

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

IN RE: Bridgeport Hospital, Inc. of Bridgeport, CT d/b/a
 Bridgeport Hospital
 267 Grant Street
 Bridgeport, Connecticut 06610

STIPULATED AGREEMENT

WHEREAS, Bridgeport Hospital, Inc. of Bridgeport, CT (hereinafter the "Licensee"), has been issued License No.0040 to operate a general hospital known as Bridgeport Hospital, (hereinafter the "Facility") under Connecticut General Statutes 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 concluding on February 28, 2007 and May 11, 2007; 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 March 14, 2007 and June 18, 2007 (Exhibits A and B – copies attached); and

WHEREAS, the parties desire to fully resolve the matter without proceeding further; and

WHEREAS, it is expressly understood that the execution of this Stipulated Agreement, and any statements or discussions leading to the execution of this Stipulated Agreement, shall not be construed to constitute any admission or adjudication of any violation of the Regulations of Connecticut State Agencies and for Connecticut General Statutes by the Licensee, its officers, directors, agents, employees, or any other person or entity in any subsequent matter, proceedings, hearing or lawsuit.

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WHEREAS, the Licensee is willing to enter into this Stipulated 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 Robert Trefry, its Chief Executive Officer, hereby stipulate and agree as follows:

1. This Stipulated Agreement fully and completely resolves the allegations above without further proceedings.
2. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Stipulated Agreement. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.
3. The INC shall function in accordance with the FLIS's INC Guidelines (Exhibit C – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements for hospitals as identified in the Regulations of Connecticut State Agencies.
4. The INC shall provide consulting services for three (3) months. At the end of the three (3) month period, the Department may assess whether it is necessary for the INC to provide consulting services for an additional three (3) month period. The Department's assessment shall be based on the INC's reports and monthly meetings with the INC and Licensee pursuant to paragraphs 9, and 12, respectively. The INC shall be at the Facility fifteen (15) hours per week and shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Stipulated Agreement.
5. The INC shall have a fiduciary responsibility to the Department.

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6. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of the contract with the INC.
7. The INC shall confer with the Licensee's Chief Operating Officer (COO), Nursing Executive, Medical Director and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state laws and regulations.
8. The INC shall make recommendations to the Licensee's executive staff for improvement in the delivery of direct patient care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
9. The INC shall submit weekly written reports to the Department documenting:
 - a. The INC's assessment of the care and services provided to patients;
 - b. The Licensee's compliance with applicable federal and state laws and regulations; and
 - c. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
10. Copies of all INC reports shall be simultaneously provided to the Nursing Executive, COO, Chief Executive Officer (CEO), Medical Director and the Department.
11. The INC shall have the responsibility for:
 - a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services as it relates to:
 - i. Fall prevention and assessment of patients following a fall;
 - ii. Measures to prevent pressure sores;
 - iii. Assessment and treatment of pressure sores;
 - iv. Assessment of patients' hydration status including monitoring intake and output;

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- v. Oversight of the implementation of prompt training and/or remediation in any area in which a staff member demonstrates a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
 - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
 - c. Monitoring the implementation of the Licensee's plan of correction submitted in response to the violation letters dated March 14, 2007 and June 18, 2007 (Exhibits A and B).
12. The INC, the Licensee's CEO and/or COO, and the Nursing Executive shall meet with the Department every four (4) weeks for the first three (3) months of this Stipulated Agreement and thereafter at twelve (12) week intervals throughout the tenure of this Stipulated Agreement. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state laws and regulations.
13. Any records maintained in accordance with any state or federal law or regulation or as required by this Stipulated Agreement shall be made available to the INC and the Department, upon request.
14. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
15. Unless the Licensee has already done so pursuant to its plan of correction, within fourteen (14) days of the execution of this Stipulated Agreement, the Facility's Medical Staff shall review and revise, as necessary, procedures by which medical and/or surgical resident staff are supervised including but not limited to the evaluation of resident staff performance. Such procedures shall

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include a plan for remediation and appropriate supervision of resident staff based on performance reviews. The Facility's Graduate Medical Education Committee, which shall include a member of the Facility's Governing Authority, shall approve such policies and procedures. A summary of said performance reviews of resident staff, including plans for remediation and supervision, as necessary, shall be provided to the Graduate Medical Education Committee annually. The Chief Medical Officer of the Facility shall report to the Professional Quality Committee of the Board of Directors concerning the Facility's progress in complying with the requirements of this paragraph 15.

16. Unless the Licensee has already done so pursuant to its plan of correction, within fourteen (14) days of the execution of this Stipulated Agreement the Nursing Executive shall develop and/or review and revise, as necessary, policies and procedures related to:
 - a. Fall prevention protocols;
 - b. Notification of attending or covering physician when a significant change in patient condition occurs;
 - c. Prevention and treatment of pressure sores; and
 - d. Assignment and monitoring of hydration, status of patients at risk of dehydration.
17. Unless the Licensee has already done so pursuant to its plan of correction, within twenty-one (21) days of the effect of the Stipulated Agreement all Facility nursing staff shall be inserviced regarding the policies and procedures identified in paragraph number sixteen (16).
18. Unless the Licensee has already done so pursuant to its plan of correction, the Licensee shall, within fourteen (14) days of the execution of this Stipulated Agreement, review and revise, as applicable, policies and procedures relative to:
 - a. Physician orders for medication administration which at a minimum shall identify the medication, specific dosage ranges, route of administration and frequency;
 - b. Parameters for administration of pain control medication;

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- c. Patient assessment prior to and post-medication administration for pain control;
 - d. Follow up procedures for negative outcomes relative to medication administration; and
 - e. Prevention and remediation responses relative to medication administration.
19. As appropriate, the Medical Executive Committee of the Facility shall review and approve policies, procedures and protocols revised as a result of this Stipulated Agreement within thirty (30) days of said revisions.
20. Within fourteen (14) days of the execution of this Stipulated Agreement, the Facility shall appoint one of its employed pharmacists to be responsible for implementation of the requirements of this paragraph 20, who shall be licensed in Connecticut. For a period of one year, beginning and ending consistent with the timeframe set forth in the plan of correction, the pharmacist, or his or designee(s), shall participate in staff rounds and weekly audits of medical records of current patients on the medical and surgical intensive care units and throughout the hospital who are receiving titrated medications or continuous narcotic infusion. This designated pharmacist shall be responsible for the following:
 - a. Reviews of medication regime and potential for alterations to said medication regime;
 - b. Reviews of medication orders are ordered to ensure and/or administered in accordance with current standards of practice;
 - c. Reviews of clinical records to ensure that the patients' primary physician is notified in a timely manner regarding any concerns related to incomplete medication orders, adverse effects or contraindications for the medications;
 - d. Provides copies of reports of audits to the hospital Pharmacy and Therapeutics Committee on a monthly basis;
 - e. Participates in the Facility's Quality Assurance Program relative to issues pertinent to medication issues.
21. Unless the Licensee has already done so pursuant to its plan of correction, the Licensee shall within thirty (30) days of the execution of this Consent

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Agreement develop and provide inservice programs to appropriate Facility professional staff responsible for ordering and/or distributing and/or administering drugs which shall include but not limited to:

- a. Pharmacology regimes relative to pain control and their potential interactions with other medications and/or medical/physical conditions;
 - b. Current standards of practice relative to physician orders and/or protocols for medication, with emphasis on intravenous medications used for analgesia and/or sedation;
 - c. Pain assessments including physical/mental components;
 - d. Patient assessments prior to and post applicable medication administration.
22. Effective upon the execution of this Stipulated Agreement, the Licensee shall ensure substantial compliance with the following:
- a. Each patient care plan is 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;
 - b. Each patient's hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
 - c. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
 - d. Necessary supervision and assistive devices are provided to prevent falls.
23. The Licensee's Quality Improvement Program (QI) shall review patient care issues including those identified in the March 14, 2007 and June 18, 2007 violation letters. The members of the QI shall at least monthly review and address the quality of care provided to patients and, if applicable, implement remediation measures. The Pharmacy and Therapeutics Committee shall review data from the pharmacist derived as a result of the requirements of Paragraph #20. Minutes of the QI meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

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24. The Licensee's COO will monitor the requirements of this Stipulated Agreement.
25. The Licensee shall pay a monetary penalty to the Department in the amount of fifteen thousand dollars (\$15,000.00) by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within one month upon signing the Stipulated Agreement. The money penalty and any reports required by this document shall be directed to:

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

26. All parties agree that this Stipulated 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 Stipulated Agreement or of subsequent violations of any other statutory or regulatory requirements (i.e. violations other than those that are the subject of this Stipulated Agreement). 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 retains all of its rights under applicable law.
27. The terms of this Stipulated Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise expressly specified in this document.
28. The Licensee understands that this Stipulated Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the

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DEPARTMENT OF PUBLIC HEALTH

Licensee: Bridgeport Hospital, Inc

future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

29. The Licensee had the opportunity to consult with an attorney prior to the execution of this Stipulated Agreement.

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BRIDGEPORT HOSPITAL
1000 BRIDGEPORT AVENUE
BRIDGEPORT, CT 06610

Licensee: Bridgeport Hospital, Inc

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

**BRIDGEPORT HOSPITAL, INC. OF
BRIDGEPORT, CT - Licensee**

August 27, 2007
Date

By: [Signature]
Robert Trefry, its President

STATE OF Connecticut

County of Fairfield) ss 8/27, 2007

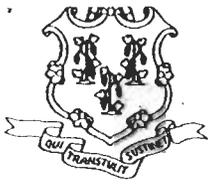
Personally appeared the above named Robert J. Trefry and made oath to the truth of the statements contained herein.

My Commission Expires: January 31, 2010
(If Notary Public) [Signature]
Notary Public
Justice of the Peace
Town Clerk
Commissioner of the Superior Court

**STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH**

8/28/07
Date

By: [Signature]
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and & Investigations
Section



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 15

March 14, 2007

Robert Trefry, President and CEP
Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610

Dear Mr. Trefry:

Unannounced visits were made to Bridgeport Hospital which concluded on February 28, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a follow up for a plan of correction violation letter dated June 14, 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 April 11, 2007 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,

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

ESA/HC/DH:jpf

c. Director of Nurses

Complaints #CT5755 and #CT5718



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

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

EXHIBIT A

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

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

1. Based on clinical record review and interview with facility personnel, the facility failed to ensure that the investigation of an adverse event involving Patient #2 and Patient #21 included all causal aspects of the event. The findings include:
 - a. Review of the adverse event for Patient #2 indicated that even though the corrective action plan addressed the need to implement preventive measures for patients at risk for falls, for which the facility implemented a new fall prevention plan, further review identified that the corrective action plan lacked documentation that issues with nursing and medical assessments, which impacted the outcome of the adverse event, were addressed in the facility performance improvement activities. Interview with the Chief Operations Officer on 1/18/07 identified that the facility focused on the fall prevention program and not other issues. (See A185, A204)
 - b. Review of the adverse event for Patient #21 indicated that even though the corrective action plan addressed a delay in utilizing surgical support, the corrective action plan failed to analyze how additional support and/or parameters would be utilized when an emergency happens in the operating room.

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 (4)(A) and/or (e) Nursing (1).

- *2. Based on clinical record review, facility documentation and interviews, the facility failed to implement preventive actions and mechanisms that included medical/nursing assessments, monitoring patients after an injury; the use of the proper chain of command throughout the hospital and protocols for surgical support when an emergency happens in the operating room. The findings include:
 - a. Review of the adverse event for Patient #2 indicated that even though the corrective action plan addressed the need to implement preventive measures for patients at risk for falls and a new fall prevention plan was initiated, further review identified that the corrective action plan failed to reflect that issues with nursing /medical assessments and issues with the chain of command were addressed in the facility performance improvement activities. The plan also lacked preventive actions throughout hospital. Interview with the Chief Operations Officer on 1/18/07 identified that the facility focused on the fall prevention program and not other issues.
 - b. Review of the adverse event for Patient #21 indicated that even though the corrective action plan addressed issues related to a delay in utilizing surgical support, the corrective action plan failed to address how additional support would be utilized when an emergency happens in the operating room.

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)(A) and/or (B).

- *3. Based on review of personnel records and interviews with facility personnel, the facility failed to

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED

provide remediation for poor resident evaluations. The findings include:

- a. Review of the personnel file of Medical Resident #3 identified that Medical Resident #3 was admitted to the residency program in 6/05 as a third year OB/GYN resident. Review of Resident #3's evaluations dated 9/05-1/07 identified that he required constant supervision and if allowed to function independently, there may be patient safety concerns. Review of hospital policy identified that when a concern arises with residents, there would be some type of remediation for the resident to improve. Interview with the Chairman of the OB/GYN residency program on 2/28/07 identified that when Medical Resident #3 came to program, he had very limited clinical skills and had improved, however the resident's performance reviews reflected no evidence of specific remedial actions or level of supervision required, to ensure patient safety. Upon interview, MD #8, the attending surgeon for Patient #21, stated that he was unaware of the resident's performance issues when the resident performed surgery on Patient #21.

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)(A) and/or (B) and/or (F).

- *4. Based on clinical record reviews and interviews with facility personnel, the facility failed to ensure the quality of care provided by the medical staff. The findings include:
 - a. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) with anticoagulant therapy. On 5/26/06 at 7:40am, Patient #2 was sitting in a wheelchair, and when attempting to stand, fell to the floor and hit her head on the examination table. Patient #2 sustained a laceration to the face, above the eyebrow (2cm), (peri-orbital/lateral) with orbital ecchymosis. Review of the Emergency Physician Notes dated 5/26/06 identified that PA #1 had sutured Patient #2's laceration. Upon interview, PA #1 stated that he had sutured Patient #2's laceration however, he did not perform a complete assessment. Although PA #1 identified that Patient #2's Attending MD (MD#1) was in the ED evaluating Patient #2, the admission assessment by MD #1 lacked documentation that Patient #2 had fallen and/or lacked a neurological assessment, and/or any other diagnostic tests related to Patient #2's fall. Interview with MD #1 identified that she thought the ED physician was handling the issues with Patient #2's fall and she was focusing on treating Patient #2's DVT and PE.
 - b. Review of progress notes dated 5/26/06 through 5/29/06 identified that following the fall with subsequent head injury, Patient #2's B/P ranged from 135/95, 156/97, 153/107, 154/102, 140/110, 160/110 and the patient was being treated with cardiac medications. Review of nurse's notes dated 5/28/06 at 6:05pm identified that Patient #2 was complaining of a headache and was given Tylenol. On 5/29/06 at 2:00am, Patient #2 had an unwitnessed fall. Patient #2 was found lying on the floor, incontinent of urine. Review of nurses notes identified that Patient #2 had no injuries noted. Further review of the nurses notes and paging records dated 5/29/06 identified that Intern #1 was notified of the fall, however upon interview on 1/18/07 Intern #1 denied being notified of Patient #2's fall. Progress notes dated

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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5/29/06 lacked documentation that Patient #2 was assessed by a physician. Further review of the morning progress notes dated 5/29/06 identified that even though MD #1 identified that Patient #2 had felt dizzy when going to the bathroom and fell, the progress notes lacked a complete/neurological assessment following the fall.

