

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

IN RE:           Norwalk Hospital Association  
                  d/b/a Norwalk Hospital  
                  24 Stevens Street  
                  Norwalk, CT 06856

CONSENT AGREEMENT

WHEREAS, Norwalk Hospital Association (hereinafter the “Licensee”), has been issued License No. 0053 to operate a general hospital known as Norwalk Hospital, (hereinafter the “Facility”) under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the “Department”); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter “FLIS”) of the Department conducted unannounced inspections on various dates commencing on January 24, 2007 and concluding on February 23, 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 a violation letter dated March 9, 2007 and May 23, 2007 (Exhibits A and B – copies attached); and

WHEREAS, while the execution of the Consent Agreement does not constitute an admission or adjudication of any facts or violation of law, the facility is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Facility, acting herein and through Geoffrey Cole, its Administrator, hereby stipulate and agree as follows:

1. The Facility shall execute a contract with an Independent Nurse Consultant (INC), who has expertise in the area of behavioral health, approved by the Department within two (2) weeks of the effective date of this Consent Agreement. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Facility shall incur the cost of the INC.
2. The INC shall function in accordance with the FLIS' INC Guidelines (Exhibit C – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies
3. The INC shall provide consulting services for the inpatient behavioral health unit for a minimum of fifteen (15) hours per week 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 laws. The INC shall arrange his/her schedule in Order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of a three (3) month period and may, in its discretion, discharge the requirements for an INC or reduce or increase the hours of the INC and/or responsibilities. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Agreement.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation within two (2) weeks after the execution of this document.
6. The INC shall confer with the Facility's Executive Administrative Staff and Chief of Medicine and other staff determined by the INC to be necessary to the assessment of psychiatric services and the Facility's compliance with federal and state statutes and regulations.

7. The INC shall make recommendations to the Facility's Administrator, Director of Nursing Services and Medical Director for improvement in the delivery of direct patient care in the Facility. If the INC and the Facility are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Facility and the INC shall make a final determination, which shall be binding on the Facility.
8. The INC shall submit weekly written reports to the Department documenting:
  - a. the INC's assessment of the care and services provided to residents on the behavioral health unit;
  - b. the Facility's compliance with applicable federal and state statutes and regulations; and
  - c. any recommendations made by the INC and the Facility's response to implementation of the recommendations.
9. Copies of all INC reports shall be simultaneously provided to the facility's executive nursing and medical staff and the Department.
10. 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 care by licensed independent providers and nursing staff and implementing prompt training and/or remediation in any area in which a staff member demonstrates a deficit. Records of said training and/or remediation shall be maintained by the Facility for review by the Department;
  - b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;
  - c. 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 Facility's plan of correction submitted in response to the violation letters dated March 9, 2007 and May 23, 2007.

11. The INC and representatives of the facility shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Agreement and thereafter at eight (8) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Facility and the Facility's compliance with applicable federal and state statutes and regulations.
12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Agreement shall be made available to the INC and the Department, upon request.
13. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
14. Within thirty (30) days of the execution of this Consent Agreement, the Facility shall review and revise, as appropriate, policies and procedures relative to the Facility's Clinical Practice Guidelines for the Psychiatric Behavioral Health Program and Scope of Practice Policy to specifically address the collaborative practice of advanced practice registered nurses and attending physicians within the Facility. The policies shall be presented to the Medical Staff for approval.
15. Within thirty (30) days of the execution of this Consent Agreement, the Facility shall review and revise, as appropriate, Clinical Practice Guidelines and the Scope of Practice for Physician Assistants practicing in the intensive care unit and throughout the Facility. The policies shall be presented to the Medical Staff for approval.
16. The Facility shall provide an inservice education program focusing on the policies outlined in paragraph fourteen (14) and fifteen (15) above for licensed independent providers.
17. The Licensee shall appoint a Pharmacist licensed in Connecticut who will conduct weekly rounds on the behavioral health unit and will conduct a random

audit of ten (10) medical records weekly for the purpose of reviewing the patients' medication regime. Said review will consist of patients who are currently residing on the unit and whose medical records are active. Said pharmacist shall have expertise in psychotropic medications and their interactions with other drugs on medical conditions. This individual shall be responsible for timely notification of the primary psychiatrist regarding any concerns, adverse effects or contraindications.

18. The Facility shall ensure that each patient who receives an as needed medication (e.g. PRN medication), is appropriately assessed prior to the administration of the medication for the purpose of determining the appropriateness of the administration of said medication and shall:

- a. Formulate policies and procedures which address parameters for the administration of as needed medications, response to the medication and applicable documentation;
- b. Conduct weekly audits of the medical records of each patient to ensure that as needed medications are administered in accordance with physician orders, the plan of care and standards of practice;
- c. Document these audits and maintain said documentation for a period of two (2) years;
- d. Provide copies of the weekly audits to each patient's primary psychiatrist; and
- e. Conduct in-service programs for all currently employed licensed staff and new employees upon employment relative to the appropriate utilization of as needed medications.

19. Within fourteen (14) days of the execution of this Consent Agreement, the Facility shall develop and/or review and revise, as necessary, Wound Care Protocols to include:

- a. A multi-disciplinary assessment of all current patients and new admissions regarding their risk for developing pressure areas;
- b. Preventive strategies for those at risk for developing pressure areas;

- c. Documentation required by all applicable disciplines for all preventive and/or treatment interventions on the care plan and revision of the care plan, as necessary, to reflect revised interventions.
20. Within twenty-one (21) days of the effective date of the Consent Agreement, all appropriate staff, including nursing and respiratory therapy staff, shall be inserviced regarding the policies and procedures identified in paragraph (19).
21. Effective upon the execution of this Consent Agreement, the Facility shall effect implementation of the corrective action plan submitted to the Department and dated April 9, 2007 (Exhibit D - copy attached).
22. Effective upon the execution of this Consent Agreement, the Facility, through its Governing Body, administrative and nursing executive, shall ensure substantial compliance with the following:
  - a. Sufficient nursing personnel are available to meet the needs of the patients;
  - b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each resident's comprehensive care plan;
  - c. Patient assessments are performed in a timely manner and accurately reflect the condition of the resident;
  - d. Each resident care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon a multi-disciplinary patient assessment and in accordance with applicable federal and state laws and regulations;
  - e. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, altered mental status, a decline in skin integrity and/or indications of an unstable health status; and
  - f. Patients with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

23. The Facility, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department within said timeframe.
24. The Facility shall incorporate into its Quality Assurance/Performance Improvement Program a method to monitor implementation of the requirements of the Consent Agreement and shall be presented to Medical Staff and to the Governing Authority. The QAPI will include outcome measures which identify and analyze the quality of behavioral health care for inpatients, the etiology of Facility acquired pressure sores, compliance with Facility protocols and treatments recommended by the clinical practice protocols, and the provision of care by Advanced Practice Registered Nurses and Physician Assistants in accordance with clinical practice guidelines throughout the Facility. Minutes of the QAPI meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
25. The Facility shall pay a monetary penalty to the Department in the amount of ten thousand dollars (\$10,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The money penalty and any reports required by this document shall be directed to:

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

26. All parties agree that this Consent Agreement is an Agreement of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Facility for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and

judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Facility in which compliance with its terms is at issue. The Facility retains all of its rights under applicable law.

27. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
28. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
29. The Facility understands that this Consent 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 exist at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Facility of any other rights that it may have under the laws of the State of Connecticut or of the United States.
30. The Facility had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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

NORWALK HOSPITAL ASSOCIATION -  
Licensee

7/30/07  
Date

By: [Signature] for Geoff Cole  
Geoffrey Cole, Administrator

STATE OF CONNECTICUT )

County of FAIRFIELD ) ss July 30, 2007

Personally appeared the above named PAULA MILTON FOR and  
made oath to the truth of the statements contained herein. Geoffrey Cole

My Commission Expires: 5-31-10  
(If Notary Public) [Signature]  
Notary Public   
Justice of the Peace   
Town Clerk   
Commissioner of the Superior Court

STATE OF CONNECTICUT,  
DEPARTMENT OF PUBLIC HEALTH

8/9/07  
Date

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



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A  
PAGE 1 OF 6

March 9, 2007

Mr. Geoffrey Cole, Administrator  
Norwalk Hospital Association  
24 Stevens Street  
Norwalk, CT 06856

Dear Mr. Cole:

Unannounced visits were made to Norwalk Hospital Association which concluded on February 23, 2007 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an 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 March 28, 2007 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

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

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

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

Respectfully,

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

ESA/jf

c. Director of Nurses  
Medical Director  
President

Complaint #6225



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

DATE(S) OF VISIT: February 23, 2007

EXHIBIT A

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-D3 (b) Administration (2) and/or (c) Medical Staff (2) (B) and/or (C).

