

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

IN RE:           Lawrence and Memorial Corporation of New London, CT d/b/a  
                  Lawrence and Memorial Hospital  
                  365 Montauk Avenue  
                  New London, CT 06320

STIPULATED AGREEMENT

WHEREAS, Lawrence and Memorial Corporation of New London, CT. (hereinafter the “Licensee”), has been issued Licensee No. 0047 to operate a General Hospital known as Lawrence and Memorial Hospital, (hereinafter the “Facility”) under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the “Department”); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter “FLIS”) of the Department conducted unannounced inspections on various dates commencing on December 28, 2006 concluding May 8, 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 13, 2007 (Exhibit A – copy attached) and May 8<sup>th</sup>, 2007 (Exhibit B – copy attached); and

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

WHEREAS, the Licensee has implemented changes in response to concerns expressed by the Department; and

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NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Bruce Cummings, its Chief Executive Officer (CEO)/Administrator, hereby stipulate and agree as follows:

1. The Consent Order executed with the Department on July 6, 2006, (Exhibit C – copy attached) shall be incorporated and made part of this Stipulated Agreement.
2. Within fourteen (14) days of the execution of this Stipulated Agreement, the facility shall develop and/or review and revise, as necessary, policies related to:
  - a. Preventative skin care and/or change in patient status;
  - b. Pressure ulcer and wound assessments;
  - c. Pressure ulcer treatments;
  - d. Physician notification pertinent to pressure ulcer development and/or deterioration and/or change in patient status;
  - e. Pain and restraint assessments and/or reassessments;
  - f. Fall assessments;
  - g. Neurological assessments;
  - h. Care planning; and
  - i. Isolation precautions for staff and visitors.
3. Whereas, the facility staff has implemented inservices for facility nursing staff on policies and procedures identified in paragraph two (2).
4. The Licensee shall continue to employ a Wound Care Nurse Specialist. The Wound Care Nurse's duties shall be performed by a single individual unless otherwise approved by the Department.
5. The Wound Care Nurse shall be employed by the facility for thirty-two (32) hours a week for the duration of the Stipulated Agreement.
6. The Wound Care Nurse Specialist shall have the responsibility for:
  - a. Assessing, monitoring of patients at risk for and/or with actual pressure ulcers and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses and nurse aides, and implementing

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prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department.

7. 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. The Licensee shall incur the cost of the INC.
8. The INC shall function in accordance with the FLIS' INC Guidelines (Exhibit D – 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 of the Regulations of Connecticut State Agencies.
9. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility twenty (20) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Stipulated Agreement.
10. The INC shall have a fiduciary responsibility to the Department.
11. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within three (3) weeks after the execution of this document.

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12. The INC shall confer with the Licensee's Administrator, Vice President of Nursing (VP Nursing), Wound Care Nurse Specialist 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 statutes and regulations.
13. The INC shall make recommendations to the Licensee's Administrator and Vice President of Nursing 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.
14. 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 statutes and regulations; and
  - c. Any recommendations made by the INC and the Licensee's response to implementation made by the INC and the Licensee's response to implementation of the recommendations.
15. Copies of all INC reports shall be simultaneously provided to the Administrator, Vice President of Nursing and the Department.
16. The INC shall have the responsibility for:
  - a. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides and patient care technicians prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training; and/or remediation shall be maintained by the Licensee for review by the Department;

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- b. Assessing, monitoring and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
  - c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
  - d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letters dated March 13, 2007 and May 8, 2007 (Exhibits A & B).
17. The INC, the Licensee's Administrator and the Vice President of Nursing shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Stipulated Agreement and thereafter twelve (12) week intervals throughout the tenure of the INC. 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 statutes and regulations.
18. 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.
19. The Department shall retain the authority to extend the period the INC's functions is required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
20. Effective immediately upon execution of the Stipulated Agreement, the Licensee shall continue to employ a full time Infection Control Nurse (ICN) whose sole responsibility is to implement an infection prevention, surveillance and control program which shall have as its purpose, the protection of patients. The RN shall

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have expertise and experience specific to infection control. The ICN, in conjunction with the Vice President of Nursing Services shall implement a mechanism to ensure that each patient with an infection is properly identified and receives the appropriate care and services pertinent to the identified infection. The ICN shall ensure the following:

- a. Maintenance of an effective infection control program;
- b. Review of the facility's policies/procedures pursuant to infection control prevention with the Vice President of Nursing Services and revise, as necessary;
- c. Inservicing of staff pursuant to infection control principles and practices;
- d. Development of policies and procedures relative to comprehensive infection control and employee health and/or specific criteria for the identification of health care associated infections and required precautions techniques; and
- e. Development of specific written criteria for surveillance program for patients, visitors and employees.

21. The Licensee shall incorporate into the hospital's Quality Assurance program indicators to analyze data and track quality pertinent to the prevention and care of at risk for and/or with actual skin impairment and/or the triage and/or assessment and/or monitoring of patients in the Emergency Department.
22. Within thirty (30) days of the completion of inservice education, the facility shall add to its quality improvement initiatives, measures to assess and ensure compliance with the terms of the Stipulated Agreement that includes a process for remediation of staff that is found to not be in compliance with facility policy and procedures. Documentation of all quality improvement activities shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

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23. Effective upon the execution of this Stipulated Agreement, the Licensee through its Governing Body/CEO and Vice President of Nursing Services, shall ensure substantial compliance with the following:
- a. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
  - b. Patient assessments, inclusive of skin assessments, are performed in a timely manner, are documented in the clinical record and accurately reflect the condition of the patient;
  - c. Each patient care plan is reviewed and revised to reflect the individual patient's problem, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulation;
  - d. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity and/or presence of any infection;
  - e. Patient's skin 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;
  - f. Necessary pressure relieving devices are provided to patients at risk for and/or with actual skin impairment; and
  - g. Patients receiving care in the Emergency Department are appropriately triaged and/or assessed and/or monitored in accordance with acceptable standards of practice.
24. Within fourteen (14) days of the execution of this Stipulated Agreement, the Licensee shall review and/or revise policies pertinent to the ongoing care of patients in the Emergency Department and/or awaiting disposition to ensure compliance with acceptable standards of care.

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25. Within twenty-one (21) days of the review and/or revision of the Emergency Department's policies identified in paragraph twenty-four (24), all nursing staff, as applicable, shall be inserviced on said policies.
26. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the facility to monitor the requirements of this Stipulated Agreement. The name of the designated individual shall be provided to the Department within said time frame.
27. The Licensee shall:
  - a. Allocate twenty-five thousand dollars (\$25,000.00) to develop and provide educational seminars on the prevention and care of patients with pressure ulcers and infection control principles and practices;
  - b. Include both internal and external health care practitioners in this seminar. There shall be no charge for attendance. The programs shall be comprehensive, held in the hospital's Baker Auditorium, which has a capacity for 110 attendees, and each session will be presented twice in order to accommodate internal and external attendees;
  - c. Ensure presenters include experts in their field of study. Conference content-handouts will be provided to each program attendee;
  - d. Ensure documentation of attendance be maintained on file for DPH's review.
28. All parties agree that this Stipulated Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Stipulated Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated as assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Stipulated Agreement

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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.

29. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MCFU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
30. The terms of this Stipulated Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
31. 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 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.
32. The Licensee had the opportunity to consult with any attorney prior to the execution of this Stipulated Agreement.

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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.

LAWRENCE AND MEMORIAL CORPORATION OF NEW LONDON, CT - Licensee

August 17 2007 Date By: [Signature] Bruce Cummings, Chief Executive Officer/ Administrator

STATE OF Connecticut )

County of New London ) ss August 17 2007

Personally appeared the above named Bruce D. Cummings and made oath to the truth of the statements contained herein.

My Commission Expires: 6/30/09 (If Notary Public) [Signature] Notary Public  Justice of the Peace  Town Clerk  Commissioner of the Superior Court  JACQUELINE E. COOPER NOTARY PUBLIC MY COMMISSION EXPIRES JUNE 30, 2009

STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC HEALTH

8/21/07 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**  
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March 13, 2007

Bruce Cummings, President  
Lawrence & Memorial Hospital  
365 Montauk Avenue  
New London, CT 06320

Dear Mr. Cummings:

Unannounced visits were made to Lawrence & Memorial Hospital on December 28, 29, February 15, 16, 21 and 22, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and reviewing the implementation of the Consent Agreement dated July 6, 2006 in response to violation letter dated March 26, 2006, reviewing the plan of correction for violation letter dated September 27, 2007 and review of the plan of correction for the violation letter dated November 15, 2006 and conducting a substantial allegation 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 March 29, 2007 at 10:00 A.M. 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,

Judy McDonald, R.N.  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

JFM:PMG:lsj

c. Director of Nurses  
CT #5742, #6110



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: December 28, 29, 2006, February 15, 16, 21 and 22, 2007

THE FOLLOWING VIOLATION(S) 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-D8t (b) Administration (2) and/or (e) Nursing Service (1) and/or (l) Infection Control (1) and/or (4)(B) and/or (D).

1. \* Based on a review of medical records, facility policies and procedures, facility documentation, and interviews, the facility failed to ensure that the occurrence of and the reasons for the development of skin breakdown and assessments, treatments and preventive interventions were a component of the Quality Assurance and Performance Improvement program and that comprehensive and structured Infection Control and Employee Health Programs were developed that included specific policies and procedures for the surveillance, prevention and control of infections.

During visits made on 12/28, and 12/29/06 and 2/15, 2/16, 2/21, and 2/22/07, the Department identified that for nine patients (Patients #15, #18, #20, #21, #25, #26, #27, #33, and #39), the facility failed to ensure that comprehensive and/or accurate skin assessments were completed, that skin protocols were implemented and/or that the physician was notified when there was a change in a patient's skin integrity.

During the same visit dates, the care plans of eight patients (Patients # 15, #18, #20, #21, #25, #28, #33, and #39) lacked individualized problems, goals, and/or interventions to address the risk for and/or development of pressure ulcers with specific interventions for skin care.

A review of the facility's Quality Improvement Committee Minutes for 2006 failed to reflect that the problem of pressure sores which had been identified in a violation letter dated 11/15/06 had been incorporated into the facility's performance improvement plan. Although the facility provided corrective measure for the problem in a plan of correction dated December 22, 2006, subsequent visits conducted at the Hospital on 12/28, and 12/29/06 and 2/15, 2/16, 2/21, and 2/22/07 identified recurrent problems in this area.

During the 12/28 and 12/29/06 visit, infection control concerns were identified for one patient (Patient #1) and were discussed with the facility on 12/28/06 and again on 1/10/07. On a subsequent visit on 2/15, 2/16, 2/21, and 2/22/07, additional observations and record reviews of six patients (Patients #13, #17, #19, #34, #35, and #36) were conducted and identified additional concerns related to infection control.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (b) Administration (2) and/or (d) Medical Records (2) and/or (e) Nursing Service (1).

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2. For nine of eighteen patients reviewed for skin impairment issues, Patients #15, 18, #20, #21, #25, #26, #27, #33, and #39, the facility failed to provide pressure relieving/pressure reducing devices for patients at risk to develop pressure ulcers and/or provide care in accordance with the plan of care, physician orders, or facility protocols and/or ensure that pressure ulcers were consistently and accurately assessed and monitored in accordance with facility policies and/or provide consults as directed by facility policy for patients at risk to develop pressure ulcers. In addition, for three patients, Patients #16, #25, and #27, who experienced a change in condition and/or were identified to have developed a pressure ulcer, the facility failed to provide documentation that physicians were promptly notified. In addition, for five of twelve patients experiencing pain or requiring restraints, Patients #3, #4, #15, #23, and #30, the facility failed to provide timely pain and restraint assessment/reassessments. In addition, for two of five patients, Patients #14 and #16 who required a Foley catheters, the facility failed to ensure that written physician orders were obtained for placement of the Foley catheter. In addition, for one patient at risk for falls (Patient #2), the facility failed to ensure that the patient was evaluated and monitored and/or that the physician was notified of a change in condition. The findings were based on review of clinical records, review of facility policies, observations, and interviews and include the following:
  - a. Patient #15 was admitted to the facility on 12/29/07 from a skilled nursing facility for diagnoses that included right ankle abscess with subsequent diagnoses of a septic right ankle and osteomyelitis. Review of the admission nursing assessment dated 12/29/07 identified that Patient #15 entered the facility without a pressure ulcer. On 1/1/07, Patient #15 was taken to the Operating Room (OR) for incision and drainage of the right ankle abscess. Two days later on 1/3/07, a photograph of the patient's right medial and lateral posterior ankle was taken. Review of the photograph identified an area of eschar at the right heel. Documentation was lacking of a nursing care plan to address the right heel eschar area, measurements of the right heel, and/or treatment to the right heel. A Physical therapy (PT) note dated 1/9/07 (six days after the photograph was taken) directed that Patient #15's heels be elevated on pillows to decrease pressure areas. A physician progress note dated 1/13/07 identified the blackened eschar area and documented that the area would need debridement, however, documentation was lacking to reflect that the procedure was completed before discharge on 1/14/07. On 1/14/07, Patient #15 was discharged back to the skilled nursing facility. Review of Patient #15's hospital discharge summary dated 1/14/07 and the interagency referral form dated 1/14/07 failed to identify the right heel eschar area. Review of the nursing readmission assessment from the skilled nursing facility dated 1/14/07 identified that Patient #15 reentered the facility with a three by two centimeter unstageable right heel pressure ulcer.

In addition, Patient #15 was admitted to the facility on 2/6/07. Review of the admission nursing assessment dated 2/6/07 identified that Patient #15 was at risk to develop

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pressure ulcers. In addition, review of the nursing care plan dated 2/6/07 identified Patient #15 with an alteration in elimination as evidenced by incontinence. Observation of Patient #15 on 2/15/07 at 11:30 AM identified that the patient was incontinent of a large amount of soft formed stool and was provided incontinent care by Patient Care Assistant #1 (PCA #1) and Nursing Student #1. PCA #1 failed to apply barrier cream to Patient #15's reddened buttocks and coccyx area. Interview with Nurse Manager #2 on 2/15/07 at 11:40 AM, identified that staff would be expected to apply barrier cream after incontinent episodes in accordance with the facility's wound care protocols. Subsequent to surveyor inquiry, PCA #1 obtained the barrier cream from the supply room and applied the cream to Patient #15's buttocks area.

