan dated 10/24/05 lacked specific interventions planned for Patient #2's diagnoses of suicide and severe depression.
- e. Patient #5 had a surgical history of superior and inferior mesenteric artery bypass grafts and was admitted to the Cardiac Step-Down (CSD) Unit with the diagnosis of abdominal pain on 6/16/04 at 10:30 PM. The Admission Documentation Policy indicated the RN would initiate the plan of care. Review of the clinical record and interview with hospital staff identified the record lacked a patient care plan as per hospital policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2), and/or (c) Medical staff (2)(B), and/or (e) Nursing service (1), and/or (g) Pharmacy (1), and/or (i) General(7).

5. Based on review of the plans of correction for violation letters dated 1/21/05 and 2/1/05, review of hospital documentation and interviews, the hospital lacked evidence that the plans of correction were completed within the timeframes identified. The findings include:
  - a. Review of the plan of correction (POC) for the violation letter dated 1/21/05 identified that the hospital's medication administration policy was to be reviewed in the Emergency Department's Physicians and Licensed Independent Practitioners monthly meeting, February 25, 2005. Review of hospital information and interviews with hospital staff identified that the hospital lacked evidence the policy was reviewed.
  - b. Review of the POC for the violation letter dated 1/21/05 identified that the Pharmacy would audit Pyxis discrepancies and random chart audits with outcome evaluation would be completed in the Emergency Department. Interviews with hospital staff identified that the hospital lacked evidence the audits were completed.
  - c. Review of the plan of correction (POC) for the violation letter dated 2/7/05 identified that a log of the cidex OPA test strip process for daily outdate checks would be kept in the Central Sterile Department. Review of the log and interviews with hospital staff revealed that daily checks were not completed.
  - d. Review of the plan of correction (POC) for the violation letter dated 2/7/05 identified that chart audits would be completed to review required intravenous documentation. Review of hospital documentation and interviews with hospital staff lacked evidence that the audits were completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i)

DATES OF VISIT: January 24, 25, 26, 27, 29, March 1 and 2, 2006

EXHIBIT A

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT  
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WERE IDENTIFIED:

General (7), and/or (l) Infection control (1).

6. Based on observations, record review and interviews for one patient, the hospital lacked evidence that laundry personnel handled dirty linen bags according to hospital policy. The findings include:
- During tour of the nursery, a housekeeper was observed in the neonatal intensive care unit handling dirty linen without gloves and gown. The hospital's Linen Policy and interview with the Infection Control Nurse identified laundry personnel handling dirty linen bags shall wear moisture resistant gloves and will take appropriate precautions when handling soiled linen (i.e. gloves and gowns).

The following 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 service (1), and/or (i) General (7), and/or (l) Infection control (1).

7. Based on record review and interviews for two patients (#6 and #8), the hospital lacked a physician order for isolation and/or a signed operative consent. The findings include:
- Physician Progress Notes dated 6/26/05 identified that Patient #6 had a post-operative wound infection and blood cultures were positive for Methicillin-resistant staphylococcus aureus (MRSA). Physician Progress Notes dated 6/26/05 recommended "gown and glove" and identified "precautions" on 6/27/05. Although interviews with nursing staff indicated isolation was implemented, the record lacked a physician order for isolation.
  - Patient #8 was transferred to the hospital on 1/21/06 from another acute care facility for an emergency coronary artery bypass graft (CABG). Review of the discharge summary and interview with MD #12 identified the patient went to the operating room (OR) on 1/31/06 for a "second look" exploratory laparotomy status post small bowel resection on 1/30/06. Although interview with MD #12 indicated a surgical resident had obtained an operative permit, the medical record lacked a signed operative permit for the "second look" exploratory laparotomy scheduled on 1/31/06.

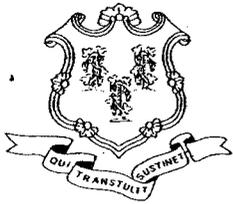
The following is a violation of the General Statutes of Connecticut Sections 19a-127n, as amended by section 123 of public act 03-278 and the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

8. Based on record review, interviews with hospital staff and review of hospital information, the hospital lacked a comprehensive adverse event report. The findings include:
- Patient #5 was admitted to the Emergency Department (ED) on 6/16/04 at 5:10 PM complaining of severe epigastric abdominal pain 10/10 (pain scale: 0-10, 10 = worst pain) that began at 12:30 PM. Review of the medical record revealed the patient's past medical/surgical history included hypertension and ischemic mesenteric artery bypass grafts. Record review and hospital staff interviews revealed the patient expired the following day after bowel infarction and septic shock. Review of the hospital's adverse event report, further record review and staff interviews identified that the hospital lacked evidence of an adequate investigation of the adverse event facts. Therefore, the hospital failed to adequately identify a

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comprehensive corrective action plan. Review of the hospital's corrective action plan failed to implement strategies that reduced the risk of similar adverse events occurring in the future, as well as, failed to develop and implement measures to evaluate the effectiveness of such strategies.