- \*1. Based on record review and interviews, the hospital lacked evidence that clinical practice guidelines of psychiatric behavioral health and scope of practice were followed for one patient admitted to the psychiatric unit. The findings include:
  - a. Review of the record identified that Patient #1 was admitted to the hospital from a psychiatric facility on 11/2/06 for mental status change. The patient diagnoses included schizophrenia, bipolar disorder and chronic kidney disease secondary to Lithium. The patient was transferred on 11/6/06 to the hospital's inpatient psychiatric unit (CP3) on a voluntary basis from the hospital's medical unit (8 East) for psychiatric stabilization. Patient #1 was hospitalized on CP3 from 11/6/07-11/20/07. Review of the Inpatient Psychiatry Standard Admission Orders included Clonazepam 0.5mg by mouth (po) twice per day (BID), Divalproex 500 mg po q hour of sleep (HS), Divalproex 250 mg q morning (AM), Zyprexa 20 mg po qHS, Paroxetine 20 mg po QD. Cogentin 1 mg po at HS was added on 11/14/06. Review of the record and interview with APRN #1 identified that Patient #1's medication management was difficult because of mood lability and that medications were changed approximately every 2 days. Review of the weekly interdisciplinary treatment plans from 11/7/06 to 11/20/06 and interview with APRN #1 identified medication adjustments included decreasing the Paroxetine, increasing the Depakote, discontinuing and then restarting the Klonopin, as well as adding Risperdal. Although not documented on the treatment plans, review of the Medication Administration Record identified that the patient received numerous doses of prn medication for agitation that included Haldol 5 mg and Diphenhydramine 50 mg po from 11/7/06-11/19/06 and Trazadone 100 mg from 11/18/06-11/20/06. The patient's orientation was questioned on 11/17/06, confusion was noted on 11/18/06 and lethargy on 11/19/06. The patient became unresponsive on 11/20/06 and was transferred to ICU. Although documentation did not reflect that the patient was confused between 11/6/06 and 11/16/06, the Chief of Psychiatry, MD #3, indicated that the patient's mental status was variable during the hospitalization and the patient was confused at times. Further review and interview identified that MD #3 examined the patient only once on 11/8/06 during the CP3 hospitalization. Interviews with MD #3 and APRN #1 indicated that the patient's condition and treatment were discussed at morning rounds, however, this was not documented and both could not recall detailed discussion of the patient's difficulty in response to treatment. Review of the Assessment-Scope of Practice Policy indicated that the psychiatrist conducts a mental status examination and makes treatment recommendations based on the client's clinical presentation. Additionally, the psychiatrist assesses the need for instituting psychopharmacological therapy, monitors efficacy and reassesses the need for continuing or discontinuing the medications prescribed. Review of the Clinical Practice Guidelines of Psychiatric Behavioral Health identified that consultation with the physician was encouraged when evaluation,

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management and/or treatment of medical conditions have been resistant to treatment. Upon surveyor inquiry of the order for Diphenhydramine 50 mg q 1 hour, MD #3 indicated that it was for dystonia, however, the record and interview with APRN #1 identified that it was for treatment of the patient's agitation. Documentation and interviews with APRN #1 and MD #3 failed to reflect collaboration regarding the patient's resistance to treatment and the need for the numerous doses of prn medications that included Diphenhydramine and lacked evidence that the Clinical Practice Guidelines of Psychiatric Behavioral Health and Scope of Practice Policy were followed.

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

- \*2. Based on record review and interviews for one patient, the hospital failed to adequately assess and monitor a patient for a change in condition. The findings include:
- a. Review of the record identified that Patient #1 was admitted to the hospital from a psychiatric facility on 11/2/06 for mental status change. The patient diagnoses included schizophrenia, bipolar disorder and chronic kidney disease secondary to Lithium. The patient was transferred on 11/6/06 to the hospital's inpatient psychiatric unit (CP3) on a voluntary basis from the hospital's medical unit (8 East) for psychiatric stabilization. Review of the record and interview with the CP#3 Patient Care Manager identified that the patient was manic and easily agitated and was signed off by the medical service on 11/10/06. Review of the Inpatient Psychiatry Standard Admission Orders included Clonazepam 0.5mg by mouth (po) twice per day (BID), Divalproex 500 mg po q hour of sleep (HS), Divalproex 250 mg q morning (AM), Zyprexa 20 mg po qHS, Paroxetine 20 mg po QD. Cogentin 1 mg po at HS was added on 11/14/06. Review of the Medication Administration Record indicated the patient consistently received numerous doses of prn medications from 11/16/06 to 11/20/06 for pain, insomnia and agitation. Those included Trazadone 100mg po at HS on 11/18/06, 11/19/06 & 11/20/06; Lorazepam 1mg po 11/16/06 at 11 AM; Acetaminphen 650 mg 11/19/06 at 3:31 AM; Ibuprofen 600 mg po on 11/18/06 at 12:50 AM and 11/19/06 at 12:38 AM; Haldol 5 mg po 11/16/06 at 11:01 AM, 11/17/06 at 7:40 PM, 11/18/06 at 12:50 AM, 11/19/06 at 12:38 AM and Diphenhydramine 50 mg po on 11/16/06 at 11:01 AM, 11/17/06 at 12:39 AM and 7:40 PM, 11/18/06 at 12:50 AM and 8:54 PM. Record review identified the patient's Risperdal and Klonopin dosages were increased on 11/17/06 as follows: Risperadol 1 mg BID to 2 mg po at HS and Klonopin 0.5 mg po qAM and 1 mg po at HS to 0.5 mg po every 6 hours. Record review indicated Patient #1 demonstrated confusion and urinary incontinence on 11/17/06 and 11/18/06. Physician Orders dated 11/7/06 had directed intake and output (I & O) every shift. Record review failed to identify intake monitoring from 11/17/06 to 11/20/06. Review of the record and interview with the CP#3 Patient Care Manager failed to reflect that I&O's were completed every shift during the patient's CP#3 hospitalization. Physician Orders dated 11/13/06 directed vital signs daily and the record lacked documentation of vital sign monitoring from 11/16/06 to 11/18/06. On

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11/19/06 at 8 AM the patient's pulse was noted as 96 and BP was 102/92. The Progress Record identified the patient was more lethargic and incontinent of urine on 11/20/06 at 2:00 PM and vital signs at 6 PM demonstrated: T 100.4 P 136 R 38 and BP unobtainable. The record indicated the patient was seen by the Resource Nurse and Nursing Supervisor at 7:30 PM and the medical intern at 8:30 PM. BP after IV insertion was 123/85 at 9:10 PM. The patient was ultimately transferred to the ICU. Record review and interviews with hospital staff indicated that on 11/20/06, Patient #1 was unresponsive with severe metabolic abnormalities: sodium 174 (131-145), potassium 5.5 (3.1-5.0), magnesium 3.4 (1.8-2.4), BUN 49 (6-25), creatinine 3.5 (0.51-0.95) and arterial blood gases (ABG's) on 40% via nasal cannula identified acidosis: 7.18/57/107/18/95%. An ICU Intern Admit Note dated 11/21/06 identified that the patient had a decreased po intake over the last 2-3 days and had been on several sedating medications that included Depakote, Zyprexa, Haldol, Ativan and Klonopin. Documentation was lacking in the medical record to reflect that during the period of 11/16/06 through 11/20/06 the patient's intake and output was monitored as directed in the physician orders dated 11/13/06.

- b. Review of the record identified that Patient #1 was transferred from the inpatient psychiatric unit to the telemetry unit and subsequently to the ICU due to lethargy and a change in mental status. Review of the record indicated the patient demonstrated severe metabolic abnormalities with a sodium of 173, potassium of 5.4 and magnesium of 3.4 and arterial blood gases (ABG's) on 40% via nasal cannula identified acidosis: 7.18/57/107/18/95%. Respiratory Service Notes indicated the patient was switched to Bilevel Positive Airway Pressure (BiPAP) on 11/21/06 at 12:24 AM at 50% via facial mask with an inspiratory pressure of 14 cm H<sub>2</sub>O and an expiratory pressure of 5 cm H<sub>2</sub>O. Review of the Respiratory Service Notes identified the patient remained on BiPAP until 11/22/06 at 12:45 PM (approximately 36 1/2 hours) and was then placed on nasal cannula at 3 liters (L) of oxygen. Review of the record and interview with RN #1 identified upon removal of the BiPAP mask on 11/22/06, it was noted that the patient sustained skin breakdown on her cheeks and nasal bridge. A Plastic Surgery Physician Progress Note dated 11/28/06 identified Patient #1 had a right cheek ulcer with demarcating necrosis 4 cm x 1 cm, nasal dorsum ulcer 1 cm x 0.5 cm and left cheek ulcer 1.0 x 0.5 cm. An Operative Note dated 12/18/06 identified the patient required plastic surgery for a pressure necrosis of the skin due to prolonged use of a BiPAP mask that included debridement and flap closure of the right cheek wound (3.8 cm x 1.8 cm). Review of the Nursing Care Record dated 11/21/06 and 11/22/06 indicated that assessment of the patient's skin in contact with tubing/devices/equipment and repositioning of the tubing/devices was to be performed every 2 hours. Although interview with the ICU Nurse Educator identified that staff education for skin assessment in contact with respiratory equipment included BiPAP masks, interview with the ICU Patient Care Manager indicated that it was the RT's responsibility to check skin integrity, not the nursing staff. The hospital lacked information to reflect that proper skin assessment was performed for Patient #1 who received BiPAP therapy.
- c. Review of the Respiratory Service Notes identified Patient #1 remained on BiPAP from

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing (1) and/or (i) General (5) and/or (7).