- b. Patient #39 was admitted to the hospital on 2/9/07 via the Emergency Department (ED) with the complaints of chest pain for three days, was hypotensive and subsequently diagnosed with sepsis, shock, pneumonia and acute renal failure. Patient #39 had a history of congestive heart failure, an ejection fraction of 15%, chronic obstructive pulmonary disease, status post automated implanted cardiac defibrillator and pacemaker and degenerative joint disease. Patient #39 entered the facility without a pressure ulcer. Review of the pressure ulcer documentation record, dated 2/20/07, identified that Patient #39 had four pressure ulcers (on the coccyx, the right foot, the ball of the left foot and the left foot) and documentation was lacking for three of the four areas for the stage and the depth of the pressure ulcers. Review of the hospital policy, titled "Skin Care and Pressure Ulcer Prevention and Treatment", identified that the depth of the ulcer is measured and documented and the stage of the ulcer is documented.

In addition, review of the nursing admission assessment, dated 2/9/07, identified that the Braden Risk Assessment for Patient #39 was inaccurate, specifically the level of activity was listed as slightly impaired when the physician order, dated 2/9/07, directed the staff to maintain the patient on bedrest. In addition review of the nursing note, dated 2/11/07 at 11:00 P.M., identified that the patient now had a Stage I pressure ulcer to the coccyx but lacked documentation to reflect that a Braden Risk Assessment was completed with that change in condition. Review of the hospital policy, titled "Skin care and Pressure Ulcer Prevention & Treatment" identified that a Braden Risk Assessment is completed upon a notable change. In addition, review of the physician's orders, dated 2/9/07, identified that the patient was to be maintained on bedrest, although the nurses notes dated 2/11/07 identified that Patient #39 was assisted out of bed to a chair.

- c. Patient #20 was admitted to the hospital on 2/7/07 with a diagnosis of congestive heart failure. Review of the clinical record with RN #21 on 2/15/07 failed to identify that an admission Braden assessment was conducted in accordance with hospital policy. In addition, review of a Braden assessment dated 2/13/06 identified that the patient was at high risk for the development of a pressure ulcer with a score of fourteen (14) points (score of 16 or less is considered high risk). The Braden tool directed that the Skin

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Protocol be implemented and the Dietician and Wound Nurse be consulted. Interviews with RN #7 (Wound Nurse) and RN #21 failed to identify that the skin protocol and consults were implemented. Review of the clinical record with RN #21 identified that the patient required assistance with positioning and transfers, and had penile and scrotal edema. On 2/15/06 and 2/16/07, the patient was observed sitting in a recliner chair without the benefit of a pressure-relieving cushion. Interview with RN #21 identified that the unit does not have pressure-relieving chair cushions.

- d. Patient #18 was admitted to the facility on 2/7/07 with diagnoses that included respiratory failure. Review of the admission assessment dated 2/7/07 identified that Patient #18 was assessed utilizing a Braden Scale assessment, with a score of twelve (a score of twelve or less placed patients at high risk to develop pressure ulcers. A reassessment for the potential for the development of pressure ulcers dated 2/13/07 identified Patient #18 with a score of fifteen. Parameters for the assessment document used on 2/13/07 identified that any patient with a score of sixteen or less would be classified as at high risk. Although the patient was identified as high risk for the development of pressure ulcers, the facility failed to ensure that a pressure relieving device was placed on the patient's chair. Observation of Patient #18 on 2/15 and on 2/16/07 at 11:30 AM identified that the patient was sitting up in a bedside chair without the benefit of a pressure relieving/pressure reducing chair cushion. Observation of Patient 18's coccyx area on 2/16/07 at 11:35 AM identified that the patient's coccyx was reddened but without skin breakdown.
- e. Patient #20 was admitted to the hospital on 2/7/07 with a diagnosis of congestive heart failure. Review of the clinical record with RN #21 on 2/15/07 failed to identify that an admission Braden assessment was conducted in accordance with hospital policy. In addition, review of a Braden assessment dated 2/13/07 identified that the patient was at high risk for the development of a pressure ulcer with a score of fourteen (14) points (score of 16 or less is considered high risk). The Braden tool directed that the Skin Protocol be implemented and the Dietician and Wound Nurse be consulted. Interviews with RN #7 (Wound Nurse) and RN #21 failed to identify that the skin protocol and consults were implemented.
- f. Patient #21 was admitted to the hospital on 2/8/07 with a diagnosis of dehydration and a history of a stroke. Review of the nursing admission assessment dated 2/9/07 identified that the patient's skin turgor was poor; the patient was dependent on staff for all activities of daily living and was at moderate risk for the development of pressure ulcers. A subsequent Braden assessment dated 2/13/07 identified that the patient was determined to be at high risk for skin breakdown. Interviews with RN #7 (Wound Nurse) and RN #21 failed to identify that the skin protocol that included individual interventions based on the Braden criteria and consults with the Wound Nurse and Dietician were implemented in accordance with the hospital's policy. On 2/15/07 at

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12:05 PM, the patient was observed seated in a recliner chair with a Hoyer pad beneath the patient. The patient's heels were resting directly on the chair. The facility failed to provide preventative measures to reduce pressure to the patient's buttocks and heels while seated in the chair. At 1:37 PM, the patient was observed lying in bed on her back with her heels lying against the mattress. The patient's skin was observed with RN #21 and LPN #4. The patient's buttocks were described as slightly reddened; the right heel was described as slightly red, boggy and soft and the right heel was slightly red and not "as boggy" as the right heel. LPN #4 stated that the patient should have been provided with a pillow beneath her heels and was subsequently positioned off her buttocks and heels elevated off the mattress.

- g. Patient #25's diagnoses included Congestive Heart Failure and obesity. The admission assessment dated 2/15/07 at 2:45 AM noted a one centimeter (cm) circular pressure ulcer to the Patient's right buttock. Wound documentation dated 2/15/07 at 7:00 AM reflected that the one cm. Stage II pressure ulcer had superficial depth and the area was washed with normal saline and a protective barrier cream was applied (Aloe Vesta). Observation on 2/16/07 at 10:35 AM noted RN #16 applied Aloe Vesta cream to the Patient's right buttock ulcer. Wound documentation by RN #16 dated 2/16/07 noted the right buttock pressure ulcer now measured 0.5cm in circumference and treatment was changed to a hydrocolloid dressing (Duoderm). Review of the facility policy for Pressure Ulcer Prevention and Treatment with the Director of In-Patient Services on 2/16/07 at 12:20 PM identified that the required treatment for Stage II partial thickness pressure ulcers was a hydrocolloid dressing (Duoderm/Tegaderm). In addition, a review of the Patient's medical record with the Director of In-Patient Services on 2/16/07 at 12:20 PM noted that documentation of any application of treatment to the right buttock was lacking for the shift that the Patient was admitted (2/15/07 at 2:45 AM). Although documentation was provided that Aloe Vesta was applied on the day shift of 2/15/07, no additional treatment was provided to the area until the day shift on 2/16/07 (approximately twenty four hours later).
- h. Patient #26's diagnoses included left hip fracture, status post left hip repair on 2/15/07. The initial nursing skin risk assessment dated 2/14/07 identified that the Patient was at "moderate risk" for the development of pressure ulcers (Braden score of 14; high =<16). The care plan dated 2/15/07 through 2/16/07 reflected impaired skin integrity, a goal of no signs of skin breakdown and an intervention for skin assessments per protocol. Review of the skin care protocol directed that both a wound care consult and nutritional consult would be obtained for any Patient with a Braden Scale of 16 or less. Interview with RN #25 on 2/16/07 at 1:45 PM identified that although a dietary consult for the Patient had been requested via the computerized system, a request for a wound care consult had not been initiated.
- i. Patient #27 was admitted on 1/28/07 with a diagnosis of cerebrovascular accident with

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left hemiparesis. Review of the nursing admission assessment with RN # 17 (on 2/21/07) identified that she observed the patient's coccyx with a four (4) centimeters (cm.) by three (3) cm area of redness with a 0.4 cm. by 0.2 cm. Stage II pressure ulcer. Review of the Pressure Ulcer Documentation Record dated 2/6/07 identified that the patient's Stage II coccyx wound was 0.4 cm by 0.2 cm. in size with no drainage noted. On 2/12/07, MD #7 ordered a wound care consult regarding the buttocks wound. Review of RN #7's (Wound Care nurse) assessment dated 2/13/07 identified that the patient's coccyx wound had yellow slough in (2) small openings "2.5 cm. or so" with a trial treatment administered. RN #7 failed to provide a comprehensive assessment (measurements, description) of the patient's wounds in accordance with the hospital's policy. Review of the Skin Care and Pressure Ulcer Prevention & Treatment policy directed that wounds would be measured for length, width and depth in centimeters. Review of the Pressure Ulcer Documentation Record dated 2/15/07 with RN #20 identified that the patient's coccyx wound measured 0.6 cm by 0.6 cm in size. In addition, during an observation of Patient #27's wound on 2/16/07 with RN #20, the patient was identified to have two (2) Stage II pressure ulcers noted on the coccyx. Review of the clinical record with RN #20 lacked failed to reflect that both wounds were monitored and/or assessed. Interview with RN #20 identified that only the top wound (closest to patient's head) was being measured as the lower wound (the wound toward the patient's feet) was related to a cyst from years ago. Subsequent to inquiry, RN #20 measured the top coccyx wound as 0.6 cm by 0.65 cm. in size. Interview with RN #7 (Wound care nurse) identified that she considered this a pressure ulcer.

- j. Patient #33 was admitted to the hospital on 2/2/07 with a diagnosis of Intercerebral hemorrhage. Review of the clinical record identified that the patient had left hemiparesis with neglect and required assistance for transfers and positioning. An undated Braden assessment identified that the patient was at risk for the development of pressure ulcers. A nursing admission assessment dated 2/2/07 identified that the patient had three (3) scabbed areas noted on the left elbow with a treatment order to apply Silvadene 1% topical cream twice daily and leave open to air. Observation of the patient with RN #18 on 2/16/07, identified that a band-aid was covering the patient's left elbow. Subsequent to inquiry of the status of the wound, RN #18 removed the band-aid where two (2) pea size open areas were observed on the left outer aspect of the elbow. RN #18 identified that although the physician's order was to leave the wound open to air, the wound had serous drainage therefore she covered the wound with a band-aid. Review of the clinical record with RN #18 failed to identify that measurements and/or a description of these wounds were located in the clinical record.

Review of the hospital policy, titled "Skin Care and Pressure Ulcer Prevention and Treatment" identified that an assessment to identify patients' risk to develop pressure ulcers utilizing the Braden Scale Risk Assessment was required on all patients upon admission and that a target number of sixteen identified that a patient was at high risk to

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develop a pressure ulcer. Interviews with facility staff identified that the facility was currently utilizing two different sets of Braden Scale Risk Assessment forms, one that identified a target number of twelve to identify a patient at high risk and another that identified the target number as sixteen to identify a patient at high risk. The policy further directed that care planning for patients at risk for pressure ulcer development included interventions based on the Braden Scale scoring criteria. The policy directed that prevention of pressure ulcers included that patients would not be out of bed in a chair for more than one hour but lacked direction for the use of pressure relieving/pressure reducing chair cushions for patient who were out of bed in a chair for greater than one hour. Although pressure reducing/relieving chair cushions were observed on the rehabilitation unit, multiple interviews with facility staff on all other nursing inpatient units identified that the facility did not utilize pressure reducing/pressure relieving chair cushions for patients who were out of bed. Subsequent to surveyor inquiry, chair cushions were ordered on 2/16/07 and were scheduled to arrive at the facility on 2/22/07. Interview with the Vice President (VP) of Nursing on 2/21/07 at 8:45 AM identified that the facility had revised the Skin Care Protocol in July of 2006 and again in January 2007 based on issues identified at previous visits to the facility. The VP of Nursing stated that the facility's wound care program was a work in progress and that the facility had increased wound prevalence rounds and monitoring over the previous months.

- k. Patient #16 was admitted to the facility on 2/10/07 with diagnoses that included mental status changes after seizure activity. Review of Patient #16's care plan dated 2/10/07 identified an alteration in elimination related to an indwelling Foley catheter. Interview with RN #12 on 2/15/07 at 11:15 AM identified that she had removed Patient #16's Foley catheter approximately ten minutes earlier due to diminished urine flow due to clotting that was unrelieved by irrigation. RN #12 stated that Patient #16 was unable to pass any urine after the Foley removal and that she had planned to reinsert the catheter. Observation of Patient #16 on 2/15/07 at 11:30 AM identified that Patient #16 did not have a Foley catheter in place but a moderate amount of bright red blood was observed at Patient #16's perineal area and inner thighs. RN #12 was observed to reinsert Patient #16's Foley catheter. Documentation was lacking in the clinical record through 2/16/07 that Patient #16's physician was notified of the clotted catheter, bleeding, removal and/or reinsertion of the patient's Foley catheter.
- l. Patient #25's diagnoses included Congestive Heart Failure and obesity. The admission assessment dated 2/15/07 at 2:45 AM noted a one centimeter (cm.) circular pressure ulcer to the Patient's right buttock. Wound documentation dated 2/15/07 at 7:00 AM reflected that the one cm. Stage II pressure ulcer had superficial depth and the area was washed with normal saline and a protective barrier cream was applied (Aloe Vesta). Observation on 2/16/07 at 10:35 AM noted that RN #16 applied Aloe Vesta cream to the Patient's right buttock ulcer. Review of the Patient's clinical record with the Director of

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In-Patient Services on 2/16/07 at 12:20 PM failed to provide documentation that the physician was notified of the Patient's Stage II pressure ulcer.