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B  
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August 8, 2006

Steven L. Strongwater, M.D., Administrator  
John Dempsey Hospital  
263 Farmington Avenue  
Farmington, CT 06032

Dear Dr. Strongwater:

Unannounced visits were made to John Dempsey Hospital on June 5, 6, 7, 8, 19 and 20, 2006 and July 18, 19 and 20, 2006 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a Licensing Renewal Inspection, a federal survey at the request of CMS and a follow-up to a plan of correction for a statement of deficiencies dated June 19, 2006 and a violation letter dated February 1, 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.

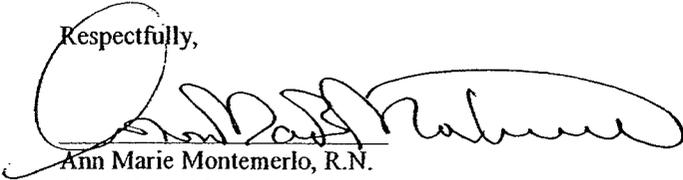
You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 22, 2006 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation 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, in-service 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,

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

AMM:zsj

- c. Director of Nurses  
vl.johndmphsp.doc  
CT #5346, CT #5223,  
CT #5602



Phone:

Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue - MS # \_\_\_\_\_

P.O. Box 340308 Hartford, CT 06134

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The following are violations of the Connecticut General Statutes Section 46a-152(d) and/or (d)(2) and/or violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Service (1).

1. Based on review of the facility quality improvement/clinical operations minutes and staff interviews, the facility failed to ensure that there was a mechanism in place to evaluate the quality of each contracted service and that the contracted services were provided in a safe and effective manner. The findings include the following:
  - a. Review of the quality improvement meeting minutes for the period of 1/05-5/06 indicated that there lacked documentation that contracted services e.g. hemodialysis, anesthesia, pediatric EKG readings, provided to the hospital were part of the Performance Improvement committee or were reviewed as part of the hospital wide quality assessment and performance improvement evaluation as other services provided directly by the hospital. While interviews revealed that these services are integrated into various hospital committees, there lacked documentation that the actual services were reviewed and/or evaluated by the Performance Improvement committee.
2. For Patient #20, the facility failed to ensure that the patient was monitored while in restraints. Based on review of the medical record, review of facility policy and staff interviews, the findings include the following:
  - a. Review of the clinical record of Patient #20 identified that on 6/1/06 the patient had an order directing the use of a vest restraint. Review of the restraint-monitoring sheet dated 6/1/06 indicated that there lacked documentation of restraint monitoring for the period of 12:00AM-9:00AM. The 9:00AM documentation indicated that the vest restraint had been removed. Review of the facility policy indicated that while a patient is in restraints, the patient will be assessed for fluid and fluid needs, toileting needs, skin integrity, range of motion and removal and reapplication of restraints every two hours. On 6/2/06, Patient #20 had an order for bilateral wrist restraints. Review of the restraint monitoring flow sheet dated 6/2/06 indicated that the patient had bilateral wrist restraints in place from 12:00 AM-6:00 AM. The flow sheet identified that the restraints had been released and reapplied at 2:00 AM and 5:00 AM, twice in an 8 hour period. Review of the nurse's note dated 6/2/06 at 6:00AM identified that the patient was noted to have sustained a reddened area under the right wrist restraint site and that the physician had been notified of the skin breakdown. The note identified that Tegaderm had covered the area. Review of the facility policy indicated the removal and reapplication should be completed every two hours.

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WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1)(A) and/or (c) Medical staff (2) and/or (d) Medical records (3).

3. Based on medical record review for Patient #30 and staff interview, the facility failed to ensure there was a mechanism in place for medical resident supervision. The findings include:
  - a. Review of the clinical record for Patient #30 identified that the patient was initially seen at the outpatient psychiatry clinic in 8/03 for medication management. Review of the record indicated that the patient was being seen every three months by the resident staff. Review of the record indicated that MD #15 who is a PGY 4 had been seeing the patient since 12/04. Review of the progress notes dated 12/2/04, 8/3/05, 12/21/05 and 3/15/06 identified that there lacked documentation that an attending physician oversaw the care provided by the Resident (PGY4). Interview with the Medical Director and the Chief of Psychiatry indicated that PGY 3's see patients in conjunction with the Attendings and the progress notes are co-signed, however PGY 4's see the patients independently and the cases are discussed with the attending physician after the visit but there is not always documentation in the record to reflect this. The facility lacked a policy that addressed resident supervision.