3. Based on record review and interview for one patient, the hospital failed to ensure that a nursing care plan was revised and implemented in a timely manner. The findings include:
  - a. Review of the record identified that Patient #1 was transferred from the inpatient psychiatric unit to the telemetry unit and subsequently to the ICU due to lethargy and a change in mental status. Record review identified the patient received BiPAP respiratory therapy for approximately 36 1/2 hours between 11/21/06-11/22/06. Review of the record and interview with RN #1 identified upon removal of the BiPAP mask on 11/22/06, it was noted that the patient sustained skin breakdown on her cheeks and nasal bridge. Review of the nursing care plan dated 11/20/06 noted skin as a focus area and the patient's goal was not to have skin breakdown. Review of the nursing care plan identified that the care plan was not revised on 11/22/06 and failed to identify the pressure ulcers and interventions until 11/29/06. Documentation was lacking to reflect that a current nursing care plan was maintained to reflect the current status of Patient #1.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (f) and/or (i) General (5) and/or (7).

- \*4. Based on record review and interviews for one patient who required Bilevel Positive Airway Pressure (BiPAP) therapy, the hospital failed to assess the patient according to the expected standard of practice and hospital policy. The findings include:
  - a. Review of the record identified that Patient #1 was admitted to the hospital from a psychiatric facility on 11/2/06 for mental status change. The patient diagnoses included schizophrenia, bipolar disorder and chronic kidney disease secondary to Lithium. Record review identified that the patient became lethargic with a decreased level of consciousness and was transferred to the ICU from CP3 on 11/20/06. An ICU Intern Admit Note dated 11/21/06 identified that the patient had a decreased po (by mouth) intake over the last 2-3 days and had been on several sedating medications including Depakote, Zyprexa, Haldol, Ativan, Benadryl and Klonopin. Review of the record indicated the patient demonstrated

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severe metabolic abnormalities with a sodium of 173, potassium of 5.4 and magnesium of 3.4 and arterial blood gases (ABG's) on 40% via nasal cannula identified acidosis: 7.18/57/107/18/95%. Respiratory Service Notes indicated the patient was switched to BiPAP on 11/21/06 at 12:24 AM at 50% via facial mask with an inspiratory pressure of 14 cm H<sub>2</sub>O and an expiratory pressure of 5 cm H<sub>2</sub>O. Review of the Respiratory Service Notes identified the patient remained on BiPAP until 11/22/06 at 12:45 PM (approximately 36 1/2 hours) and was then placed on nasal cannula at 3 liters (L) of oxygen. Review of the record and interview with RN #1 identified upon removal of the BiPAP mask on 11/22/06, it was noted that the patient sustained skin breakdown on her cheeks and nasal bridge. A Plastic Surgery Physician Progress Note dated 11/28/06 identified Patient #1 had a right cheek ulcer with demarcating necrosis 4 cm x 1 cm, nasal dorsum ulcer 1 cm x 0.5 cm and left cheek ulcer 1.0 x 0.5 cm. An Operative Note dated 12/18/06 identified the patient required plastic surgery for a pressure necrosis of the skin due to prolonged use of a BiPAP mask that included debridement and flap closure of the right cheek wound (3.8 cm x 1.8 cm). Review of the Respiratory Service Notes from 11/21/06 to 11/22/06 failed to identify the patient's tolerance on and off BiPAP and skin assessment. Although the hospital lacked a Skin Assessment Policy for Non-Invasive Ventilation, interviews with the Respiratory Technology Supervisor, the Administrative Director and the Chief of Pulmonary Medicine/Critical Care, MD #1 identified the Respiratory Therapist (RT) would be expected to assess the patient's ability to tolerate being on/off BiPAP and conduct a skin assessment at least once per shift. Additionally, review of the Non-Invasive Ventilation via BiPAP/CPAP for Respiratory Insufficiency Policy indicated that an arterial blood gas (ABG) should be done 30-60 minutes after set up of equipment. Review of the record identified the ABG was obtained 2 1/2 hours after application. Information was lacking to reflect that the patient was appropriately assessed and/or maintained during her BiPAP therapy.



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B  
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May 23, 2007

Mr. Geoffrey Cole, Administrator  
Norwalk Hospital Association  
24 Stevens Street  
Norwalk, CT 06856

Dear Mr. Cole:

Unannounced visits were made to Norwalk Hospital Association on April 9, 10, 11, 12, 24, 25, 26, 2007; May 2 and 3, 2007 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensure renewal inspection and for the purpose of reviewing for the implementation of a plan of correction for a violation letter dated November 7, 2006.

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

An office conference has been scheduled for June 7, 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  
vlnwkhsp.doc  
Complaints CT #6486, CT #6452

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).

1. Based on observation and staff interview, the hospital failed to ensure the confidentiality of Patient #36's clinical record. The findings include:
  - a. On 4/10/07 at 10:45 AM, while touring the maternity unit, Patient #36's clinical record was noted on a hand rail in the hallway. The record contained patient assessment information dated from 4/7/07 to 4/9/07 and was accessible to all patients and visitors in the hallway. This clinical record was observed by the Nurse Manager and DNS who identified that Patient #36 had been discharged on 4/9/07 and that the record should not have been in the hallway.

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

2. \* Based on record review and staff interviews for one patient who required ventral hernia repair, the hospital failed to ensure that post-operative care provided by Physician Assistants was coordinated and supervised in accordance with Connecticut General Statutes 20-12a(7) as amended by Public Act 06-110. The findings include:
  - a. Patient #29 was admitted to the hospital on 2/14/07 for an elective laparoscopic ventral hernia repair with Gortex dual mesh. Review of the clinical record and interview with MD #7 identified that the patient was stable throughout the procedure and that MD #7 did not visualize any bowel injury or bowel contents at anytime. Review of the post-anesthesia care unit (PACU) Record identified that the patient arrived screaming in pain and Patient #29 was admitted to a medical unit on 2/14/07 at 5:15 PM for pain management. MD #7 signed the case over to his partners on 2/16/07 at 12:05 PM when he departed for vacation. The patient's condition did not subsequently improve as the patient continued to experience severe pain, abdominal distention, nausea and coffee colored drainage on the abdominal dressing. PA #1 saw the patient at 11:30 PM on 2/16/07, inserted a naso-gastric tube and ordered a normal saline bolus. PA #2 later assessed the patient at 1:55 AM on 2/17/07 and again ordered a saline bolus. The patient was then transferred to the intensive care unit at 6:30 p.m. on 2/17/07 and followed by another physician's assistant. The patient was not assessed by a surgeon until 4:30 AM on 2/18/07. On 2/18/07 the patient was assessed by MD #8 who decided to return the patient to surgery. The surgery identified bowel perforation and peritonitis, the patient was returned in critical condition to the intensive care unit where PA #3 managed the patient on a ventilator

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and IV pressors with a note indicating the patient was discussed with MD #8. Review of the record identified that at 4 PM on 2/18/07 the patient's arterial blood gases (ABGs) were 7.22/42/66/92/16 and the patient was hypotensive. Patient #29 had a cardiac arrest at 10:40 PM, resuscitation efforts were unsuccessful and the patient was pronounced dead at 11:06 PM. Review of the Surgery Delineation of Privileges for Surgical Physician Assistants noted that PAs provided care in collaboration with the supervising physicians and that NGT insertion and emergency resuscitation and stabilization measures were implemented as a "physician-directed treatment plan". Review of the clinical record and interviews with hospital staff failed to reflect that the procedures performed on Patient #29 were physician directed. Review of hospital documentation and interview with the PA Program Director identified that PAs were assigned to teams, as well as on-call rotation that covers several departments including ICU and the OR. The Director identified that the PA would report to and be supervised by the patient's attending surgeon regarding the patient's condition and change in treatment plan, however, the PA could also be assigned to a different team of surgeons at the same time. Review of hospital documentation lacked clear identification of physician supervision for the care provided to Patient #29 by physician assistants and failed to provide evidence of a specific supervising physician for each Physician Assistant.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (7) and/or (l) Infection control (6).

