Approved
9/4/25

Yale NewHaven Health
Lawrence + Memorial Hospital

August 29, 2025

RE: CMS Deficiency Letter Lawrence + Memorial Hospital, dated August 21, 2025

Millicent Reynolds
Supervising Nurse Consultant
Facility Licensing & Investigations Section

Attached please find the Lawrence + Memorial Hospital's response to the CMS letter of violation dated August 21, 2025, which contains the plan of correction and responses for the violation set forth in the letter.

Please confirm receipt of the corrective action plans and their acceptance status.

If you need additional information, please contact me at gail.turner@lmhosp.org or by phone at (203) 645-1746.

Sincerely,

Gail Turner RN, MSN, CNML, CPHQ
Director Accreditation & Regulatory Affairs
Yale New Haven Health
Lawrence + Memorial and Westerly Hospitals
365 Montauk Ave.
New London, CT 06320

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE & MEMORIAL HOSPITAL	365 MONTAUK AVE NEW LONDON, CT 06320

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A 000	INITIAL COMMENTS This report is the result of an unannounced complaint survey [CT 44934] completed on July 1, 2025 at Lawrence and Memorial Hospital. It was determined the hospital was in substantial compliance at the time of the visit with the requirements of 42 CFR, Title 42, Part 482-Conditions of Participation for Hospitals. Standard level deficiencies were identified.	A 000		
A 119	PATIENT RIGHTS : REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on a review of clinical records, hospital documentation, and staff interviews, for 1 of 5 sampled patients reviewed for grievances (Patient #133) the hospital failed to ensure patient concerns were addressed in the grievance. The finding includes: a. Patient #133 filed a grievance on 517/25 identifying the Physician Assistant (PA) had an attitude and they had an unpleasant interaction with a PA. The grievance identified the patient alleged that the PA rolled their eyes at the patient and did not want to wrap the patient's elbow. Review of the hospital documentation and interview with a representative from Patient	A 119	**Corrective Action Plan – A 119** 1. The grievance for patient #133 has been re-opened by Patient Relations and is being re-addressed ensuring all required grievance procedures are followed. — 9/25/2025 2. The Patient Relation staff have been re-educated on the grievance process via a read and sign of the Yale New Haven Health System (YNHHS) Patient Complaint and Grievance Management policy. — 8/29/2025 3. Two Patient Relation staff members are currently on a leave of absence. Upon their return they will be re-educated on the grievance process via a read and sign on the YNHHS Patient Complaint and Grievance Management policy. — 9/26/2025 The Senior Vice President, Patient Care Services will be responsible for monitoring this corrective action plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President	8/28/2025

An y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 119	Continued From page 1 Relations on 7/1/25 at 9:20AM identified when a grievance is filed, it is shared with the leadership team and management of the area identified in the grievance. The representative stated in this case, there was no response from the PA and the staff person assigned to complete the grievance was unavailable to review the concerns. However, there was documentation that a closure letter was sent to the complainant although the investigation was not completed. The representative stated the expectation is that the allegations are addressed, and a written response letter is sent to the complainant which was not done in this case. Review of the hospital policy for patient complaint and grievance management identified that all grievances will be investigated and resolved promptly.	A 119	**Monitoring – A 119** 10 or all Lawrence + Memorial Hospital (L+M) grievances will be audited monthly for three months to assess compliance with the grievance process.	11/30/2025
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on a review of clinical records, hospital documentation, and staff interviews, for 1 of 3 sampled patients reviewed for bruising of unknown origin, the hospital failed to investigate how the bruises occurred and failed to document the location and size of the bruises. The finding includes: a. Patient #125 was admitted to the hospital on 2/26/25 for shortness of breath and found to have a right upper lobe pneumonia. Review of the H&P	A 144	**Corrective Action Plan- A 144** 1. The event and an SBAR regarding expectations of the management of bruises of unknown origin will be reviewed and shared at 6.2 daily staff huddles for 2 weeks. 2. All Registered Nurses (RN) on 6.2 will be educated via an SBAR format, i.e. read and sign regarding the expectation that the RNs must document the location and size bruises of unknown origin and notify the provider. The Director of Nursing will be responsible for monitoring this corrective action plan.	9/16/2025 9/16/2025