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

4. Based on medical record review, review of facility policy and procedure, staff interview and observations, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for each patient e.g. Patients #5, #16, #21, #23 and #34. The findings include:
  - a. Patient #15 was admitted to the hospital on 4/22/05 with diagnoses of lumbar disc displacement and spondylolisthesis and underwent multiple surgical procedures of the spinal column. Following the surgical procedures and post-operative recovery period, Patient #15 was admitted to a hospital unit on 4/22/06 at approximately 10 PM with a PCA pump (patient controlled analgesia). Review of Patient #15's clinical record identified that vital signs were obtained shortly after the patient's arrival on the unit at 10 PM and were not obtained again until 1:45 AM, when the patient was found unresponsive, approximately 3 1/2 hours later. Interviews with the Director of Performance Improvement & Patient Safety on 6/7/06 and again on 6/14/06 identified that, per the hospital's patient controlled analgesia pain policy, a patient's vital signs were to be assessed every 2 hours.

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- b. Patient #16, with diagnosis that included Diabetes Mellitus and was on hemodialysis, was admitted on 6/2/06 with chest pain. Review of the medical record identified that the initial nursing database assessment on 6/2/06 lacked completion.
  - c. For one (1) of two (2) patients on hemodialysis, the facility failed to ensure that the patients weight had been obtained after the hemodialysis treatment. Review of Patient #21's dialysis treatment flow sheets dated 5/29/06 and 6/2/06, indicated that there lacked documentation that the patient had been weighed at the end of the dialysis treatments. Review of the facility policy indicated that at the end of the treatment, the patient should be assessed and the assessment should include comparing the pre and post dialysis weights to determine the amount of fluid removed.
  - d. Patient #23 had a history of breast cancer and was admitted to the facility on 6/1/06 due to dehydration, malignant ascites, nausea and vomiting. A review of physician orders identified vital signs and pulse oximetry were to be done every four hours, weights were to be done daily, and the physician was to be notified if designated vital sign parameters were not met. A review of the daily nursing flow sheets and progress notes identified documentation was lacking that vital signs and pulse oximetry were done every four hours and that daily weights were done. In addition, physician orders directed he be notified if the systolic blood pressure was less than 90. A review of the nurse's flow sheet identified on 6/3/06 that the blood pressure was 89/67. Documentation was lacking of physician notification.
  - e. A review of Patient #23's and Patient #34's IV lines identified they were labeled with a piece of tape and had the date 6/5/06 written on them. A review of facility policy and interview with the Nurse Manager identified that a standard label with the start date/time and expiration date/time should be used because it was not possible to determine whether the 6/5/06 date was a start date or end date.
5. Based on medical record review and review of facility policy and procedure, the facility failed to ensure for five (5) of six (6) care plans reviewed that nursing staff developed and/or kept current a nursing care plan for Patients #20, #21, #22, #23 and #27. The findings include:
- a. Review of the medical record for Patient #20 indicated that the patient had been admitted on 5/31/06 with expressive aphasia and to rule out a cerebral vascular accident (CVA). Review of the clinical record on 6/5/06 identified that there lacked a current care plan.
  - b. Review of the medical record for Patient #21 identified that the patient had been admitted on 4/26/06 with diagnoses of aspiration pneumonia, diabetes, acute renal failure and respiratory failure. During the patient's hospitalization, the patient had a tracheostomy, permacath placement and received hemodialysis, developed a small bowel obstruction and was started on parenteral nutrition. Review of the care plan on 6/5/06 indicated that the patient's active

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- problems were alteration in gas exchange and alteration in nutrition. The care plan failed to address the patients other issues related to dialysis or diabetes. Review of the care plan policy indicated that the RN or LPN is responsible for initiating; reviewing, updating and/or revising the care plan for each assigned patient.
- c. Patient #22, who was status post a fall, was admitted on 6/4/06 with complaints of syncope. Review of the medical record identified that the patient was identified as a high risk for falls. Review of the facility protocol for falls directed that an individualized fall prevention treatment plan would be developed for each patient based on the patient's risk for falls. Review of the patients Nursing outcomes/plan of care for falls, failed to identify individualized interventions.
- d. Patient #23 with a history of breast cancer was admitted to the facility on 6/1/06 due to malignant ascites, dehydration, nausea and vomiting. Physician orders directed the need for daily weights, vital signs and pulse oximetry every four hours. The patient underwent a paracentesis during which 2100 cc's of fluids was removed, received Dilaudid for pain as needed, was not able to take nourishment by mouth, was nauseous and vomited, required parenteral nutrition, and the insertion of a PICC line. A review of the patient's care plan identified Problem #1 as discharge planning and identified the intervention of "discharge planning protocol" but lacked identification of patient specific needs. Problem #2 identified educational needs regarding hospitalization and illness and identified the intervention of "admission protocol" but lacked specifics of what the patient needed education for or how to approach it. Problem #3 identified alteration in fluid volume with interventions that included IVF, labs, antiemetics, and to replace electrolytes as ordered. Problems, interventions, and goals were lacking regarding the nausea and vomiting, nutrition needs, post paracentesis monitoring, pain control, and fluid retention monitoring.
- e. Patient #27 was admitted to the facility on 6/1/06 with meningococemia. The patient was placed on respiratory isolation, had episodes of chest and musculo-skeletal pain, had a rash from the meningococemia, and required pain medication. A review of the patient 's care plan identified problems of pain control, IV's, pulse oximetry with desired outcomes but lacked any patient specific interventions. Problems, interventions, and outcomes relative to respiratory isolation, the rash, and any educational needs were lacking.
- A review of the facility's policy on Nursing outcomes/plan of care identified there were a list of categories of actual or potential problems as well as nursing standards (protocols, procedures) that staff must consider for each patient and identify if it was an active problem or not. Outcomes were identified but there were not references to what interventions were required for the patient problems

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identified. Where a protocol was identified, specific interventions within the protocol relative to the patient needs were not identified.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1).