3. For three (3) of three (3) patients reviewed (e.g. Patients #44, #45, #46), the facility failed to ensure that the patient's skin was assessed. The findings are based on review of the medical records, staff interview and review of facility policy and include the following:
  - a. Patient #44 was admitted to the hospital on 3/15/07 with shortness of breath and a history of end stage multiple sclerosis. Review of the initial nursing assessment identified that the patient had a Stage Two pressure ulcer on the thoracic spine that measured 6 cm x 4 cm x 0.8 cm. Review of the Skin Assessment Monitoring tool on 3/28/07 identified the thoracic pressure ulcer as 5 cm x 5 cm x .5cm in size. On 4/9/07 the ulcer measured 5 cm x 4.1 cm x .3 however, documentation failed to identify the stage of the pressure ulcer on 3/28/07 and 4/9/07. Although the facility's policy directs assessment of pressure ulcers every five days, the facility failed to perform a complete assessment of Patient #44's pressure ulcer on 3/20/07, 3/25/07, 3/28/07 and 4/5/07 inclusive of measuring and staging. Review of the facility's Pressure Ulcer Policy identified that the pressure ulcer should be assessed every five

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- days for measurements and staging. Interview with the Wound Nurse identified that on review of the pictures of the wound taken on 3/15/07 the wound should have been classified as a Stage four-pressure ulcer.
- b. Review of the clinical record for Patient #45 identified that the patient was admitted to the hospital on 3/31/07 after being found unresponsive. Review of the clinical record identified that during the period of 3/31/07 through 4/9/07 the patient was restrained. Review of nursing flow sheets dated 4/6/07 identified that the patient had bilateral abrasions on the his elbows and that a hydrocolloid dressing had been applied. Review of the flow sheets during the period of 4/7/07 through 4/10/07 identified that the patient had bilateral elbow abrasions and the dressing was intact. The flow sheets failed to identify the size and/or description of the abrasions.
  - c. Patient #46 was admitted to the hospital on 4/2/07 after a period of unresponsiveness. The patient had a history of two cerebral vascular accidents, end stage renal disease and a left hand contracture. Review of the clinical record identified that the patient was seen on 4/3/07 by the wound nurse for an open area on the left palm. The wound care note dated 4/3/07 identified that the patient had a .5 cm diameter wound in the center of her palm due to pressure from the contracted ring finger. Review of the clinical record for the period of 4/4/07 through 4/10/07 failed to identify the size and/or description and/or treatments provided on a consistent basis. Review of the Patient Care Record guidelines identified that for all wounds the site, type of wound, length, width, depth, color, drainage, treatment and dressing status should be addressed each day.
4. Based on clinical record reviews, observations, staff interview and review of facility policy, the facility failed to ensure that nursing staff developed and/or kept current a nursing care plan for Patients #24, 34, 44, 47 and 51. The findings include:
- a. Patient #24 was admitted to the psychiatric unit on 3/19/07 with problems of impulsivity with bizarre behaviors and an altered thought process. Observation of the patient on 4/9/07 at 11:30 PM identified the patient was in a private room with a staff member present at all times. Interview with the Nurse Manager identified the patient required one-to-one monitoring due to psychosis and behaviors including disrobing, eating non-food items and inserting objects into body cavities. The clinical record was reviewed with the Nurse Manager and identified that the treatment plan failed to address the patient's problems of eating non-food items and inserting objects into body cavities. The Nurse Manager identified the behaviors should have been addressed under the problem of impulsive behaviors.
  - b. Patient #34 was admitted to the pediatric unit on 4/8/07 with gastroenteritis and diarrhea. According to the Nurse Manager, all patients with gastrointestinal

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- symptoms are considered infectious until ruled out. Those patients are restricted to their rooms and not allowed to enter the general play room for infection control reasons. Patient #34's clinical record was reviewed with the Nurse Manager on 4/9/07 and failed to address a plan of care for the patient's unit restrictions and precautionary measures staff and family should take related to the diarrhea, diaper changes and hand-washing. Subsequent to surveyor inquiry, an informational handout dated 7/8/03 was produced that identified infection control expectations on the pediatric unit, however, there was no evidence in the clinical record that this information was supplied to the parents of Patient #34.
- c. Patient #44 was admitted to the hospital on 3/15/07 with shortness of breath, history of end stage multiple sclerosis and a thoracic spine pressure ulcer. Review of the clinical record identified that on 3/15/07 the patient was receiving feedings via a jejunostomy tube. Review of the initial nursing assessment identified that the patient was five feet tall and weighed 160 pounds on admission (3/15/07). Review of the clinical record for the period of 3/16/07 through 4/8/07 failed to identify that the patient had been weighed. On 4/9/07, the patient was weighed and a weight of 111 pounds was identified. Review of the care plan on 4/9/07 failed to identify a problem and/or interventions related to the patient's nutritional status.
- d. Patient #47 was admitted to the hospital on 4/3/07 with intractable vomiting, abdominal pain and chronic pancreatitis. Review of the initial nursing assessment identified that a nutritional consult had been initiated. Review of the clinical record identified that for the period of 4/4/07 through 4/9/07 that the patient had been on a clear or full liquid diet and continued to experience nausea and vomiting. The initial nursing assessment identified that that the patient weighed 199.5 on 4/3/07. The nursing flow sheet dated 4/10/07 identified that the patient weighed 130.9 pounds. The patient was reweighed and a weight of 119 pounds was identified. Review of the care plan on 4/10/07 identified that the patient's nutritional problem had not been added to the care plan until 4/10/07. Interview with the VP of Quality on 4/25/07 identified that the weights on Patients #44 and 47 were estimated, not actual weight and that the current computer system did not allow for the word estimated to be part of the computer record. Review of the facility policy identified that an actual weight should be obtained on admission and documented on the admission assessment.
- e. Patient #51's diagnoses included epilepsy and seizure disorder. The Pain Management Care Focus dated 4/10/07 identified that Patient #51 was medicated for head pain, which was a level "8" on a pain scale of "1-10". Reassessment of the patient at 2:30 p.m. identified that the pain persisted at a level "8"; however, the medical record failed to reflect that additional interventions were initiated to address Patient #51's continued pain. The Pain Management Care Focus dated 4/10/07 at

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6:00 p.m. (three and half hours later) identified that Patient #51 reported pain at a level "7" and although cold compresses were given, the patient's pain was not reassessed. The facility pain management policy identified that additional interventions relevant to the patient are documented, including non-drug interventions and a pain assessment will be completed within one hour of a pain management intervention.

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

5. For two (2) of two (2) sampled patients reviewed (e.g. Patients #44 and #47) with identified weight discrepancies, the facility failed to ensure that an accurate medical record was maintained. Based on clinical record reviews, observations, review of facility policies and staff interviews, the findings include the following:
  - a. Patient #44 was admitted to the hospital on 3/15/07 with shortness of breath, history of end stage multiple sclerosis and a thoracic spine pressure ulcer. Review of the clinical record identified that on 3/15/07 the patient was receiving feedings via a jejunostomy tube. Review of the initial nursing assessment identified that the patient was five feet tall and weighed 160 pounds on admission (3/15/07). Review of the clinical record for the period of 3/16/07 through 4/8/07 failed to identify that the patient had been weighed. On 4/9/07, the patient was weighed and a weight of 111 pounds was identified. Review of the care plan on 4/9/07 failed to identify a problem and/or interventions related to the patient's nutritional status.
  - b. Patient #47 was admitted to the hospital on 4/3/07 with intractable vomiting, abdominal pain and chronic pancreatitis. Review of the initial nursing assessment identified that a nutritional consult had been initiated. Review of the clinical record identified that for the period of 4/4/07 through 4/9/07 that the patient had been on a clear or full liquid diet and continued to experience nausea and vomiting. The initial nursing assessment identified that that the patient weighed 199.5 on 4/3/07. The nursing flow sheet dated 4/10/07 identified that the patient weighed 130.9 pounds. The patient was reweighed and a weight of 119 pounds was identified. Review of the care plan on 4/10/07 identified that the patient's nutritional problem had not been added to the care plan until 4/10/07. Interview with the VP of Quality on 4/25/07 identified that the weights on Patient's #44 and 47 were estimated, not actual weight and that the current computer system did not allow for the word estimated to be part of the computer record. Review of the facility policy identified that an actual weight should be obtained on admission and documented on the admission assessment.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (h) Dietary Service (1).

6. Based on review of facility policies, staff interviews, and observation, the facility failed to ensure proper food storage. The findings include:
  - a. During tour of the kitchen on 4/12/07 with the Director of Food Services, an opened undated bottle of honey in the cold food prep area and two (2) opened undated boxes of cake mix in the dry goods storage area were observed. Review of the facility food storage policy identified that dry ingredients or products, once opened, must be stored in airtight containers with the ingredient name and expiration date clearly labeled.