- c. Review of the nurses notes dated 5/29/06 at 8:50am identified that Patient #2 had periods of confusion during the night. On 5/30/06 at 5:30am, Patient #2 fell again on the floor near the bathroom. Patient #2 reported hitting her head and elbow. Review of the nurses notes dated 5/30/06 identified that Intern #2 was notified that Patient #2 had fallen and was complaining of a headache. Further review identified that Intern #2 had given an order for Tylenol. Upon interview on 1/8/07, Intern #2 denied being notified that Patient #2 had fallen. Review of the nurses notes dated 5/30/06 identified that MD #1 had evaluated Patient #2 and removed her sutures. Review of the morning progress notes dated 5/30/06, and written by MD #1, identified that Patient #2 was complaining of a headache, B/P 140-160's, less dizzy but still not able to stand without unsteadiness. Further review failed to reflect any information in the progress notes regarding the patient's most recent fall or any mention of a neurological assessment subsequent to the fall and/or removal of sutures. Review of hospital policy and interview with the Director of Internal Medicine and the Residency Program identified that Interns are to respond to calls to assess patients with acute problems on the hospital floors in a timely manner. Further interview identified that when a patient falls the expectation is to see the patient within 30 minutes. Further interview identified that the senior resident on night call checks regularly with interns to assure that they have performed their duties during the night call. Subsequently, on 1/23/07 the policy for supervision of interns on night call was changed so that the senior resident checks with interns more often during the night call at a minimum of two times a shift.
- d. After Patient #2 had fallen on 5/30/06 at 5:30am, the nurses notes dated 5/30/06 identified that Patient #2 was having an increase in mental status changes with a B/P of 162/112. MD #2 (MD #1's partner) was notified immediately and requested the teamcare intern to evaluate Patient #2. MD #2 ordered a stat CT scan of the head. Progress notes dated 5/30/06 lacked documentation that Patient #2 was evaluated by a intern/resident from teamcare until Patient #2 was transferred to the intensive care unit. Review of the CT scan report dated 5/30/06 at 2:47pm identified that Patient #2 had a large left subdural hematoma with approximately 1 cm of midline shift to the right. Further review of the CT scan report dated 5/30/06 at 5:09pm identified that Patient #2 had a left-sided subdural hematoma unchanged and a new right subdural hematoma. Patient #2 was sent to the medical intensive care unit. Patient #2 underwent bilateral craniotomies and evacuation of subacute and subdural hematomas. Review of the discharge summary dated 10/24/06 identified that Patient #2 was discharged to a skilled nursing facility in a permanent vegetative state, status post tracheostomy and PEG placement. Review of hospital policy and interview with the Director of Internal Medicine/Residency Program identified that when a patient has an acute condition, a progress note is to be written identifying the assessment, plan, and the name of the attending physician with whom the care plan had been discussed.
- e. Patient #21 underwent a Versapoint Hysteroscopic removal of submucous fibroids and a

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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dilatation and curettage and a removal of a intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Review of the ambulatory surgery medical examination dated 1/16/07 and the anesthesia pre operative assessment failed to identify that a hematocrit (HCT) was included in the medical record. Interviews with hospital personnel identified that while Patient #21 was having complications, MD #8 called his office to find out what Patient #21's hematocrit was prior to surgery. Review of hospital policy identified that a hematocrit is to be completed preoperatively if a patient has a history of blood loss. Patient #21 had multiple complications post operatively and expired due to exsanguination.

- f. Patient #21 was taken to the operating room at 12:02pm. Medical Resident #3 performed surgery while MD #8 was visualizing on camera. Review of the operative reports dated 1/16/07 identified that during the procedure, an attempt to remove the submucous fibroid was unsuccessful due to a stalk noted to be thick. A decision was made to amputate the fibroid with the Bovie on cautery. It was then cauterized carefully and the fibroid and IUD were then removed. Further review identified that during the use of the Bovie, MD #8 stated that there were two jolts and he reassessed the patient and found no issues. The procedure was then uneventful. Review of the (Post Anesthesia Care Unit) PACU and Anesthesia notes identified that when the patient was undraped, Patient #21 was noted to be pale. SRNA (Student Registered Nurse Anesthetist) #1 called MD #9 (Anesthesia) who assessed the patient and felt that she was pale. Upon transfer to the PACU at 1:10pm, Patient #21's B/P decreased to 55/30, Patient #21 was placed in trendelenberg and given intravenous fluids (IVF) wide open. MD #8 was called. MD #9 ordered a stat blood count. Review of the laboratory data identified Patient #21's Hct-21/ Hbg-7.3 at 1:20pm. An ultrasound was done at 2:23pm which showed free blood in the abdomen. MD #8 identified that he thought that Patient #21 had perforated her uterus and was not concerned about hemorrhage. MD #8 called his office to get Patient #21's Hct level since the clinical record lacked a preoperative Hct level. MD #9 identified that he told MD #8 that Patient #21 was shocky and it was decided to transfuse Patient #21 with blood before bringing her back to the operating room. Patient #21 had 4 units of packed red cells given starting at 2:15pm with the 4th unit finishing at 3:00pm. Review of the operating room log dated 1/16/07 identified that MD #8 was performing a dilatation and curettage on another patient from 2:22pm-2:57pm. MD #8 stated that he was waiting for blood transfusions to finish. Medical Resident #3 stated that he was in the clinic examining patients before Patient #21 was brought back to the operating room. At 3:15pm, Patient #21 was reassessed by MD #8, complaining of back pain with her abdomen distended. Patient #21 was transported back to the operating room. Interview with the Chairman of OB/GYN on 2/28/07 identified he went back to operating room to do a delivery and MD #8 was looking for Medical Resident #3 since Patient #21 had to go back to operating room. Further interview with the Chairman of OB/GYN identified that he scrubbed in with MD #8 when Patient #21 was brought back to operating room along with Medical Resident #3. Upon making a vertical midline incision, a hemoperitoneum was noted with blood evacuated by suction. A right broad ligament hematoma was evacuated with bright red bleeding ensued. The area was packed and placed on pressure until vascular surgeons took over. Patient #21

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

went into cardiac arrest at this time and CPR was continuing when the trauma team took over. Further review identified that additional surgical support was not requested, however MD #11 (a vascular surgeon) stated that he offered assistance when he observed Patient #21 in arrest. Review of the trauma/vascular surgeon operative report dated 1/16/07 identified that Patient #21 sustained a mesenteric vein laceration (IMV) and a right iliac artery laceration. Patient #21 received multiple units of blood products (12). Patient #21 was transported to the recovery room in critical condition at 5:20pm with a B/P 138/90 and a heart rate of 88. Review of the laboratory report dated 1/16/07 at 5:30pm identified that Patient #21's H/H was 3.2/9.3. At 5:30pm, Patient #21 was unresponsive, B/P 39/5 HR 42, chest compressions started and stopped at 5:49pm with no B/P noted. Patient #21 was pronounced dead at 5:49pm. Review of the operative note identified that Patient #21's estimated blood loss was 2,000ml. Review of the medical examiners report identified that Patient #21's cause of death was exsanguination due to lacerated right internal iliac artery during uterine surgery.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing (1) and/or (i) General (7) and/or (j) Emergencies (2).

- *5. Based on record reviews and interviews for 5 of 27 patients, the hospital lacked information to reflect that nursing assessments and/or neurological assessments and /or vital signs were completed in a timely manner when a patient had a fall and/or had a change in condition. The findings include:
- a. Patient #2 was a 49 year old admitted to the Emergency Department (ED) on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE with antiocoagulant therapy. On 5/26/06 at 7:40am, emergency nursing progress notes identified that Patient #2 was sitting in a wheelchair and when attempting to stand, fell to the floor and hit her head on the examination table. Patient #2 sustained a laceration to the face, above the eyebrow (2cm)(peri-orbital/lateral) with orbital ecchymosis. The Nursing ED assessment dated 5/25/06 and 5/26/06 lacked a nursing assessment upon admission to the ED and post fall. Further review failed to identify that Patient #2 had neurological assessments and vital signs completed after a head injury. Review of hospital policy and interview with the Nursing Director of the Emergency Department on 1/29/07 identified that a secondary nursing assessment following triage is to be completed including the time of the secondary assessment. Further review identified that neurological assessments and vital signs are to be completed for patients who have a head injury.
 - b. Review of the admission nursing assessment dated 5/26/06 identified that Patient #2 was a high fall risk (3-conley scale) and on fall precautions including bedrest. Review of the medication administration record dated 5/28/06 identified that Patient #2 was given Ambien 5mg at 10:11pm. On 5/29/06 at 2:00am, Patient #2 had an unwitnessed fall. Patient #2 was found lying on floor, incontinent of urine. Review of the nursing assessment on 5/29/06 at 3:29am identified that Patient #2 was alert and disoriented x 3 however the nursing assessment lacked documentation of a neurological assessment and/or vital signs after the fall. Review of the nurses note dated 5/29/06 at 8:56am identified the Patient #2 had periods of

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

- confusion during the night however the nursing action note lacked documentation that Patient #2 had fallen during the night. Review of the hospital incident report dated 5/29/06 identified that Patient #2 had fallen and RN #5 had notified MD #1 and the nursing supervisor. Review of paging records dated 5/29/06 identified that Intern #1 was notified of the fall; however Intern #1 denied that he was notified that Patient #2 had fallen. Review of the progress notes dated 5/29/06 failed to identify that Patient #2 was assessed by a physician. Further review identified that a nurses note must be entered when a patient has a change in condition and/or when a significant event occurs. Interview with RN #5 on 1/11/07 identified that Intern #1 was to see Patient #2 however when she left at 8am, Intern #1 had not seen Patient #2 and RN #5 did not follow-up with Intern #1. Further interview with RN#5 on 1/11/07 identified that she documented the incident regarding Patient #2 on a incident report but had not written a nurses note related to the fall. Interview with the 11-7am nursing supervisor on 1/31/07 identified that she was alerted by RN #5 that Patient #2 had fallen and the intern was to evaluate the patient. Interview with the Richardson 10 Nurse Manager on 1/18/07 identified that a nurses note and complete assessment should have been completed for Patient #2.
- c. Review of the admission nursing assessment dated 5/26/06 identified that Patient #2 was a high fall risk (3-conley scale), was on bedrest and on fall precautions. The patient had a fall on 5/29/06. Review of the nurses notes dated 5/29/06 at 8:50am identified that Patient #2 had periods of confusion during the night. Review of the medication administration record identified that Patient #2 had received Ambien 5mg on 5/30/06 at 12:22am. On 5/30/06 at 5:30am, Patient #2 had fallen on the floor near the bathroom. Patient #2 reported hitting her head and elbow. Review of the nurses notes dated 5/30/06 identified that Intern #2 and the nursing supervisor were notified that Patient #2 had fallen and was complaining of a headache. Further review identified that Intern #2 had given an order for Tylenol. Interview with Intern #2 on 1/11/07 identified that she denied being notified that Patient #2 had fallen. Review of the progress notes lacked documentation that Patient #2 was evaluated by the night intern and/or resident. Further review of the nurses notes dated 5/30/06 failed to identify that Patient #2 had neurological assessments and/or frequent vital signs after a fall. Facility policy regarding Documentation of Nursing Care identified that nurses note must be entered when a patient has a change in condition and/or when a significant event occurs. Interview with RN #4 on 1/11/07 identified that she had called Intern #2 and the nursing supervisor when Patient #2 had fallen however no evidence of an assessment was documented during her shift. Further interview with RN #4 identified that she assessed and did vital signs once during her shift. Interview with the 11-7am nursing supervisor identified that she was alerted that Patient #2 had fallen and had a head injury and she told RN #4 to make sure that the physician ordered a CT scan, however a CT scan was not ordered nor was the patient medically evaluated immediately after the fall. Interview with the Richardson 10 Nurse Manager on 1/18/07 identified that a nurses note and complete assessment should have been completed on Patient #2.
- d. Review of nurses notes dated 5/30/06 identified that Patient #2 was having an increase in mental status changes with a B/P of 162/112. MD #2 was notified and requested the teamcare intern to evaluate Patient #2. Further review of the nurses notes on 5/30/06 failed to identify

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

EXHIBIT A

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

- that Patient #2 had frequent neurological and/or vital signs completed after the change of condition was noted. Patient #2 was sent for an stat CT scan. Review of the CT scan report dated 5/30/06 at 2:47pm identified that Patient #2 had a large left subdural hematoma with approximately 1 cm of midline shift to the right. Further review of the CT scan report dated 5/30/06 at 5:09pm identified that Patient #2 had a left-sided subdural hematoma unchanged and a new right subdural hematoma. Further review of the medical record failed to reflect documentation and assessment related to the course of events when Patient #2 was unresponsive and intubated by Anesthesia. Patient #2 was sent to the medical intensive care unit. Patient #2 underwent bilateral craniotomies and evacuation of subacute and subdural hematomas. Patient #2 was discharged from the hospital on 10/24/06 in a permanent vegetative state, status post tracheostomy and PEG placement. Further record review and interviews failed to identify that a neurological assessment was performed in a timely and consistent manner that included the Glasgow coma scale, pupil size/reaction and motor/sensory function after Patient #2 hit her head secondary to multiple falls.
- e. Following admission to the Emergency Department the emergency nursing flowsheet for Patient #2 dated 5/23/06 at 12:03pm lacked a nursing assessment and or signature by the nurse. Patient #2 was discharged at 12:40pm.
- f. Patient #14 was admitted to the hospital on 1/12/07 after multiple falls at home. Review of the Emergency Nursing hand-off sheet identified that Patient #14 was a fall risk and fall precautions were identified. The admission nursing assessment dated 1/12/07 failed to include an accurate assessment on admission that identified that Patient #14 was a high fall risk.
- g. Patient #16 was admitted to the hospital on 12/29/06. Review of the Emergency Nursing hand-off sheet identified that Patient #16 had a small dime size pressure area at mid sacrum. Review of the admission assessment identified that Patient #16 had a Braden score of 17 and noted that the skin was intact. Review of the skin assessment dated 1/2/07 identified that Patient #16 had a pressure sore to buttocks however failed to identify the staging and/or sizing of pressure sore until a nursing assessment on 1/2/07 at 8:19pm identified that Patient #16 had a stage I red coccyx area measuring 2.0cm X 2.0cm. Review of the skin assessments dated 1/4/07-1/8/07 identified that Patient #16's skin was noted to be a Stage I, red area to the coccyx measuring 2.0cm X 2.0cm. Review of the nursing assessment dated 1/10/07-1/15/07 identified that Patient #16 had a Stage II open area to coccyx and was being treated with Xenaderm however lacked an assessment of measurements. Review of hospital policy identified that pressure ulcers are to be documented on the admission assessment and ongoing assessment on Millenium Powerchart. Further review of hospital policy identified that ongoing assessment of pressure sores are to re-assessed with dressing changes and/or at least Monday, Wednesday and Friday.
- h. Patient #21 underwent a Versapoint Hysteroscopic resection of fibroids and a removal of an intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 was brought back to the operating room due to complications related to hemorrhage. Patient #21 underwent a repair of a right iliac artery and a IMV laceration by the trauma team and upon discharge to the PACU had a nasogastric and abdomen drains inserted.

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

Review of the intraoperative nursing assessment lacked documentation of the types of drains and/or the amounts of drainage post operatively and subsequently in the PACU. Review of hospital policy identified that fluid monitoring is to be completed intraoperatively and in the PACU.

- i. Patient #21 underwent a Versapoint Hysteroscopic resection of fibroids and a removal of an intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 was brought back to the operating room due to complications related to hemorrhage. Patient #21 underwent a repair of a right iliac artery and a IMV laceration by the trauma team and upon discharge to the PACU had a nasogastric and abdominal drain inserted. Patient #21 went into cardiac arrest during the procedure in the operating room. Review of the intraoperative nursing assessment failed to identify that Patient #21 had coded during the operative procedure and lacked documentation of the disposition of Patient #21 when admitted to the PACU. Review of hospital policy identified that any complications and/or disposition should be documented in the intraoperative note.
- j. Patient #12 was admitted to the hospital on 12/7/06 with hematuria. Review of the record indicated the patient was confused on 12/22/06 at 2:16am and was found on the floor in the hallway on 12/22/06 at 3:10pm. Record review and interviews with hospital staff identified the patient sustained a head injury secondary to the fall. Patient #12 remained confused after the fall, wrist restraints were applied and vital signs were completed every two hours per the Restraint Protocol. Further record review failed to reflect that a neurological assessment was performed in a timely and consistent manner.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing (1) and/or (i) General (7).