6. Based on medical record review and review of facility policy for one (1) of one (1) hemodialysis patient reviewed, the facility failed to ensure that Patient #21 had a valid physicians order in place for an administered treatment. The findings include:
  - a. Review of Patient #21's hemodialysis treatment flow sheet dated 6/2/06 identified that the patient was being dialyzed with a 2.0 Potassium and 2.5 Calcium bath. The flow sheet further indicated that at 3:35 PM, the patient had a potassium level of 2.9 and was placed on a 4.0 Potassium bath. Review of the physician's orders indicated that there lacked a physician's order directing the administration of a 2.0 Potassium bath or the subsequent change to the 4.0 Potassium bath. Review of the corresponding physician order's indicated an order for a 3.0 Potassium and 2.5 Calcium bath however, the orders while signed by an RN had not been authenticated by a Licensed Independent Practitioner. Review of the facility policy identified that the physician's order should be checked prior to the start of the hemodialysis treatment to verify the orders.
  
7. Based on clinical record review and staff interviews, the hospital failed to ensure that patient clinical records were accurately written and promptly completed for five (5) patients, Patients #12, #13, #14, #15 and #30. The findings include:
  - a. Patient #12 was admitted into the Partial Hospital Program on Friday, June 2, 2006, and was to attend the program 5 days a week. The patient was identified with severe depression, had feelings of being overwhelmed and having feelings of killing herself but would not carry them out. Although the clinical record identified the patient participated in a safety plan, the content of the safety plan was not documented. In addition, a progress note dated Monday, June 5, 2006, identified that Patient #12 called and stated that she would not be coming to the program that day, but would return the next day. Interview with the Licensed Professional Counselor on 6/5/06 at 1:45 PM identified that a safety plan was discussed with Patient #12 at the time of the call, but not documented.
  - b. Patient #13 was admitted to the psychiatric unit on 5/31/06 with a diagnosis of dementia and a major depressive disorder. Patient #14 was admitted to the psychiatric unit on 5/19/06 with a diagnosis of schizophrenia with a history of threatening behaviors.

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The master treatment plans for Patients #13 and #14 were reviewed with the Nurse Manager on 6/5/06. The plans for both patients identified a problem related to an altered thought process but failed to identify specific interventions appropriate to the patients. The plans referred to a hospital protocol related to an altered thought process, but staff failed to identify which aspects of the protocol applied to the patients.

- c. Patient #15 was admitted to the hospital on 4/22/05 with diagnoses of lumbar disc displacement and spondylolisthesis and underwent multiple surgical procedures of the spinal column. Following completion of the surgical procedures, the patient was placed in the post anesthesia care unit (PACU) at 8 PM. The PACU records were reviewed with RN #11 and identified that although the PACU clinical record reflected that admitting, interim and discharge assessments were completed and the patient assessments were within normal limits, the printed computerized clinical record documentation did not reflect dates and times that the assessments were performed. RN #11 identified that some dates and times related to specific aspects of the assessment could be found elsewhere in the record, but the printed record did not allow for each assessment to be dated and timed.

In addition, following the PACU, Patient #15 was admitted to a hospital unit on 4/22/06 at approximately 10 PM. On 4/23/05 at 1:45 AM, NA #1 entered Patient #15's room to obtain routine vital signs. The patient was identified as snoring, had no obtainable blood pressure and her lips were blue. An emergency code was called, the patient was resuscitated, intubated and transferred to ICU. On 4/23/05, a neurological consult was obtained that identified the patient had suffered a cardiopulmonary arrest of unknown duration, occurring sometime within a 40 minute time period. The patient was identified as experiencing a severe ischemic anoxic brain injury with a lack of brain stem function. On 4/24/05, the patient was extubated with family present, and death was pronounced at 11:53 AM. Interview on 6/13/06 at 9:30 AM with MD #20, the pathologist, identified that the patient died from a massive saddle-type pulmonary embolism that completely blocked the patient's airway. The pathologist identified that pulmonary embolisms of this type are fatal and death is instant. The clinical record was reviewed with RN #10, RN #11 and the Risk Manager and failed to identify specific dates and/or times that care was provided to Patient #15 between 4/22/05 at 10 PM and 4/23/05 at 1:45 AM.