- m. Patient #26 was admitted to the hospital on 2/13/07 with diagnoses that included left hip fracture and anemia. Observation on 2/16/07 at 11:00 AM noted the Patient had a nasal cannula and received oxygen continuously at three liters per minute. Review of physician orders from 2/13/07 to 2/16/07 and interview with Quality Coordinator #1 on 2/21/07 failed to reflect a physician order for the use of oxygen for Patient #26. Review of the facility policy for Oxygen Therapy identified, in part, that although a practitioner (Respiratory/Nursing) may initiate oxygen therapy, the practitioner should notify the physician, ensuring patient safety, and obtain written orders.
- n. Patient #27 was admitted on 1/28/07 with a diagnosis of cerebrovascular accident with left hemiparesis. Review of MD #10's History & Physical dated 1/28/07 (dictated at 3:39 PM on 1/28/07) identified that the patient had no skin breakdown. Review of the nursing admission assessment with RN #17 on 2/21/07 identified that she observed the patient's coccyx with a four (4) cm. by three (3) cm. area of redness with a 0.4 cm by 0.2 cm Stage II pressure ulcer. Surveyor interview with RN #17 identified that although she left a note in the unit's logbook for the physician, she did not call the physician for a treatment order. Review of the clinical record failed to identify that a treatment to this area was rendered until 1/29/07 at 10:00 AM when MD #7 directed that Xenaderm gel be applied topically twice daily.
- o. Patient #3 was admitted to the facility on 12/28/06 with diagnoses that included a fractured left hip. Review of the Patient Care Plan (PCP) dated 12/28/06 identified Patient #3's alteration in comfort related to the hip fracture with interventions that included administration of analgesics, ongoing assessment to ensure that reported pain levels would be acceptable to the patient. Review of physician orders dated 12/28/06 directed the use of the narcotic analgesic, Morphine, to be administered via a Patient Controlled Anesthesia (PCA) machine. The physician order directed that after an initial dose of five milligrams (mg.) of Morphine, Patient #3 was to receive one mg. every five minutes up to thirty mg. in a four hours period. Review of the clinical record on 12/29/06 that included Patient #3's Medication Administration Record (MAR) and an undated twenty four hour pain assessment flow sheet identified a pain assessment completed at 3:40 AM and reported as eight out of ten at assessment and reassessment. A second assessment at 6:40 AM also reported Patient #3's pain as eight out of ten with no documented reassessment. Interview with facility staff identified that the facility lacked a policy to direct licensed staff on how often pain assessments/reassessments are completed for patients who receive analgesic medication via a PCA.
- p. Patient #4 was admitted to the facility on 12/23/06 with diagnoses that included spinal stenosis with accompanying severe, persistent low back and right buttocks pain. Review

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of the PCP dated 12/23/06 identified Patient #4's alteration in comfort due to back and knee pain with interventions that included administration of analgesics, ongoing assessment to ensure that reported pain levels would be acceptable to the patient. Physician orders dated 12/23/06 directed the administration of the narcotic analgesic, Dilaudid, to be administered intravenously in varying dose ranges every four to six hours. Although review of the MAR dated 12/23/06 through 12/29/06 identified that Patient #4 received multiple doses of Dilaudid, review of the clinical record with facility staff lacked documentation to reflect that Patient #4 was consistently assessed for pain intensity prior to the administration of the Dilaudid and/or reassessed after administration for the effectiveness of the Dilaudid.

- q. Patient #15 was admitted to the facility on 2/6/07 with diagnoses that included osteomyelitis of the right ankle and anorexia. Review of physician orders dated 2/6/07 directed the administration of controlled release Oxycodone ten milligrams (mg.) every twelve hours for pain management and the administration of Oxycodone five mg. every four to six hours for breakthrough pain. Although Patient #15 required the additional medication for breakthrough pain on 2/8, 2/9, and 2/13/07, documentation was lacking in the clinical record that the patient's pain was assessed and/or reassessed with administration of the Oxycodone ordered for breakthrough pain.
- r. Patient #23's diagnoses included polypharmacy overdose, chronic low back pain, fibromyalgia, and bipolar disorder. The medical record dated 1/25/07 identified that Patient #23 attempted to remove the endotracheal tube and Level II (wrist) restraints were applied. Review of the medical record on 2/16/07 with Nurse Manager #4 failed to reflect that it lacked documentation that the patient's skin and circulation were assessed hourly and/or that the appropriate application of the restraint, the environment, and the patient's emotional well-being were assessed every two hours from 5:00 PM. until 9:00 PM (four hours), and/or that the restraints were released and the patient was repositioned every two hours from 3:00 PM until 9:00 PM (six hours) in accordance with the facility restraint policy.

In addition, Patient #23 was transferred to the psychiatric unit on 1/29/07 and the Master Treatment Plan identified problems of low back, right shoulder, and right arm pain. Nurses' notes dated 1/29/07 on the evening shift identified that although Patient #23 reported low back pain at a level "5" out of "10", the patient's pain was not addressed or reassessed in accordance with the facility pain policy. The patient was seen by the Pain Service on 2/1/07 and Lidoderm and Flexeril were initiated. Patient #23 continued to report pain and on 2/7/07, Tylenol was ordered. Review of the medical record on 2/16/07 with RN #13 identified that although Patient #23 reported pain on 1/29/07, 2/1/07, 2/2/07, 2/4/07, and 2/10/07, the patient's pain was not assessed and/or reassessed in accordance with the facility pain policy.

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- s. Patient #30's diagnoses included an injury to the right arm and the patient was evaluated in the emergency department on 2/16/07 at 9:44 AM. Patient #30 reported pain at a level "7" out of "10" upon admission and Nurse Manager #4 stated that ice was applied to the right arm. The patient was examined by the physician at 11:45 a.m. and Motrin 600 milligrams was administered at that time. Review of the medical record on 2/16/07 with Nurse Manager #4 identified that the patient's pain level had not been reassessed again until 2:00 PM when the patient was being prepared for discharge and the patient stated that the pain level remained at a level "7". The facility pain policy identified that the pain intensity will be assessed after each pain management intervention. Review of the facility's policies related to pain assessments/reassessments directed that pain intensity, as reported by the patient, would be assessed and documented routinely at regular intervals (at least every shift), with each new report of pain, and after each pain management intervention once sufficient time has elapsed for the treatment to reach peak effect. Factors to be assessed will include pain intensity on a scale of "1-10" and interventions will include both pharmacologic and non-pharmacologic methods.
- t. Patient #14's admitting diagnoses included questionable stroke and right lower extremity leg ulcers. The Emergency record dated 2/13/07 identified the need to monitor urinary output and the nurse in the Emergency Department (ED) inserted a urinary catheter. Observation on 2/15/07 at 10:55am noted that the Patient had a urinary catheter in place that drained clear yellow urine and a dressing to the right lower extremity. Review of Physician orders dated 2/13/07 to 2/15/07 failed to reflect a physician's order for the use of the urinary catheter. Interview with Quality Coordinator #1 on 2/21/07 at 11:50 AM indicated it was standard procedure for the ED nurse to insert a urinary catheter when the physician ordered to monitor output. Quality Coordinator #1 further identified that a physician's order should have been written when Patient #14 was admitted to the hospital and to the 4.1 Unit.
- u. During tour of the Labor & Delivery Unit on 12/28/06, the code cart located in the resuscitation room failed to identify that the code cart was consistently checked daily in accordance with hospital policy. Review of the hospital policy identified that code cart checks are to be checked on a daily basis. Interview with the Coordinator of Quality/Risk management identified that the charge nurse was responsible to check the cart daily and the Nurse Manager was responsible to collect the documentation that the checks were performed at the end of each month.
- v. Review of Patient #2's admission nursing assessment with RN #4 on 1/3/07 identified that the patient utilized a rolling walker for ambulation. The assessment identified that the patient scored fifteen (15) points for having a debilitating diagnoses (Question #2) but inaccurately assessed the patient by failing to address the fact that the patient utilized an assistive device for ambulation (Question #9). This would have added an additional five (5) points to the patient's total score from fifteen points to twenty (20) points.

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Although the assessment was inaccurate, the patient scored fifteen points making the patient a high fall risk.

- w. Review of Patient #2's admission assessment dated 4/13/06 indicated that the patient's neurological function was tested utilizing the Glasgow Coma Scale (GCS). The patient scored a fifteen (15), the highest possible score. Further review of this assessment identified that the patient's left and right pupil were documented as three (3) millimeters (mm) in size with the pupillary reaction coded as a two (2). During a review of this assessment with RN #2 and Quality Coordinator #2, they were unable to identify what the patient's pupillary reaction coded as a two (2) indicated.
- x. Patient #2 had an admission assessment dated 4/13/06 that identified she was at high risk for falls. Review of the care plan dated 4/13/06 identified that the patient was at risk for falls with interventions that included assess patient for specific risks, maintain safe environment, and educate the family and patient. The care plan failed to identify that the patient utilized a walker for ambulation. Review of a nurse's note dated 4/17/06 identified that the patient fell in the bathroom and hit her head and on 4/20/06 identified that the patient fell again this morning because she was moving around without the walker. Review of the Hospital's Safety Protocol identified that patient's at high risk for falls would have a safety risk assessment documented in a narrative progress note every 24 hours. Documentation will include the reason the patient is at risk for falls as well as nursing interventions implemented. Review of the clinical record failed to indicate that the patient's safety risk was documented in narrative form on 4/17/06 and 4/19/06 in accordance with hospital protocol.
- y. Patient #2 presented to the hospital's Emergency Department (ED) on 4/13/06 with complaints of weakness, shortness of breath, a sore throat and a low-grade temperature. The patient's past medical history is significant for kidney transplant (1999), anemia, neutropenia, pancytopenia, deep vein thrombosis (on Coumadin therapy), repair of a detached retina of the left eye and numerous squamous cell skin cancers status post excisions with skin grafting. Review of the physician's physical examination conducted in the emergency room on 4/13/06 at 5:40 PM identified that the patient's pupils were equal, round and reactive to light, extraocular muscles were intact, sclera and conjunctiva were normal. Review of laboratory values upon entry to the hospital included a platelet count 109 (normal 140-400), white blood count of 1.5 (normal 4.0-10.0), and international normalized ratio (INR) of 7.9 (normal 0.8-1.1). The patient was admitted with acute renal failure and severe anemia. Review of the admission nursing assessment dated 4/13/06 identified that the patient was determined to be at high risk for falls. Further review of this assessment identified that the patient's left and right pupil were documented as three (3) millimeters (mm) in size. Review of facility documentation dated 4/16/06 identified that Patient #2 was found sitting on the shower stall floor at 11:50 PM and stated that she "banged her head on the

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wall". Review of the documented neurological examination at 12:00 AM on 4/17/06 identified that the patient's left pupil was dilated, a change from previously documented assessments. Review of the nurse's note at 12:20 AM indicated that the patient's neurological assessment was within normal limits. Record review and interview with RN #2 on 1/3/07 identified that she could not recall if she performed the neurological assessment of if the patient's assigned nurse (RN #5) had completed the assessment and could not comment on the change in the patient's pupillary status. RN #2 further indicated that since no injury was identified, the physician would be notified in the morning. Interview with RN #5 on 1/23/07 identified that subsequent to the patient's fall, she questioned the patient about her eye and was informed by the patient she had some kind of surgery on the eye previously. RN #5 could not recall if she compared the neurological assessment to previously documented assessments. Review of the neurological assessment dated 4/16/06 between 11:00 PM-7:00 AM identified that both of the patient's pupils were Equal, Round, Reactive to Light and Accommodation (PERRLA). This was the most recent assessment prior to the patient's fall. Nursing staff failed to investigate and/or document whether there had been a change in the patient's pupillary status from prior neurological assessments. Review of the clinical record lacked documentation that the physician was notified of the patient's fall.

- z. Review of Patient #2's daily lab reports identified that the patient's platelet count continued to decrease from 66 (4/17/06) to 42 (4/18/06) to 41 (4/19/06) to 33 (4/20/06), and to 41 (4/21/06). The patient's INR was 3.4 on 4/19/06, 4.0 on 4/20/06, and 3.0 (11:30 AM) on 4/21/06 (refer to previously identified normal lab values). Review of the 24-hour flow records during the period of 4/17/06 through 4/20/06 on the 11 PM-7 AM shift identified that the patient was alert and oriented to person, place, and time. Review of the 24-hour flow record dated 4/20/06 at 8:00 AM indicated that the patient was alert, oriented to person, place, and time, had intermittent confusion with clear speech, both pupils were "PERRLA" and the patient's strength was equal but weak. Review of the nurse's note dated 4/20/06 (7-3 shift) identified that the patient fell again this morning because she was moving around without the walker. The hospital failed to ensure that documentation in the clinical record contained specific information regarding the fall including the time of the fall and/or that a comprehensive assessment was conducted subsequent to the fall and/or that the physician was notified of the fall. The RN who completed the 24-hour flow record and nurse's note was unavailable for interview. Interview with the Director of Quality on 12/28/06 identified she had a Quality Referral Form for the fall from 4/16/06 but no additional falls were reported. Review of the hospital's fall policy directed that a Quality referral form would be completed when a patient falls. In addition, the incident must be documented in a progress note with any nursing interventions implemented.
- aa. Review of patient #2's nurse's note dated 4/20/06 at 7:15 PM identified that Patient #2 was alert, mostly oriented although increased confusion was noted. Review of the

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clinical record failed to identify that a neurological assessment was conducted related to the patient's increased confusion in light of the fact that the patient sustained a fall on 4/17/06 and hit her head, had a fall earlier that morning, and had a platelet count of 33 and an INR of 4.0 that day. Interview with MD #3 (on 1/3/07) identified that the patient told him that she slipped out of bed to the floor, got back up, felt fine and denied hitting her head. MD #3 was unable to identify the date in which the patient stated she fell as no mention of this fall was documented in his progress notes.

Review of a nurse's note dated 4/21/06 (during the 11PM-7AM shift) with RN #3 (on 1/3/07) identified that the patient was acting oddly, admitted to feeling out of it, had an episode of urinary incontinence (normally continent) and was picking at the sheets. A neurological assessment identified that the patient's right pupil was sluggish to react to light and that the left pupil had a "detached retina". Review of the graphic chart identified that the patient's oxygen saturation at 12:00 AM was 97% on two (2) liters of oxygen. Review of the clinical record and interview with RN #3 identified that the patient's oxygen saturation was 94 % on room air and that she subsequently administered oxygen (O2) at 2 liters per minute (unable to recall the time that O2 was applied) as there was a possibility of hypoxemia. RN #3 stated that she informed RN #4 (Clinical Coordinator) of her assessment and that she had not notified the physician of the patient's status and/or that oxygen was administered. Record review and interview with RN #4 (on 1/3/07) identified that she evaluated the patient with RN #3 and agreed with RN #3's assessment. RN #4 identified that she was aware that the patient had fallen and hit her head on 4/16/06 and had reviewed the patient's lab work with RN #3. RN #4 stated that she would have called the physician if she felt that the patient was in immediate danger. RN #3 and RN #4 failed to notify the physician of the patient's change in condition.