- *6. Based on record review and interviews for 6 of 27 patients, the hospital lacked evidence of care plan revision to reflect the patient's current status. The findings include:
 - a. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE with anticoagulant therapy. Review of the admission nursing assessment dated 5/26/06 identified that Patient #2 was a high fall risk (3-conley scale) and on fall precautions including bedrest, side rails and a call light. Review of the nursing care plan dated 5/26/06 identified that Patient #2 was a high fall risk however after Patient #2 had multiple falls, the care plan was not evaluated for additional interventions to prevent Patient #2 from falls. Review of the Documentation of Nursing Care Policy indicated that nursing treatment orders and interventions within the plan of care would be reviewed and modified based on individual patient assessment. Review of the Interdisciplinary Plan of Care and interviews with hospital staff identified that although the patient was identified as a fall risk and fall prevention protocol was initiated on admission, the care plan lacked evidence of revisions and/or alternative interventions for fall prevention.
 - b. Patient #3 was admitted to the hospital on 1/5/07 for a nephrectomy. Review of the nursing care plan on 1/15/07 identified that the care plan was not reviewed and/or revised since admission date of 1/5/07. Review of the Documentation of Nursing Care Policy indicated that

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

nursing will review the interventions at least every 24 hours and date, time and initial discipline on the care plan signature sheet.

- c. Patient #15 was admitted to the hospital on 1/5/07. Review of the care plan dated 1/5/07 identified that Patient #15 had a potential for falls and on 1/7/07 was re-assessed as a high fall risk, however the care plan was not revised to identify Patient #15's risk for falls. Further review of the care plan documentation identified that the hospital's care plans did not reflect new protocols (i.e., reassess safety needs every two hours; use of safety devices such as alarms) as identified in the fall prevention protocols last revised on 10/06. Interview with the Director of Cardiology on 1/16/07 identified that he was unaware that the nursing staff was utilizing the care plans that reflected the old fall protocol.
- d. Patient #13 was admitted to the hospital on 1/15/07. Review of the care plan on 1/17/07 failed to identify that Patient #13 had a care plan. Upon surveyor inquiry, a care plan was written for Patient #13. Review of hospital policy identified that on admission, a care plan will be initiated for all patients.
- e. Patient #16 was admitted to the hospital on 12/29/06. Review of the Emergency Nursing hand-off sheet identified that Patient #16 had a small dime size pressure area at mid sacrum. Review of the admission assessment identified that Patient #16 had a braden score of 17 (high risk) and noted that the skin was intact. Review of the skin assessment dated 1/2/07 identified that Patient #16 had a pressure sore to buttocks. Review of the skin assessment dated 1/4/07-1/8/07 identified that Patient #16's skin was noted to be a Stage I, red and 2.0cm X 2.0cm and the nursing assessment dated 1/10/07-1/15/07 identified that Patient #16 had a Stage II open area to coccyx and was being treated with Xenaderm. Review of the nursing care plan identified on 12/29/06 that Patient #16 had a potential risk for alteration of skin integrity however the nursing care plan lacked documentation as to the actual pressure sore and interventions being utilized for Patient #16. Review of the Documentation of Nursing Care Policy indicated that nursing will review and revise the care plan including interventions at least every 24 hours and date, time and initial discipline on the care plan signature sheet.
- f. Patient #12 was admitted to the hospital on 12/7/06 with hematuria. Review of the record indicated the patient fell and sustained a head injury on 12/22/06 at 3:10 PM. The next revision of the Interdisciplinary Plan of Care (IPOC) regarding Safety was noted on 1/8/07. Review of the Documentation of Nursing Care Policy indicated that nursing treatment orders and interventions within the plan of care would be reviewed and modified based on individual patient assessment. Review of the Interdisciplinary Plan of Care and interviews with hospital staff reflected that although the patient was identified as a fall risk and fall prevention protocol was initiated on admission, the IPOC lacked evidence of review for appropriateness after the patient fell and hit his head on 12/22/06.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(D) and/or (d) Medical Records (2) and/or (3) and/or (7) and/or (e) Nursing (1) and/or (i) General (7).

*7. Based on record review and interviews for 3 of 27 patients, the hospital lacked evidence the

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

medical records were complete and accurate. The findings include:

- a. Patient #1 was admitted to the hospital on 6/26/06 with a diagnosis of syncope and was discharged on 6/29/06. Review of Physician Progress Notes dated 6/29/06 identified the patient was at risk for another syncopal episode with initiating BP medication and to monitor 24-48 hours prior to discharge. The Nurse Case Manager (RN #7) had written a telephone order in the Physician Orders dated 6/29/06 that directed cardiology and neurology clear the patient for 6/30/06 discharge, however, the patient was discharged on 6/29/06 with no discharge order. Interview with the covering attending physician, MD #7 identified that she had discussed the patient's status with neurology and cardiology physicians, however, she did not recall speaking with them on 6/29/06 regarding the discharge plan. Review of the Discharge Planning Policy indicated that the discharge plan was implemented with a written physician's order for the patient's discharge. Interviews with hospital staff and record review identified Patient #1 lacked a physician order for discharge and the discharge summary was incomplete.
- b. Patient #17 was admitted to the hospital for bilateral knee arthroplasty on 1/12/07. Review of the record identified the patient had left knee arthroplasty on 1/12/07 and right knee arthroplasty on 1/15/07. Record review and interviews with hospital staff identified the record lacked an operative note for 1/15/07.
- c. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE. Review of nurses notes dated 5/30/06 identified that Patient #2 was having an increase in mental status changes with a B/P of 162/112. MD #2 was notified and requested the teamcare intern to evaluate Patient #2. MD #2 ordered a stat CT scan of the head. Review of the progress notes dated 5/30/06 lacked documentation that Patient #2 was evaluated by a intern/resident from teamcare. Further review lacked documentation as to the course of events leading up to Patient #2 becoming unresponsive, intubated and sent to the medical intensive care unit. Review of the CT scan report dated 5/30/06 at 2:47pm identified that Patient #2 had a large left subdural hematoma with approximately 1 cm of midline shift to the right. Further review of the CT scan report dated 5/30/06 at 5:09pm identified that Patient #2 had a left-sided subdural hematoma unchanged and a new right subdural hematoma. Patient #2 underwent bilateral craniotomies and evacuation of subacute and subdural hematomas. Review of hospital policy and interview with the Director of Internal Medicine/Residency Program identified that when a patient has an acute condition, a progress note is to be written identifying the assessment, plan and the name of the attending physician and with whom the care plan had been discussed with.
- d. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE with antiocoagulant therapy. The admission assessment by MD #1 lacked a date or time that the note was written. Progress notes dated 5/27/06 and 5/28/06 lacked a time that MD #1 had evaluated Patient #2. Review of hospital policy identified that all physician notes are to be timed and dated.
- e. Patient #21 underwent a Hysteroscopic removal of fibroids and a removal of an intrauterine device on 1/16/07. Review of the ambulatory surgery discharge data identified that Patient #21's post operative discharge assessment identified that Patient #21's post operative condition

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

was good with 5 cc of blood loss. Further review failed to identify documentation regarding multiple complications post operatively and that the patient had expired.

- f. Patient #21 underwent a Versapoint Hysteroscopic resection of fibroids and a removal of an intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 was brought back to the operating room due to complications related to hemorrhage. Patient #21 underwent a repair of a right iliac artery and a IMV laceration by the trauma team and upon discharge to the PACU had a nasogastric and abdomen drains inserted. Patient #21 went into cardiac arrest during the procedure in the operating room. The intraoperative nursing assessment failed to include documentation that Patient #21 had coded during operative procedure and lacked documentation of the patients condition prior to transfer to the PACU. Review of hospital policy identified that any complications and/or disposition should be documented in the intraoperative note.
- g. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE with anticoagulant therapy. On 5/29/06 at 2:00am, Patient #2 had an unwitnessed fall. Patient #2 was found lying on floor, incontinent of urine. Review of the nursing assessment on 5/29/06 at 3:29am identified that Patient #2 was alert and disoriented x 3 however the nursing assessment lacked documentation of any neurological assessment and/or vital signs after a fall. Review of the nursing action note dated 5/29/06 at 8:56am identified the Patient #2 had periods of confusion during the night however the nursing action note lacked documentation that Patient #2 had fallen during the night. Review of hospital incident report dated 5/29/06 identified that Patient #2 had fallen and RN #5 had notified MD #1 and the nursing supervisor. Review of hospital policy identified that nurses notes are to be written when a patient has a change in condition and/or when a significant event occurs. Interview with RN#5 identified that she documented the incident with Patient #2 on a incident report but had not written a nurses note related to the fall. Interview with the Richardson 10 Nurse Manager on 1/18/07 identified that a nurses note and complete assessment needed to be completed for Patient #2.
- h. Patient #21 underwent a Versapoint Hysteroscopic resection of fibroids and a removal of an intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 was brought back to the operating room due to complications related to hemorrhage. Patient #21 underwent a repair of a right iliac artery and a IMV laceration by the trauma team and upon discharge to the PACU had a nasogastric and abdomen drains inserted. Patient #21 went into cardiac arrest during the procedure. Even though the code sheets were completed during the code, the medical record lacked rhythm strips during the code per hospital policy.
- i. Patient #2 was a 49 year old admitted to the Emergency Department on 5/25/06 at 5:45pm with complaints of leg pain. Patient #2 was treated for DVT and PE with anticoagulant therapy. Patient #2 was discharged from the hospital on 10/24/06. Review of the discharge summary identified that it was signed on 12/6/06. Review of hospital policy identified that the medical record needs to be completed within 30 days after discharge.
- j. Patient #21 underwent a Hysteroscopic removal of fibroids and a removal of a intrauterine device on 1/16/07. Review of the ambulatory surgery discharge data identified that

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

Patient #21's post operative discharge assessment identified that Patient #21's post operative condition was good with 5 cc of blood loss. Further review failed to identify documentation regarding multiple complications post operatively and that the patient expired.

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)(A) and/or (B) and/or (4)(A) and/or (i) General (7).

- *8. Based on clinical record reviews and interviews with facility personnel, the facility failed to assure that high standards of medical practice and patient care monitoring occurred during a surgical procedure. The findings include:
- a. Patient #21 underwent a Versapoint Hysteroscopic resection of fibroids and a removal of an intrauterine device performed by Resident #3 with oversight by MD #8 on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 had an uneventful surgical procedure however when Patient #21 was undraped post procedure, the patient was noted to be pale. Even though RN #9 identified that she immediately checked the patient and did not see any significant blood loss and the Surgical Tech #1 identified that she checked the output cannisters and did not see anything unusual, the intraoperative assessment lacked documentation as to Patient #21's disposition post operatively and lacked documentation of Patient #21's fluid intake and output post operatively. Review of the Versapoint manufacturers recommendations identify that strict intake and output must be monitored to prevent patient complications. Review of hospital policy identified that the scrub tech will keep track of all irrigation fluids administered during a procedure. Further review identified that the patient's disposition including the patients overall skin condition and disposition upon discharge from the operating room. Interview with the Senior Vice President and the Director of the Surgical Services on 2/28/07 identified that there is no policy on the use of the Versapoint machine and that staff were only eyeballing the fluids and reporting any deficits to the MD.
 - b. Patient #21 underwent a Versapoint Hysteroscopic resection of submucous fibroids and dilatation and curettage and a removal of a intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Patient #21 was taken to the operating room at 12:02pm. Resident #3 was performing surgery while MD #8 was visualizing on camera. Review of the operative reports dated 1/16/07 identified that during the procedure an attempt to remove the submucous fibroid was unsuccessful due to a stalk noted to be thick. A decision was made to amputate the fibroid with the Bovie on cautery and it was then cauterized carefully and the fibroid was removed as was the IUD. Further review identified that during the use of the Bovie, MD #8 stated that there were two jolts and he reassessed the patient and found no issues. The procedure was then uneventful. Review of the PACU and Anesthesia notes identified that when the patient was undraped, Patient #21 was noted to be pale. SRNA #1 called MD #9 (Anesthesia) who assessed the patient and felt that she was pale. Upon transfer to the PACU at 1:10pm, Patient #21's B/P decreased to 55/30, Patient #21 was placed in trendelenberg and given IVF wide open. MD #8 was called. MD #9 ordered a stat blood count. Review of the laboratory data identified Patient # 21's Hct-21/ Hbg-7.3 at

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

1:20pm. An ultrasound was done at 2:23pm which showed free blood in the abdomen. MD #8 identified that he thought that Patient #21 had perforated her uterus and was not concerned about hemorrhage. MD #8 called his office to get Patient #21's Hct level since the clinical record lacked a preoperative Hct level. MD #9 identified that he told MD #8 that Patient #21 was shocky and the decision was made to transfuse Patient #21 with blood before bringing her back to operating room. Patient #21 had 4 units of packed red cells given starting at 2:15pm with the 4th unit finishing at 3:00pm. Review of the operating room log dated 1/16/07 identified that MD #8 was performing a dilatation and curettage on another patient from 2:22pm-2:57pm. MD #8 stated that he was waiting for blood transfusions to finish. Resident #3 stated that he was in the clinic examining patients before Patient #21 was brought back to the operating room. At 3:15pm, Patient #21 was reassessed by MD #8, complaining of back pain with her abdomen distended. Patient #21 was transported back to the operating room. Interview with the Chairman of OB/GYN on 2/28/07 identified he went back to operating room to do a delivery and saw that MD #8 was looking for Resident #3 since Patient #21 had to go back to operating room. Further interview with the Chairman of OB/GYN identified that he scrubbed in with MD #8 when Patient #21 was brought back to operating room along with Resident #3. Upon making a vertical midline incision, a hemoperitoneum was noted with blood evacuated by suction. A right broad ligament hematoma was evacuated and bright red bleeding ensued. The area was packed and placed on pressure until vascular surgeons took over. Patient #21 went into cardiac arrest at this time and CPR was continuing when the trauma team took over. Further review identified that additional surgical support was not requested, however MD #11 (a vascular surgeon) identified that he offered assistance when he observed Patient #21 in arrest. Review of the trauma/vascular surgeon operative report dated 1/16/07 identified that Patient #21 sustained a in mesenteric vein laceration and a right iliac artery laceration. Patient #21 received multiple units of blood products (12). Patient #21 was transported to the recovery room in critical condition at 5:20pm B/P 138/90 HR 88. Review of the laboratory report dated 1/16/07 at 5:30pm identified that Patient #21's H/H was 3.2/9.3. At 5:30pm, Patient #21 was unresponsive, B/P 39/5 HR 42, chest compressions started and stopped at 5:49pm with no B/P noted. Patient #21 was pronounced dead at 5:49pm. Review of the operative note identified that Patient #21's estimated blood loss was 2,000ml. Review of the medical examiners report identified that Patient #21's cause of death was exsanguination due to lacerated right internal iliac artery during uterine surgery.

- c. During tour of the operating room on 1/25/07, it was identified that a Bovie machine had an inspection expiration date of 12/06. Review of hospital policy identified that the Bovi machine is to be checked semi annually. Interview with the Director of BioMed on 2/16/07 identified that the machine was not checked per 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)(D) and/or (d) Medical Records (2) and/or (3).