Interviews with the Director of Performance Improvement & Patient Safety on 6/7/06 and again on 6/14/06 identified that, per the hospital's patient controlled analgesia pain policy, a patient's vital signs were to be assessed every 2 hours. Review of Patient #15's clinical record identified that vital signs were obtained

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shortly after the patient's arrival on the unit at 10 PM and were not obtained again until 1:45 AM, when the patient was found unresponsive, approximately 3 1/2 hours later.

- d. Review of the clinical record for Patient #30 identified that the patient had been seen initially on 8/13/03. The clinical record indicated that the current treatment plan had been completed on 4/21/05. Interview with the Program Director indicated that the treatment plans are to be updated every six months.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (g) Pharmacy (4) and/or (i) General (7).

8. Based on observation, staff interview and review of facility policy, the facility failed to ensure that medications that required refrigeration were appropriately stored. The findings include:
  - a. During a tour of Surgery 7 on 6/6/06, observation identified the Pyxus medication refrigerator temperature, that contained medications, was fifty degrees and warm inside. Documentation was lacking that temperature monitoring had been performed and the freezer was a solid block of ice. A review of the policy for management of the unit medication refrigerator identified the temperature range should be between thirty-six and forty-six degrees, checked at least every twenty-four hours by authorized unit staff and that a temperature log would be maintained. If the temperature was outside the acceptable range, a call would be placed to Facilities for repair and to Pharmacy for disposition of the medications. During interviews with Surgery 7 staff, no one was able to identify whose responsibility it was to monitor the temperature and defrost the freezer.
  - b. During tour of the Labor and Delivery unit on 6/7/06, the medication refrigerator freezer that contained Cervidil suppositories, was observed compacted with ice build-up. Interview with the Pharmacist on 6/7/06 identified that nursing is responsible for the defrosting of the refrigerators/freezers.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (4).

9. Based on observation, staff interview and review of facility policy, the facility failed to ensure that drugs and/or biologicals were kept in a locked storage area. The findings include:
  - a. During tour of the pre-testing area of the Operating Suite on 6/5/06, the medication refrigerator was observed unlocked. Review of the facility policy on

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- the management of the medication refrigerator directed that all drugs requiring refrigeration shall be kept locked.
- b. An anesthesia cart in the outer core hallway of the OR suite was observed unattended and unlocked with the key hanging in the lock. Additionally, an unlocked difficult airway cart containing medications was observed in this same area.
  - c. During tour of OR #9, an unattended and unlocked anesthesia cart was observed. Additionally, an unlocked Latex box containing medications was observed on the floor of this OR.
  - d. During tour of the unattended Procedure Room 1, the key to the medication cabinet was observed stored in the unlocked drawer below the cabinet. Interview with the RN of that area identified the key should be on the nurse, not in the drawer.
  - e. During tour of the Cesarean Section OR on 6/7/06, an unlocked and unattended anesthesia cart was observed. Interview with the Chief of Anesthesia identified that the anesthesia carts should be locked at the conclusion of a case.
10. Based on observation and staff interviews, the facility failed to ensure that outdated drugs and/or biologicals were not available for patient use. The findings include:
- a. Anesthesia carts in the holding area of the Operating room suite contained expired medications vials of Romazicon that had expired on 4/05, and Naloxone HCl that had expired on 1/03 and 11/05, mixed in with regular medications.
  - b. Anesthesia carts in OR #7 contained expired medication vials of Metoprolol that had expired on 10/05, Benadryl that had expired on 4/05, and Dopamine that had expired on 9/04, mixed in with the regular medications.
  - c. A medication room in the OR suite was observed to contained tackle boxes with medications in them, piled on the floor. The one inspected contained expired Lidocaine medication dated '05. Interview with the Chief of Anesthesia on 6-8-06 identified that the OR anesthesia techs had the responsibility of checking the anesthesia carts for expired medications and to restock them. Additionally, he noted that the individual tackle boxes belonged to individual licensed staff who should check for out dated medications.
  - d. During a review made on 6/5/06 and 6/6/06 of medications in Interventional Radiology, sterile water, Urikinase, and Barium sulfate had expiration dates of 12/05, 6/1/06, and 4/06.
  - e. A review of medications in the Cancer Clinic identified Coumadin, Jantiva, Mag Ox, Amoxicillin, Lidocaine, Alamag plus, and normal saline that had expirations dates of 1/06, 5/06, 12/05, 8/05, 9/05, 7/05, and 2/13/06 respectively.

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- f. A review of medications on Oncology 6 identified multiple vials of depotassium, a study drug that had expired on 5/15/06.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (g) Pharmacy (1).