Review of the surgical APRN note dated 4/21/06 at 9:15 AM identified that the patient appeared confused, noted that the patient's left pupil (old eye injury) is always more dilated and "PERRLA". The note indicted a platelet count of 33 and INR of 4.0 on 4/20/06 and subsequently ordered a CT Scan of the patient's head "today" to rule out a bleed. Review of MD #3's progress note dated 4/21/06 identified that the patient had a decreased platelet count and an elevated INR and changed the Head CT order to be performed as soon as possible (ASAP) to rule out subdural hematoma. Review of the Radiology report dated 4/21/06 identified that the patient had a history of confusion and trauma. The report identified that there was extraaxial fluid collection on the right compatible with chronic/subacute subdural hematoma and acute subdural hematoma with associated mass affect. The patient underwent a right frontal craniotomy and evacuation of an acute subdural hematoma on 4/21/06. Subsequent to this surgery the patient developed a recurrent acute subdural hematoma with marked cerebral edema. Review of MD #4's (Neurological surgeon) Operative report dated 4/21/06 identified that the patient underwent an emergency evacuation of the recurrent right frontal subdural hematoma and despite numerous interventions, the patient's brain continued to herniate. The patient expired on 4/23/06.

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In addition, Patient #2 had an admission assessment dated 4/13/06 that identified she was at high risk for falls. The admission assessment indicated that the safety/fall risk protocol was instituted based on this assessment. Review of the 24-hour flow sheets dated 4/14/06, 4/15/06, 4/16/06, 4/17/06, 4/19/06 and 4/20/06 lacked consistent documentation that the patient was maintained on this protocol. Review of the Hospital's Safety Protocol identified that nursing would document that the Fall Protocol was instituted by checking the box on the 24-hour flow record.

- bb. Review of Patient #2's admission assessment dated 4/13/06 indicated that the patient's left and right pupil were documented as three (3) millimeters (mm) in size. Subsequent flow records identified that the patient's pupils were Equal, Round, Reactive to Light and Accommodation (PERRLA). Review of a nurse's note dated 4/17/06 at 12:10 AM identified that the patient was found sitting on the floor of the shower stall and stated that she hit her head. Interview with RN #2 on 1/3/07 identified that the patient stated she, "tripped and fell". Review of the nursing assessment identified that the patient's left pupil was fixed and that the right pupil was "PERRLA". Review of the flow records during the period of 4/17/06 through 4/20/06 lacked documentation that the patient's neurological status was consistently assessed despite the fact that the patient hit her head and had abnormal lab values during this time frame (platelet count continued to decrease from 66 (4/17/06) to 42 (4/18/06) to 41 (4/19/06) to 33 (4/20/06).
- cc. Additionally, review of a nurse's note dated 4/20/06 identified that Patient #2 fell again this morning because she was moving around without the walker. The record lacked details of the fall. The documented neurological assessment identified that both of the patient's pupils were "PERRLA", handgrips were equal, and that the lower extremities were weak. Review of the clinical record dated 4/20/06 during the 3-11 shift indicated that increased confusion was noted, however, a complete neurological assessment was not conducted. Further review of the clinical record during the 11-7 shift on 4/21/06 identified that the patient was acting oddly, admitted to feeling out of it, had an episode of urinary incontinence (normally continent) and was picking at the sheets. A neurological assessment identified that the patient's right pupil was sluggish to react to light and that the left pupil had a "detached retina". Although the patient had a change in status, nursing staff failed to inform the Attending physician of these changes. Patient #2 was diagnosed with a subdural hematoma that required surgical intervention on 4/21/06.
- dd. Review of Patient #2's twenty-four (24) hour flow record dated 4/16/06 during the 3:00 PM-11:00 PM shift with RN #4 (on 1/3/07) identified that the assessment was "blank". Interview with RN #4 identified that the patient should be assessed every

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shift. Review of the Hospital's Documentation policy identified that the 24-hour flow record is used to coordinate patient care, provide documentation at the point of care delivery, and provide documentation of ongoing patient assessment. The policy directed that the 24-hour flow record is completed every shift.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (b) Administration (2) and/or (d) Medical Records (2) and/or (e) Nursing Service (1).

3. \* For eight of eighteen patients reviewed for actual skin impairment and/or the risk of skin impairment, Patients #15, #18, #20, #21, #25, #28, #33, and #39, and/or for nine of twenty one patients reviewed for isolation requirements and/or nutrition and/or oxygen delivery and/or mobility deficits, and/or communication deficits and/or indwelling Foley catheters and/or care of facial sutures, Patients #13, #14, #16, #17, #19, #22, #26, #34, and #35 the facility failed to develop a comprehensive, individualized nursing care plan and/or revise the plan of care with changes in condition to address the patients' potential risks for problems and/or nursing care needs. The findings were based on review of clinical records, review of facility policies, observations, and interviews and include the following:
  - a. Patient #15 was admitted to the facility on 12/29/07 from a skilled nursing facility for diagnoses that included right ankle abscess with subsequent diagnoses of a septic right ankle and osteomyelitis. Review of the admission nursing assessment dated 12/29/07 identified that Patient #15 was at moderate risk to develop impaired skin integrity and that the patient entered the facility without a pressure ulcer. On 1/1/07, Patient #15 was taken to the Operating Room (OR) for incision and drainage of the right ankle abscess. Two days later on 1/3/07, a photograph of the patient's right medial and lateral posterior ankle was taken. Review of the photograph identified an area of eschar at the right heel. Documentation was lacking of an individualized plan of care to address the right heel eschar area, measurements of the right heel, and/or treatment to the right heel. Review of nursing flow sheets addressed only the patient's surgical site under the skin assessment section. A Physical therapy (PT) note dated 1/9/07 (six days after the photograph was taken) directed that Patient #15's heels be elevated on pillows to decrease pressure areas. A physician progress note dated 1/13/07 identified the blackened eschar area and documented that the area would need debridement. On 1/14/07, Patient #15 was discharged back to the skilled nursing facility. Review of Patient #15's hospital discharge summary dated 1/14/07 and the interagency referral form dated 1/14/07 failed to identify the right heel eschar area. Review of the nursing readmission assessment from the skilled nursing facility dated 1/14/07 identified that Patient #15 reentered the facility with a three by two centimeter unstageable right heel pressure ulcer.
  - b. Patient #18 was admitted to the facility on 2/7/07 with diagnoses that included respiratory failure. Review of the admission assessment dated 2/7/07 identified that

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- Patient #18 was assessed utilizing a Braden Scale assessment, with a score of twelve (a score of twelve or less placed patients at high risk to develop pressure ulcers. A reassessment for the potential for the development of pressure ulcers dated 2/13/07 identified Patient #18 with a score of fifteen. Parameters for the assessment document used on 2/13/07 identified that any patient with a score of sixteen or less would be classified as at high risk. Although Patient #18 was assessed on admission and reassessed one week later, review of the Patient Care Plan (PCP) dated 2/7/07 lacked documentation to reflect that a comprehensive plan of care was developed to address the potential for skin impairment based on the assessments. Observation of Patient #18's coccyx area on 2/16/07 at 11:35 AM identified that the patient's skin in the area was reddened but without skin breakdown.
- c. Patient #20 was admitted to the hospital on 2/7/07 with a diagnosis of congestive heart failure. Review of a Braden assessment dated 2/13/07 identified that the patient was at high risk for the development of a pressure ulcer with a score of fourteen (14) points (score of 16 or less is considered high risk). Review of the clinical record with RN #21 identified that although the patient required assistance with positioning and transfers, and had penile and scrotal edema, a care plan to address the patient's skin was not developed.
- d. Patient #21 was admitted to the hospital on 2/8/07 with a diagnosis of dehydration and a history of a stroke. Review of the nursing admission assessment dated 2/9/07 identified that the patient's skin turgor was poor; the patient was dependent on staff for all activities of daily living and was at moderate risk for the development of pressure ulcers. Review of a Braden assessment dated 2/13/07 identified that the patient was determined as a high risk for the development of pressure ulcers. Review of the clinical record with RN #21 failed to identify that a nursing care plan was developed that addressed the patient's skin.
- e. Patient #25's diagnoses included obesity and Stage II pressure ulcer to the right buttock. The admission assessment dated 2/15/07 identified that the patient was at moderate risk for pressure ulcer development (Braden Scale =14), had a one cm. pressure ulcer and skin integrity and infection risk problems were identified. The assessment also indicated that the Patient did not ambulate, utilized a wheelchair, and had mobility problems. Review of the patient's medical record with Director of In-Patient Services on 2/16/07 at 12:20 PM noted when a problem was identified on the assessment a plan of care was developed. Review of the patient's care plan dated 2/15/07 on 2/16/07 failed to reflect the problem of altered mobility to include patient specific goals and interventions. Although impaired skin integrity was identified as a problem, the interventions failed to include wound care protocol measures.
- f. Patient #28 was admitted to the hospital on 2/1/07 with a diagnosis of thoracic

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myelopathy. Review of the nursing admission assessment identified that the patient was admitted with a Stage III (3) pressure ulcer on the coccyx and a Stage II (2) pressure ulcer on the right buttock. Review of the Interdisciplinary Team Plan (care plan) with RN #20 identified that although the patient's skin was identified as a problem, the care plan lacked interventions and goals to address this problem.

- g. Patient #33 was admitted to the hospital on 2/2/07 with a diagnosis of Intercerebral hemorrhage. Review of the clinical record identified that the patient had left hemiparesis with neglect and required assistance for transfers and positioning. An undated Braden assessment identified that the patient was at risk for the development of pressure ulcers. A nursing admission assessment identified that the patient had three (3) scabbed areas noted on the left elbow with a treatment order to apply Silvadene 1% topical cream twice daily and leave open to air. On 2/16/07 the patient was observed with RN #18 to have two (2) pea size open areas on the left outer aspect of the elbow. RN #18 identified that although the physician's order was to leave the wound open to air, the wound had serous drainage therefore she covered the wound with a band-aid. Review of the clinical record with RN #18 failed to identify that a care plan was developed that addressed the skin care needs of the patient.
- h. Patient #39 was admitted to the hospital on 2/9/07 via the Emergency Department (ED) with the complaints of chest pain for three days, was hypotensive and subsequently diagnosed with sepsis, shock, pneumonia and acute renal failure. Patient #39 had a history of congestive heart failure, an ejection fraction of 15%, chronic obstructive pulmonary disease, status post automated implanted cardiac defibrillator and pacemaker and degenerative joint disease. Review of the clinical record identified that the nursing plan of care was not initiated until two to four days after the completion of the patient admission assessment. Review of facility policy, titled "Patient Documentation", identified that the patient care plan will be initiated at the completion of the nursing assessment. In addition review of the Patient #39's care plan lacked documentation that addressed and/or identified the problems of the level of assistance that the patient required to complete activities of daily living-i.e. eating, washing, and/or the unique communication needs of the patient and/or the impaired mobility of Patient #39 related to the physician order of bedrest. Interview with the Nurse Manager of the unit, on 2/21/07, identified that the care plan for Patient #39 was not comprehensive related to the identified areas. Review of the nursing admission assessment, dated 2/9/07, identified that the patient had no skin breakdown at time of the hospital admission. Review of the nursing note, dated 2/11/07 at 11:00 P.M. identified that Patient #39 had a Stage I pressure ulcer to the coccyx. Review of the patient care plan regarding impaired mobility (physician order for bedrest) identified that the problem was not identified until 2/13/07 (four days) after the patient had been maintained on bedrest and two days after the patient had developed a pressure ulcer.

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- i. Patient #13's diagnoses included jaw wiring and insertion of a feeding tube on 1/22/07. The care plan dated 1/22/07 through 2/8/07 reflected altered nutrition and interventions included the use of the feeding tube, monitor oral intake and nutritional consult per protocol. Observation on 2/15/07 at 10:30 AM noted the Patient in the chair with the feeding tube capped. Interview with RN #15 on 2/15/07 at 1:55 PM noted Patient #13 received feedings via the feeding tube every night. Although the patient's plan of care from 2/9/07 to 2/15/07 indicated a problem of altered nutrition, the current care plan failed to reflect interventions to include the use of the feeding tube and oral intake monitoring.
- j. Patient #14's admitting diagnoses included questionable stroke and right lower extremity leg ulcers. Physician orders dated 2/13/07 directed the use of oxygen 2-4 liters/minute to maintain oxygen saturation levels greater than 90%. Observation of Patient #14 on 2/15/07 at 10:55am identified that the patient received oxygen via a nasal cannula, had a urinary catheter in place and a dressing on the right lower leg. Review of the patient's medical record with Quality Coordinator #1 on 2/15/07 at 11:25am noted that the patient's plan of care dated 2/13/07 failed to reflect the Patient #14's altered skin integrity (leg ulcers), ineffective breathing pattern, and need for oxygen, altered elimination and urinary catheter use and/or goals and/or interventions for these problems.
- k. Patient #16 was evaluated in the Emergency Department (ED) at 1:00 AM on 1/23/07 after falling out of bed at home. Review of the ED record dated 1/23/07 identified that Patient #16 had a laceration above the right eye that measured 2.5 centimeters (cm.) in length and required six sutures. Patient #16 was discharged from the ED to home on 1/23/07 at 6:35 AM with instructions for removal of the sutures in six to seven days. On 2/10/07, Patient #16 returned to the ED for evaluation of mental status changes following seizure activity and was subsequently admitted to the hospital. Review of the ED record dated 2/10/07 identified that the sutures above Patient #16's right eye remained in place at the time of the admission. Documentation was lacking in the clinical record to reflect that a nursing care plan had been developed to address care to and/or removal of Patient #16's sutures. Observation of Patient #16 on 2/16/07 identified that the sutures above Patient #16's right eye remained intact. Interview with Person #5 on 1/16/07 identified that she did not understand why the sutures had not been removed and was told that skin had grown over the sutures. Subsequent to surveyor inquiry, Patient #16's sutures were removed on 2/16/07, twenty four days after placement.
- l. Patient #17 was admitted to the facility on 2/9/07 with diagnoses that included an acute exacerbation of chronic bronchitis and had subsequently been diagnosed and treated for Clostridium Difficile (C-Diff). Although a "Contact Isolation" sign was posted outside the door of Patient #17, documentation was lacking in the clinical record of a care plan to address Patient #16's new diagnosis of an infectious process, isolation requirements,

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and/or the source of the infection.