- *9. Based on clinical record reviews and interviews with facility personnel, the facility failed to ensure that a history and physical was updated prior to surgery and/or that pre operative data

DATES OF VISIT: January 8, 9, 10, 11, 16, 17, 18, 25 and February 5 and 28, 2007

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

was included in the medical record. In addition, the facility failed to ensure that the operative report contained accurate information and that the physician signed the report in a timely manner. The findings include:

- a. Patient #25 was admitted to the ambulatory surgery on 1/25/07 for a Laparotomy Electrode Incision Procedure. Review of the surgical ambulatory history form identified that Patient #25's history and physical was completed on 11/20/06. Review of hospital policy identified that history and physicals must be completed within 30 days prior to the procedure.
- b. Patient #21 underwent a Hysteroscopic removal of fibroids and a removal of a intrauterine device on 1/16/07. Patient #21 had a history of vaginal bleeding since 9/06. Review of the ambulatory surgery medical examination dated 1/16/07 and the anesthesia pre operative assessment failed to identify that a hemocrit was included in the medical record. Interviews with hospital personnel identified that while Patient #21 was having complications, MD #8 called his office to find out what Patient #21's hemocrit was prior to surgery. Review of hospital policy identified that a hemocrit is to be completed preoperatively if a patient has a history of blood loss.
- c. Patient #2 underwent a frontal craniotomy for chronic sub-dural hematoma on 6/15/06 and discharged to a skilled nursing facility on 10/24/06. Review of the operative report identified that Patient #2's surgery was dated incorrectly as 6/12/06 and signed on 11/27/06.
- d. Patient #2 underwent a placement of ventriculoperitoneal shunt and aspiration of ventricular fluid for laboratory analysis and pressure assessment on 7/7/06 and discharged to a skilled nursing facility on 10/24/06. Review of the operative report identified that it was signed by a physician on 11/27/06. Review of hospital policy identified that all operative procedures shall be fully described immediately in the medical record and all operative reports are to be dictated, completed and signed within 24 hours of the operation or invasive procedure.
- e. Patient #21 underwent a Hysteroscopic removal of fibroids and a removal of a intrauterine device on 1/16/07. Review of the multiple operative reports (5) dated 1/16/07 either lacked a MD signature and/or the MD signature was not timely. Further review lacked documentation and/or complete documentation of the operative notes post surgery. Review of hospital policy identified that all operative procedures shall be fully described immediately in the medical record and all operative reports are to be dictated, completed and signed within 24 hours of the operation or invasive procedure.
- f. Patient #21 underwent a Hysteroscopic removal of fibroids and a removal of a intrauterine device on 1/16/07. Review of the operative report dated 1/16/07 identified that it was dictated on 1/31/07 and signed by an MD on 2/27/07. Further review lacked documentation of an immediate operative note that identified an issue during the initial electrosurgical resection. Review of hospital policy identified that all operative procedures shall be fully described immediately in the medical record and all operative reports are to be dictated, completed and signed within 24 hours of the operation or invasive procedure.

June 18, 2007

Robert Trefry, Administrator
Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610

Dear Mr. Trefry:

Unannounced visits were made to Bridgeport Hospital which concluded on May 11, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and review for the purpose of fill federal survey.

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

An office conference has been scheduled for June 29, 2007 at 1:30 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

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

Respectfully,

Janet M. Williams, RN

Janet M. Williams, RN
Public Health Services Manager
Facility Licensing and Investigations Section

Elizabeth S. Andstrom

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

ESA/DJS/DH:jpf

- c. Director of Nurses
President
Complaints #CT6478 and #CT6571



Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

EXHIBIT B

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (1) and/or (i) General (7).

1. Based on clinical record reviews, review of hospital documentation and interviews with facility personnel, the hospital's governing body failed to act effectively to ensure that departments within the hospital (medicine, nursing and pharmacy) were accountable for safe and effective ordering, distribution and administration of medications.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (1) and/or (c) Medical Staff (2)(B) and/or (i) General (7).

2. Based on clinical record reviews, review of hospital documentation and interviews with facility personnel, the facility failed to ensure the accountability of medical staff for the quality of care provided to patients. For eight of fifteen sampled patients (Patient #85, #86, #87, #88, #89, #90, #91, #95), the facility failed to ensure that medication orders for narcotics, sedatives and/or other intravenous drip medications were complete, including a starting dose, parameters for increasing the dose, dose increments and/or dose limits. As a result patients received medication dosages, which were titrated without physician orders or within parameters outlined by hospital protocols.
 - a. Patient #85 was admitted to the hospital on 3/11/07 with slurred speech and right facial droop. Patient #85 had a history of TIA's and a Glioma resection. Review of the physician's orders dated 3/12/07 identified that Patient #85 was to receive morphine sulfate IV, titrated to comfort. Further review reflected that the physician's order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Review of the nursing flowsheets dated 3/12/07-3/14/07 identified that Patient #85's RAAS Score (Richmond Agitation Sedation Score) was a minus five (unarousable), and the patient was extubated and started on morphine sulfate IV at 5mg an hour at 2:40PM. Further review identified that Patient #85's morphine sulfate IV was increased over a course of 4 hours to 100mg per hour at 6:00PM and remained at 100 mg per hour until 3/14/07 at 9:30AM (2,087mg total of Morphine Sulfate IV received during this time frame), when a physician's order reflected that the morphine sulfate IV be changed to 5 mg per hour. Review of nursing documentation identified that Patient #85 remained comatose, pulse oximetry levels of 59-80's %, with no signs of discomfort. Review failed to identify that a physician was notified for either clarification of the morphine order and/or when the morphine was increased. Although hospital policy requires a physician's order for titrating morphine sulfate IV for sedation, review of hospital policy failed to identify parameters and/or that a protocol was utilized for administrating morphine sulfate drip/continuous IV for palliative care.
 - b. Review of the progress notes dated 3/13/07 identified that Patient #85 was to be transferred to Richardson 7 unit. Patient #85 was transferred on 3/13/07 at 7:00 PM. Further review of the physician's orders on 3/13/07-3/14/07 identified that transfer orders were not completed

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

until 3/14/07 at 10:00 AM. Interview with Nurse Manager #11 on 5/08/07 identified that on 3/14/07, she and the oncology nurse consultant had to make twenty phone calls to see who was covering Patient #85 to get transfer orders completed and also to clarify the morphine sulfate IV dose. Interview with the Senior VP of Medical Affairs on 5/11/07 identified that when Patient #85's code status changed to comfort measures only, the patient was to be covered by the private attending. Further interview identified that there was some confusion regarding the physician covering Patient #85. Interview with Attending MD # 22 identified that she thought Patient #85 was being cared for by the Intensive Care Team until the patient was transferred to Richardson 7. Review of hospital policy identified that transfer orders are to be completed by a physician when the patient is to be transferred.

- c. Patient #88 was admitted to the hospital on 5/6/07 with a drug overdose. Review of the physician's orders dated 5/6/07 identified that the patient was to receive Propofol drip. Review of the computer physician's orders identified the order as Propofol set 1000mg/100ml at 10mg per hour with final concentration at 10mg/ml. Further review failed to identify the specific parameters/protocols for dosing and/or monitoring. Review of the nursing flowsheets dated 5/6/07 and 5/7/07 identified that Patient #88's RAAS (Richmond Agitation Sedation Score) was a negative one (-1) which reflects that the Propofol drip needed to be decreased. (Goal of RAAS score is zero). Patient #88 received Propofol at 15mg per hour and it was increased to 25mg per hour due to the patient pulling up from the bed. Further review identified that Patient #88's RAAS score remained at negative one (-1) and Patient #88 continued on Propofol at 25mg per hour. Further review failed to identify that based on the RAAS score (Richmond Agitation Sedation Score), the medication was adjusted per hospital protocol. Review of hospital policy identified that titration orders must include patient parameters. Interview with the Director of the Critical Care Unit on 5/7/07 identified that titration orders need to include parameters for dosing and that the sedation protocol was not followed.
- d. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral upper extremities, face and neck with a history of hypotension, status post left arm fracture, osteoporosis and difficulty walking. Review of the physician's order, dated 2/1/07, directed the staff to administer the continuous medication of Ativan 80 milligrams (mg) in solution and "titrate to anxiety relief". The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Ativan.
- e. In addition, review of the physician's order, dated 2/1/07, directed the staff to administer the continuous medication of Fentanyl 2500 micrograms (mcg) in solution and "titrate to pain relief". The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Fentanyl. Interview with MD #25, the attending physician, on 5/11/07, identified that there are no protocols for Fentanyl. In addition review of the physician's order, dated 3/15/07, directed the staff to administer the continuous medication of Propofol 100 mg in solution and "titrate for dressing changes". The order failed to specify a starting dose, parameters for increasing the dose, dosage

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- increments and/or dosage limits.
- f. In addition, review of the physician's order, dated 3/15/07, directed the staff to administer the continuous medication Propofol 100mg in solution and "titrate for dressing changes". The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits.
 - g. Patient #86 was admitted to the hospital on 4/17/07 with pulmonary embolism. Review of the physician's orders dated 5/6/07 identified that the patient was to receive Fentanyl 2500mcg/250ml- titrate and Norepinephrine 4mg/250ml-titrate. Further review failed to identify the specific parameters for dosing and/or monitoring. Review of hospital policy identified that all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy.
 - h. Patient #87 was admitted to the hospital on 5/4/07 with Ascending Aortic Dissection. Review of the physician orders dated 5/4/07 identified that the patient was to receive Propofol 1000mg/100ml-titrate. Further review failed to identify the specific parameters/protocols for dosing and/or monitoring. Review of hospital policy identified that all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Also, review of the nursing flowsheets dated 5/6/07-5/7/07 identified that Patient #87 received Dopamine 400mcg/250ml at 5mg an hour. Further review failed to identify that a physician's order was obtained before administration of the medication.
 - i. Patient #89 was admitted to the hospital on 4/15/07 with shortness of breath. Review of physician's orders on 4/17/07 identified that the patient was to be titrated off an Epinephrine Drip, start Dopamine and sedate per RAAS protocol. Further review of physician's orders on 4/18/07 identified that the patient was to receive Dobutamine at 5mcg however all the orders failed to specify a starting dose and parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nursing Director of Critical Care on 5/11/07 identified that there are no protocols for Epinephrine, Dopamine, Dobutamine drips for titration. On 4/19/07, Ativan and Haldol were discontinued however further review failed to identify that physician orders were obtained for the Epinephrine Drip, Ativan and Haldol. Review of hospital policy identified that all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy.
 - j. Patient #90 was admitted to the hospital on 4/7/07 with difficulty breathing. Review of the physician's orders dated 4/19/07 identified that Patient #90 was to receive a Propofol drip-titrate to sedation. Review of the nursing flowsheets dated 4/19/07-4/21/07 identified that the Propofol was started at 5mg at 5:00 AM with a RAAS (Richmond Agitation Sedation Score) score of negative one (-1). Further review of the nursing flowsheets dated

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

4/19/07-4/21/07 identified that Patient #90's RAAS score remained a negative one (-1) (RAAS score goal is zero) and the Propofol drip was increased. Review of the sedation protocol identified that it was not followed based on Patient #90's RAAS score. Review of hospital policies identified that all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Interview with the Director of Critical Care on 5/10/07 identified that the sedation protocol was not followed.

- k. Patient #91 was admitted to the hospital on 2/3/07 with Sepsis. Review of the physician's orders dated 2/3/07 identified that the patient was to receive Propofol drip-titrate for sedation and on 2/11/07 Morphine Drip to keep patient in comfort. Review of the nursing flowsheets dated 2/3/07- 2/12/07 identified that on 2/3/07, the patient received Dopamine IV started at 10mg per hour and Dobutamine IV started at 6mg per hour. Further review of the nursing flowsheets on 2/5/07 identified that the patient was started on a Fentanyl IV drip at 5mg per hour however a physician's order was lacking for the narcotic. Further review of the nursing flowsheets dated 2/3-2/12/07 identified that even though the patient was given Fentanyl, Propofol and Morphine IV drip for sedation. Although Patient #91's RAAS score was a negative three, the medications for sedation were increased, reflecting that the sedation protocol was not followed. Review of hospital policies identified that all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. In addition, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (7).

3. Based on clinical record reviews, review of hospital documentation and interviews with staff, the facility failed to ensure that medications were administered in accordance with facility policy. For 3 of 15 patients (Patients #92, #93, and #94), nursing staff failed to document morphine sulfate doses administered by intravenous titration and/or failed for 8 of 15 patients (Patients #85, #86, #87, #88, #89, #90, #91, and #95) to ensure that medication orders were clarified with a physician and/or that medication protocols were followed when administering narcotics, sedatives, and/or IV drip medications. According to hospital policies the nursing staff will administer medications as ordered by a physician and clarify an order before carrying out an incomplete, illegible or unclear order.
- a. Patient #93 was admitted to the hospital on 2/19/07 with Stage 4 lung cancer and respiratory distress. Physician orders dated 2/21/07 directed morphine sulfate IV drip be administered at 3 mg per hour then titrate up to comfort to a maximum of 10 mg per hour.

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

Review of hospital documentation identified that morphine advantage 250mg/10 ml was removed from the Pyxis Medstation on 2/22/07 at 11:44 AM for the patient. Review of the Patient #93's clinical record failed to reflect the time the morphine sulfate IV drip dose was titrated with the effect as per physician order.

- b. Patient #92 was admitted to the hospital on 2/6/07 with diarrhea and dehydration. Physician orders dated 2/11/07 directed morphine sulfate IV drip be administered at 2 mg per hour then titrate up to comfort to a maximum of 5 mg per hour. Review of hospital documentation identified that morphine advantage 250mg/10 ml was removed from the Pyxis Medstation on 2/11/07 at 4:13 PM for the patient. Although a nursing note dated 2/11/07 and Medication History Report dated 2/11/07 identified a morphine IV was initiated, review of Patient #92's clinical record failed to reflect the time the morphine sulfate IV drip dose was titrated with the effect as per physician order.
- c. Patient #94 was admitted to the hospital on 2/27/07 with lung cancer and hypercalcemia. Physician orders dated 3/1/07 directed morphine sulfate IV be administered 100mg/100cc D5W begin drip at 3ml per hour and may titrate 1-3ml per hour up/down for pain, dyspnea to a maximum of 20 mg per hour. Review of hospital documentation identified that morphine advantage 250mg/10 ml was removed from the Pyxis Medstation on 3/1/07 at 11:23 AM, 3/3/07 at 1:41 PM and 3/4/07 at 4:58 PM for the patient. Although nursing notes dated 3/1/07, 3/2/07 and 3/3/07 identified the morphine IV drip was increased and the Medication History Report identified a morphine IV was maintained, review of Patient #94's clinical record failed to reflect the time the morphine sulfate IV drip dose was titrated with the effect as per physician order.
- d. Patient # 85 was admitted to the hospital on 3/11/07 with slurred speech and right facial droop. Patient #85 had a history of TIA's and a Glioma resection. Review of the physician's orders dated 3/12/07 identified that Patient #85 was to receive morphine sulfate IV, titrated to comfort. Further review reflected that the physician's order failed to include start dose and parameters for dosing. Review of the nursing flowsheets dated 3/12/07-3/14/07 identified that Patient #85's RAAS Score (Richmond Agitation Sedation Score) was a minus five (unarousable), and the patient was extubated and started on morphine sulfate IV at 5mg an hour at 2:40 PM. Further review identified that Patient #85's morphine sulfate IV was increased over a course of 4 hours to 100mg per hour at 6:00 PM and remained at 100mg per hour until 3/14/07 at 9:30 AM when a physician's order reflected that the morphine sulfate IV be changed to 5mg per hour. Review of nursing documentation identified that Patient #85 remained comatose, pulse oximetry levels of 59-80's %, with no signs of discomfort. Further review failed to identify that a physician was notified for either clarification of the morphine order and/or when the morphine was increased. Although a hospital policy identifies that a physician's order needs to be followed for titrating morphine sulfate IV for sedation, further review of hospital policy failed to identify parameters and/or that a protocol was utilized for administering morphine sulfate drip/continuous IV for palliative care. Interview with RN #32 identified that she had received an order from MD #23 for the morphine drip, however the physician order's and/or nursing flowsheets failed to identify the a