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A 144	Continued From page 2 dated 2/26/25 at 9:30PM noted the patient's skin was warm, dry, with no edema and negative for a rash. Review of the nursing admission assessment dated 2/27/25 at 5:32AM identified the Heparin drip (blood thinner) was infusing at 15 units/kg/hr. The assessment lacked documentation of the patient's skin assessment. A Physician's order dated 2/27/25 at 11:25AM directed to administer Lovenox (blood thinner) 80mg subcutaneous every 12 hours. The physician orders identified the Lovenox 80mg was discontinued on 2/28/25 at 10:50AM. A Physician's order dated 2/28/25 at 10:50AM directed to administer Eliquis (blood thinner) 10mg every 12 hours and was discontinued on 3/6/25 at 9:55PM. The Physician's order dated 3/7/25 at 9:00AM directed to administer Eliquis 5mg every 12 hours. Review of the clinical record with RN #121 on 7/1/25 at 11:30AM identified the first indication of bruising was noted in the patient's flow sheets on 2/28/25 (2 days after admission) at 4:00PM. The assessment failed to include the location or size of the bruising. Review of the flow sheets during the period of 3/1/25 through 3/12/25 identified the patient had bruising. The documentation failed to identify the location, appearance or size of the bruising on the patient. Review of a nurses note dated 3/3/25 at 6:38PM	A 144	**Monitoring – A 144** Ten patient skin assessment audits will be conducted on 6.2 a month for three months, to verify that the patient's prevalent skin assessment matches the skin assessment documented in the patient's medical record.	11/30/2025

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A 144	Continued From page 3 identified the patient had multiple eccyhmotic bruising on the upper extremities. Nurse's notes dated 3/4/25 at 5:18PM identified skin to upper and lower extremities ruddy in appearance which family reports is new since patient became ill. An interview with RN #121 on 7/1/25 at 11:30AM stated that when a patient is identified with bruising, it is the expectation that nurses document the location, size and appearance. RN #121 stated that will help to determine when new bruising occurs. Interview with the Director of Quality on 7/1/25 at 12:00PMstated that the hospital does not have a policy for bruising of unknown origin, but staff are expected to document the bruises and implement interventions to help protect the patient's skin. The Director further identified that they did not conduct an investigation as to how the bruises occurred. The interview with the Chief of Medicine on 7/1/25 at 12:15PM stated that it is relatively normal for a patient to bruise while on anticoagulant therapy. The Chief of medicine stated that he reviewed the patient's chart and identified several risk factors for the bruising including agitation, medications, and a pulmonary embolism.			
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by	A 168	**Corrective Action Plan – A 168** 1. Individual review with the Emergency Department (ED) provider involved in the identified cases was conducted on 8/27/2025 by physician leadership. Individual review with the Hospitalist involved in the identified cases will be conducted on 9/2/2025, at the beginning of their next shift, by physician leadership. This review included the expectations of completing orders for restraints and conducting a face-to-face evaluation within 1 hour restraint application.	9/2/2025