- m. Patient #19 was admitted to the facility on 1/31/07 with diagnoses of Methicillin Resistant Staphylococcus Aureus (MRSA) in a finger wound and the nares. Although a "Contact Isolation" sign was posted outside the door of Patient #19, documentation was lacking in the clinical record to reflect that a care plan had been developed to address the source of the infection.
- n. Patient #22 was admitted to the Newborn Intensive Care Unit (NICU) on 2/12/07 with a diagnosis of Neonatal abstinence syndrome (NAS). Review of the clinical record with Nurse Manager #6 on 2/15/07 failed to identify that the patient had a nursing care plan in place. During an interview with the Nurse Manager, she explained that nurses utilize APRN progress notes and work sheets (not part of the medical record) to guide the nursing care of the patient and that care plans are not utilized on the NICU. Nurse Manager #6 further identified although the hospital recognized that this was an issue and were in the process of having "Clinical Pathways" printed, the process of printing, education of staff and implementation of the clinical pathways would take at least six (6) more weeks and that there were no interim care plans in use for any of the patients in the NICU. Tour of the NICU identified that there were a total of seven (7) patients in the NICU on 2/15/07.
- o. Patient #26 was admitted to the hospital on 2/13/07 at 10:38pm with diagnoses that included left hip fracture, status post left hip repair on 2/15/07. The admission nursing assessment dated 2/14/07 at 2am identified that the Patient was dependent for ambulation and toileting and failed to reflect mobility as a problem. Review of the Patient ' s plan of care with the Quality Coordinator #1 on 2/16/07 at 11:30am noted that although the Patient had problems with mobility upon admission, the problem to include goals and interventions was not initiated until 2/16/07.
- p. Patient #34 was admitted to the hospital on 2/9/07 with a history of hydrocephalus and had a shunt revision. On 2/16/07 at 2:15 PM, a contact precaution sign was observed on the patient's door. Three visitors were observed to be in direct contact with the patient's environment as they sat on the patient's bed and/or chairs in the patient's room. Review of the clinical record and interview with RN #20 on 2/16/06 identified that although MD #7 ordered MRSA precautions upon admission on 2/9/07, the source of the MRSA was not identified and a nursing care plan was not implemented.
- q. Patient #35 was admitted to the hospital on 2/6/07 with a diagnosis of lower extremity cellulites and a history of end stage renal disease (hemodialysis). On 2/15/07, an order to obtain a stool culture for Clostridium difficile (C-Diff) was received. On 2/15/07 and 2/16/07, a Contact Precautions sign was posted on the outside of the patient's door. Review of the clinical record with RN #21 on 2/16/07 failed to identify that a care plan

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was developed that addressed the isolation precautions.

- r. Patient #38 was admitted to the hospital on 1/29/07 with diagnoses that included bilateral knee surgery and a stage 4, sacral pressure ulcer. The admission history and physical dated 1/29/07 identified that the Patient had wound- base sepsis as well as Methacillin Resistant Staphylococcus Aureus (MRSA) colonization and current treatment included the administration of an intravenous (IV) antibiotic, Vancomycin. Admission physician orders dated 1/29/07 directed the administration of IV Vancomycin every twelve hours and a medication for pain as needed. The laboratory report (culture) dated 2/1/07 reflected a heavy MRSA growth in the sacral wound. Review of the Patient's problem list for the plan of care from 1/30/07 to discharge on 2/18/07 failed to reflect the problem of MRSA colonization, potential for infection and/or goals and /or interventions related to the MRSA colonization. The plan of care also failed to identify pain as a problem and/or potential problem to include specific goals and interventions. Interview with RN #19 on 2/21/07 at 11:20am noted that although Patient #38 had been on contact precautions since admission, this was only reflected on the computerized Patient Care Profile which was not a part of the medical record and could not be accessed after a patient had been discharged. RN #19 further indicated that although Patient #38 received medication for pain throughout the Patient's hospital stay, the pain was controlled with the ordered medication, therefore was not an actual problem and was not addressed within the Patient's plan of care.

Review of the facility policy for documentation that included direction for the patient care problem/goal list identified, in part, that the patient care plan will serve as a rapid reference for the active problems and measurable goals/interventions will be identified at the completion of the nursing assessment. The problems and goals will be reviewed at least every twenty- four hours. The policy further directed that measurable goals for the established problem would be identified and the patient's progress towards resolution of the problem would be documented on the interdisciplinary care planning form by priority codes. Multiple interviews with facility staff identified that a computerized nursing assignment sheet was routinely updated for new problems and interventions (though did not identify measurable goals) but that the form was not part of the patients' permanent record.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (b) Administration (2) and/or (d) Medical Records (2) and/or (e) Nursing Service (1) and/or (i) General (7).

4. Based on review of clinical records, review of facility policies, observations, and interviews, the facility failed to ensure that medications were administered in accordance with physician orders, secured, and/or that written physician orders for medications included all necessary components

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of the orders to include dosage and/or route of administration for four of eight patients reviewed for medication administration, Patients #13, #15, #39, and #40. The findings include:

- a. Patient #13's diagnoses included traumatic brain injury and newly diagnosed Hepatitis C. Physician orders dated 2/5/07 directed Dilantin oral suspension 300mg three times a day via the feeding tube. Observation on 2/15/07 at 10:30am noted LPN #3 brought the computerized medication record into Patient #13's room and exited the room leaving three doses of Dilantin suspension unattended on top of the computerized record system. Patient #13 and Patient #13's sitter were also observed in the room at this time. LPN #3 walked down the hall, into the medication room, and the medication room door closed behind her. Interview with Quality Coordinator #1 on 2/15/07 at 10:30am identified it was not recommended for a nurse to leave meds unattended in a patient's room.

In addition, Patient #13's diagnoses included traumatic brain injury and newly diagnosed Hepatitis C. Physician orders dated 2/5/07 directed Dilantin oral suspension 300mg three times a day via the feeding tube. Review of the February 2007 medication records indicated that the Dilantin was to be administered every six hours and at 8:00 AM, 2:00 PM, and 8:00 PM. The medication record dated 2/9/07 identified that the first daily doses of Dilantin was administered at 1:30 PM and the second dose was administered 3 hours and seven minutes later at 4:37 PM. The first and second daily doses of Dilantin were administered to the Patient at 1:42 PM and 1:46 PM on 2/10/07. On 2/14/07 the first dose of Dilantin was administered to the Patient three hours late at 11:08 AM, the second dose was administered two hours later at 2:00 PM and the third dose of Dilantin was administered two hours late at 10:11 PM. Observation on 2/15/07 at 10:30 AM noted LPN #3 administered Patient #13's first daily dose of Dilantin and that this was two and one half hours after the scheduled administration time. Interview with LPN #3 on 2/15/07 at 10:35 AM indicated that although the Patient was due to receive the Dilantin at 8:00 AM, the medication was not available on the unit. Interview with Pharmacist #1 on 2/15/07 at 11:30 AM identified that the pharmacy received automatic notices to replenish medications according to programmed "par levels". Pharmacist #1 further reflected that a unit might exhaust the medication supply when there is an increased need for the medication and before the pharmacy can readjust the par level and/or replenish the medication. Interview with RN #15 on 2/15/07 at 1:55 PM noted it was acceptable for the nurse to administer 600 mg. or more of Dilantin at one time (giving two of the Patient's doses together) and it was not necessary to notify a patient's physician when doses or scheduled administration times were altered. Interview with the Director of Pharmacy on 2/16/07 at 10:15 AM identified that when a medication was ordered three times a day, the time that the medication is administered needed to be "spaced appropriately". The Director of Pharmacy further indicated that when a patient received medication in suspension form, it was important to adequately space the medication to maintain a steady state of effectiveness.

- b. Patient #15 was admitted to the facility on 2/6/07 with diagnoses that included

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osteomyelitis of the right ankle and anorexia. Review of physician orders dated 2/6/07 directed the administration of controlled release Oxycodone ten milligrams (mg.) every twelve hours for pain management and the administration of Oxycodone five mg. every four to six hours for breakthrough pain. Review of the Medication Administration record (MAR) with facility staff identified that the controlled release Oxycodone was scheduled to be administered at 8:00 AM and 8:00 PM. Review of the MAR dated 2/13/07 identified that Patient #15 was given Oxycodone five mg. at 4:29 PM and again at 11:22 PM on 2/13/07 but lacked documentation to reflect that Patient #13 received the 8:00 PM scheduled dose of controlled release Oxycodone. Interview with Nurse Manager #1 on 2/21/07 identified that the clinical record lacked documentation of any reason for the omission of Patient #15's controlled release Oxycodone.

- c. Patient #39 was admitted to the hospital on 2/9/07 via the Emergency Department (ED) with the complaints of chest pain for three days, was hypotensive and subsequently diagnosed with sepsis, shock, pneumonia and acute renal failure. Patient #39 had a history of congestive heart failure, an ejection fraction of 15%, chronic obstructive pulmonary disease, status post automated implanted cardiac defibrillator and pacemaker and degenerative joint disease. Review of the physician's orders, not dated, directed the staff to administer two bronchodilators (Xopenex and Atrovent) routinely and as needed although documentation was lacking that identified the route of administration for the medications. Interview with the Nurse Manager of the unit, on 2/21/07, identified that the route of administration was lacking for the identified bronchodilator medications.

In addition, review of the physician's orders, dated 2/11/07, directed the staff to administer two bronchodilators (Duoneb and Albuterol) and one medication to reduce the viscosity of the pulmonary secretions (Mucomyst) routinely and as needed, although documentation was lacking that identified the dosage to be administered and the route of administration for the medications. Interview with the Nurse Manager of the unit, on 2/21/07, identified that the dosage and the route of administration were lacking for the identified medications.

In addition, review of the physician's orders, dated 2/18/07, directed the staff to administer a medication to reduce the viscosity of the pulmonary secretions routinely (Mucomyst), although the documentation was lacking that identified the route of administration of the medication. Interview with the Nurse Manager of the unit, on 2/21/07, identified that the route of administration was lacking for the identified medication.

- d. Patient #40 was admitted to the hospital on 2/19/07 via the Emergency Department from a long-term care facility with the complaints of increased temperature and respiratory distress and was subsequently diagnosed with respiratory arrest. Patient #40 had a history of an infectious disease, dementia, chronic obstructive pulmonary disease,

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chronic bronchitis, seizure disorder status post left cerebrovascular accident, hypothyroidism, Methicillin Resistant Staphylococcus Aureus (MRSA) in the urine and Vancomycin Resistant Enterococcus in the stool. Review of the physician's orders, dated 2/20/07, directed the staff to administer a bronchodilator (Duoneb) routinely and as needed although documentation was lacking that identified that medication dosage to be administered and the route of administration for the medication. Interview with the Nurse Manager of the unit, on 2/21/07, identified that it is the hospital policy that all medication orders include the dose of the medication and the route of the administration of the medication.

Review of facility policy directed that medication orders should include drug name, drug dosage, dosage form (if appropriate), route, and frequency. In addition, the policy directed that safe medication practices that included ordering, storage, preparation, dispensing, administration, patient monitoring, and documentation, must be followed at every step.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (7) and/or (l) Infection Control (1) and/or (2) and/or (4)(B) and/or (4)(C) and/or (4)(E).

5. \* For seven of nine patients reviewed who required isolation for an infectious process, Patients #1, #13, #17, #19, #34, #35, and #36 the facility failed to ensure that all persons (nursing staff, physicians, social service workers, and visitors) who entered the rooms of these patients, were compliant with facility policies that directed the need for personal protective wear and or hand hygiene when entering or exiting the rooms and or when in contact with the patients or the patients' environment; and/or failed to ensure that infection control practices were adhered to during the performance of a treatment to a Stage IV pressure ulcer and/or during the insertion of a Foley catheter; and/or failed to ensure that soiled linen was appropriately handled for two patients, Patients #15 and #37. The findings were based on review of clinical records, review of facility policies, observations, and interviews and include the following:
  - a. Patient #1 was admitted to the facility on 9/1/06 with diagnoses that included anoxic encephalopathy. Review of the Patient Care Plan (PCP) dated 12/20/06 identified an infection of Vancomycin Resistant Enterococcus (VRE) in the patient's urine with interventions that included maintenance of contact isolation. Observations on 12/28/06 at 9:30 AM identified that a "Contact Isolation" sign was clearly posted outside the door of Patient #1. Interview at that time with RN #6, the charge nurse, identified that only those who were to come in direct contact with the patient and/or the patient's environment needed to wear gloves and protective gowns. Upon entrance into Patient #1's room, Patient #1's bed was observed to be soaked with urine and RN #7 was

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observed to be in the process of performing wound care to Patient #1's sacral decubitus without the benefit of a protective gown. In addition, Patient Care Assistant #3 (PCA #3) was observed to have full uniform contact with the patient's side rails as well as direct skin contact with Patient #3 and the patient's environment without benefit of a protective gown as she assisted RN #7 by holding Patient #1 over to the left side. Upon surveyor inquiry, RN #7 interrupted Patient #1's treatment application to don a protective gown as well as change gloves. PCA #3's position was simultaneously relieved by RN #8 who also donned a protective gown.

- b. In addition, observation of Patient #1 on 12/29/06 at 11:25 AM identified that the patient had two visitors in the room and were speaking with the licensed nurse. The visitors were observed to have direct contact with the patient's environment as they straightened bed linens, adjusted pillows, and moved items around in the patient's rooms. Upon further observation, the visitors were observed to be reaching through the raised side rail of Patient #1's bed and intermittently holding Patient #1's hand and stroking the patient's arm without the benefit of a gown or gloves. Interview with RN #8 at the time of the observation identified that family members of patients who require contact precautions are provided with education regarding the importance of good handwashing before leaving the patient's room but are not required to don protective gowns/gloves. Despite the visitors' repeated contact with Patient #1's environment, the licensed nurse did not intervene to educate the visitor about the need for contact precautions.
- c. Patient #1 was admitted to the facility on 9/1/06 with diagnoses that included anoxic encephalopathy. Review of the Patient Care Plan dated 12/20/06 identified the presence of a facility acquired Stage IV sacral pressure ulcer with interventions that included daily treatment in accordance with physician orders. During a tour of the facility on 12/28/06 at 9:30 AM, the facility's wound care nurse, RN #7, was observed to be in the process of completing the treatment to Patient #1's sacral pressure ulcer. At the time of the observation, Patient #1's bottom bed linens were observed to be soaked with urine. A semi-dried appearing urine ring like stain was observed to continue from underneath Patient #1's mid back, down toward the foot of the patient's bed. After the new wound dressing was applied by RN #7, Patient #1 was turned over the soiled linens from her left side to her back. At that time, Patient #1 was observed to have a moderate amount of soft stool present at the left hip and groin fold and perineal area and required incontinent care. Interview with RN #7 at the time of the observation identified that Patient #1 did not have a brief on when she first began the wound treatment, that she had hurried to complete the treatment, and that the patient should have received incontinent care and a linen change prior to beginning the wound treatment.
- d. Patient #13's diagnoses included newly diagnosed Hepatitis C, the insertion of a feeding tube on 1/22/07, and jaw wiring on 1/26/07. Physician orders dated 1/30/07 directed medication administration via the gastric (feeding) tube. Observation on 2/15/07 at

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10:30 AM identified that LPN #3 donned clean gloves and administered medications to Patient #13 via the gastric tube. LPN #3 removed the gloves, exited the Patient's room and entered the medication room without the performance of hand hygiene. Interview with Quality Coordinator #1 on 2/15/07 at 10:45 AM reflected that Quality Coordinator #1 also observed that LPN #3 had not washed her hands before LPN #3 exited Patient #13's room. Interview with LPN #3 on 2/15/07 at 10:50 AM noted LPN #3 usually washed her hands and did so very frequently. Review of facility policy/procedure identified, in part, that hands are washed after glove removal.