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

7. For one (1) of one (1) patient reviewed (e.g. Patient #47) identified as requiring a dietary consult, the facility failed to ensure that the dietary needs of the patient were addressed. The findings are based on review of the clinical record and staff interview and include the following:
  - a. Patient #47 was admitted to the hospital on 4/3/07 with intractable vomiting, abdominal pain and chronic pancreatitis. Review of the initial nursing assessment identified that a nutritional consult had been initiated on 4/3/07. Review of Patient #47's clinical record identified that for the period of 4/4/07 through 4/9/07 the patient had been on a clear or full liquid diet and continued to experience nausea and vomiting. Although the referral to the dietician was made on 4/3/07, the dietician failed to evaluate Patient #47 until 4/8/07. Interview with the Nursing Director identified that the patient should be seen by a dietician within forty-eight hours of the consult.

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

8. Based on clinical record review, observation, staff interview and review of facility policies, the facility failed to ensure infection control practices were implemented and/or maintained for Patients #34 and 52. The findings include:
  - a. Patient #34 was admitted to the pediatric unit on 4/8/07 with gastroenteritis and diarrhea. According to the Nurse Manager, all patients with gastrointestinal symptoms are considered infectious until ruled out. Those patients are restricted to their rooms and not allowed to enter the general play room for infection control

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reasons. Interview with Patient #34's parents on 4/9/07 at 1:45 PM identified that they did not receive instructions from staff regarding the handling of Patient #34's dirty diapers and were not instructed to wash their hands following diaper changes or when leaving the room. Interview with the Nurse Manager on 4/9/07 at 1:30 PM identified that in the past, the pediatric unit had policies governing infection control practices with pediatric patients, however, when hospital policies were computerized, the pediatric infection control policies were not included. The Nurse Manager identified that staff continued to follow infection control practices in the absence of policies. Interview with the Infection Control Nurse (ICN) on 4/11/07 at 2:05 PM identified that the hospital is moving away from unit specific policies and the pediatric unit should follow the hospital-wide policies. The hospital policy for standard precautions identified that gloves should be worn when exposed to feces. The hospital policy for contact precautions identified that staff would instruct visitors on the use of protective equipment, disposal of infectious materials and hand washing. The ICN identified that there was no current mechanism in place for staff to instruct parents regarding infection control precautions.

- b. Patient #52's diagnoses included pneumonia. The patient was placed on Contact Precautions on 3/25/07 for methicillin-resistant staph aureus (MRSA) in the sputum. A contact Precautions sign was noted on the patient's door. Although the medical record identified that the patient and family were instructed regarding the precautions, observation on 4/11/07 with Nurse Manager #2 identified a visitor in the patient's room sitting on the patient's unmade bed with the isolation gown opened in back. The Infection Control Nurse stated that this practice should have been discouraged.

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

9. Based on review of the medical record, review of facility policies and staff interviews, the facility failed to ensure that the Universal Protocol Time Out was followed for Patient #31. The findings include:
  - a. Patient #31's diagnoses included anemia and dehydration. The medical record identified that the patient underwent a debridement of the left lower leg and sacral decubitus on 4/4/07. The Universal Protocol Time Out form dated 4/4/07 lacked documentation that the correct patient, correct procedure, and correct side and site were verified prior to initiation of the procedure. Review of the medical record on 4/9/07 with Nurse Manager #3 identified that the "Second Verification" was not completed in accordance with the facility Time Out policy.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (l) Infection control (6).

10. Based on observation, staff interview and review of facility policy, the facility failed to ensure that MD #10 followed the Operating Room Infection Control Policy. The findings include:
  - a. During tour in the OR on 4/9/07, the anesthesiologist, MD #10, was observed in Room #2 administering anesthesia to a patient undergoing a mediastinoscopy. MD #10 was observed wearing a surgical mask below his nose, not covering his nares. Interview with the OR Nurse Manager and review of the Operating Room Infection Control Policy identified masks would be worn at all times in the OR and must fully cover the mouth and nose.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (d) Medical records (3).

11. Based on review of the medical record, review of facility documentation and staff interview, the facility failed to ensure that Patient #31's medical record contained a post anesthesia report. The findings include:
  - a. Patient #31's diagnoses included anemia and dehydration. The medical record identified that the patient underwent a debridement of the left lower leg and sacral decubitus on 4/4/07. Review of the medical record on 4/9/07 with Nurse Manager #3 identified that it lacked a postanesthesia note. The facility Guidelines for Anesthesia Care identified that when a patient remains in the hospital for forty-eight hours or longer, one or more anesthesia notes should appear in addition to the discharge note from the Postanesthesia Care Unit.

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

12. For one (1) patient (e.g. Patient #45) that utilized restraints, the facility failed to ensure that the least restrictive device was utilized. The findings are based on review of the clinical record and review of facility policy and include the following:
  - a. Review of the clinical record for Patient #45 identified that the patient was admitted to the hospital on 3/31/07 after being found unresponsive. Review of the clinical record identified that during the period of 3/31/07 through 4/9/07 the patient was restrained. Review of the restraint orders dated 4/1/07, 4/4/07, 4/5/07, 4/6/07 and

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4/8/07 directed that the patient have a constant sitter and four point rubber limb restraints for the identified behaviors of trying to get out of bed. Orders dated 4/2/07 and 4/3/07 directed the use of four point rubber restraints, a chest strap and a constant sitter for combativeness, verbal abuse and trying to get out of bed. Review of the progress notes and the restraint flow sheets failed to identify that the least restrictive restraint had been utilized and/or discontinued at the earliest time.

13. For one (1) patient (e.g. Patient #45) that utilized restraints, the facility failed to ensure that the patient was monitored while in restraints as per facility policy. The findings are based on review of the clinical record, review of facility policy and staff interview and include the following:

- a. Review of the clinical record for Patient #45 identified that the patient was admitted to the hospital on 3/31/07 after being found unresponsive. Review of the clinical record identified that during the period of 3/31/07 through 4/9/07 the patient was restrained.

Review of Patient #45's restraint monitoring flow sheet dated 4/2/07 identified that the patient had four point plastic restraints in place. The monitoring flow sheets failed to identify that the patient had been monitored every fifteen minutes during the period of 11:00 AM through 3:00 PM on 4/2/07. Review of the facility policy identified that when in four point plastic restraints, a patient needs to be monitored every fifteen minutes.

Review of Patient #45's restraint-monitoring sheet dated 4/4/07 failed to identify that the limb restraint was released during the period of 12:00 PM through 10:00 PM. The restraint monitoring flowsheet identified an area for "limb release" every two hours. Review of the facility policy identified that every two hours, while awake the restrained limb would be monitored for circulation, sensation and motion.

Observation of Patient #45 on 4/9/07 at 11:00 AM identified that Patient #45 was in bed with a posey vest restraint in place with a sitter present. Review of the restraint monitoring flow sheet on 4/9/07 at 1:00 PM identified that for the period of 7:00 AM through 1:00PM the patient had bilateral wrist restraints in place and a vest restraint. The facility failed to ensure that the restraint monitoring flow sheet was accurately completed in that it correctly identified that the patient had wrist restraints on during 7:00 AM to 1:00 PM on 4/9/07. Interview with the sitter identified that when she came on duty at 7:00 AM on 4/9/07 the patient had only a vest restraint in place and that the patient did not have wrist restraints in place until approximately 1:00PM on 4/9/07.

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14. For one patient (e.g. Patient #45) that utilized restraints, the facility failed to ensure that the clinical record contained documented behaviors necessitating the use of behavioral restraints. The findings are based on review of the clinical record and review of facility policy and include the following:
- a. Review of the clinical record for Patient #45 identified that the patient was admitted to the hospital on 3/31/07 after being found unresponsive. Review of the clinical record identified that during the period of 3/31/07 through 4/9/07 the patient was restrained. Review of the physician's orders dated 4/4/07, 4/5/07, 4/6/07 and 4/7/07 identified that the patient had orders for behavioral restraints. Review of the behavioral restraint orders identified that the patient was a danger to self and/or others with the documented behavior exhibited that required the restraints was getting out of bed. Review of the facility restraint policy identified that a behavioral restraint should be limited to emergencies in which there is an imminent risk of the patient physically harming himself, staff or others.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (4)(C) and/or (d) Medical records (3).

15. Based on review of Patient #42's clinical record, the post anesthesia report failed to be timed. The findings include:
- a. Patient #42 was admitted to the hospital on 4/9/07 and had an appendectomy on 4/10/07. Review of Patient #42's clinical record identified that the post anesthesia note was dated 4/10/07 and indicated no apparent anesthesia related complications, however, the note was not timed.

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

Microbiology

16. Based on record review and confirmed by the staff, the laboratory failed to document remedial action when the incubator temperature was not within the acceptable range. The findings include:
- a. The CO2 incubator lower chamber has an acceptable temperature range of 35° - 37° C. The temperature was recorded as 34.5° - 34.9°C from 1/1/06 to 2/14/07, and from 3/6/07, 3/15/07 to the present as 34.5° - 34.9° C. Remedial action was not documented. The digital reader on the thermometer was verified on 10/4/06 by a NIST certified thermometer. The microbiology testing personnel stated that the incubator is used for AFB testing.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19a-36-A51(c) Responsibilities of registrant and director.

