STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner-Designate

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

March 10, 2020

Melissa Woodin, Person-in-Charge
Fernwood Rest Home Inc
Torrington Road, Po Box 548
Litchfield, CT 06759

Dear Ms. Woodin:

Unannounced visits were made to Fernwood Rest Home Inc on December 18, 19, and 20, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by March 24, 2020.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by March 24, 2020 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant via email at dph.flisadmin@ct.gov or right fax number 860-622-2655. Please direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

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

Respectfully,

Karen Gworek, RN

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb

c. Mairead Painter, LTC Ombudsman Program

Complaint #22353, #22712, 22899, #24847

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or the General Statutes of Connecticut Section 19a-535a (c) and/or (d)(1)(3).

1. Based on clinical record review, facility documentation and interviews for one of eight sampled residents (Resident #8) who was transferred to the hospital for a change in condition, the facility failed to serve a thirty (30) day involuntary discharge notice, readmit the resident if the resident had requested an appeal with the hearing office. The findings include:
   a. Resident #8's diagnoses included depression, anxiety, and alcohol abuse. Review of facility documentation identified Resident #8 was provided a final warning on 11/15/19 after a physical altercation with another resident and if any other incident occurred Resident #8 would be served an involuntary discharge notice. The Reportable Event form dated 12/17/19 identified Resident #8 got into an agreement with another resident and Resident #8 pulled a butter knife out and threatened to stab the resident in the back. The report identified Resident #8 would be seen in follow-up at the behavioral health center. Interview with the Person-in-Charge on 12/20/19 identified Resident #8 was admitted to the hospital on 12/18/19 as a result of a choking incident and on 12/20/19 the hospital called the facility to inform them Resident #8 was ready to return to the residential care home. The Person-in-Charge informed the hospital Resident #8 had already been discharged and the facility was not going to take the resident back. The Person-in-Charge identified Resident #8 had been told verbally on 12/18/19 that he/she was being discharged and Resident #8 was not provided a thirty (30) day involuntary discharge notice and instructions of the right to appeal the discharge notice. The Person-in-Charge identified that an ambulance driver picked up Resident #8's belongings on 12/20/19 and brought the resident to a community shelter.

Approved
3/20/20
KEG

Fernwood Rest Home, Inc.

03/20/2020

[redacted]

In regards to the plan of correction for the unannounced visit made to Fernwood Rest Home on December 18, 19, and 20, 2019, the facility has taken the following actions concerning the alleged deficiency identified as: *(section 19-13-D6 (c) Administration (1) and/or the General Statues of Connecticut Section 19a-535a (C) and/or (d) (1) (3).*

1. Effective 03/20/2020, the facility will ensure that a 30-day written notice of discharge policy and procedure is followed so the alleged deficient practice does not affect other residents.
2. Effective 03/20/2020, the resident or their legally liable relative, guardian, or conservator will be notified by Person In Charge (PIC) that resident will be involuntary discharged or transferred from facility and that the resident and/or responsible person may appeal such transfer or discharge to the Commissioner of Public Health by filing a request for a hearing with the Commissioner within ten (10) days of receipt of discharge notice.
3. Effective 03/20/2020, the 30-day written notification of discharge will include reason for involuntary discharge or transfer, and instructions of the right to appeal the discharge notice, contact information for local Ombudsman and Commissioner of Public Health.
4. Effective 03/20/2020, if in an emergency, facility will request that commissioner make a determination as to the need for an immediate transfer or discharge of a resident.

The following measures have been taken by the facility to ensure that proper practices continue:

1. As of 03/20/2020, Fernwood Rest Home Administration Team (PIC, BOM, RN Supervisor, Owner) have been educated on the involuntary discharge/transfer policy, notice of involuntary transfer or discharge and the opportunity for a hearing.

Effective 03/20/2020, the Person In Charge or designees will monitor continued compliance via the following Quality Improvement programs:

1. Upon decision to issue a 30-day involuntary notice, the Person In Charge or designees, will utilize the QA tool which has been developed to ensure compliance with the involuntary transfer policy, notice of involuntary transfer of discharge and the opportunity for a hearing.
2. The Person In Charge will be responsible for ensuring the facilities continued compliance with this plan of correction.

Sincerely,

Melissa Woodin

Melissa Woodin, Person In Charge
Fernwood Rest Home Inc.