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- clarification and/or parameters of the morphine drip was completed by RN #32. Interview with RN #35 identified that she questioned increasing the morphine with MD #22, however the documentation failed to identify that MD #22 was consulted. Interview with RN's #33 and #34 identified that they did not call an MD when they questioned the morphine dose when the patient was transferred to his unit but received clarification from the ICU nurse. Interview with RN #35 identified that when she came on shift at 7AM, she questioned the morphine dosage and called the oncology nurse consultant. Subsequently, on 3/14/07 at 9:30 AM, Patient #85's morphine sulfate dose was changed to 5mg per hour. Patient #85 expired on 3/14/07. In addition, although the physician's order, dated 3/11/07, directed the staff to administer IV Propofol per RASS protocol, (if patient fights with vent), the order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Further review failed to identify that a nurse reviewed and/or clarified the titration order.
- e. Patient #88 was admitted to the hospital on 5/6/07 with a drug overdose. Review of the physician's orders dated 5/6/07 identified that the patient was to receive Propofol drip. Review of the computer physician orders identified the order as Propofol set 1000mg/100ml at 10mg per hour with final concentration at 10mg/ml. Further review failed to identify the specific parameters/protocols for dosing and/or monitoring. Review of the nursing flowsheets dated 5/6/07 and 5/7/07 identified that Patient #88's RAAS (Richmond Agitation Sedation Score) was a negative one (-1). Patient #88 received Propofol at 15mg per hour and it was increased to 25mg per hour due to the patient pulling up from the bed. Further review identified that Patient #88's RAAS score remained at negative one and Patient #88 continued on Propofol at 25mg per hour. Further review failed to identify that based on the RAAS score (Richmond Agitation Sedation Score), the medication was adjusted per hospital protocol. Review of hospital protocol identified that if the RAAS score is below a zero for 2 hours, the physician would be notified and the propofol would be decreased by 0.3mg/kg/hr every 5 minutes until RASS score is zero. Subsequently to surveyor inquiry on 5/7/07, Patient #88's propofol was discontinued.
- f. Patient #86 was admitted to the hospital on 4/17/07 with pulmonary embolism. Review of the physician's orders dated 5/6/07 identified that the patient was to receive Fentanyl 2500mcg/250ml- titrate and Norepinephrine 4mg/250ml-titrate. Further review failed to identify the specific parameters for dosing and/or monitoring. Review of hospital policy identified that all incomplete medication orders were to be clarified by a nurse and also pharmacy. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.
- g. Patient #87 was admitted to the hospital on 5/4/07 with Ascending Aortic Dissection. Review of the physician orders dated 5/4/07 identified that the patient was to receive Propofol 1000mg/100ml-titrate. Further review failed to identify the specific

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- parameters/protocols for dosing and/or monitoring. Review of hospital policy identified that all incomplete medication orders were to be clarified by a nurse and a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Also, review of the nursing flowsheets dated 5/6/07-5/7/07 identified that Patient #87 received Dopamine 400mcg/250ml at 5mg an hour. Further review failed to identify that a physician's order was obtained before administration of the medication.
- h. Patient #89 was admitted to the hospital on 4/15/07 with shortness of breath. Review of physician's orders on 4/17/07 identified that the patient was to be titrated off an Epinephrine Drip, start Dopamine and sedate RAAS protocol. Further review of physician orders on 4/18/07 identified that the patient was to receive Dobutamine at 5mcg however all the orders failed to specify a starting dose and parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nursing Director of Critical Care on 5/11/07 identified that there are no protocols for Epinephrine, Dopamine, Dobutamine drips for titration. On 4/19/07, Ativan and Haldol were discontinued however further review failed to identify that physician orders were obtained for the Epinephrine Drip, Ativan and Haldol. Review of hospital policy identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.
- i. Patient #90 was admitted to the hospital on 4/7/07 with difficulty breathing. Physician orders dated 4/19/07 identified that Patient #90 was to receive a Propofol drip-titrate to sedation. Nursing flowsheets dated 4/19/07-4/21/07 identified that the Propofol was started at 5mg at 5:00 AM with a RAAS (Richmond Agitation Sedation Score) score of negative one (-1). Further review of the nursing flowsheets dated 4/19/07-4/21/07 identified that Patient #90's RAAS score remained a negative one (-1) (RAAS score goal is zero) and the Propofol drip was increased. Review of the sedation protocol identified that the protocol was not followed based on Patient #90's RAAS score. Review of hospital policies identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.
- j. Patient #91 was admitted to the hospital on 2/3/07 with sepsis. Review of the physician's orders dated 2/3/07 identified that the patient was to receive Propofol drip-titrate for sedation, 2/11/07- Morphine Drip to keep patient in comfort. Review of the nursing

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

flowsheets dated 2/3/07- 2/12/07 identified that on 2/3/07, the patient received Dopamine IV started at 10mg per hour and Dobutamine IV started at 6mg per hour however no physician's order was noted. Nursing flowsheets on 2/5/07 identified that the patient was started on a Fentanyl IV drip at 5mg per hour however the clinical record lacked a physician's order for the narcotic. Further review of the nursing flowsheets dated 2/3-2/12/07 identified that the patient was given Fentanyl, Propofol and Morphine IV drip for sedation, Patient #91's RAAS score was a negative three (-3) and the medications for sedation were increased rather than decreased as per sedation protocol. Review of hospital policies identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points.

- k. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral upper extremities, face and neck with a history of hypotension, status post left arm fracture, osteoporosis and difficulty walking. Review of the physician's order, dated 2/1/07, directed the staff to administer the continuous medication of Ativan 80 milligrams (mg) in solution and "titrate to anxiety relief," however the order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Ativan. In addition review of physician orders, dated 2/1/07, directed the staff to administer the continuous medication of Fentanyl 2500 micrograms (mcg) in solution and "titrate to pain relief", although the order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Fentanyl. In addition review of physician orders, dated 3/15/07, directed the staff to administer continuous medication of Propofol 100 mg in solution and "titrate for dressing changes" although the order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits.

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

4. Based on review of the medical record, interview with facility personnel and review of the facility policy for one of nineteen patients (Patient #68) reviewed who had issues related to pain control, the facility failed to ensure that nursing staff followed the physician's order and/or reassessed the patient following analgesic medication administration. The findings include:
- a. Patient #68 underwent an excision of a mass of the upper lobe of the left lung on 4/18/07. Review of the anesthesiologist's orders dated 4/18/07, directed the patient to receive epidural Morphine at 7:50 AM after which the pulse oximetry was to be monitored every hour times ten (10). The patient was monitored in the operating room until discharge at 10:15 AM. The patient was then transferred to the post anesthesia care unit (PACU). Review of the PACU documentation identified that the pulse oximetry was last monitored at 97 % at 2 PM while the patient was on four (4) liters nasal oxygen. Documentation also

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

reflected that the patient's pulse oximetry was 90% on room air at that time. Although the patient was not transferred out of PACU until 4:40 PM, further pulse oximetry readings failed to be documented. During interview the patient's PACU nurse stated that the patient was on continuous pulse oximetry while in the unit however although the pulse ox was monitored, it was not documented. Once Patient #68 was transferred to the surgical nursing unit, although a nursing assessment was documented in the progress narratives, oxygen saturation and oxygen therapy were not documented as completed until 9 PM. Review of the medication administration record for Patient #68 reflected that the patient was medicated three (3) times on 4/19/07 for a pain level on a scale of 8 out of 10. At 3:46 AM on 4/19/07, the patient was medicated with 30 mg of Toradol for a pain level of 8/10 but failed to be reassessed for effective pain control. At 6 AM on the same day, the patient was assessed for a pain level of 7 but failed to be medicated for the pain. At 10 AM the patient was assessed for a pain level of 8/10 and the patient was medicated with Toradol 30 mg. The patient failed to be reassessed for medication effectiveness. At 2 PM on 4/19/07, the patient was assessed for a pain level of 8/10 and the patient was started on an epidural drip for pain control. Review of the facility policy for Pain Assessment/Reassessment directs that pain intensity should be rated by the patient both before and after a pharmacological intervention and should be documented on the electronic medication record.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (7).

5. For five of eight patients, (Patients #31, #62, #65, #76 and #95) who were identified with altered skin integrity, the facility failed to ensure that nursing staff assessed and monitored wounds, consulted with the physician regarding changes in wound status and/or used appropriate technique in caring for wounds. Based on clinical record review, staff interviews and a review of facility policies and procedures, the findings include:
 - a. Patient #62 was transferred to the rehabilitation unit on 4/20/07 with diagnoses that included Diabetes. Although review of a Braden Scale skin assessment dated 4/21/07 identified Patient #62 as low risk to develop pressure ulcers, the nursing action note dated 4/21/07 identified that Patient #62 was admitted to the rehabilitation unit with a Stage II pressure ulcer on the coccyx and that the product, Xenaderm, was applied. Review of the clinical record failed to identify that the patient's pressure ulcer was measured, described, and/or reassessed, in accordance with facility policies through 4/24/07. Observation of Patient #62's buttocks and coccyx area with facility staff and subsequent interview with RN #26 on 4/24/07 at 2:00 PM identified that Patient #62 had a reddened, excoriated buttocks and a Stage II elongated, oval shaped coccyx pressure ulcer that measured approximately 2.5 centimeters (cm.) by 0.5 cm. Review of facility policy directed that assessments of patients with impaired skin integrity be ongoing. The policy directed that pressure ulcers must be re-assessed with dressing changes and/or at least every Monday, Wednesday, and Friday and that the assessment include the location, stage, size, drainage, tunneling, necrotic tissue, odor, and treatment. In addition, the policy directed that the

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

documentation of the assessment be included in the clinical record.

- b. Patient #65 was admitted to the facility on 12/9/06 with diagnoses that included a Traumatic Brain Injury (TBI) as a result of a fall. Observation of Patient #65 on 4/23/07 at 10:45 AM identified that the patient had developed four blisters on the left flank area. Three of the blisters observed through a Tegaderm dressing that only partially covered the areas, were flattened and appeared reddened with dark circumferences. The three areas appeared to range in size from 0.5 centimeters (cm.) to 1.0 cm. The fourth blister was approximately two cm. in diameter, fluid filled, and appeared to be forming from just beneath the Tegaderm dressing causing the dressing to peel away downward. Interview with RN #21 at the time of the observation identified that the blisters were caused by friction. RN #21 stated that treatment to the areas was provided by using a soap and water wash followed by a Tegaderm dressing. Interview with MD #20 on 4/24/07 at 1:45 PM identified that she was not notified of the changes in Patient #65's skin integrity. Subsequent to surveyor inquiry, MD #20 evaluated Patient #65's blisters and directed treatment to the areas that included daily application of bacitracin ointment and a dry sterile dressing to the left flank blister site. Review of facility policy directed that the physician be notified of changes in a patient's medical condition including changes in skin integrity.
- c. Patient #76 was admitted to hospital on 4/18/07 with diagnoses of shortness of breath, hypotension, lethargy and pneumonia and was identified with pressure ulcers. Review of the emergency room Physician's Note and the Adult Admission Part I Form dated 4/18/07 at 14:45PM (2:45PM) and 8:49PM identified in part, blisters to the sacrum, grade two bed sores peri-rectally, and four (4) small stage two ulcers on the buttocks, pink and red in color. Interview and review of the clinical record with the Wound Consultant on 4/25/07 at 2:42PM failed to identify the size and description of the blisters to the sacrum, the grade two bed sores to the peri-rectal area and the four (4) small stage two ulcers to the buttocks as per facility policy.
- d. Patient #31 was admitted to the hospital on 3/16/07 with diagnoses that included a left foot puncture wound, left foot cellulitis and diabetes. Review of the Nursing Critical Care Flowsheet dated 4/22/07 indicated that the patient had 6 pressure ulcers, however failed to identify Stage classification. Review of the patient's Interdisciplinary Plan of Care identified one left foot wound, however, lacked any revisions and failed to reflect any pressure ulcers. Observation of Patient #31 on 4/26/07 identified that the patient had 9 pressure ulcers and Acticoat was applied to several areas that included the patient's right and left axillae, the left hip and the back. Desitin was applied to three Stage II buttock wounds and the wounds were not covered by a dressing as recommended in the Pressure Ulcers: Staging, Nursing Management and Documentation Policy. Review of the hospital's policies titled, Pressure Ulcers: Staging, Nursing Management and Documentation and The Procedure for Nursing Actions regarding a pressure sore directed in part, that the documentation of the assessment of pressure ulcers on the admission assessment would include the location, stage, size, drainage, tunneling, necrotic tissue, odor, and treatment. Review of the Policy also indicated that documentation of pressure sores would be documented on the ongoing assessment, that pressure ulcers must be re-assessed with dressing changes and that the sores would be classified as Stage I through Stage IV.
- e. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral

DATE OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

upper extremities, face and neck with a history of hypotension, status post left arm fracture, osteoporosis and difficulty walking. The medical record, dated 3/25/07, identified that Patient #95 had a pressure ulcer on the back of the head and the patient had been maintained on a pressure relieving mattress since admission. Review of the medical record, from 4/20/07 to 5/11/07 failed to identify documentation of the pressure ulcer location, a complete description of the surrounding tissue and/or the stage of the ulcer. Interview and chart review with Nurse Manager #12 and the Nursing Director of the Critical Care Units, on 5/11/07, identified that there was no documentation of Patient #95's head pressure ulcer location, the description of the surrounding tissue and/or the stage of the ulcer. Review of the hospital's policies titled, "Pressure Ulcer" and The Procedure for Nursing Actions regarding a pressure sore directed in part, identified that ulcers must be re-assessed with dressing changes and/or at least Monday, Wednesday and Friday and that the assessment of pressure ulcers includes the location, stage (stage I through IV), size, drainage, tunneling, necrotic tissue, odor, and treatment.

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

6. For three patients who had physician orders for monitoring fluid intake and output, (Patients #61, #62, and #66), the facility failed to ensure that oral and/or intravenous fluids were consistently documented in the clinical record. Based on review of clinical records, review of facility policy, and interviews, the findings include:
 - a. Patient #62 had diagnoses that included respiratory failure and recent Coronary Artery Bypass Graft (CABG). Patient #62 was transferred to the rehabilitation unit on 4/20/07. Review of the clinical record identified a physician's order dated 4/20/07 to monitor the patient's fluid intake and output. Review of the computerized intake and output monitoring record dated 4/20/07 through 4/24/07 identified that Patient #62 had daily negative fluid balances (urine output exceeds fluid intake) ranging from twenty five hundred cubic centimeters (cc.) to more than six thousand cc. within a twenty four hour period. Review of the documentation and subsequent interview with the Rehabilitation Program Director on 4/24/07 at 10:50 AM identified that although Patient #62's output had been documented, the patient's oral and intravenous fluid intake had not been recorded on the flow sheet causing the twenty-four hour totals and subsequent fluid balances to be inaccurate.
 - b. Patient #66 was admitted to the facility on 4/14/07 with community acquired pneumonia. On 4/15/07, Patient #66 was identified with dysphagia and at risk for aspiration. Physician orders dated 4/15/07 directed monitoring of fluid intake and output. Review of the clinical record with facility staff failed to identify that Patient #66's fluid intake that included intravenous fluids, was consistently monitored in accordance with physician orders.
 - c. Patient #61 was admitted to the hospital on 04/22/07 with diagnoses of multiple sclerosis, urinary tract infection and sepsis. The patient had an indwelling catheter that was replaced upon admission to the hospital. The admitting physician orders included the continuous infusion of intravenous fluids of 5% dextrose in water with 0.45% normal saline at 75cc per hour. Review of the electronic record of Patient # 61's intake and output with the Nurse Manager of Tower 7

DATE OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

on 04/25/07 at 11AM identified a negative balance of 1,010 cc on 04/24/07. The Nurse Manager recalled having personally given fluids to Patient # 61 during meals on 04/24/07, however the amount given was not recorded, hence the negative fluid balance upon daily calculation. The hospital policy directed the recording of daily intake and output by nursing staff for all patients receiving intravenous therapy and / or using a retention catheter, for the purpose of monitoring the patient 's hydration status. Review of facility policy identified that the purpose of intake and output policy was to monitor the patient's hydration status, to accurately document intravenous therapy, and to maintain an accurate record of output in relation to amounts of fluid intake. The policy directed that patients would have fluid intake and output recorded when ordered by a physician.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1).