- e. Patient #17 was admitted to the facility on 2/9/07 with diagnoses that included an acute exacerbation of chronic bronchitis. Review of the clinical record identified that Patient #17 had also developed Clostridium Difficile (C-Diff) during the hospitalization. Observations on 2/15/07 at 10:10 AM 12/28/06 at 9:30 AM identified that a "Contact Isolation" sign was clearly posted outside the door of Patient #17. Licensed Practical Nurse #1 (LPN #1) was observed to be at the bedside of Patient #17 with both of her hands resting on the patient's siderail, without the benefit of wearing a gown and/or gloves. Interview with LPN #1 following the observation identified that the LPN was aware of the patient's contact precautions prior to entering the room and stated that she should have donned the personal protective equipment before entering Patient #17's room.
- f. Patient #19 was admitted to the facility on 1/31/07 with diagnoses that Methicillin Resistant Staphylococcus Aureus (MRSA) in a finger wound and the nares. Observations on 2/15/07 at 12:05 PM identified that a "Contact Isolation" sign was clearly posted outside the door of Patient #19. Social Service Worker #1 (SSW #1) and an unidentified visitor were observed in Patient #19's room, were observed to have repeated contact with various areas of Patient #19's environment, and that both parties were without the benefit of wearing a gown and/or gloves. Interview with SSW #1 following the observation identified that SSW #1 stated that she did not notice the "Contact Isolation" sign prior to entering Patient 19's room.
- g. During a Tour of 5-1 on 2/16/07 at 2:15 PM with RN #20 (Charge Nurse), Patient #34 had a contact precaution sign posted on the outside of her room. Three visitors were observed to be in direct contact with the patient's environment as they sat on the patient's bed and/or chairs in the patient's room without the benefit of wearing gloves and gowns in accordance with the posted signage on the door. During an interview with RN #20, she was unable to identify why the patient was on contact precautions. Upon review of the clinical record, RN #20 identified that MD #7 ordered MRSA precautions when the patient was admitted to the unit on 2/9/07 but failed to identify the source of the MRSA. During an interview with MD #7 on 2/16/06 he identified that based upon the patient's history of MRSA (leg wound last spring) he ordered MRSA precautions.

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- h. Patient #35 was admitted to the hospital on 2/6/07 with a diagnosis of lower extremity cellulites and a history of end stage renal disease (hemodialysis). On 2/15/07, an order to obtain a stool culture for *Clostridium difficile* was received. A Contact Precautions sign was posted on the outside of the patient's door. On 2/16/07 at 10:25 AM, MD #3 was observed to enter the patient's room with out the benefit of donning gloves and/or a gown, examined the patient and exited the room with out hand washing. MD #3 was further observed to review the patient ' s record while sitting at the nurse's station and washed his hands at 10:40 AM. Interview with MD #3 on 2/16/07 identified that he was aware of the Contact Precautions sign posted on the patient's door.
- i. Patient #36 was admitted to the facility on 2/16/07 with diagnoses that included MRSA in the sputum and a recent history of MRSA in a leg wound. Observations on 2/16/07 at 11:15 AM identified that a "Contact Isolation" sign was clearly posted outside the door of Patient #36. An unidentified visitor was observed seated at Patient #36's bedside handling the patient's food items from a tray, assisting the patient with fluids, and wiping the patient's mouth with a napkin. A licensed nurse was also observed to be in the room during the observation and had brought the community medication administration computer into Patient #36's room. Both the visitor and the licensed nurse were without the benefit of wearing a gown and/or gloves. Despite the visitor's repeated contact with Patient #36's environment, the licensed nurse did not intervene to educate the visitor about the need for contact precautions.

Review of facility policy on contact precautions directed that a clean non-sterile gown should be worn when entering the patient's room if you anticipate that your clothing will have substantial contact with the patient, environment surfaces, or items in the patient ' s room. The policy directed that a gown should be worn if the patient is incontinent, has diarrhea, or wound drainage not contained within a dressing. The policy lacked direction to address any precautions required by visitors of patients who require contact precautions. Interview with the Infection Control Nurse (ICN) on 1/10/07 at 2:45 PM identified that the facility did not have a written policy to direct how and by whom visitors should be educated, monitored, or interventions if visitor non-compliance was identified. The ICN stated that the facility's signage posted at each isolation door directed visitors to the nursing desk. The ICN stated that nurses at that point should be educating visitors on the appropriate necessary attire and on good handwashing. The ICN stated that anyone who entered the isolation room of a patient who required contact isolation would be expected to wear gloves and a gown if they were going to have direct contact with the patient.

- j. Patient #16 was admitted to the facility on 2/10/07 with diagnoses that included mental status changes after seizure activity. Review of Patient #16's care plan dated 2/10/07 identified an alteration in elimination related to an indwelling Foley catheter. In preparation for the reinsertion of Patient #16's Foley catheter on 2/15/07 at 11:20 AM,

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RN #12 was observed to provide perineal care wearing unsterile gloves. Without the benefit of washing her hands or changing her gloves, RN #12 proceeded to open the sterile set up for Foley insertion and opened all sterile packets within the set up. RN #12 then discarded her original unsterile gloves, applied the sterile gloves provided in the sterile set up, again without washing her hands, and proceeded with the insertion of Patient #16's catheter. Following the procedure, RN #12 removed the sterile gloves, donned another pair of non-sterile gloves without washing her hands, and flushed Patient #16's Foley catheter with sterile normal saline. Review of facility policy/procedure directed that insertion of a Foley catheter is inserted using sterile technique and should be performed with extreme care to prevent injury and infection.

- k. Patient #15 was admitted to the facility on 2/6/07. Review of Patient #15's care plan dated 2/6/07 identified an alteration in elimination due to incontinence. On 2/15/07 at 1:30 PM, stool soiled linens removed from Patient #15's bed, were observed on the floor next to the patient's bed. Interview with Patient Care Assistant # 2 (PCA #2) at the time of the observation identified that she had just placed the linen on the floor and that "they were only the top sheets." Subsequent to surveyor inquiry, PCA #1 placed the soiled linen in a hamper just outside Patient #15's room.
- l. During Tour of 5-4 on 2/16/07 at 10:05 AM, soiled linen was observed on Patient #37's floor. Interview with PCA #5 identified that she had performed morning care and placed the soiled linen on the patient's floor when she was called to another patient's room. PCA #5 stated that she should have disposed the linen into a dirty hamper.

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) and/or (3) and/or (e) Nursing Services (1) and/or (i) General (7).

6. Based on review of the clinical records of review of facility policies, and interviews for three patients, Patient #15, #16, and #30, the facility failed to ensure that all documentation in the clinical record was accurate and/or was reflective of the patients' current status and/or was filed in the correct patient record. The findings include:
  - a. Patient #15 was admitted to the facility on 12/29/07 from a skilled nursing facility for diagnoses that included right ankle abscess that required incision and drainage on 1/1/07. Review of the admission nursing assessment dated 12/29/07 identified that Patient #15 entered the facility without a pressure ulcer. Review of a photograph of the patient's right medial and lateral posterior ankle that was taken 1/3/07, identified an area of eschar at the right heel. A physician progress note dated 1/13/07 identified the blackened eschar area and documented that the area would need debridement. On 1/14/07, Patient #15 was discharged back to the skilled nursing facility. Review of

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Patient #15's hospital discharge summary dated 1/14/07 and the interagency referral form dated 1/14/07 failed to identify the right heel eschar area. Review of the nursing readmission assessment from the skilled nursing facility dated 1/14/07 identified that Patient #15 reentered the facility with a three by two centimeter unstageable right heel pressure ulcer.

- b. Patient #16 was admitted through the Emergency Department (ED) to the facility on 2/10/07 with diagnoses that included mental status changes following seizure activity. Review of the ED record dated 2/10/07 identified that Patient #16 had a history of a recent fall that had required sutures to the area above the right eye and that the sutures remained in place. Documentation was lacking in the clinical record dated 2/11 through 2/13/07 of the presence of Patient #16's sutures. Review of the nursing assessments dated 1/14 and 1/15/07 described Patient #16's sutures as on the left eye. Observation of Patient #16's sutures on 1/16/07 identified that the sutures were actually above the patient's right eye. Interview with facility staff identified that the documentation that described Patient #16's sutures over the left eye was an error.
- c. Random patient records were reviewed during a tour of the emergency department on 2/16/07. Review of Patient #30's medical record with the Quality Risk Manager identified that it contained Patient #32's ambulance "run" sheet. Upon surveyor inquiry, Patient #32's paperwork was removed and appropriately filed.

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) and/or (3) and/or (i) General (7).

7. Based on review of clinical records, review of facility policies, the facility failed to ensure that the physician orders and/or progress notes for seven patients, Patients #13 #15, #38, #39, #40, #41 and #42, were consistently dated and timed at the time of the entry. The findings include:
  - a. Patient #13 was admitted to the facility on 1/16/07 with diagnoses that included traumatic brain injury. Review of progress notes from 2/8/07 to 2/11/07 noted that four out of nine progress note entries lacked the time the entry was made. The review further reflected that the entries were physicians' documentation.
  - b. Patient #14 was admitted to the facility on 2/15/07 with diagnoses that included Congestive Heart Failure and obesity. Review of progress notes from 2/15/07 to 2/16/07 noted that the only two progress notes entered by either the physician or Advanced Practice Registered Nurse for medicine lacked the time in which the entry was made.
  - c. Patient #15 was admitted to the facility on 2/6/07 with diagnoses of anorexia and right ankle osteomyelitis. Review of progress notes from 2/6/07 to 2/16/07 noted that eleven

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of twenty one progress notes entered by physicians and/or Physician Assistants (PA) and/or Advanced Practice Registered Nurses (APRN) lacked the time the entry was made.

- d. Patient #38 was admitted to the facility on 1/29/07 with diagnoses that included bilateral knee surgery and a stage 4, sacral pressure ulcer. Review of the Patient's medical record dated 1/29/07 to 2/18/07 identified that progress notes and/or physician orders were dated yet the time for the entry was inconsistently documented.
- e. Patient #39 was admitted to the hospital on 2/9/07 via the Emergency Department (ED) with the complaints of chest pain for three days, was hypotensive and subsequently diagnosed with sepsis, shock, pneumonia and acute renal failure. Patient #39 had a history of congestive heart failure, an ejection fraction of 15%, chronic obstructive pulmonary disease, status post automated implanted cardiac defibrillator and pacemaker and degenerative joint disease. Review of the physician's orders lacked a date and time for eight orders, that were written on the lower half of a physician's order sheet (the top of the sheet in a different handwriting was dated 2/9/07). Interview with the Nurse Manager of the unit, on 2/21/07, identified that for the eight identified orders were not dated and/or timed and she did not know when the identified orders were written. In addition, review of the clinical record identified that multiple progress notes lacked the time of day, including notes on 2/13/07, 2/14/07, 2/15/07, 2/16/07 and 2/17/07.
- f. Patient #40 was admitted to the hospital on 2/19/07 via the Emergency Department from a long-term care facility with the complaints of increased temperature and respiratory distress and was subsequently diagnosed with respiratory arrest. Patient #40 had a history of dementia, chronic obstructive pulmonary disease, chronic bronchitis, seizure disorder status post left cerebrovascular accident, hypothyroidism, Methicillin Resistant Staphylococcus Aureus (MRSA) in the urine and Vancomycin Resistant Enterococcus in the stool. Review of the clinical record identified that multiple progress notes lacked the time of day, including notes on 2/19/07, 2/20/07 and 2/21/07.
- g. Patient #41 was admitted to the Emergency Department (ED) on 2/20/07 and admitted to the Overflow Unit on 2/21/07 with diagnoses that included terminal illness and aspiration pneumonia. Review of the Patient's medical record on 2/21/07 reflected that the progress note, written by the Hospitalist on 2/20/07, lacked the time that the entry was documented.
- h. Patient #42 was admitted to the hospital on 2/18/07 via the Emergency Department with the complaints of a fall and was subsequently diagnosed with head injury, "skim" subdural hematoma and acute alcohol intoxication with a history of hypertension, benign prostatic hypertrophy and alcohol abuse. Review of the clinical record identified that multiple progress notes lacked the time of day, including notes on 2/18/07, 2/20/07 and

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2/21/07.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1)(A) and/or (2) and/or (d) Medical Records (3) and/or (i) General (7) and/or a violation of the Connecticut General Statutes Section 19a-127n and/or 19a-127o.

8. Based on review of the clinical record, interviews, and hospital policies, the facility failed to report one patient death (Patient #2) as a result of a fall. The findings included:
  - a. Patient #2 was admitted to the hospital on 4/13/06. Review of facility documentation dated 4/16/06 identified that the patient fell in the bathroom and hit her head on the wall. A nurse's note dated 4/20/06 identified that the patient fell again this morning but failed to document details of the fall. The record identified that the patient exhibited changes in mental status on 4/20/06, subsequently had a Head CT Scan performed on 4/21/06 related to confusion and trauma. The report identified that there was extraaxial fluid collection on the right compatible with chronic/subacute subdural hematoma and acute subdural hematoma with associated mass affect. The patient underwent a craniotomy for evacuation of the hematoma on 4/21/06 and required a subsequent surgery on the same day for a rebleed. The patient expired on 4/23/06. Review of the Decease Patient Checklist identified that this case was reportable to the Medical Examiner's Office, staff at the hospital documented that they contacted the Medical Examiner's office, was given a case number and were informed that MD #5 would come to the hospital. Review of the death certificate completed by MD #5 (Medical Examiner) identified that the immediate cause of death was closed head trauma related to a fall. The manner of death was an accident that occurred on 4/17/06 in the early morning. During an interview with the Director of Quality and Risk Management and the VP of Medical Affairs on 1/3/07, they identified that the fall was not reported to the Department of Public Health because they disagreed with the cause of death, however, made no attempts to contact the Medical Examiner's office to discuss the issue. During an interview with MD #5 on 1/4/07, it was identified that the hospital reported the death as a trauma and based upon review of the clinical record, determined the cause of death was related to the fall. Interview with MD #4 (Neurosurgeon) on 1/10/06 identified that he did not feel that the subdural hematoma was related to the fall on 4/17/06 and felt that the hematoma was caused by the patients low platlets which was low enough to cause the patient to bleed.
  - b. Review of Patient #2's clinical record during the period of 4/17/06 through 4/23/06 failed to identify that MD #3 documented the time of his assessments in the progress notes and/or the time he had written orders making the sequence of events difficult to follow. Although the hospital's Medical Staff By-laws didn't indicate that entries in the medical record needed to be timed, review of the Federal Regulations (Medical Records) directed that all entries must be timed, dated, and authenticated.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (7).