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A 168	A 168 Continued From page 4 hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on clinical record review, hospital policy and staff interview for 2 of 4 sampled patients reviewed for restraints, (Patient#126 and#127) the hospital failed to ensure a Physician's order was obtained for the use of violent restraints. The findings include: a. Patient #126 was admitted on 4/11/25 on a PEC (Physician emergency certificate). A nurse's note dated 4/12/25 at 6:51PM reflected that between 3:00PM and 7:00PM the patient was in non-violent restraints for escalating behaviors and threatening to leave. The patient was actively removing the non-violent restraints, the MD was notified, and the patient was transferred to violent restraints at 4:00PM. Review of the clinical record and interview with the Clinical Coordinator for Critical Care on 6/30/25 at 11:30AM identified that when the patient was placed in violent restraints staff did not obtain a physician order. The Clinical Coordinator stated that when a patient's restraints go from non-violent to violent a physician's order must be obtained. b. Patient #127 presented to the ED on 5/30/25 for agitation and combativeness. The nurse's note dated 5/30/25 at 2:45AM identified the patient was screaming, using profanity, and attempting to hit and kick staff in the ambulance bay. The note identified that the patient was placed in 4-point restraints for safety. The ED provider note dated 5/30/25 at 3:10AM	A 168	2. A Review of the YNHHS Medical Staff Education pertinent to Restraint and Seclusion will be performed at the September Hospitalist section meeting. 3. A Review of the YNHHS Medical Staff Education pertinent to Restraint and Seclusion will be performed at the September Emergency Department Physician staff meeting. 4. Mandatory education for ED and Hospitalist providers will include the 2 slides from Medical Staff Education that are pertinent to Restraint and Seclusion. The Associate Chief Medical Officer will be responsible for monitoring this corrective action plan. **Monitoring – A-168** Ten (if less than ten all) violent restraint use charts within the ED and 5.2 will be audited monthly for three months, assessing compliance of complete restraint documentation to include verified order, face to face evaluation within 1 hour of application, and patient behavior documentation every 15 minutes.	9/24/2025 9/17/2025 9/15/2025 12/8/2025

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A 168	Continued From page 5 reflected that upon arrival to the ED the patient was extremely agitated, combative and attempting to hit and kick staff requiring 4-point restraints. Review of the clinical record and interview with the Clinical Coordinator for Critical Care on 6/30/25 at 11:45AM failed to identify a physician's order was written for the use of restraints. The Clinical Coordinator stated when the patient was placed in 4-point restraints, a physician's order is to be written for the use of restraints within one hour of the application. Review of the hospital policy for restraint and seclusion identified restraint standards for violent, self-destructive behavior, orders are to be written within one hour of restraint initiation.	A 168		
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length time identified in the order. This STANDARD is not met as evidenced by: Based on a review of clinical records, hospital documentation, and staff interviews, for 2 of 5 sampled patients reviewed for restraints, (Patient #126 and #127) the hospital failed to ensure the patient's behaviors were documented while the patient was in restraints in accordance with hospital policy. The findings include: a. Patient #126 was admitted on 4/11/25 on a PEC (Physician emergency certificate).	A 174	**Corrective Action Plan – A 174** 1. Individual review with the 5.2 and ED nursing staff involved in the identified cases was conducted by nursing leadership, this included reviewing the expectations of restraint documentation. 8/29/2025 2. All RNs (ED and 5.2) will complete the LMS learning module for restraints and seclusion. 9/15/2025 3. All RNs (ED and 5.2) will complete a read and sign education and policy review of the YNHHS Restraint and Seclusion policy. 9/15/2025 4. Restraint Documentation requirements will be reviewed at the ED and 5.2 daily department huddles for two weeks. 9/15/2025	

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A 174	Continued From page 6 A nurse's note dated 4/12/25 at 6:51PM reflected that between 3:00PM and 7:00PM the patient was in non-violent restraints for escalating behaviors and threatening to leave. The patient was actively removing the non-violent restraints, the MD was notified, and the patient was transferred to violent restraints at 4:00PM. The nurse's note dated 4/13/25 at 3:58AM reflected that the patient was removed from the violent restraints at 2:45AM and placed in 4-point soft wrist restraints applied. Review of the clinical record and interview with the Clinical Coordinator for Critical Care on 6/30/25 at 11:50AM identified that from 6:00PM until 7:30PM and from 10:30PM until 2:45AM (time of discontinuation) the patient's behaviors were not documented in the clinical record. The Clinical Coordinator stated that the patient's behaviors are to be documented every fifteen minutes while the patient is in restraints to determine when the restraints can be discontinued. b . Patient #127 presented to the ED on admitted on 5/30/25 for agitation and combativeness. A nurse's note dated 5/30/25 at 2:45AM noted patient screaming, using profanity, attempting to hit and kick staff in the ambulance bay, the patient was placed in 4-point restraints for safety. Review of the behavior flow sheets dated 5/30/25 identified the patient was in 4-point restraints from 2:45AM until 4:15AM when the restraints were removed. The flowsheets identified that at	A 174	The Director of Nursing will be responsible for monitoring this corrective action plan. **Monitoring – A 174** Ten (if less than ten all) violent restraint use charts within the ED and 5.2 will be audited monthly for three months, assessing compliance of complete restraint documentation to include verified order, face to face evaluation within 1 hour of application, and patient behavior documentation every 15 minutes.	12/8/2025