Blood Bank

17. Based on record review and interview with blood bank staff, it was determined that the laboratory failed to adequately document quality control results. The findings include:
  - a. A review of the immunohematology quality control record for reagent rack 3 and the saline bottle on May 2, 2007 revealed that the current lot in use of saline reagent was recorded as Lot # 021315. Inspection of the saline bottle revealed the lot of saline in use, was Lot # 0213157. The control record indicated that the wrong Lot # was documented on May 1, 2007 and was not corrected on the following day, May 2, 2007. The saline Lot # was documented correctly on April 30, the first day recorded on the control sheet for that week. An interview with the blood bank technical specialist on May 2, 2007 revealed that the last digit of the Lot # was difficult to see because it was close to the initials of the tech who filled the saline bottle.

FLIS Independent Nurse Consultant Guidelines

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

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

Relationship between INC and the Institution:

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

Response to State Of Connecticut Letter Dated 3/9/07

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
<p>Section 19-13-D3 (b) #1a</p>	<p>The hospital lacked evidence that Clinical Practice Guidelines of Psychiatric Behavioral Health and Scope of Practice were followed for one patient admitted to the psychiatric unit.</p> <p>Documentation and interviews with APRN and MD failed to reflect collaboration regarding the patient's resistance to treatment and the need for numerous doses of PRN medications, and lacked evidence that the Clinical Practice Guidelines were followed. ("consultation with the physician was encouraged when evaluation, management and/or treatment of medical conditions have been resistant to treatment")</p>	<p>APRN will seek consultation with their collaborating MD in accordance with The Clinical Practice Guidelines of Psychiatric Behavioral Health and Scope of Practice.</p> <ul style="list-style-type: none"> <li>APRN will document in the progress notes for each patient the summary of the discussion with the collaborating MD as well as the plan for treatment as overseen by the MD.</li> <li>100% of medical records of inpatients assigned to collaborative APRN/MD team will be concurrently audited for evidence of above documentation, to include evidence that the psychiatrist is overseeing the medication regime and the patient's response to it. Deviations from standard of care will be addressed concurrently.</li> <li>Aggregated data regarding the concurrent review will be presented monthly to Department of Psychiatry Chairman for review and presentation at the Psychiatric Performance Improvement meeting.</li> </ul> <p>Multidisciplinary Treatment Plans will be revised to identify PRN medications prescribed along with frequency of administration and patient's response.</p> <ul style="list-style-type: none"> <li>Care sets have been developed for CPOE (Computerized Physician Order</li> </ul>	<p>Dr. Maiberger/Alan Barry</p> <p>Date of Completion for Education of MD's and APRN's: 4/9/07</p> <p>Dr. Maiberger/Alan Barry/APRN's/Karen Simpson Date of Implementation: 4/2007</p> <p>Dr. Maiberger/Alan Barry Date of Implementation: 5/16/07 (after the collection of one month's data)</p> <p>Karen Simpson/Joanne Svogun Date of Completion: 5/31/07</p> <p>Karen Simpson/Carole Gabor/Dr. Maiberger</p>





VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
Section 19-13-D3 (b), #2a	<p>The hospital failed to adequately assess and monitor a patient for a change in condition.</p> <p>Review of Medication Administration Record indicated that the patient consistently received numerous doses of PRN medications from 11/16/06 to 11/20/06 for pain, insomnia and agitation.</p> <p>Record review indicated that the patient demonstrated confusion and urinary incontinence on 11/17/06 and 11/18/06.</p>	<p>reviewed and acted upon by the Department of Psychiatry's ongoing Performance Improvement.</p> <p>Currently working with Behavioral Health Consultant (Ellen Rogan) to develop Nursing Care Standards for inpatient unit. Recommendations of consultant to be acted upon and documented.</p> <p><b>ASSESSMENT:</b> Critical Thinking and Decision-Making Educational Programs to be presented to the staff of Behavioral Health by the Resource Nurses.</p> <ul style="list-style-type: none"> <li>Actual cases will be reviewed and discussed with staff on a monthly basis.</li> <li>Educational flyers which identify reasons to call the Resource Nurse and/or the Rapid Response Team have been created and posted on the unit.</li> </ul> <p><b>MONITORING:</b> Vital signs will be completed as ordered by the Psych Tech and/or RN and will be documented on the Vital Signs worksheet.</p>	<p>Karen Simpson/ Joanne Svogun Consultant visits have been held on: 10/27/2006, 1/11/2007, 2/1/2007, 2/2/2007, &amp; 3/17/2007. Ongoing for a one year time frame (October 2006 – October 2007)</p> <p>Debbie Bailey/Resource Nurses Date of Implementation: 5/1/07</p> <p>Educational in-services have been ongoing for the RN's in Behavioral Health and include: IV Therapy (2/23/06), PLOCC Line Use (3/9/06), Isolation Precautions (4/13/06), Diabetes Management (6/8/06 &amp; 7/13/06), Respiratory Meds &amp; Inhalers (9/14/06), Basics of Care (10/12/06), Face-to-Face Assessment of Patients in Restraints (1/31/07)</p> <p>The purpose of these in-services is to focus on the medical needs and assessment of psychiatric patients.</p> <p>Karen Simpson/Staff of Behavioral Health Date of Implementation: 3/21/07</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (S)
	<p>Record review failed to identify intake monitoring from 11/17/06 to 11/20/06. Physician orders dated 11/7/06 had directed intake and output (I&amp;O) every shift.</p> <p>Record lacked documentation of vital sign monitoring from 11/16/06 to 11/18/06. Physician orders dated 11/13/06 directed vital signs daily.</p>	<p><b>INTERIM PROCESS CREATED:</b></p> <ul style="list-style-type: none"> <li>All I&amp;O sheets are reviewed by the RN and totaled at the end of the shift. 24 hour totals are completed by the night shift before the sheets are filed.</li> <li>The unit secretary or designee will document the vitals in the patient's medical record each shift. The worksheet will be signed and dated by the staff member transcribing the results and the sheet will be left in the Patient Care Manager's mailbox.</li> <li>RN will review all vital signs every shift to ensure appropriate assessment and intervention.</li> </ul> <p><b>NEW PROCESS:</b></p> <ul style="list-style-type: none"> <li>A new vital signs worksheet will be created. The sheet will be used for a 24 hour period. All vital signs taken for each patient will be recorded on the worksheet.</li> <li>The unit secretary or designee will document the vitals in the patient's medical record each shift. The sheet will then be signed and dated by the staff member transcribing the results.</li> <li>The RN will review all vital signs every shift to ensure appropriate assessment and intervention.</li> <li>The worksheets will be kept in a binder on the unit and will be kept on file for the designated period of time.</li> <li>Unit Secretary will review all medical records daily to ensure all vital signs</li> </ul>	<p>Karen Simpson/Joanne Svogum/Staff of Behavioral Health Date: 5/31/07</p>