11. Based on review of facility documentation, observation and staff interview, the facility failed to ensure controlled drugs were accounted for and/or failed to follow facility policy for drug discrepancies. The findings include:
  - a. Review of the Oncology unit controlled drug discrepancy report on 6/5/06 identified a discrepancy for epidural Hydromorphone 2.5mg/250cc solution bags. The Pyxis machine that dispenses medication, reflected that three (3) IV bags of the epidural Hydromorphone 2.5mg/250cc bags were listed as being available in the machine, yet were not observed inside of the Pyxis drawer. Review of facility documentation and/or interview with the Director of Pharmacy on 6/8/06 at 12:45 PM identified the following: 1. On 5/2/06, a pharmacy technician actually delivered three bags of Hydromorphone 20mg/100cc IV bags to the Pyxis machine and entered the bags as epidural Hydromorphone 250cc into the Pyxis system. 2. A Pharmacist tried to correct the error on 5/2/06, placed the Hydromorphone 20mg/100cc bags into the correct drawer, and added the three bags into the Pyxis tracking system. 3. The Pharmacist failed to delete the error entry for the three bags of Hydromorphone 2.5mg/250cc. 4. The discrepancy continued from 5/2/06 to 6/7/06 until it was brought to the attention of the Pharmacy Director. Further interview with the Director of Pharmacy at this time identified that when nursing could not resolve the discrepancy they should have entered this into the Pyxis system, this would have generated a report in the Pharmacy department and in turn, an investigation by the Director of Pharmacy would have been conducted. The Director of Pharmacy indicated that she did not always receive the weekly, controlled substance inventory audit which nursing was responsible to complete nor were the monthly pharmacist reviews done for approximately the last six months. Review of the Automated Dispensing System policy on 6/8/06 noted all nursing units must perform a weekly inventory audit of all controlled substances in the Pyxis machine. Assigned pharmacy personnel will perform a monthly physical inventory of controlled substances. For any discrepancy that cannot be resolved by nursing, " unresolved " must be entered into the Pyxis system.

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

12. Based on observation and staff interview, the facility failed to ensure consistent oversight of the daily management of dietary services. The findings include:
- a. Observation on 6/7/06 at 10:15 AM identified a dietary aide clearing food debris and kitchenware from soiled trays with disposable gloves donned. The dietary aide removed the soiled gloves and proceeded to don clean gloves to empty the cleaned kitchenware from the dish machine. Subsequently, the Director of Food Services indicated the dietary aide should have washed his hands between glove changes. Subsequent to surveyor inquiry, the Dietary Aide was educated to wash his hands prior to donning clean gloves.
  - b. During a review of patient food storage refrigerators on Surgery 7 and in the Emergency Department, sandwiches were identified stored in individual plastic baggies with no date identified on the bags. During an interview the Director of Food Services identified the food should be labeled with the expiration date.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (2) and/or (7) and/or (l) Infection control (6).

13. Based on tours of the facility, staff interview and review of facility policy, the facility failed to ensure that supplies and/or equipment was maintained to ensure an acceptable level of safety and quality. The findings include:
- a. During tour of the pre-testing area in the holding area of the OR's, multiple outdated blood tubes dated from 10-05 to 1-06 were observed in Exam room 2.
  - b. The medication refrigerator in the OR med room lacked consistent temperature monitoring for the months of April '06, May '06 and June '06. Interview with the RN Clinical Manager on 6-5-06 identified that this is assigned to a nurse.
  - c. The refrigerator in the Anesthesia storage room of the Labor & Delivery OR suite contained vials of Zemuron and Succinylcholine medication and lacked the monitoring of the temperature. Interview with the Unit Manager identified that anesthesia noted there has been no log for the monitoring of the temperatures on that refrigerator.
  - d. The closets in the outer core of the OR's were observed with patient positioning devices and pillows on the floor. The floor was observed to have large amounts of dirt and dust on them. Interview with the RN Clinical Manager identified that the cleaning of these closets were the OR techs responsibility.

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- e. Observation of the breast milk freezer on 6/7/06 in the newborn area identified an excessive build up of ice with a bottle of breast milk covered in frost.
  - f. During a review of Interventional Radiology on 6/6/06, multiple blood collection tubes were observed with expiration dates of May 2006.
  - g. During tour of Oncology 6 on 6/5/06, clean chemotherapy spill kits were identified stored in the soiled utility room.
  - h. In the Emergency Department (ED) on 6/5/06, clean supplies that included betadine, handsoap, alcohol and hand lotion were stored in the soiled utility room. Additionally, a large, glass bottle of 95% Ethyl Alcohol was observed stored in the soiled utility room on the counter. During an interview, staff identified a physician poured the Ethyl Alcohol into a small container that contained a wick and lit it with a lighter in a treatment room to defog instruments before they were used. The facility lacked a policy or procedure for this. Based on surveyor inquiry, the facility removed the Ethyl Alcohol and will no longer allow this practice to be performed.
  - i. During tour in the ED, a patient was observed seated in a treatment room without staff in attendance, with a bag of insulin syringes in a drawer in the room. During interview, the Nurse Manager stated they should not have been stored there.
  - j. Tour of the adult and geriatric psychiatry units with the Nurse Manager on 6/5/06 identified that the specimen and nourishment refrigerators and/or freezers contained ice build-up several inches thick, rendering the freezers unusable. Interview with the Nurse Manager on 6/5/06 identified that the dietary staff were responsible for maintaining the nourishment refrigerators and nursing staff were responsible for the maintenance of the specimen refrigerators.
14. Based on observation, review of manufacturers recommendations and staff interview, the following was identified:
- a. Observation on 6/5/06 in the G.I. suite identified 2 (two) scopes in the storage closets that were observed touching the bottom of the closet.
  - b. During tour of the OR suite on 6/5/06, OR # 8 was observed having the door opened to the substerile room while surgery was in progress.
  - c. Review of the Central Sterile Supply biological log monitoring for the Sterrad sterilizer on 6/5/06 identified that the facility was checking biologicals on this equipment on a weekly basis. Review of the manufacturer's recommendation identified testing was to be done on a daily basis. Interview with the Manager of the Department identified that the facility lacked a policy for this practice. Additionally, review of the spore testing readout facility logs, lacked consistent 48-hour reading documentation per the manufacturer's recommendation.