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A 174	Continued From page 7 3:30AM and at 3:45AM, the patient's behaviors were not documented and at 4:00AM the patient's behavior was documented as calm. Review of the clinical record and interview with the Clinical Coordinator for Critical Care on 6/30/25 at 12:00PM identified the patient's behaviors were not documented at 3:30AM and 3:45AM while the patient was in 4-point restraints. The Clinical Coordinator stated that the patient's behaviors are to be documented every fifteen minutes while the patient is in restraints to determine when the restraints can be discontinued. Review of the hospital policy for restraint and seclusion identified restraints are discontinued at the earliest possible time when the behaviors necessitating the use of the restraint cease, regardless of the length of time identified in the order. The policy identified staff are to conduct and document patient visual checks every fifteen minutes which include the behavior	A 174		
A178	of the patient. PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-Hour after the initiation of the intervention -- oBy a- - Physician or other licensed practitioner; or - Registered nurse who has been trained in accordance with the requirements specified in paragraph(f) of this section.	A 178	**Corrective Action Plan – A 178** 1. Individual review with the ED provider involved in the identified cases was conducted on 8/27/2025 by physician leadership. Individual review with the Hospitalist involved in the identified cases will be conducted on 9/2/2025, at the beginning of their next shift, by physician leadership. This review included the expectations of completing orders for restraints and conducting a face-to-face evaluation within 1 hour restraint application.	9/2/2025

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A 178	Continued From page 8 This STANDARD is not met as evidenced by: Based on a review of clinical record, hospital documentation, and staff interview for 1 of 5 sampled patients reviewed for restraints, (Patient #126) the hospital failed to ensure a face-to-face evaluation was completed within one hour of the application of the restraint. The finding includes: Patient #126 was admitted on 4/11/25 on a PEC (Physician emergency certificate). A nurse's note dated 4/12/25 at 6:51PM noted between 3:00PM and 7:00PM the patient was in non-violent restraints for behaviors escalating, threatening to leave. The patient was actively removing the non-violent restraints, the MD was notified, and the patient was transferred to violent restraints at 4:00PM. Review of the clinical record and interview with the Clinical Coordinator for Critical Care on 6/30/25 at 11:30AM identified when the patient was placed in violent restraints, a face-to-face evaluation was not completed on the patient. The Clinical Coordinator stated that a face-to-face evaluation is to be completed within one hour of the initiation of a restraint. Review of the hospital policy for restraint and seclusion identified within one hour of the restraint initiation, the provider or trained RN must make a face-to-face evaluation of the patient. The evaluation shall include a physical and behavioral health assessment which includes both a face-to-face assessment and discussion with staff of the patients' physical and psychosocial status and evaluation of the immediate situation, the patient's reaction to the intervention, the patient's behavioral and medical condition and the	A 178	2. A Review of the YNHHS Medical Staff Education pertinent to Restraint and Seclusion will be performed at the September Hospitalist section meeting. 3. A Review of the YNHHS Medical Staff Education pertinent to Restraint and Seclusion will be performed at the September Emergency Department Physician staff meeting. 4. Mandatory education for ED and Hospitalist providers will include the 2 slides from Medical Staff Education that are pertinent to Restraint and Seclusion. The Associate Chief Medical Officer will be responsible for monitoring this corrective action plan. **Monitoring – A-178** Ten (if less than ten all) violent restraint use charts within the ED and 5.2 will be audited monthly for three months, assessing compliance of complete restraint documentation to include verified order, face to face evaluation within 1 hour of application, and patient behavior documentation every 15 minutes.	9/24/2025 9/17/2025 9/15/2025 12/8/2025

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A 178	Continued From page 9 need to continue or terminate the restraint.	A 178		