7. Based on reviews of the medical record, facility policies and procedures, and staff interviews for one patient (Patient #34), the facility failed to ensure that nursing assessments related to the need for psychotropic medication were performed.
 - a. Patient #34's diagnoses included depression and schizoaffective disorder. The patient was evaluated in the emergency department on 4/19/07 following a Police Emergency Request. A fifteen-day Physician's Emergency Certificate was executed on 4/20/07 and the patient was placed on Close Observation. Physician's orders dated 4/22/07 included Ativan two milligrams (mg) every four hours as needed for agitation. The Medication Administration Record identified that Patient #34 received Ativan two mg on 4/22/07 at 8:55 PM, 4/23/07 at 5:43 PM, and on 4/24/07 at 2:10 PM. Review of the medical record on 4/26/07 with the Director of the Emergency Department identified that it failed to reflect the symptoms indicating the need for the medication and/or the patient's response to the administered medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-(b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1).

8. For five of eight medical records reviewed (Patients #65, #66, #31, #95 and #96), the facility failed to ensure that the nursing care plans were comprehensive and individualized to the patient. Based on clinical record review, staff interviews and review of policies and procedures, the findings include:
 - a. Patient #65 was admitted to the facility on 12/9/06 with a Traumatic Brain Injury (TBI) as a result of a fall. Review of a Braden Scale skin assessment dated 4/22/07 identified Patient #65 as low risk to develop skin impairment but with potential for problems with the skin due to friction and shearing. Observation of Patient #65 on 4/23/07 at 10:45 PM identified that the patient had developed four blisters on the left flank area. Three of the blisters observed through a Tegaderm dressing that partially covered the areas, were flattened and appeared reddened with dark circumferences. The three areas appeared to range in size from 0.5

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

centimeters (cm.) to 1.0 cm. The fourth blister was approximately two cm. in diameter, fluid filled, and appeared to be forming from just beneath the Tegaderm dressing causing the dressing to peel away downward. Interview with RN #21 at the time of the observation identified that the blisters were caused by friction. Review of the clinical record failed to identify that the patient's care plan was updated to include Patient #65's blistered areas, treatment to the blisters, and/or regular assessments to monitor for healing/worsening of the blisters. In addition, although RN #21 stated that the staff was providing treatment to the areas with soap and water washes followed by Tegaderm dressings, the clinical record failed to reflect when or what treatment was provided to the described areas by the nursing staff.

- b. Patient #66 was admitted to the facility on 4/14/07 with community acquired pneumonia. Review of a Braden Scale skin assessment dated 4/15/07 identified Patient #66 as low risk to develop skin impairment but with potential for problems with the skin due to friction and shearing. Observation on 4/23/07 at 1:55 PM identified that Patient #66 had developed an extensive, generalized red, spotted rash over the back and flank areas from waistline to shoulders. Interview with RN #20 at the time of the observation identified that she had provided care for the patient for several days prior to the observation and had not observed the rash. Interview with Patient #66's family members who were also present at the time of the observation identified that another staff member had questioned them about the rash the previous week. The family members expressed concern related to the lack of treatment to the area. Interview with MD #21 on 4/25/07 at 9:30 AM identified that he was notified of Patient #66's rash and had previously observed the area. MD #21 stated that he did not believe the rash was based on any allergic reaction but more of a contact dermatitis that could be treated with moisturizing lotions. Review of the care plan dated 4/21/07 failed to identify that the plan was revised to include identification of Patient #66's rash, treatment to the area, and/or regular assessments to monitor for healing/worsening of the rash. Review of facility policy directed that active problems, described as problems that affect the patient in terms of signs and symptoms, require an adjustment in treatment.
- c. Patient #31 was admitted to the hospital on 3/16/07 with diagnoses that included a left foot puncture wound, left foot cellulitis and diabetes. Review of the Nursing Critical Care Flowsheet dated 4/22/07 indicated that the patient had 6 pressure ulcers, however failed to identify Stage classification. Review of the patient's Interdisciplinary Plan of Care identified that the Plan was initiated on admission, 3/16/07 and noted one left foot wound, however, the Plan lacked any revisions and failed to reflect any pressure ulcers. Observation of Patient #31 on 4/26/07 identified that the patient had 9 pressure ulcers with varying treatments. Review of the Pressure Ulcers: Staging, Nursing Management and Documentation Policy indicated that the patient's Interdisciplinary Plan of Care should be individualized to reflect an alteration in skin integrity that includes the appropriate nursing interventions and that the sores would be classified as Stage I through Stage IV. Patient #31's Interdisciplinary Plan of Care failed to reflect an accurate and individual plan for the patient's altered skin integrity as per hospital policy.
- d. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral upper extremities, face and neck with a history of hypotension, status post left arm

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- fracture, osteoporosis and difficulty walking. During a tour of the unit, on 5/11/07, outside of Patient #95's room facility notification identified that the patient required isolation and Nurse Manager #12 identified that Patient #95 was on isolation for an infection of Methicillin-Resistant Staphylococcus Aureus (MRSA) in the blood. The Interdisciplinary Plan of Care failed to address the infection of MRSA in the patient's blood. Interview and chart review with Nurse Manager #12, on 5/11/07, identified that the Interdisciplinary Plan of Care for Patient #95 does not identify and/or address the patient's MRSA blood infection. In addition review of the medical record identified that Patient #95 had a pressure ulcer identified on the back of the head, on 3/25/07. Review of the Interdisciplinary Plan of Care failed to identify and/or address the patient's head pressure ulcer. Interview and chart review with Nurse Manager #12, on 5/11/07, identified that the Interdisciplinary Plan of Care for Patient #95 did not identify and/or address the patient's pressure ulcer.
- e. Patient #96 was admitted to the hospital on 1/21/07 with the diagnosis of burn to both legs. During a tour of the unit, on 5/11/07, outside of Patient #96's room facility notification identified that the patient required isolation and Nurse Manger #12 identified that Patient #96 was on isolation for an infection of Methicillin-Resistant Staphylococcus Aureus (MRSA) in a wound. The Interdisciplinary Plan of Care failed to address the infection of MRSA in the patient's wound. Interview and chart review with Nurse Manager #12, on 5/11/07, identified that the Interdisciplinary Plan of Care for Patient #96 did not address the patient's MRSA wound infection. In addition, the Interdisciplinary Plan of Care failed to address that the patient required education via an interpreter regarding the MRSA infection in the wound. During a tour of the unit, Nurse Manager #12 identified that Patient #96's primary language is Spanish. Interview with the Nurse Manager #12, on 5/11/07, identified that the Interdisciplinary Plan of Care for Patient #96 did not address the patient's unique educational needs related to the MRSA wound infection. Review of the facility policy, titled "Documentation of the Interdisciplinary Plan of Care", identified that the plan of care would be based on the assessment of the patient's individualized needs and that interventions would be changed as needed to reflect patient needs based on current assessments. The facility policy, titled "Pressure Ulcers", identified that the patient's Interdisciplinary Plan of Care includes presence of a pressure ulcer and the appropriate nursing interventions.

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

9. Based on review of clinical record, observation and interview with facility personnel, for one of two patients (Patient # 36) receiving medications and nutrition through a gastrostomy tube, the nursing staff failed to ensure that feeding solution was free of foreign substances. The findings include:
- a. Patient #36 was admitted to the hospital on 02/21/07 following a hypertensive pontine hemorrhage, and underwent a gastrostomy tube placement on 02/28/07. During a visit with Patient #36 on 04/23/07 at 10:50 AM, the patient's tube feeding bag (dated 04/23/07 at 6 AM) contained a small amount of enteral feeding solution, which filled approximately the last inch

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

of the feeding bag. Inside the empty space of the bag, above the feeding solution, light brown-to-orange solid particles of various sizes were clumped against the inner aspect of the clear plastic feeding bag. At the bottom of the feeding bag, mixed to the enteral feeding solution, were large white particles with an orange-colored outer coating. The chamber of the tubing of the feeding system also contained two large fragments of solid white and light brown-to-orange compound. RN # 21 identified the fragments as "curdled tube feeding solution"; however, no odor of spoiled enteral feeding solution was noted in the bag, and no outdated enteral feeding container was identified in the patient's room. The facility pharmacy was unable to identify the fragments contained in the feeding bag. Review of Patient #36's scheduled medications from 6 AM to 10 AM on 04/23/07 included medications in the form of white tablets (Labetalol 200mg, Norvasc 10mg), and white tablets coated with orange coloring (Prevacid 30mg).

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

10. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that an order for oxygen delivery for one patient (Patient #60) included parameters for the adjustment of the patient's oxygen based on oxygen saturation and/or that documentation that led to the oxygen adjustments was complete.
 - a. Patient #60 was admitted to the hospital on 4/23/07 with a diagnosis of sickle cell disease. Review of physician orders dated 4/23/07 directed the use of nasal oxygen at two liters per minute as needed and to notify the physician if the patient's oxygen saturation via Pulse Oximetry (POX) was less than ninety percent (< 90%). The nursing action note dated 4/24/07 at 7:56 AM identified that Patient #60's oxygen saturation decreased but documentation failed to identify the actual POX value. Patient #60's nasal oxygen was increased at that time to five liters per minute but the medical record did not reflect the patient's response to the increase in oxygen. Review of the nursing action notes dated 4/24/07 at 3:40 PM identified that Patient #60 again had a decrease in oxygen saturation to seventy five percent (Normal 94-100 %) while ambulating in the corridor and that the patient's nasal oxygen was increased to three liters per minute with an increase in oxygen saturation to ninety nine percent. The documentation was unclear as to whether or not Patient #60 was receiving any oxygen at the time of ambulation. On 4/25/07 at 10:30 AM, Patient #60 was observed sitting in bed, appeared comfortable, and was without apparent respiratory distress. Patient #60 was receiving nasal oxygen at four liters per minute. Review of the clinical record with Nurse Manager #1 failed to reflect physician orders for titration of nasal oxygen in accordance with the patient's POX values and/or accurate documentation to reflect the patient's complete medical condition in relation to fluctuating oxygen saturation levels.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (2) and/or (4) and/or (i) General (7).

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

11. Based on clinical record reviews, facility documentation and staff interviews, the facility failed to ensure that narcotics were monitored by a licensed pharmacist.
- a. Patient #85 was admitted to the hospital on 3/11/07 with slurred speech and right facial droop. Patient #85 had a history of TIA's and a Glioma resection. Patient #85's code status was changed to a Code III (comfort measures only) due to complications from a previous fall. Physician's orders dated 3/12/07 directed Patient #85 to receive morphine sulfate IV, titrated to comfort, but failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Review of the nursing flowsheets dated 3/12/07-3/14/07 identified that Patient #85's RAAS Score (Richmond Agitation Sedation Score) was a minus five (-5, unarousable). The patient was extubated and started on morphine sulfate IV at 5mg an hour at 2:40PM. Further review of nursing flow sheets identified that Patient #85's morphine sulfate IV was increased to 12mg on 3/13/07 at 8:00 AM and subsequently increased at 6:00 PM to 100mg per hour over a course of 15 hours. The dosage remained at 100mg per hour until 3/14/07 at 9:30 AM when a physician's order directed that the morphine sulfate IV be changed to 5mg per hour. (total dose 3/13/07 2 PM-9 AM 3/14/07/19 hour period = 2,087mg) Interview with the Director of Pharmacy on 5/7/07 identified that the nursing staff removes the morphine from pyxis and mixes the medication on the units. Also, a pharmacist failed to review the medication orders and clarify incomplete orders. Further interview with the Director of Pharmacy on 5/7/07 identified that it is the responsibility of the pharmacy technician to alert the pharmacist when a high volume of a narcotic is taken out of the pyxis machine. Also, a recently implemented computer system for physician orders did not provide an alert for the incomplete order. The print out from the pyxis machine to the pharmacist did not specify per patient who received high volumes of narcotics as it was only unit specific. In addition, review of hospital policy identified that standard concentration of morphine sulfate drips are to be prepared by the Department of Pharmacy. Further review identified that excessive use/ordering patterns for controlled substances are discussed with Director of Pharmacy or other manager to determine follow-up.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (2) and/or (4) and/or (i) General (7).

12. Based on clinical record reviews and interviews with facility personnel for eight of fifteen sampled patients (Patient's #85, #86, #87, #88, #89, #90, #91 and #95), the facility failed to ensure that patients medication orders were accurate, reviewed and monitored to ensure patient safety. The findings include:
- a. Patient #85 was admitted to the hospital on 3/11/07 with slurred speech and right facial droop. Patient #85 had a history of TIA's and a Glioma resection. Patient #85's code status was changed to a Code III (comfort measures only) due to complications from a previous fall. Physician's orders dated 3/12/07 directed Patient #85 to receive morphine sulfate IV, titrated to comfort, the physician's orders failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Review of the nursing flowsheets dated 3/12/07-3/14/07 identified that Patient #85's RAAS Score (Richmond Agitation Sedation Score) was a minus five (-5, unarousable). The patient was extubated and started on morphine

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

sulfate IV at 5mg an hour at 2:40 PM. Further review of nursing flow sheets identified that Patient #85's morphine sulfate IV was increased to 12mg on 3/13/07 at 8:00 AM and subsequently increased at 6:00 PM to 100mg per hour over a course of 10 hours. The dosage remained at 100mg per hour until 3/14/07 at 9:30 AM when a physician's order directed that the morphine sulfate IV be changed to 5mg per hour. Review of nursing documentation identified that Patient #85 remained comatose, had pulse oximetry levels of 59-80's %, and had no signs of discomfort. Further review identified that a physician was not notified for either clarification of the morphine and when morphine was increased. Interview with MD #22 identified that she could not recall if a nurse called her to clarify or increase morphine. Interview with the Director of Pharmacy on 5/7/07 identified that the pharmacist failed to review the medication orders and clarify incomplete orders. A recently implemented computer system for physician orders did not provide an alert for the incomplete order. Although a hospital policy exists for utilizing morphine sulfate IV for sedation, further review of hospital policy failed to identify a protocol, including specific parameters for administration of morphine sulfate drip/continuous IV for palliative care. In addition review of physician orders, dated 3/11/07, directed the staff to administer IV Propofol per RASS protocol, (if patient fights with vent). The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Further review failed to identify that a pharmacist reviewed and/or clarified the titration order.