VIOLATIONS	Summary of Violation	Plan of Correction	Completion Date, Responsible Person (\$)
	<p>Record identified the patient was more lethargic and incontinent of urine on 11/20/06 at 2pm. Vital signs</p>	<p>have been documented.</p> <ul style="list-style-type: none"> <li>Compliance will be monitored through monthly audits using the revised Super Audit Tool (10 charts/month).</li> </ul> <p><b>DOCUMENTATION:</b>  R3 Documentation Rollout (Right Plan/Right Care/Right Outcome)</p> <ul style="list-style-type: none"> <li>Current R3 documentation tools will be adapted to align with the needs of a Behavioral Health milieu.</li> <li>Current Multidisciplinary Treatment Plan form will be revised. Policy will be revised to include twice weekly updates and/or when patient condition changes.</li> <li>Multidisciplinary Treatment Plan will be revised to identify PRN medications prescribed along with frequency of administration and patient's response.</li> <li>Education to be provided to all CP3 nursing staff on new documentation system.</li> <li>Compliance with documentation will be monitored through medical record audits using the Super Audit Tool (10 charts per month).</li> </ul> <p><b>COLLABORATION:</b>  <u>RN/Psych Tech Collaboration</u></p> <ul style="list-style-type: none"> <li>Staff member from CP3 will be selected to start RRHOC program (Relationship and Results Oriented Healthcare) in June. This program focuses on the delivery of patient</li> </ul>	<p>Karen Simpson/Designee  Date of Implementation: 4/9/07</p> <p>Karen Simpson/Joanne Svogun/Ellen Rogan  Date of Completion: 5/31/07</p> <p>Karen Simpson/Joanne Svogun/Ellen Rogan  Date of Completion: 5/31/07</p> <p>Karen Simpson/Joanne Svogun/Ellen Rogan  Date of Completion: 5/31/07</p> <p>Donna Esposito/Educators  Education to be completed by:  5/31/07</p> <p>Karen Simpson/RN staff on Behavioral Health.  Date of Implementation: June 2007</p> <p>Karen Simpson/Joanne Svogun  Date: June 2007</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
	<p>at 6pm demonstrated T 100.4 P 136 R 38 BP unobtainable. Patient was seen by Resource Nurse at 7:30pm and the medical intern at 8:30pm. BP after IV insertion was 123/85 at 9:10pm. The patient was ultimately transferred to ICU.</p>	<p>centered care.</p> <ul style="list-style-type: none"> <li>Medically complicated patients will be assigned to an RN.</li> </ul> <p><u>RN/MD Collaboration</u> Critical Thinking and Decision-Making Educational Programs to be presented to the staff of Behavioral Health by the Resource Nurses.</p> <ul style="list-style-type: none"> <li>Actual cases will be reviewed and discussed with staff on a monthly basis.</li> <li>Educational flyers which identify reasons to call the Resource Nurse and/or the Rapid Response Team have been created and posted on the unit.</li> </ul> <p><u>PLAN FOR MONITORING:</u></p> <ul style="list-style-type: none"> <li>100% of cases of psychiatric patients transferred to medical units or critical care will undergo peer review for timeliness, appropriateness or any evidence of "failure to respond".</li> <li>Transfers to medical units or critical care will become a new, ongoing, generic screen for Psychiatric Performance Improvement</li> <li>Department of Psychiatry will receive feedback from Resource Nurse/Rapid Response Team calls that occur on Behavioral Health unit.</li> </ul>	<p>Ongoing</p> <p>Karen Simpson/Joanne Svogun/Dr. Maiberger/Alan Barry</p> <p>Karen Simpson/Joanne Svogun/Dr. Maiberger/Alan Barry Date of Implementation: 5/1/07</p> <p>Debbie Bailey/Resource Nurse Date of Implementation: 5/1/07</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
Section 19-13-D3 (b)	The hospital lacked information to reflect that proper skin assessment was performed for Patient #1 who received BIPAP therapy.	<p>Current policy revised by representatives from nursing, respiratory, and physicians, "NPPV via CPAP/BIPAP In the Critical Care Setting".</p> <p>Policy includes:</p> <ul style="list-style-type: none"> <li>• Delineation of responsible care provider for skin inspection with the CPAP mask.</li> <li>• Defines responsibility for the notification of the physician when a skin care issue is identified.</li> <li>• Documentation of which healthcare provider (MD/PA) that were notified.</li> <li>• Description of next steps after skin care issue is identified for the process of management and the decision to continue NPPV despite skin breakdown.</li> <li>• An order will be required from the physician to continue NPPV despite skin breakdown.</li> <li>• The respiratory therapist will consult the nurse with any questions regarding skin assessment.</li> </ul> <p>Identify areas where patients are located and educate staff members.</p> <ul style="list-style-type: none"> <li>• All professional staff in the following areas will be educated on the revised policy.</li> <li>• ICU/CCU</li> <li>• Telemetry</li> <li>• Emergency Department</li> </ul>	<p>Completed: 1/25/07</p> <p>Debbie Bailey/Steve Winter MD/representatives from each specific area Education completed for all staff scheduled on 1/25-1/26/07.</p>

VIOLATIONS	Summary of Violation	Plan of Correction	Completion Date, Responsible Person (s)
		<p>Submit verification of all staff members oriented to the policy to Debbie Bailey. No staff member will work prior to the education of the new policy at the beginning of their shift. To assure 100% compliance with education of the staff on all shifts the following staff will be responsible for the education process;</p> <ul style="list-style-type: none"> <li>• Respiratory Therapists</li> <li>• Critical care educator</li> <li>• ED coordinators</li> <li>• Respiratory therapists supervisors</li> <li>• Resource nurses</li> </ul> <p>Assure that there are no conflicts in multiple policies regarding CPAP and BIPAP for the care providers.</p> <ul style="list-style-type: none"> <li>• Four policies were consolidated into one policy, NPPV via CPAP/BIPAP in the Critical Care Setting, to avoid conflicting practices.</li> </ul> <p>Based on discussions with Dawn Hubbard, review of an article "Your patients receiving noninvasive positive pressure ventilation; learn to assist his breathing without the need for intubation" and recommendations from a multidisciplinary group, the following revisions</p>	<p>Completed Debbie Bailey/Steve Winter MD</p> <p>Completed : 1/25/07 (Debbie Bailey/Steve Winter)</p> <p>3/2/07 Debbie Bailey/Steve Winter</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (S)
		<p>were made to the "NPPV via CPAP/BIPAP In the Critical Care Setting";</p> <ul style="list-style-type: none"> <li>• Removal of duoderm</li> <li>• Assessment of skin no less than q4h unless specific criteria are met and than the skin assessment is no less than q2h.</li> <li>• Algorithm: "NPPV Skin Assessment Algorithm", to be utilized by the therapist if there are any signs of early pressure necrosis.</li> <li>• Develop and document competency for the respiratory therapist on proper sizing and fitting of a cpap mask</li> </ul> <p>Educational plan for the revised policy:</p> <ul style="list-style-type: none"> <li>• Nursing will educate and review policy with the following areas: ICU/CCU, telemetry, emergency department.</li> <li>• The newest changes to the policy will be pointed out to the staff with emphasis on,               <ul style="list-style-type: none"> <li>○ Elimination of duoderm as a barrier</li> <li>○ Use of a decision tree by the therapist when there are skin issues.</li> </ul> </li> <li>• All respiratory therapists will be educated to the policy and be educated and signed off on competency.               <ul style="list-style-type: none"> <li>○ If a respiratory therapist has not been deemed competent for fitting of the mask, a therapist that has been signed</li> </ul> </li> </ul>	<p>Policy implemented on 3/15/07</p> <p>Completed 3/07 Critical Care Nursing Team</p> <p>Steve Winter/Cindy Sennewald</p>

VIOLATIONS	Summary Of Violation	Plan Of Correction	Completion Date, Responsible Person (s)
		<p>Multidisciplinary planning meeting for loop closure on policies and competency development.</p> <ul style="list-style-type: none"> <li>• Review of respiratory competency sheets.               <ul style="list-style-type: none"> <li>○ Evaluation of patient for sizing of full face mask for cpap or nappv</li> <li>○ Evaluation of patient for sizing of nasal mask for cpap or nppv</li> <li>○ Evaluation of patient for sizing of hybrid mask for cpap or bipap</li> <li>○ Evaluation of patient for proper fit of total face mask</li> </ul> </li> <li>• Competency's to be completed on all current therapists.</li> <li>• Competencies to be completed on all new hires</li> <li>• Competencies to be completed on an annual basis</li> </ul> <p>• Revision of respiratory documentation form, "NPPV Daily Respiratory Data Sheet". The area that indicates "barrier" will be removed and will add "mask size" to the form. There was an area created to document the name of the nurse and the name of the physician</p>	<p>off will be requested to size and for the patient.</p> <p>Cindy Sennewald/ Steve Winter MD Completed : 3/26/07</p> <p>Steve Winter/ Cindy Sennewald</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
		<p>Revisions of R3 policies and skin policies to reflect exceptions to the q2h repositioning of BIPAP/CPAP masks. The ICU and telemetry staff education to include:</p> <ul style="list-style-type: none"> <li>• Reinforcement of standards to reposition all medical devices q2h with the exception of BIPAP/CPAP masks which are to be repositioned every 4 hours by the respiratory therapist. Education to the respiratory therapists to include:               <ul style="list-style-type: none"> <li>• Exception to the q4h assessment is if the following criteria are met:                   <ul style="list-style-type: none"> <li><input type="checkbox"/> FIO2 greater than or equal to 60%.</li> <li><input type="checkbox"/> IPAP greater than or equal to 20 cmH2O.</li> <li><input type="checkbox"/> Respiratory rate is greater than 30.</li> <li><input type="checkbox"/> NPPV is being used for acute or impending respiratory failure.</li> </ul> </li> <li>• If any of the above criteria are met, the patient will be classified high risk for skin breakdown and the therapists will monitor/assess the skin every 2 hours.</li> </ul> </li> </ul> <p>There will be 100% auditing of all CPAP/BIPAP patients for compliance to</p>	<p>Jo Ritchie/Debbie Bailey 3/22/07 (R3) 4/2/07 (skin policies)</p> <p>Steve Winter/Cindy Semmewald New policy effective: 3/15/07 Education completed: 3/15/07 Exception: No staff member will work prior to the education of the new policy @ the beginning of their shift.</p> <p>Steve Winter</p>