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- d. During tour of the Central Sterile Supply wrapping area, an employee's duffle bag was observed underneath the counter.
- e. During tour of Medical/Surgical 4 on 6-6-06, the storage room was observed to contain patient's wound vac supplies in a box on the floor as well as sterile wrapped trach supplies dated between '03, '04, and '05. These supplies were mixed in with piles of patient clothing in plastic bags on the floor.
- f. A review of the monthly attendance for the members of the Infection Control Committee meetings for 2004, 2005 and 2006 to date identified the required department representatives from Faculty Practice, Neonatal, Infectious Disease, Pharmacy, Surgery, Administration, Facilities Management, Laboratory, OB/GYN, and Employee Health attended between 20% and 92% of the time. A review of the facility Infection Control Committee policy identified appointed departmental representatives were required to attend monthly meetings or send an alternate.

The following are violations of the Regulations of Connecticut State Agencies Section 19a-36-D35(c) Responsibilities of Director.

Chemistry

15. Based on a review of the clinical chemistry procedure manual, patient test reports, and interview with the supervisor, it was determined that the director failed to ensure that the normal ranges on the patient test report correlate with the normal ranges in the procedure manual. Findings include:

<u>Test</u>	<u>Proc. Manual</u>	<u>Pt. Test Report</u>
Glucose	74-106 mg/dl	75-115 mg/dl
BUN	6-20 mg/dl	8-24 mg/dl
Creatinine	M-0.9 mg/dl F-0.6-1.1 mg/dl	0.6-1.2 mg/dl
Chloride	98-107 meq/L	100-111 meq/L
Calcium (Total)	8.6-10.0 mg/dl	8.9-10.4 mg/dl
Bilirubin (Total)	0.4-1.4 mg/dl	0.3-1.2 mg/dl
Protein (Total)	6.2-8.1 g/dl	6.4-8.3 g/dl

FSH - Mid Follicular Phase 3.85-8.78 mIU/mL

3.83-8.78 mIU/mL

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (i) General (7).

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16. Based on review of the clinical record and interviews, the facility failed to ensure that all items utilized during surgery were accounted for at the completion of surgery. The findings include the following:
- a. Review of the clinical record for the hospital stay dated 1/10/06 indicated that Patient #19 was admitted for surgical repair of a ventral hernia. Review of the operation note dated 1/11/06 indicated that after the initial laparotomy was performed a retained foreign body was noted within the abdominal cavity. The foreign body was identified, as a large surgical visceral retained known as a "FISH." Interview with MD #16, the assistant surgeon for the 1/11/06 surgery for a large incisional hernia repair identified that during the surgery, the "FISH" was observed to be laying in the abdominal cavity. MD #16 stated that the "FISH" was not adhered and was lying unattached in the abdominal cavity. Interview with the Director of Performance Improvement indicated that on investigation it was determined the patient had a ventral hernia repair in February of 2004 and the "FISH" had been left in at that time. The Director of Performance Improvement indicated that MD #17 who performed the initial surgery is no longer at the facility but was involved in the review of the case and felt he always removed the "FISH" and was unsure how it could have happened.
17. Based on review of the clinical record, review of policies and interviews, the facility failed to have a mechanism in place to ensure that all items utilized during surgery were accounted for at the completion of surgery. The findings include the following:
- a. Review of the clinical record for the hospital stay dated 1/10/06 indicated that Patient #19 was admitted for surgical repair of a ventral hernia. Review of the operation note dated 1/11/06 indicated that after the initial laparotomy was performed a retained foreign body was noted within the abdominal cavity. The foreign body was identified as a large surgical visceral retainer known as a "FISH". Review of the clinical record dated 2/10/04 indicated that the patient was admitted for an incisional hernia repair. Interview with RN #9 indicated that she was the circulating nurse for the February 2004 incisional hernia repair surgery and that she remembered seeing a "FISH" on the equipment table but does not recall the time of this observation. Interview with RN #9 indicated that at the time of the February 2004 surgery, the "FISH" was not included in the sponge/equipment count. Review of the facility policy in place in 2004 identified that the "FISH" was not included in the final count.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (7).