- b. Patient #86 was admitted to the hospital on 4/17/07 with Pulmonary Embolism. Review of the physician's orders dated 5/6/07 identified that the patient was to receive Fentanyl 2500mcg/250ml- titrate and Norepinephrine 4mg/250ml-titrate. Further review failed to identify the specific parameters for dosing and/or monitoring. Review of hospital policy identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points.
- c. Patient #87 was admitted to the hospital on 5/4/07 with Ascending Aortic Dissection. Review of the physician orders dated 5/4/07 identified that the patient was to receive Propofol 1000mg/100ml-titrate. Further review failed to identify the specific parameters/protocols for dosing and/or monitoring. Review of hospital policy identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Also, review of the nursing flowsheets dated 5/6/07-5/7/07 identified that Patient #87 received Dopamine 400mcg/250ml at 5mg an hour. Further review failed to identify that a physician's order was obtained for the medication and/or that a pharmacist reviewed Patient #87's medication regime.
- d. Patient #88 was admitted to the hospital on 5/6/07 with a drug overdose. Review of physician orders dated 5/6/07 identified that the patient was to receive Propofol drip. Review of the computer physician orders identified the order as Propofol set 1000mg/100ml at 10mg per hour with final concentration at 10mg/ml. Further review failed to identify the specific parameters/protocols for dosing and/or monitoring. Review of the nursing

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- flowsheets dated 5/6/07 and 5/7/07 identified that Patient #88 received Propofol at 15mg per hour and increased to 25mg per hour due to the patient pulling up from the bed. Further review identified that Patient #88's RAAS score remained at negative one (-1; RAAS score goal= zero) and Patient #88 continued on Propofol at 25mg per hour. Further review failed to identify that based on the RAAS score (Richmond Agitation Sedation Score), the medication was decreased per hospital sedation protocol. Review of hospital policy identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.
- e. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral upper extremities, face and neck with a history of hypotension, status post left arm fracture, osteoporosis and difficulty walking. Review of the physician orders, dated 2/1/07, directed the staff to administer the continuous medication of Ativan 80 milligrams (mg) in solution and "titrate to anxiety relief." The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Ativan. In addition review of the physician's order, dated 2/1/07, directed the staff to administer the continuous medication of Fentanyl 2500 micrograms (mcg) in solution and "titrate to pain relief". The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nurse Manager #12, on 5/11/07, identified that there is no protocol for titration of Fentanyl. In addition review of the physician's order, dated 3/15/07, directed the staff to administer continuous medication of Propofol 100 mg in solution and "titrate for dressing changes". The order failed to specify a starting dose, parameters for increasing the dose, dosage increments and/or dosage limits.
- f. Patient #89 was admitted to the hospital on 4/15/07 with shortness of breath. Review of physician's orders on 4/17/07 identified that the patient was to be titrated off an Epinephrine Drip, start Dopamine and sedate RAAS protocol. Further review of physician's orders dated 4/18/07 identified that the patient was to receive Dobutamine at 5mcg however all the orders failed to specify a starting dose and parameters for increasing the dose, dosage increments and/or dosage limits. Interview with Nursing Director of Critical Care on 5/11/07 identified that there are no protocols for Epinephrine, Dopamine, Dobutamine drips for titration. Also, further review on 4/19/07 indicated that Ativan and Haldol were discontinued. Review failed to identify that physician orders were obtained for the Epinephrine Drip, Ativan and Haldol. Review of hospital policy identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.

- g. Patient #90 was admitted to the hospital on 4/7/07 with difficulty breathing. Review of physician orders dated 4/19/07 identified that Patient #90 was to receive a Propofol drip-titrate to sedation. Review of the nursing flowsheets dated 4/19/07-4/21/07 identified that the Propofol was started at 5mg at 5:00AM with a RAAS (Richmond Agitation Sedation Score) score of negative one (-1). Further review of the nursing flowsheets dated 4/19/07-4/21/07 identified that Patient #90's RAAS score remained a negative one (-1; RAAS score goal is zero) and the Propofol drip was increased. Review of the sedation protocol identified that it was not followed based on Patient #90's RAAS score. Review of hospital policies identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.
- h. Patient #91 was admitted to the hospital on 2/3/07 with sepsis. Review of the physician's orders dated 2/3/07 identified that the patient was to receive Propofol drip-titrate for sedation, 2/11/07 Morphine Drip to keep patient in comfort. Review of the nursing flowsheets dated 2/3/07- 2/12/07 identified that on 2/3/07, the patient received Dopamine IV started at 10mg per hour and Dobutamine IV started at 6mg per hour however no physician's order was noted. Review of the nursing flowsheets dated 2/5/07 identified that the patient was started on a Fentanyl IV drip at 5mg per hour however a physician orders for the narcotic was lacking. Further review of the nursing flowsheets dated 2/3-2/12/07 identified that even though the patient was given Fentanyl, Propofol and Morphine IV drip for sedation. Patient's #91 RAAS score was a negative three and the medications for sedation were increased. Further review failed to identify that the sedation protocol was not followed. Review of hospital policies identified that all incomplete medication orders were to be clarified by a pharmacist. Also, all titrated medications must be written to include the required components of a written medication order and are to include patient parameter end points. Interview with the Director of Pharmacy on 5/7/07 identified that they recently implemented a computer system for physician orders and if the physician writes "titrate", the system does not alert pharmacy. Further interview identified that the pharmacist was to review and verify all medication orders and enter them in the computer system.

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

13. Based on review of the medical record, review of facility policy and interview for one patient reviewed (Patient #95) that had the right to privacy, the facility failed to ensure that the patient's

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

privacy and safety was protected. The findings include

- a. Patient #95 was admitted to the hospital on 2/1/07 with the diagnoses of burns to torso, bilateral upper extremities, face and neck with a history of hypotension, status post left arm fracture, osteoporosis and difficulty walking. Review of the medical record, identified full and/or partial body photographs (inclusive of the perineal area) of Patient #95, dated 2/1/07, 3/22/07 and 4/20/07. The record failed to identify that the patient (identified at the time periods as unable to give permission) and/or the patient's representative gave permission to the hospital for the identified photographs. Interview and medical record review with Nurse Manager #12 and Physician Assistant #1, on 5/11/07, identified that the photographs identified are used to document the progression and/or changes of the patient's burns. The facility policy, titled "Permission to Photograph Patient", identified that "permission to photograph a patient must first be obtained from the patient".

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

14. Based on review of clinical record, observation and interview with facility personnel, for one of patients (Patient #36) receiving medications and nutrition through a gastrostomy tube, the nursing staff failed to document medication administration in a timely manner. The findings include:
 - a. Patient #36 was admitted to the hospital on 02/21/07 following a hypertensive pontine hemorrhage, and underwent a gastrostomy tube placement on 02/28/07. Review of Patient #36's electronic medication administration record (EMAR) with the Nurse Manager of Richardson 9 on 04/23/07 at 10:45 AM did not reflect documentation for the administration of Labetalol 200 milligrams (mg) at 6 AM on 04/23/07. Interview with Registered Nurse (RN) #22 on 04/26/07 at 1:30 PM indicated that RN #22 administered the Labetalol at 6 AM on 04/23/07, but failed to document its administration in the EMAR before leaving work at 7 AM.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (g) Pharmacy (2) and/or (4) and/or (i) General (7).

15. Based on reviews of facility policies and procedures, facility documentation, observation, and staff interviews, the facility failed to ensure that outpatient medications for two patients (Patient #83 and Patient #84) were maintained in accordance with facility policy. The findings are as follows:
 - a. During a tour of the Outpatient Psychiatric Services area on 4/25/07, medications for Patient #83 and Patient #84, inclusive of Dextroamphetamine and Depakote, were observed stored in a locked cabinet. Review of the patients' Medication Administration Records (MAR) with RN #25 identified that although the facility confirmed the amount of medications initially brought to the facility by the patients' guardians, the facility lacked a mechanism to continually verify the amount remaining in the container on an on-going basis. RN #25 stated that she notifies the patients' guardians when additional medication is needed. The Children's Partial Hospital Program Medication policy identified that all medications must be delivered

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

to the staff nurse by the patient's legal guardian in its original pharmacy labelled container. A medication receipt is completed, and a count of the medications is confirmed by another staff member. Each medication administered is reflected on the MAR and on proof of use sheet/twenty-four hour control drug record. The facility was unable to provide proof of use sheets for Patient #83 and Patient #84.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (h) Dietary Services (3).

16. Based on observation and interview, the facility failed to ensure that spoiled produce were removed promptly from the produce storage refrigerator and/or that food service personnel maintained acceptable hygiene practices. The findings include:
- During a tour of the dietary department with the Chief Dietician on 4/24/07 at 11:15 AM a large cardboard container stored in the facility's fresh produce refrigerator was observed to contain several apples and included two spoiled apples whose juices had soaked across the bottom of the cardboard container. In addition, a large plastic bin dated 4/20/07 was observed to contain chopped lettuce that had browned and wilted. Interview with the person responsible for daily checks of the produce refrigerator at the time of the observation identified that he had already completed his check of the produce refrigerator earlier that morning. Subsequent to the observation, the items were removed from the refrigerator.
 - During a tour of the Food Services Department on 04/24/07 at 11:30 AM, Food Services Worker (FSW) #1 donned disposable plastic gloves on both hands, used the gloved left hand to open cabinet doors located under the counter, then used the same gloved left hand to directly pick up (using no utensil) shredded lettuce and slices of cucumber to prepare a salad, and sliced bread to prepare a sandwich. Interview with Dietician #1 on 04/24/07 at 11:35 AM indicated that FSW #1 should have gloved only one hand, handled the food with the gloved hand, and opened cabinet doors with the ungloved hand.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (1) and/or (b) Administration (2) and/or (4) and/or (i) General (7).

17. Based on observations, review of hospital policies and procedures, review hospital documentation and interviews with personnel, the hospital failed to ensure an acceptable level of environmental safety and quality. The findings include:
- A tour of the Tower 5/Postpartum Area on 4/26/07 identified that multiple rooms had damaged or broken blinds (Rooms 542, 541, 533 and 531). Interview with the Director of Women's Health on 4/26/07 identified that she was aware of the damaged blinds and was planning to include this in the capital budget for 2007.
 - A tour of the NICU on 4/26/07 identified that the breast milk freezer was noted to have large amounts of ice build-up (4 shelves were full of ice). Review of hospital policy

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- identified that refrigerators are defrosted by Environmental Services as needed however the policy failed to identify the frequency of monitoring. Interview with the Director of Women's Health on 4/26/07 identified that housekeeping was responsible for monitoring the refrigerators.
- c. Tour of the SICU on 4/23/07 identified the upper cabinet of the warming unit was used for warming fluids and registered 117 degrees Fahrenheit. Review of the Use of Warming Unit For Irrigation Solutions/Fluids and Blankets Policy identified that the temperature of the upper cabinet would be maintained at a range of 100-110 degrees Fahrenheit. The Policy indicated that the Biomed Department was to be notified if the temperature range deviated or the warming unit malfunctioned. Interview with the SICU Nurse Manager identified the Biomed Department was not notified because the cabinet had a temperature alarm and the alarm was not activated. Review of the Preventive Maintenance Form for the warming unit identified that the unit was checked and passed on 2/19/07, when the unit was initially put into service. Review of the manufacturer's manual identified that the when the actual temperature in a chamber exceeds the set point by at least 7 degrees Fahrenheit the alarm continuously sounds. The warming unit's upper cabinet failed to alarm as per manufacturer's guidelines.
 - d. Tour of the MICU on 4/23/07 identified two dirty head boards and two foot boards for patient beds were located under the sink in the dirty utility room. Interview with the MICU Nurse Manager identified that the boards did not belong there.
 - e. During a tour of Tower 8 with facility staff on 4/24/07 at 10:10 AM, a corridor storage area identified as the facility's storage area for wound supplies was observed to also store staff members personal clothing that included outerwear and shoes. Interview with the Rehabilitation Program Manager at the time of the observation identified that other options that included a staff coat closet, were available to store staff members' personal belongings.
 - f. Tour of the Primary Care Clinic on 4/25/07 identified that in the patient waiting room, approximately six feet of the vinyl flooring was torn near the door to the medical clinic. Interviews with hospital personnel failed to explain the floor damage.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (1) and/or (4) and/or (b) Administration (2) and/or (4) and/or (i) General (7).

18. Based on a tour of the facility, review of facility policies and procedures, and staff interviews, the facility failed to ensure that equipment was stored, cleaned and/or monitored in accordance with facility policy. The findings include:
 - a. Tour of the Emergency Department on 4/23/07 with the Director identified that the code cart checklists in three areas were not documented in accordance with facility policy. The Urgent Care cart (#3), the Cardiac Cart (#7), and the Holding Room Cart (#10) lacked complete and accurate documentation of the main cart and Pedi-Box lock numbers. The Checking Code Cart policy identified that the code carts in the emergency department are to be checked at the beginning of each shift and the procedure includes

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- ensuring that the main cart drawers and the Pedi-Option box are closed and that the locks are intact. The code Cart Checklist includes separate documentation for the main code cart and lock numbers and the Pedi-Option box and lock numbers.
- b. Tour of the OB/GYN clinic on 4/25/07 identified that the abdominal and transvaginal ultrasound probes were hanging in the ultrasound holster. The abdominal probe was covered with clear, blue-tinted gel and transvaginal probe was tinted blue with a question of gel. Interview with RN #23 identified that, after use, the transvaginal probe was sent to the antenatal testing unit (ATU) for cleaning. However, RN #23 could not identify when the probe was last cleaned. Review of the Cleaning of Transvaginal Ultrasound Probe Policy identified that the transducer was cleaned and soaked for 12 minutes at 20 degrees Celsius with Cidex OPA Solution and that the solution and test strip results would be logged. Interview with the ATU Nurse Manager indicated that the clinic's transvaginal probe was cleaned in ATU and sent back covered in a plastic bag to the clinic, however, the clinic's probe cleaning was not documented. The clinic also lacked a policy regarding cleaning of the abdominal transducer probe.
 - c. Tour of the MICU on 4/23/07 identified that four patient recliner chairs were located in the clean utility room. Interviews with personnel identified the hospital lacked a policy regarding chair cleaning between patient use.
 - d. Tour of the S-7 on 4/25/07 at 1:00 PM identified eight walkers, three patient recliner chairs, and one patient total lift chair located in the clean utility storage area. Interview with Nurse Manager #9 identified that staff nurses wipe off the recliner chairs and total lift chair with "Sani-Wipes" between patient use; however, the Nurse Manager was unable to determine how the walkers were cleaned. Additional interviews with facility personnel identified that the hospital lacked a policy regarding equipment cleaning between patient use.
 - e. Interview and review of the cleaning log for hydroculator #1 with Physical Therapist (PT) #1 in the Outpatient Rehabilitation Center on 04/26/07 at 11:30 AM indicated that hydroculator #1 was cleaned on 04/06/07, then again on 04/25/07 (nineteen days later). According to PT # 1 and the cleaning log directions, hydroculators should have been cleaned on a weekly basis.
 - f. On 04/23/2007 through 04/25/07 at 11:30 AM and at various times throughout the survey, the surveyors observed that the smoke barrier walls above the suspended ceiling assembly in the Tower, Luscomb, Podium, Schine, and Richardson buildings had voids around penetrations used for the passage of wires and conduit, that were not sealed with materials having at least a one-half (1/2) hour fire resistance rating as required and in accordance with the facility's building maintenance program. The facility did not assure that a fire alarm system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4.
 - g. On 04/25/07 at 11:30 AM, the surveyor was not provided documentation by the hospital engineering staff to indicate the semi-annual fire alarm system inspection, testing and maintenance for the fire alarm system at the Mill Hill facility was completed in 2006. The system was recently inspected in 03/07 by Simplex Grinnell.

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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 (e) Medical Staff (1) and/or (i) General (7) and/or (1) Infection Control (4)(E).