VIOLATIONS	Summary of Violation	Plan of Correction	Completion Date, Responsible Person (s)
<p>Section 19-13-D3 (c), #2c</p>	<p>It was noted that the patient sustained skin breakdown on her cheeks and nasal bridge. Further record review and interviews with hospital staff lacked information to reflect that the physician was notified regarding the patients change in condition.</p>	<p>Notification/Education: Pulmonary physician staff, pulmonary fellows, house officers, physician's assistants and internal medicine residency director of revisions for NPPV in the critical care setting.</p> <p>The following are key points:</p> <ul style="list-style-type: none"> <li>• Therapists remove the mask and visually inspect the skin for evidence of early injury every 4 hours. If skin changes are found suggesting early injury (e.g., persistent blanching, blister formation) the therapists must report this to the house officer or physicians assistant who must take an affirmative action. This should be reviewed with the attending physician. The actions may be as follows:               <ul style="list-style-type: none"> <li>○ Continue non-invasive ventilation with an alternative mask.</li> <li>○ Intubate the patient</li> <li>○ Discontinue non-invasive ventilation if no longer needed</li> <li>○ Continue non-invasive ventilation despite the evolving skin injury based upon benefits of continued non-invasive ventilation exceeding the risks.</li> </ul> </li> </ul> <p>• The physician to place a CPOE order,</p>	<p>Steve Winter MD All MD's/PA's notified verbally or by e-mail by 1/26/07</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
		<p>“continue BIPAP despite skin breakdown” along with an explanatory note in the patients chart.</p> <ul style="list-style-type: none"> <li>o A requisition will print in the pulmonary department for the tracking of events. This will assist in the early identification of any trending of breakdown secondary to NPPV.</li> <li>o A request has been placed in IT for a report that will be printed in the department summarizing number of events. This will allow the tracking and trending of occurrences to enable timely assessment of the potential needs for change in practice.</li> </ul> <p>1. Revision of the respiratory documentation form, “NPPV Daily Respiratory Data Sheet”. There will be an area within skin integrity that allows the documentation of the RN notified and name and the MD notified and name.</p> <p>2. There will be re-education of the nursing staff and then monitoring by the ICU nursing educator and/or ICU patient care manager for the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The “pressure ulcer documentation form, # 17953, must be completed irregardless of the consent being obtained for photography of the area. The photograph can be taken at</li> </ul>	<p>Steve Winter MD</p> <p>Steve Winter MD</p> <p>Steve Winter/Cindy Sennewald Date: 3/26/07</p> <p>Denise White/Jo Ritchie Completed by 3/15/07</p>

VIOLATIONS	Summary of Violation	Plan & Correction	Completion Date, Responsible Person (s)
<p>Section 19-13-D3 #3a</p>	<p>Review of the nursing care plan identified that the care plan was not revised on 11/22/06 and failed to identify the pressure ulcers and interventions until 11/29/06. Documentation was lacking to reflect that a current nursing care plan was maintained to reflect the current status of Patient #1.</p>	<p><input type="checkbox"/> a later point after the consent has been obtained.  <input type="checkbox"/> The physician notification at the bottom of the form is to be completed.</p> <p><input type="checkbox"/> Review of care planning for all ICU nursing staff members currently in process. There will be 100% compliance with this educational initiative.  <input type="checkbox"/> Monitoring by the ICU patient care manager or ICU educator of 25% of patients in the ICU per week for the initial care plans and revisions as there are changes in patient's condition.  <input type="checkbox"/> Development of an audit tool to monitor patient specific care planning and revisions as to changes in patient's condition. Results will be tracked and trended and specific action plans will be developed based on results.  <input type="checkbox"/> Additional care planning books will be purchased for the ICU for their staff libraries.  <input type="checkbox"/> Unit based educational rounds will be conducted by the patient care manager or ICU educator with the wound care specialist on a weekly basis with available staff members to review patients and their care plans. Attendance will be recorded and copies maintained by the ICU manager.  <input type="checkbox"/> Educational posters regarding care planning will be developed and posted for the staff reference  <input type="checkbox"/> ICU staff member will be requested to</p>	<p>Jo Ritchie Completion Date: 4/13/07</p> <p>Jo Ritchie/Denise White March 19, 2007 (6 months)</p> <p>Denise White/Debbie Bailey 4/9/07</p> <p>Denise White Ordered 3/28/07</p> <p>Denise White/Jo Ritchie/Wound Care Specialist Started 4/3/07 and then weekly</p> <p>Denise White/Jo Ritchie March 28, 2007</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (S)
<p>Section 1-13-D3 #4a</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review of the Respiratory Service Notes from 11/21/06 to 11/22/06 failed to identify the patient's tolerance on and off BIPAP and skin assessment.</li> <li><input type="checkbox"/> MD#1 identified the respiratory therapist would be expected to assess the patients ability to tolerate being on/of BIPAP and conduct a skin assessment at least once per shift.</li> </ul>	<p>participate in a patient centered care program starting in June 2007, Relationship and Results Oriented Health Care (RROHC).</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Refer the issue of care planning to the ICU unit based shared governance council to create strategies for the developing, revising and communication of patient centered outcomes.</li> <li><input type="checkbox"/> Refer the issue of care planning to the hospital shared governance practice council.</li> </ul> <p>Revision to Policy "NPPV via CPAP/BIPAP In The Critical Care Setting", to include: Monitoring/Documentation, (#7).</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> At least one (1) trial off period of NPPV will be performed on patients requiring continuous NPPV &gt; 8 hours. (This does not include NPPV at hour of sleep for nocturnal hypoventilation). A trial off will be performed every shift after the first 8 hours of continuous use. The patient's tolerance to this trial will be circled YES or NO and include documentation in the Comments section of specifics.</li> </ul> <p><u>Skin Assessment</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The Respiratory Therapist will assess the patient's skin prior to initiation of NPPV.</li> <li><input type="checkbox"/> Every 4 hours the mask is to be removed and the respiratory therapist will assess</li> </ul>	<p>Denise White/Debbie Bailey</p> <p>Referral placed with the ICU shared governance committee March 23, 2007.</p> <p>Referral placed with the Hospital Shared Governance Practice Council on March 23, 2007.</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (\$)
	<p><input type="checkbox"/> Review of the non-Invasive Ventilation via BIPAP/CPAP for respiratory Insufficiency Policy indicated that an arterial blood gas (ABG) should be done 30-60 minutes after setup of equipment.</p>	<p>underlying skin for evidence of early pressure ulceration such as blanching or blistering.</p> <p><input type="checkbox"/> Ask the patient of any pain or discomfort to skin/mask contact site. Adjust mask straps to comfort level without significant leaks.</p> <p><input type="checkbox"/> The respiratory therapist has primary responsibility for assessment of skin integrity prior to initiation of NPPV and during removal and repositioning of the NPPV mask.</p> <p><input type="checkbox"/> The nurse attending the patient may be consulted by the respiratory therapist if there is any question regarding skin assessment.</p> <p><input type="checkbox"/> If there are any signs of early pressure necrosis at the mask site, the RN and the MD/PA responsible for the patient should be notified by the respiratory therapist.</p> <p>Revision of the respiratory documentation form, "NPPV Daily Respiratory Data Sheet". This sheet will be a permanent part of the record.</p> <p>Revision to policy, Monitoring and Documentation, #4; "Unless clinical deterioration dictates earlier ABG assessment, an ABG should be obtained within 4 hours after the application of NPPV to assess the adequacy of ventilation. Adequacy of oxygenation should be confirmed by the RRT by pulse oximetry immediately after the application</p>	<p>Official date: 3/20/07</p>

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person (s)
	<p><input type="checkbox"/> Review of the record identified the ABG was obtained 2 ½ hours after application.</p> <p><input type="checkbox"/> Information was lacking to reflect that the patient was appropriately assessed and/or maintained during her BIPAP therapy.</p>	<p>of NPPV and documented in the NPPV flow sheet.</p> <ul style="list-style-type: none"> <li>• All respiratory therapists will be educated to the revisions of the policy regarding standards for obtaining the ABG.</li> <li>• All nursing staff members in critical care and the emergency department will be educated to the ABG standard via e-mail and staff meetings.</li> <li>• Revision of the respiratory documentation form, "NPPV Daily Respiratory Data Sheet". This sheet will be a permanent part of the record.</li> <li>• Audit for compliance to standards of 100% of charts x 6months.</li> <li>• All results obtained will be forwarded to the critical care quality improvement committee.</li> </ul> <p>This corrective action plan will be concurrently monitored to ensure all actions are taken and all follow-up monitoring occurs.</p>	<p>Stephen Winter MD</p> <p>Denise White/Arlene Timpone/Lorraine Salavec</p> <p>Stephen Winter MD</p> <p>New Vice President for QI to monitor CAP, beginning 4/2/07 and ongoing to completion of all time lines. The Executive Staff of the Hospital will assess and oversee and ensure actions for designated areas of responsibility.</p>

RESPONSE TO STATE OF CONNECTICUT LETTER DATED 3/9/07

VIOLATIONS	Summary Of Violation	Plan of Correction	Completion Date, Responsible Person(s)
		<p>This corrective action plan will be concurrently monitored to ensure all actions are taken and all follow-up monitoring occurs.</p>	<p>New Vice President for QI to monitor CAP, beginning 4/2/07 and ongoing to completion of all time lines. The Executive Staff of the Hospital will assess and oversee and ensure actions for designated areas of responsibility.</p>