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18. The facility did not assure that electrical devices in-patient areas were being inspected as required in NFPA 99 "Health Care Facilities."
- a. On 6/20/06 at 10:30 AM, the surveyor observed a component of the anesthesia monitoring equipment in OR #19, item number A00481, with a Clinical Engineering inspection date of 2/22/05 and failure to provide documentation that this patient care electrical device was inspected/tested as required in NFPA 99, Section 7-5.1.3, 7-5.2.2.1 and 7-6.2.1.2. Upon inquiry and through a review of the preventative maintenance records for this unit, it was determined that this required a Clinical Engineering PM and was removed from the Operating Room.

The following are violations of the Regulations of the Connecticut Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (2) and/or (3) and/or (e) Nursing service (1).

19. Patient #101 was admitted to the facility on 7-18-06 for an angiogram with croplasty procedure. Although review of the medical record identified a history and physical (H & P) dated 4/14/06, it lacked a current H & P.
20. Patient #116 was admitted to the facility on 7/17/06 for an ultrasound guided liver biopsy. Although the record contained a gastroenterology progress note dated 5/18/06, the medical record lacked a history and physical.
21. Patient #117 was admitted to the facility on 7/17/06 for a renal angiogram procedure. Although the record contained a hypertension/vascular note dated 6/22/06, the medical record lacked a history and physical.
22. Patient #123 was admitted to the facility on 7/19/06 for repair of the eyelid. Although the record through a consultation dated 7/5/06 identified that the patient had an extensive and complex medical history, the medical record lacked a history and physical.
23. Patient #102 who underwent a lung biopsy in Interventional Radiology on 7/18/06 failed to have documentation (vital sign monitoring and progress note) in the medical record post procedure that identified the whereabouts and condition of the patient from 9:10 AM, when the last vital signs were taken, until 10:05 AM when the patient was admitted to PACU for recovery. Review of the Conscious Sedation/Analgesia Flow Sheet identified that the patient received Xanax 1 mg at 8:20 AM, a time out was completed at 9 AM and the specimen was sent to Cytology at 9:15 AM. During interview the patient's nurse stated that after the procedure she accompanied the patient to x-ray for a chest x-

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ray to rule out pneumothorax and then took the patient to PACU. Review of the facility policy for documentation identified that a progress narrative should be written following a procedure.

24. For Patients #103 and 105, the facility failed to ensure that a history and physical was completed and in the record prior to surgery. The findings include:
- Patient #103 underwent radical neck surgery on 7/12/06. Review of the surgical record failed to provide evidence that a history and physical was completed and/or updated within seven days of surgery.
  - Patient # 105 underwent a cardiac valve replacement surgery on 7/12/06. Although the patient was seen for a cardiac review on 6/20/06 and a pulmonary review on 6/28/06 there failed to be an update notation of the patient's condition prior to the actual surgery on 7/12/06. Review of the facility's Medical Bylaws identified a failure to address the requirements of a surgical history and physical.

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

25. For Patient #108 with a known history of Alzheimer's Disease who was restrained during a hospitalization from 3/15/06 through 3/17/06, the following was identified:
- Review of the medical record for Patient #108 failed to identify that on the evening of 3/16/06 through the morning of 3/17/06 attempts were made to utilize the least restrictive manner of restraint. Although a nurse's narrative for that shift identified that the patient was confused and walking from room to room, the narrative failed to identify least restrictive interventions utilized prior to restraining the patient with a posey vest in a recliner with a tray in place. The narrative identified that the patient's attending physician was aware of the restlessness and the patient was given Ativan without noticeable effect. The medical record lacked an assessment for use of restraints and a flow record identifying interventions and patient response for the restraint period. During review of the physician's narrative dated 3/17/06 and interview on 7/20/06, the attending physician stated that she was aware of the patient's restlessness on the evening of 3/16/06. She requested the nurse give one dose of Ativan and if the Ativan was not helpful the nurse should utilize a 1:1 sitter. The physician stated that she was not notified of the use of vests and wrist restraint nor would she approve it. Review of the physician's orders identified that on 3/16/06 at 7:30 PM the patient's nurse initiated use of a posey vest and/or bilateral wrist

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restraints. Although the orders reflected that the attending directed the order, the order was not signed until 3/17/06 at 7:10 AM by the geriatric fellow. Additionally, a nursing narrative reflecting patient response while receiving constant observation on 3/15/06 through 3/16/06 was lacking. Review of the facility policy for Restraints: Acute Medical/Surgical directs that a progress narrative and assessment and care of the patient while in restraints must be documented on the restraint flow sheet. The progress narrative should reflect any attempts to reduce and/or eliminate restraints, patient reaction and plan of action.

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.