19. Based on review of facility policy, observation, and interview, the facility failed to ensure that a staff member maintained isolation precautions during direct care to one patient (Patient #36) who required contact isolation precautions. In addition, for two patients (Patients #76 and #82), the facility failed to utilize clean technique during a dressing change. In addition review of the medical record and interview for one patient reviewed (Patient #96) that required isolation, the facility failed to ensure that the isolation techniques were carried out in a manner to control the spread of infection. The findings included:
- a. Patient #36 had diagnoses that included Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum. Review of the nursing care plan identified the need to maintain contact precautions during the care of the patient. On 4/23/07 at 2:40 PM, Patient Care Assistant #1 (PCA #1) was observed to don an isolation gown and gloves prior to entering Patient #36's room. PCA #1 proceeded to provide direct care to Patient #36 including repositioning and handling of the resident's tracheostomy humidifier tubing. During the care observation, PCA #1's facility issued cell phone rang. PCA #1 was observed to reach beneath her isolation gown to answer the cell phone without the benefit of removing her gloves and/or washing her hands. Interview with facility administrative staff who also witnessed PCA #1's actions identified that staff members were expected to delay answering the phone when in an isolation room. Review of facility policy for contact precautions identified that contact precautions were implemented in addition to Standard Precautions when a patient was known or suspected to be infected or colonized with epidemiology important microorganisms that can be transmitted by direct or indirect contact. The policy directed that gowns and gloves were to be worn by anyone entering the room and that handwashing is done after all patient and environmental contact. In addition, the policy directed staff to ensure that personal clothing does not contact potentially contaminated surfaces.
 - b. Patient #76 was admitted to the hospital on 4/18/07 with blisters to the sacrum, grade two bed sores peri-rectally, and four (4) small stage two ulcers on the buttocks, pink and red in color. Observation of wound care for the patient on 4/25/07 at 2:15 PM with the Wound Consultant Nurse and RN #27 identified that the patient had stage 2 pressure ulcers to the peri-rectal and buttocks areas, and that the patient had been incontinent of a small amount of stool. After using a wet cloth and gloves to cleanse the peri-rectal and buttocks areas, RN #27 was observed providing care to the pressure sores without the benefit of hand washing and/or changing gloves. Interview with the Wound Consultant on 4/25/07 at 2:35 PM identified that the nurse should have changed her gloves prior to providing care to the patient's wounds. Review of the facility's policies regarding Incontinence and Skin Care and/or Hand Washing identified in part, that after each episode of incontinence staff should put on gloves, cleanse the soiled skin, pat dry and

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

change gloves. Hand washing was to be done before and after contact with wounds and after contact with equipment and/or articles contaminated with potentially infectious material. Further review of the facility's policy for Incontinence and Skin Care failed to provide instructions for staff after cleansing the patient's soiled skin and prior to the use of a barrier cream. Interview and review of the policy and procedure for Incontinence and Skin Care with the Chief Operations Officer (COO) on 4/26/07 at 1:35 PM identified that the instructions for a glove change was omitted from the policy and that it would be added. Subsequent to the surveyor's inquiry the policy was revised on 4/26/07 to include change of gloves following cleansing of the patient's soiled skin.

- c. Patient #82 was admitted on 2/28/07 with sepsis and multi-system failure. Review of nursing documentation identified that Patient #82 had three Stage II pressure areas to the left ishium, coccyx and left buttocks. Observation of the dressing change on 4/24/07 identified that RN # 30 had washed the three Stage II pressure areas with a wet washcloth and applied a Tegaderm dressing without changing her gloves. Review of hospital policy identified that clean technique dressing change consisted of washing the wound with normal saline, pat dry with a gauze and applying a Tegaderm dressing. Interview with the infection control nurse on 4/26/07 identified that clean technique should be used with any treatment of a Stage II pressure area.
- d. Patient #96 was admitted to the hospital on 1/21/07 with the diagnosis of burns legs. During a tour of the unit, on 5/11/07, outside of Patient #96's room it was identified that a disposable isolation gown was hanging on the doorknob and facility notification identified that the patient required isolation. Nurse Manager #12 identified that Patient #96 was on isolation for an infection of Methicillin-Resistant Staphylococcus Aureus (MRSA) in a wound, the patient hangs the disposable gown, after use, on the doorknob (and that is not acceptable practice) and the staff has educated/informed the patient, through an interpreter, about the MRSA infection and isolation techniques. Review of the Interdisciplinary Plan of Care, dated 1/21/07, identified that Patient #96 was "limited in English proficiency" although documentation was lacking that the patient and/or family members were educated/informed of the MRSA wound infection and/or on the appropriate isolation techniques. Interview with Nurse Manger #12, on 5/11/07, identified that there is no documentation that Patient #96 was educated and/or informed about the MRSA wound infection and/or the appropriate isolation techniques.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (1) Infection Control (4)(C) and/or (D).

20. Based on a tour of the facility, the following was identified:
 - a. A tour of the Tower 5/newborn nursery on 4/26/07 identified that soiled instruments were stored in the nursery area after a circumcision. Interview with the Director of Women's Health on 4/26/07 identified that all soiled instruments are to be brought to the soiled utility room for pick up by central sterilization.
 - b. A tour of the Tower 5/Postpartum Area on 4/26/07 identified that the soiled utility room

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

- contained multiple containers of sterile water and Enfamil. Interview with the Director of Women's Health on 4/26/07 identified that these items are to be kept in the clean utility room. Subsequently, the items were immediately removed from the soiled utility room.
- c. A tour of the NICU on 4/26/07 identified that clean paper items and clean equipment was stored in the soiled utility room. Interview with the NICU manager and the Director of Women's Health on 4/26/07 identified that these items are to be kept in the clean utility room. Subsequently, the items were removed from the soiled utility room.

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

21. Based on review of medical record, interview with facility personnel and review of the facility policy, for two of 10 surgical records reviewed (Patients #45 and #46), the facility failed to ensure that the history and physical (H&P) completed prior to surgery was completed and/or dated as to when it was completed. The findings include:
- Patient #45 underwent an excision of basal cell carcinoma of the right eyelid with reconstruction on 4/23/07. Review of the patient's H&P identified that it failed to be dated as to when it was completed prior to the surgery.
 - Patient #46 underwent outpatient surgery on 4/23/07. Review of the surgical record failed to identify that a pre-operative H&P had been completed. Review of the Medical Staff Bylaw Rules and Regulations directs that the H&P must be completed within thirty (30) days prior to surgery with an update at the time of surgery.

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 (d) Medical Records (8).

22. Based on review of medical records, interview with facility personnel and review of the facility policy, for three (3) of 17 medical records reviewed (Patients #44, #50 and #51) for informed consents, the facility failed to ensure that the physician performing the surgery/procedure signed the informed consent form. The findings include:
- Review of the surgical record for Patients #44, #50 and #51 identified that the informed consent obtained prior to surgery failed to have the physician's signature and the risk/benefits listed as explained to the patient. Review of the facility policy for Patient Consent to Medical Treatment, Surgery and Anesthesia directed that the responsibility for completion of the consent form rested with the attending physician however, failed to direct documentation of the actual informed consent process. During interview the VP of Medical Staff stated that the policy is in revision and has not yet received approval. He stated that the informed consent form was revised on 4/2/07 and while the new forms were distributed throughout the hospital and physician offices, some "old" forms were still being utilized.

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

EXHIBIT B

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

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

23. Based on review of the medical record, review of the Medical Staff Bylaw Rules and Regulations and interview with facility personnel, for one (1) Patient (#68) reviewed for surgical services, the facility failed to ensure that an immediate post-operative note was written post surgery. The findings include:
- a. Patient #68 underwent a left upper lobe lobectomy on 4/18/07. Review of the medical record reflected that an immediate post-operative note was lacking. Review of the Medical Staff Bylaw Rules and Regulations identified that all operations and invasive procedures should be fully described immediately by narrative in the medical record.

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

24. Based on reviews of the medical record, facility policies and procedures, and staff interviews for one patient (Patient #72), the facility failed to provide a post-anesthesia report. The findings include:
- a. Patient #72 underwent an anterior cervical discectomy and fusion on 3/19/07. Review of the medical record with Nurse Manager #9 on 4/25/07 identified that documentation was lacking to reflect that a post-operative evaluation had been conducted by anesthesia. Review of the facility's anesthesia policy identified that anesthesia must review each patient's condition post-operatively.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (j) Emergencies (2).

25. Based on reviews of the medical records, facility policies and procedures, facility documentation, and staff interviews for two patients (Patient #30 and Patient #34), the facility failed to ensure that timely assessments were conducted and/or that care was provided to meet the needs of emergency patients in accordance with facility policies. The findings include:
- a. Patient #30 arrived at the emergency department on 11/16/06 at 7:53 PM with right upper quadrant abdominal pain. The initial nursing assessment identified that the patient was triaged at a level III, urgent, which according to the facility triage policy indicated the utilization of at least two or more resources. Patient #30's abdominal pain was rated a level "4" on a "1-10" scale; however, the patient's abdomen was not assessed at that time. The "Emergency Department Initial Treatment Guidelines", which were revised 10/2005, identified that lab work, inclusive of a complete blood count, urine dip, lipase, and complete metabolic panel can be obtained for patients exhibiting moderate abdominal pain and that patients triaged at a level III should be evaluated by a physician within sixty minutes. RN #24, the triage nurse, stated that patients in the waiting room are constantly observed and typically if a patient is triaged at a level III, a reassessment

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

EXHIBIT B

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

is done within two hours; however, guidelines may not have been followed if it was busy. The Emergency Department Nursing Assessment policy identified that patients assigned a Triage Acuity III, whose length of stay exceeds four hours, will have a secondary nursing assessment. Review of the medical record with the Director of the Emergency Department on 4/24/07 identified that Patient #30 was not reassessed following the initial nursing triage at 7:58 PM, despite a moderate level of abdominal pain and a triage acuity level III. RN #24, the triage nurse, stated that after a patient is triaged, he brings the chart to the emergency department and the charge nurse becomes responsible for the patient. The medical record failed to reflect that additional assessments or procedures were performed. Facility documentation dated 11/17/06 at 2:11 AM identified that the patient was no longer in the facility. Patient #30 reported that he questioned the waiting time and expressed concern on several occasions and that after waiting approximately four and a half hours, left the facility without being seen by a physician. Patient #30 was subsequently admitted to another facility and underwent an appendectomy. The Director of the Emergency Department stated that Patient #30 should have had another assessment completed by 12:00 AM, the charge nurse dictates the reassessments, and the charge nurse should have been notified if the patient expressed concerns about waiting. Review of the Nursing Assessment Emergency Services and Triage policies on 4/26/07 with the Director of the Emergency Department identified that the initial patient assessment begins at the time of presentation and the Triage Nurse provides a verbal report to the Primary Nurse on all patients triaged at a level I, II or III. The Triage Nurse will observe and continually reassess patients awaiting treatment in the waiting room and reassessments of patients will occur based on acuity and initial assessment until transferred into the emergency department for treatment.

- b. Patient #34's diagnoses included depression and schizoaffective disorder. The patient was evaluated in the emergency department on 4/19/07 following a Police Emergency Request. A fifteen-day Physician's Emergency Certificate was executed on 4/20/07 and the patient was identified as a flight risk. Review of the medical record dated 4/20/07 to 4/23/07 with the Director of the Emergency Department on 4/23/07 identified that it failed to reflect a comprehensive plan of care to address the patient's psychiatric needs while the patient was in the emergency department awaiting placement at an in-patient psychiatric facility. Although the patient was medicated daily, the medical record lacked identification of the patient's daily care, interventions to address the patient's exhibited behaviors, and/or psychiatric treatment goals. Patient #34 was discharged to an in-patient psychiatric facility on 4/24/07 at 2:00 PM (five days after admission to the emergency department). The Emergency Department Multidisciplinary Behavioral Health Treatment Plan policy identified that the Psychiatric Crisis staff in the Emergency Department will utilize the Emergency Department Multidisciplinary Behavioral Treatment Plan form to document mental health patients' daily care and goals. A treatment plan will be generated on each mental health patient who has a length of stay greater than twenty-four hours.

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

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

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (7).

26. Based on clinical record reviews and interviews with facility personnel for one of one sampled patients, (Patient #82), the facility failed to ensure that restraint orders are timed and/or that a face to face evaluation is completed. The findings include:
- Patient #82 was admitted to the hospital on 2/28/07 with septic shock. Review of the restraint order sheets dated 3/2/07, 3/3/07, 3/15/07, 3/16/07, 3/20/07 and 3/30/07 identified that Patient #82 had wrist restraints applied due to restlessness, agitation and pulling at tubes. Although the restraint order was signed by a licensed independent practitioner, the time of the evaluation and the face to face assessment was not completed. Interview with the Chief Operating Officer on 4/27/07 identified that the facility was unaware that a face to face evaluation was required within one hour for all initial restraints.

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

27. Based on review of the medical record, review of facility policy and interview with facility personnel, the facility failed to ensure that all patient medical record entries were complete.
- Patient #51 underwent anesthesia during an endoscopy procedure. Review of the anesthesia record with the VP of Patient Care Services reflected that the patient received the medications Ketamine and propofol during the procedure. The amount of the propofol administered was lacking. The anesthesiologist and CRNA responsible for the patient were notified and the omission was corrected immediately.
 - Based on review of the clinical record, facility documentation and staff interview for two patients (Patients #31 and #76) with orders for treatments to their decubitus ulcers the facility failed to ensure that the physician's order for the treatments were complete. The findings include:
 - Patient #76 was admitted to hospital on 4/18/07 with diagnoses that included shortness of breath, hypotension, lethargy and pneumonia and was identified with blisters to the sacrum, grade two bed sores peri-rectally, and four (4) small stage two ulcers on the buttocks, pink and red in color. Review of the nursing note dated 4/22/07 at 21:50 (9:50 PM), identified multiple open areas bilaterally to the buttocks. The physician was notified and Xenaderm was ordered and applied. A physician's order dated 4/22/07 directed the use of Xenaderm Ointment BID (twice daily). A review of the physicians order dated 4/18/07 identified an order for a hydrocolloid dressing to the right buttocks. Interview and review of the clinical record with RN #27 on 4/25/07 at 2:38 PM

DATES OF VISIT: April 23, 24, 25, 26 and May 7, 10 and 11, 2007

EXHIBIT B

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
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- identified that the patient was receiving a hydrocolloid dressing (i.e. Tegaserb) to the right side of the buttocks and Xenaderm ointment twice a day to the buttocks and coccyx area. Interview further identified that the physician's order failed to specify the area of treatment for the use of the Xenaderm ointment.
- d. Patient #31 was admitted to the hospital on 3/16/07 with diagnoses that included a left foot puncture wound, left foot cellulitis and diabetes. Review of the Medication Administration History directed topical bacitracin and topical vitamin A & D daily, however, failed to identify the application location. The Medication Administration History also directed Acticoat dressing to the right posterior arm/axilla area every 72 hours. Observation of Patient #31 on 4/26/07 identified that the patient had 9 pressure ulcers and Acticoat was applied to several areas that included the patient's right and left axillae, the left hip and the back. Desitin was applied to three Stage II buttock wounds. Interviews with hospital staff identified that the physician's orders failed to specify the other areas of treatment for the use of the Acticoat dressing and the Desitin ointment.
- e. Patient # 78 was admitted to the hospital on 4/24/07 for a vaginal delivery. Review of the medical record identified that the CRNA ordered an obstetrical epidural. Review of the order, a preprinted form, failed to identify what the medication was, when the order was written or at what time. In addition, the pre-anesthesia evaluation failed to be timed. During interview the anesthesiologist acknowledged that the order was incomplete. Review of the facility Protocol for Continuous Analgesia In Obstetrics directs that the CRNA, MD or pain control nurse who attaches the tubing to the epidural will verify the drug, dose and site of infusion with another member of anesthesia.

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.