9. Based on review of the clinical record, review of facility policies, and interviews, the facility failed to ensure that the clinical record of one patient, Patient #1, contained complete and/or accurate assessments of the patient after family members reported concerns of unexplained bruises and/or that the facility's grievance policy was followed upon receipt of those concerns. The findings included:

- a. Patient #1 was admitted to the facility on 9/1/06 with diagnoses that included anoxic encephalopathy. Review of the clinical record identified that Patient #1 required total assistance from staff for all Activities of Daily Living (ADLs) including repositioning and transfers. Interview with Person #1 on 12/20/06 identified that Patient #1 had an unexplained bruise on her nose (though was unable to recall the date) and more recently another bruise on her knee. Person #1 believed that as Patient #1 was unable to move on her own, that there was no other explanation other than that staff members intentionally caused the bruising. Interview with the Nurse Manager #1 on 12/29/06 identified that a family member of Patient #1 reported that the patient had sustained a bruise on the nose and although the family member alleged abuse, the family member frequently used the word "abuse" when reporting concerns related Patient #1's care. Nurse Manager #1 stated that she assessed Patient #1's nose upon receipt of the report of a bruise and that it was not a bruise at all but more like a tiny scratch that disappeared without treatment within a few days. Review of the clinical record lacked documentation to reflect that an assessment of Patient #1's nose was performed and/or that an investigation was initiated in response to the allegation of abuse by the patient's family member.

In addition, interview with Person #2 on 12/20/06 identified that Patient #1 had an unexplained bruise on her left knee. Interview with the Nurse Manager #1 on 12/29/06 identified that a family member of Patient #1 reported that the patient had sustained a bruise on the knee and alleged that hospital staff had intentionally caused the bruise. Review of nursing notes dated 12/11/06 at 2:30 PM identified that Person #4 reported that he had noted a bruise on Patient #1's left knee. Review of the clinical record identified a nursing note dated 12/11/06 by RN #11 who described the area as a 1.5 centimeters (cm.) by 0.4 cm. reddened mark on the left knee of uncertain age and that staff would continue to monitor the area. Review of the clinical record lacked documentation to reflect that any further monitoring of the left knee area was performed.

Review of facility's policy regarding documentation directed that progress notes be

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written at least every twenty four hours but must be written under certain circumstances including unanticipated circumstances experienced by the patient. In addition, the policy directed that the twenty four hour flow sheet be used to provide documentation of ongoing patient assessment. Review of facility documentation failed to identify that facility staff followed facility policy that included filing of the appropriate documented reports with the Patient Relations Officer regarding either of the allegations of abuse reported by Patient #1's family members. Review of the facility's policies on patient complaints and grievance management described the difference between a patient complaint and a patient grievance. The policy identified that a patient complaint is a verbal complaint that is made to the hospital by a patient or the patient's representative that may be resolved promptly by staff present. The policy identified that a patient grievance included when a complaint, whether verbal or written, was one regarding abuse, neglect, or patient harm. The policy directed that patient grievances would need to be forwarded to the Patient Relations Officer for further action.



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

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May 8, 2007

Bruce Cummings, President  
Lawrence and Memorial Hospital  
365 Montauk Avenue  
New London, CT 06320

Dear Mr. Cummings:

Unannounced visits were made to Lawrence & Memorial Hospital on March 8, 12, 13, 27, 28, 29, 30 and April 12, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a full Medicare survey at the request of CMS, a licensure renewal inspection and a complaint investigation.

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

An office conference has been scheduled for May 22, 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,

Ann Marie Montemerlo, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

AMM:zsj

c. Director of Nurses  
Medical Director  
President  
vllawmem.doc  
CT #6592

Phone:



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

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

P.O. Box 340308 Hartford, CT 06134

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

1. Based on observation and staff interviews, the facility failed to maintain a safe environment in the emergency department. The findings include:
  - a. During a tour of the behavioral health unit of the emergency department on 3/27/07, locker #11, located in the units hallway, was noted to be in an opened position. Nurse Manager #4 stated that the lockers are used for patient belongings and that a combination lock is utilized to secure the contents. The contents of the open locker included hand sanitizer, a cell phone, and a key ring with an attached black case containing mace. PCA #6 (who was providing one-to-one observation of a psychiatric patient in the hallway) stated that the contents of locker #11 belonged to her and that she had forgotten to re-lock the locker.

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

2. Based on medical record reviews, review of facility policy and procedure and staff interview, the facility failed to ensure that a registered nurse supervised and/or evaluated the nursing care for Patients #44, #46 and #63. The findings include:
  - a. Patient #44 was admitted to the hospital on 3/23/07 with atrial fibrillation, shortness of breath and a history of congestive heart failure. Review of the care plan identified an intervention that the patient be weighed daily. Review of the nursing documentation for the period of 3/23/07 through 3/27/07 failed to identify that the patient had been weighed on 3/24/07, 3/25/07 and 3/26/07.
  - b. Patient #46 was admitted to the hospital on 3/12/07 with abdominal pain and subsequently experienced multi-system failure that required the patient to be placed on a ventilator and receive daily hemodialysis. Review of the hemodialysis treatment post dialysis assessment flow sheets dated 3/16/07, 3/17/07, 3/18/07 and 3/19/07 failed to identify the patient's respiratory status, cardiac status, presence of edema and access status.
  - c. Patient #63 was admitted on 3/24/07 to the NICU with diagnoses of pre-maturity and respiratory distress. Review of the NICU admissions orders directed monitoring of vital signs with blood pressures every one (1) hour. Review of the NICU flowsheet from 11:00 AM on 3/24/07 through 7:00 AM on 3/25/07 failed to identify hourly blood pressures for 2:00 PM, 3:00 PM, 5:00 PM through 11:00 PM on 3/24/07 and for 12:00 AM through 2:00 AM and 4:00 AM through 7:00 AM on 3/25/07.

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

3. Based on medical record, observation, review of facility policies, review of facility documentation and staff interview, the facility failed to ensure that medications were administered based on a physician's order for Pt. #68 and that medication discrepancies were resolved according to hospital policy. The findings include the following:
  - a. Review of the Emergency Department (ED) record identified that Patient #68 presented with shortness of breath and back pain. The ED order directed that the patient receive Morphine 2 mg intravenously, may repeat dose once as needed. Review of the nurse's documentation identified that the patient subsequently received Morphine 2 mg intravenously at 3:05 PM, 3:15 PM, 5:40 PM and 6:20 PM. Review of the physician's orders failed to identify an order for two of the four doses of Morphine documented as given.
  - b. During tour of 5-4 on 3/27/07, an automative dispensing machine (ADM) discrepancy report was printed at 11:32 AM on 3/27/07. The report identified 2 discrepancies were noted on 3/26/07 at 10:35 PM that included Lorazepam .5 mg and Lorazepam 1 mg. However, the report did not identify how the discrepancies were resolved. Review of the Controlled Substances Policy identified that discrepancies must be resolved as soon as possible and the nurse in charge would run a discrepancy report before the end of the shift and an attempt should be made to resolve them before the end of the shift. The policy indicated that unresolved discrepancies should be reported to the Patient Care Manager for further action. Interview with the Patient Care Manager identified that she was not aware of the unresolved discrepancies.
4. Based on medical record, review of facility documentation, and staff interviews, the facility failed to maintain an accurate medical record for Patient #49. The findings include:
  - a. Patient #49's diagnoses included a fall with head injury. Review of the medical record with the Director of Quality Improvement identified that although Patient #49's demographic information, inclusive of the patient's address, phone number, and insurance information was entered into the facility's information system, it was entered under Patient #74's established profile. Subsequently, the reviewed medical record contained information pertaining to both patients. Review of the documentation with the Manager and Supervisor of Registration identified that when Patient #49 presented to the emergency department on 3/22/07, the registrar entered Patient #49's last name into the system, which was similar to Patient #74's last name,

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and that Patient #49 must have responded to verify her identity. Subsequently, Patient #74's profile was changed to reflect Patient #49's address, phone number, and insurance information and Patient #49's 3/22/07 visit information was entered under Patient #74's medical record number. In addition, Patient #49's identification bracelet, which contained this incorrect information, was placed on the patient.

The following is a violation of the Regulations of Connecticut State Agencies 19-13-D3 (c) Medical staff (2)(D) and/or (d) Medical records (3) and/or (8).

5. Based on medical record review and a tour of the Medical Records Department, the facility failed to ensure that a properly executed informed consent was done for Patient #53. The findings include:
  - a. During tour of the Medical Records Department, review of Patient #53's medical record identified the patient had a colonoscopy on 12/26/06. Review of the patient's informed consent for the procedure lacked the patient's name, date, specified relationship and an "X" was noted in the patient signature area with no indication if it was the patient's signature. Additionally, the physician note on the bottom of the consent form lacked the name of the patient and relationship specification.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing services (1) and/or (g) Pharmacy (1) and/or (4) and/or (i) General (7).

6. Based on tours of the facility and staff interview, the facility failed to ensure that code cart medication trays were monitored as per facility policy. The findings include:
  - a. During tours of the patient units, code cart medication trays were identified as checked by the pharmacy for expiration dates of medications on a monthly basis. Interview with the Director of the Pharmacy on 3/30/07 identified that the code carts are checked monthly by the pharmacy department and that medications are removed 1(one) month before they are due to expire. Review of the code cart tray expiration log identified that there were 4 trays that had medications that would have expired on 4/07 that were still in the code carts.
7. Based on tours of the facilities Outpatient psychiatric service area and the Medical infusion area, review of facility policy and procedure, review of facility documentation and staff interview, the facility failed to ensure that sampled medications were handled as per facility policy. The findings are as follows:
  - a. During tour of the Medical Infusion Area, sample medications were observed in the medication room. Interview with staff identified that when the sample medications

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- are administered; a notation was made in the clinical record. Review of facility policy identified that a log that included the drug name, lot number, expiration date, patient name and quantity would be maintained for all sample medications. The unit failed to have a system in place as per facility policy.
- b. During tour of the Outpatient Psychiatric Services area on 3/29/07, sample medications were observed stored in a locked cabinet. Review of the Drug Sample Log forms with the Manager of Ambulatory Psychiatric Services identified that the log for two medications (Abilify 5 mg and Abilify 10 mg) lacked documentation of the location of the outdated medications and the log for one medication (Abilify 15 mg) lacked an accurate account of the medication as three packages were unaccounted for. APRN #1 stated that she takes medications from the on-site Outpatient Psychiatric Clinic and transports them to the satellite site. Once at the satellite, the APRN enters the medications into a log, however, she does not document the lot number until she dispenses the drug to a patient. APRN #1 stated that she periodically goes through the medications and brings outdated medications back to the on-site location, however, the facility was unable to provide documentation that this process occurred. The Director of Pharmacy stated that he was unaware of this practice. The facility policy identified that the use of drug samples is not permitted for inpatients or outpatients within the hospital. Specific areas may be designated to have sample medications for indigent patients or to patients requiring medication compliance monitoring. Drug samples would be dispensed directly by the physician or approved provider in specified clinic areas of the hospital and are reviewed by the pharmacy.
8. Based on tours of the facility, review of facility policy and staff interview, the facility failed to ensure the security of drugs. The findings include:
- a. During a tour of the Ambulatory Surgical Unit (ASU) on 3/27/07, once inside the medication room through one locked door, an open entrance into the Pain Management Procedure Room was observed. Observations in the Pain Management Procedure Room, revealed a doorway leading to an outside corridor and a doorway that lead to a bathroom that also had another doorway leading to an outside corridor. The medication room contained an unlocked medication refrigerator and unlocked drawers with needles and syringes. Review of the facility's Safe Medication Practice policy identified that medications would be stored securely to prevent access or tampering by patients, visitors and unauthorized staff and that the storage of needles and syringes, when not in use by authorized staff, must be stored in a locked room or drawer.

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- b. During a tour of the Cesarean Suite on 3/28/07, OR #1 was observed to contain an unlocked anesthesia cart. Observations further identified that there was no staff in attendance in this area, no cases were in progress and no rooms were being set up for cases. Review of the Anesthesia Department scope of service policy directed that anesthesia supply carts would be locked at all times when not attended by a member of the Anesthesia Department.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing services (1) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (7).

9. Based on tours of the facility and review of facility policy, the facility failed to ensure that fluid filled containers were labeled as to their contents and/or with expiration dates as per facility policy. The findings are as follows:
  - a. During tour of an Endoscopy Procedure Room, an unlocked cabinet was observed to contain 12 (twelve) unlabeled fluid filled containers. Interview with the Nurse Manager identified that the containers were filled with a fluid from the Cytology Department.
  - b. During tour of the Operating Room Area, containers labeled with Formulin 10% failed to have an expiration date identified. Review of the laboratory department's labeling policy identified that each hazardous chemical transferred outside the laboratory that was not in its original container, must be labeled with the contents and identify an expiration date.
  - c. During a tour of the Cesarean Suite area, OR #1 and OR #2 were observed to contain semi-rigid irrigation fluid bottles in warmers with dates ranging from 3/1/07 through 3/28/07. Review of the facility Warming Cabinet Guidelines directed all solutions would be dated upon being stored in the warmer by labeling with the date of expiration.

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

10. Based on observations and review of facility policy, the facility failed to ensure all food items were labeled and dated as per facility policy. The findings include:
  - a. A tour of the Dietary Department on 3/29/07 identified that there were several trays of foods observed in refrigerators that were either in the process of defrosting and/or had been previously cooked that were not dated or labeled as per policy. There was a box with an uncooked defrosted hamburger patty observed in a refrigerator that was

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not covered, dated or labeled. Further observations identified a box of defrosted meat observed in a refrigerator that was not labeled and/or dated. According to facility policy titled Dating and Marking Procedure, all foods that are removed from their original container that are processed by the facility will be dated and labeled as to what the contents are.

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

11. Based on observation, review of facility policy and staff interview, the facility failed to ensure that equipment and/or supplies were maintained to ensure an acceptable level of safety and quality. The findings include:
  - a. Tour of the Pequot Health Center on 3/29/07 identified that the ice machine utilized for patients and staff, contained a large ice scoop which was located in the center of the ice. An appropriate method to store the ice scoop was not apparent. Interview with Nurse Manager #9 identified that staff uses a new plastic cup to scoop up the ice each time. A sign observed on the front of the ice machine instructed staff to use a plastic cup.
  - b. Review of the 6-2 specimen refrigerator log dated September 2006-present identified that the refrigerator temperatures were not recorded daily. Review of the Refrigerator Monitoring Policy indicated that refrigerator/freezers temperatures would be monitored on a daily basis.
  - c. During tour of 5-4 on 3/27/07, 2 large toys that needed cleaning were observed placed on top of a commode in the dirty utility room. Review of the Cleaning of Toys Policy indicated that environmental services would wash dirty toys daily, however the policy did not specify where to put the toys that needed to be cleaned. Interview with the Patient Care Manager identified that toys in need of cleaning were usually put in a small box in the dirty utility room and not on top of a commode.
  - d. The soiled utility room of the ASU was observed to contain holiday supplies and decorations.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (e) Nursing services (1) and/or (i) General (7).

12. Based on observations, review of facility policy and staff interview, the facility failed to ensure that infection control practices were maintained in the operating room. The findings include:
  - a. During tour of the operating room suite on 3/27/07, Anesthesiologist #10 in OR #2 was observed with a newspaper crossword puzzle located on the anesthesia equipment as a

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procedure was being conducted. Interview with the OR Manager identified that it was not the practice in the OR.

- b. OR #6, that had just been cleaned, was observed with a small tackle box containing candy and writing supplies on top of the anesthesia cart. Review of facility policy titled Infection Control Guidelines for Anesthesia identified that eating and drinking were restricted to the lounge.

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 clinical record review, staff interviews and review of facility policies and procedures, the facility failed to ensure that emergency services were provided for Patients #48. The findings include:
  - a. Patient #48 was admitted to the ED with behavioral symptoms that required intermittent restraints and psychotropic medication. Transfer of Patient #48 to a facility with an Inpatient Pediatric Psychiatric Unit was not immediately possible and the patient required continued care in the ED. Although the patient was not admitted to the facility, the patient was housed on another floor while still under the care of the Emergency Department.

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).

14. \* Based on a review of facility policies and procedures, review of facility documentation, observation, and staff interviews, the facility failed to establish provisions for the care of a psychiatric pediatric patient. The findings include:
  - a. Patient #48's diagnoses included acute psychosis and behavior disorder. The patient was evaluated in the emergency department on 3/22/07 at 5:19 PM following an episode of violent behavior. Review of the medical record with Nurse Manager #4 on 3/27/07 identified that Patient #48 was awaiting in-patient psychiatric placement and was transferred to the pediatric unit on 3/26/07 at approximately 5:00 PM. Nurse Manager #4 stated that the patient was "boarding" on the pediatric unit. Review of the medical record on 3/28/07 with Nurse Manager #10 identified that although an interdisciplinary plan of care was initiated when the patient arrived on the pediatric unit, the plan of care was not specific to the psychiatric needs of the patient. Nurse Manager #10 stated that Patient #48 was "housed" on the unit and was still considered an emergency department patient at that time. Patient #48 was returned to the emergency department on 3/27/07 at 9:30 AM. The Pediatric Patient with

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Behavioral/Psychiatric Disorders in the Emergency Department Policy identified that if a child remains in the emergency department for one overnight period waiting for placement, a team meeting is called and the options for the care of the child are considered.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical record (3) and/or (e) Nursing services (1).

15. \* Based on review of the medical record, review of facility policies and procedures, review of facility documentation, and staff interviews for one patient (Patient #49), the facility failed to provide the necessary services required by the patient. The findings include:
- a. Patient #49 presented to the emergency department on 3/22/07 at 12:46 PM following a backward fall with a head injury. The patient was triaged at a level "3" which is considered urgent according to the facility policy. The Triage Guidelines identified that patients placed at levels 2, 3, 4, and 5 are returned to the waiting room, reassessed based on their acuity and that the triage nurse would continue to observe patients. According to Person #6, it was reported that Patient #49 had sustained a fall, had swelling at the back of the head and nausea and was taking anticoagulants. The patient was also noted to have an elevated blood pressure. The medical record failed to reflect that a neurological assessment had been performed during the triage of the patient. RN #26, the triage nurse, stated that she obtained Patient #49's vital signs and assessed the patient's range of motion, but she was unable to perform a neurological assessment because the patient was weepy and uncooperative with raising her head at the time of triage. RN #26 stated that Patient #49 also had a strange affect and wouldn't follow commands. RN #26 also stated that Patient #49's condition did not deteriorate; however, the medical record failed to reflect that additional assessments were completed while the patient was waiting to be evaluated. Patient #49 left the facility at approximately 3:30 PM (approximately two and one half hours after arrival) without being treated. Patient #49 sought treatment at another acute care facility at 5:20 PM (less than two hours later) and a CT scan performed at that time identified a large acute subdural hematoma with extensive intracranial bleeding.

The following are violations of the General Statutes of Connecticut Section 46a-152-(d)(2) and/or the Regulations of Connecticut State Agencies Section (d) Medical record (3) and/or (e) Nursing services (1) and/or (i) General (7).

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16. Based on review of the medical record, review of facility policies and procedures, review of facility documentation, and staff interviews for one patient restrained on the psychiatric hall of the emergency department, (Patient #48), the facility failed to ensure reduction or elimination of restraints at the earliest possible time. The findings include:
- a. Patient #48's diagnoses included acute psychosis and behavior disorder. The medical record identified that wrist restraints were applied on 3/22/07 at 8:30 PM, ankle restraints were applied at 9:30 PM, and a vest restraint was applied at 10:15 PM. Nurses' notes dated 3/23/07 at 12:50 AM identified that Patient #48 became agitated when the restraints were checked and that the patient was medicated with Ativan. Nurses' notes at 6:00 AM identified that the patient continued to sleep and remained asleep at 7:00 AM. Review of the medical record on 3/28/07 with Nurse Manager #4 identified that although the Close Observation flow sheet dated 3/23/07 noted that Patient #48 was sleeping from 1:15 AM until 8:45 AM, restraints remained in place until 9:00 AM. The facility restraint policy identified that early release trial must be implemented when mental status improvements have been documented for more than two hours. In addition, orders were not obtained in accordance with the facility level IV restraint protocol which identified that physician orders were required every two hours for children between the ages of nine and seventeen; to a maximum of four hours.
17. Based on review of the medical record, review of facility documentation, review of facility policies and procedures, and staff interviews for one patient (Patient #48), the facility failed to ensure that the use of restraints was reflective of an individual patient assessment and/or utilized in accordance with the patient's plan of care. The findings include:
- a. Patient #48's diagnoses included acute psychosis and behavior disorder. The restraint flow sheet dated 3/22/07 at 8:30 PM identified that two point restraints were applied because the patient was agitated and four point restraints were applied at 9:30 PM because the patient was agitated. The medical record also identified that a vest restraint was applied at 10:30 PM; however, the medical record lacked an assessment of the patient's behaviors. Although the medical record lacked documentation of the changes in Patient #48's exhibited behaviors, RN #27 stated that Patient #48 was biting and kicking and the decision was made to use four point restraints. Review of the medical record on 3/28/07 with RN #27 identified that it lacked a physician's order for the implementation of restraints on 3/22/07 at 8:30 PM, failed to reflect an assessment of the patient's behaviors indicating a need for a more restrictive restraint, and failed to incorporate the use of the restraints into the patient's plan of care. RN

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#27 stated that she was utilizing the 3/22/07 order that was written at 5:40 PM and was unaware that she needed to obtain a new order.

18. Based on review of the medical record, review of facility policies and procedures, review of facility documentation, and staff interviews for one patient restrained in the psychiatric hall of the emergency department, (Patient #48), the facility failed to utilize the restraints in accordance with facility policy. The findings include:
- a. Patient #48's diagnoses included acute psychosis and behavior disorder. The medical record dated 3/22/07 at 8:30 PM until 3/23/07 at 9:00 AM identified that restraints were utilized for Patient #48 due to agitated and combative behaviors. Although the continuous observation flow sheets dated 3/22/07 to 3/23/07 identified that the resident was observed every fifteen minutes, review of the medical record on 3/28/07 with Nurse Manager #4 identified that the medical record lacked appropriate physician's orders, was not reflective of the type of restraints used, and failed to consistently address the patient's behavior, safety, and physical well-being in accordance with the facility policy. The facility restraint policy identified that observation of the patient in restraints must be addressed by a nurse on the restraint flowsheet every fifteen minutes.  
The facility policy identified that when Level IV (behavioral) restraints are utilized on a child between the ages of nine and seventeen, physician's orders were required every two hours. Documentation on a Restraint Flowsheet was required by a nurse which addressed the patient's mental status, appropriate application of restraint including circulation assessments and restraint release, safety measures, and repositioning every two hours. Additionally, the facility restraint log was not reflective of the use of the restraints for Patient #48 during this time.
19. Based on medical record, review of facility policies and procedures, review of facility documentation, and staff interviews for one patient restrained on the psychiatric hall of the emergency department, (Patient #48), the facility failed to obtain a physician's order prior to the application of restraints. The findings include:
- a. Patient #48's diagnoses included acute psychosis and behavior disorder. The medical record dated 3/23/07 at 11:00 AM identified that Patient #48 became uncooperative with the physician and four point restraints were applied for patient and staff safety. The patient was also medicated at that time with Geodon and Diphenhydramine for agitation and unsafe behavior. Review of the medical record on 3/30/07 with RN #28 identified that it lacked a physician's order for the use of restraints at that time. Nurses' notes dated 3/23/07 at 5:44 PM identified that Patient #48 became combative and wrist restraints were applied. Review of the medical record on 3/29/07 with

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Nurse Manager #4 identified that although a verbal order was obtained on 3/23/07 to restrain the patient for safety, the order was not signed and lacked specifications for the indication for use, type of restraint, and duration. Nurse Manager #4 stated that an appropriate restraint packet is used every time a restraint is initiated. The medical record lacked the required physician order for restraints document which is included in the restraint packet. The facility restraint policy identified that the physician's order sheet provides a place for the required documentation and verbal orders must be signed within twenty four hours.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical plant (2).

20. On 3/27/07, during a tour of the facility, the following was observed:
- a. The fire doors (5/501/19 DR), (5.601.15DR), (4.601.12DR), (4/501/15DR), (3/30/09DR), (2/101/13DR), (2/701/03DR), and the fourth floor fire doors located next to office # 4.534, either bound on the doorframe, bound at the meeting astragal, did not positively latch, and/or lacked a coordinating device that would allow each leaf in the pair to close independently of the other leaf thereby not maintaining the integrity of the barrier at these openings.
  - b. There were voids in the walls and around pipe sleeves above the suspended ceiling assemblies above the smoke doors (L&M 09214 and L&M 09215) to the One-Day Surgery Operating room from the corridor, above the fire doors at the passageway from building 700 to building 600, and above fire doors (2.201.08DR) that were not sealed with materials having a fire resistance rating of at least ½ hour, in order to maintain integrity of the barrier.
  - c. The fourth floor elevator vestibule doors (4.401.21DR) when closed, did not positively latch, and the second floor green elevator and the second floor building 700 blue elevator vestibule doors bound on the coordinating devices thereby not maintaining the integrity of the barrier at these opening.
21. On 3/28/07, during a tour of Building 600, the following was observed:
- a. The fire doors at the fourth and fifth floors to the construction area when closed, bound on the floor and/or doorframe, not providing at least a one (1) hour separation between the construction area and the occupied areas of the facility.
  - b. The fourth and fifth floor walls separating the construction area from the occupied areas, had voids around penetrations for wiring and piping which were not sealed with materials having a fire resistance rating of at least one (1) hour.

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22. On 3/28/07 and 3/30/07 during record review, the following was identified:
- Documentation was not provided by the Facilities Department Staff that electrical receptacle outlets in patient care areas were inspected annually or that documentation that would justify longer intervals of inspection and testing were in accordance with NFPA 99, Section 3-6.2.3, and as part of the facilities preventive maintenance program.
  - Documentation was not provided by the Facilities Department Staff to indicate that the automatic sprinkler system had been inspected on a quarterly basis during the past twelve (12) months by an authorized service company or licensed employees of the facility; i.e. the system was inspected semi-annually, May and November 2006.

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

Microbiology

23. Based on record review and confirmed on interview with the laboratory staff, the laboratory failed to quality control the rapid test kits for Cryptosporidium and Rotavirus at least each new lot or shipment and then once a month. The findings include the following:
- A review of the quality control records for the Meridian Immuno card Stat for Cryptosporidium, lot # 0861130, expiring on 10/06/07 revealed that quality control had not been documented. Patient tests were performed on 3/2/07, 3/5/07, 3/6/07, 3/7/07 using this test kit lot. The Immunostat Rotavirus test kit, lot # 750130.265, expiring on 3/8/08 was quality controlled but results were not documented. The supervisor stated that quality control was performed and entered into the computer system at the same time as Giardia results, but Rotavirus results were not documented.

Histology

24. Based on record review and confirmed on interview by the staff, the laboratory failed to document the source of the specimens used for histology special stain controls. The findings include the following:
- The laboratory uses previous positive patient tissue for special stain control but does not document which case the specimen came from. The laboratory must be able to identify the control.

Blood Bank Donor Room

25. Based on a tour of the Donor Room, it was determined that the laboratory failed to remove blood collection tubes that had expired and were available for patient care. The findings include:

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- a. An inspection of the blood collection drawer in the Donor Room on March 12, 2007 revealed that outdated vacutainer tubes were not discarded. The following tubes were observed:

Tube	Lot Number	Expiration Date
Dark Blue (2 bags)	6039018	2/2007
Red (3)	5215776	2/2007

The following is a violation of the Regulations of Connecticut State Agencies Section 19a-36-D38 Minimum standards for the operation of clinical laboratories.

Serology:

26. Based on a tour of the Serology laboratory and interview with the Chemistry supervisor, it was determined that adequate safety precautions were not enforced to protect against biological chemical and physical hazards. The findings include:
- a. At the time of the inspection, caustic chemicals (hydrochloric acid) were stored above eye level. Two (2) 24 hour urine containers filled with liquid hydrochloric acid were stored on a shelf above eye level in the Serology section of the laboratory.