# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

November 8, 2022

Edward Weigen, Person-in-Charge
Fernwood Manor
27-29 Girard Avenue
Hartford, CT 06105

Dear Mr. Weigan:

An unannounced visit was made to Fernwood Manor on October 27, 2022 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

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 visit. 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 fourteen 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 November 22, 2022.**

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.

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*

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.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by November 22, 2022 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant and direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

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

Respectfully,

*Karen Gworek, RN*

Karen Gworek, RN, BSN
Supervising Nurse Consultant
Facility Licensing & Investigations Section

KEG:csf

cc. Mairead Painter, LTC Ombudsman Program

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(F)(ii).

1. Based on resident record reviews, facility documentation, and interviews for two of twenty-one sampled residents (Resident #1 and #2) who were reviewed for medication administration, the facility failed to ensure medications were secured under lock. The findings include:

    a. Observations during a tour of the facility on 10/27/22 identified a bottle of Meloxicam 15 milligrams (mg) and a bottle of Aspirin 325 mg on a dresser chest in Resident #1's room. Interview with Resident #1 at the time of observations identified he/she took the medication once a day and the medications were prescribed by his/her doctor. Interview with Housekeeper #1 at the time of observation identified she did not know Resident #1 had medications in his/her room. Observations in Resident #2'sroom identified two (2) bottles of Aspirin 81 mg and a bottle of Tylenol 650 mg on a dresser chest. Interview with Resident #2 at the time of observations identified he/she took the medication every day if he/she had a headache. Interview with the Facility Manager at the time of observation identified she did not know Resident #2 had medications in his/her room. The Facility Manager indicated the residents go to the store, buy medications, and do not let the facility staff know about it. The Facility Manager identified the residents were not to have medications in their rooms. The facility routine directs medical appointments and prescriptions should be turned over to house staff after a resident returns from an appointment. Prescription medications must be locked up and supervised at all times.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2).

2. Based on resident record reviews, facility documentation, and interviews for two of twenty-one sampled residents (Resident #1 and #2) who were reviewed for medication administration, the facility failed to ensure a physician's order directed the residents were able to self-administer medications. The findings include:

    a. A review of Resident #1 and #2's resident records on 10/27/22 failed to reflect documentation Resident #1 and Resident #2 had a physician's order to self-administer medications and the residents are evaluated to ensure the residents were able to safely administer medications. Interview with the Facility Manager identified the residents did not have an order to self-administer medications.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (m) Administration of Medications (2)(E)(i).

3. Based on resident record reviews, facility documentation, and interviews for two of twenty-one

sampled residents (Resident #3 and #4) who were reviewed for medication administration and received Visiting Nurse Agency (VNA) service, the facility failed to ensure a copy of Medication Administration Record was available to the facility staff. The findings include:

a. Interview with the Administrative Assistant on 10/27/22 identified the facility did not have access to the Medication Administration Record (MAR) of two (2) residents (Resident #3 and #4), because the residents received their medications from VNA nurses. The Administrative Assistant indicated although the Medication Administration Records were on the facility premises in locked boxes in the medication room, the facility staff did not have access to the Medication Administration Records because the staff did not have a key to the locked boxes. The Administrative Assistant identified the VNA nurse did not provide keys for the facility staff to access the Medication Administration Records.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(D)(2) and/or (b) Physical Plant (2)(S) and/or (c) Administration (1) and/or (c) Administration (5).

4. Based on observations and interviews, the facility failed to maintain a clean, comfortable, and home like environment. The findings include:

   a. During a tour of the facility on 10/27/22 the following were identified:

      i. The bathroom located in Room #1 had a missing grab bar in the bathtub.
      ii. The bathroom located in Room #2 had cracked floor tile at the tub area.
      iii. The bathroom located next to Room #12 the grab bar in the bathtub was rusted.

   Interview with the Facility Manager on 10/27/22 identified she was unaware of the missing grab bars, cracked floor tile and a rusted grab bar in the bathrooms. The Facility Manager indicated she would inform the owner of the needed repairs.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (2)(b) and/or (c) Administration (1) and/or (c) Administration (5).

5. Based on review of facility documentation, observations, and interviews, the facility failed to ensure the State of Connecticut Fire Safety Code and the National Fire Protection Association was implemented. The findings include:

   a. On 10/27/22 at 9:00 A.M., during a tour of the facility and while accompanied by the facility manager, the following observations were identified:

      i. Documentation was not provided to the surveyor from the facility to indicate that the fire drills were being completed as required by NFPA 1 Section 20.5.2.3. i.e.,

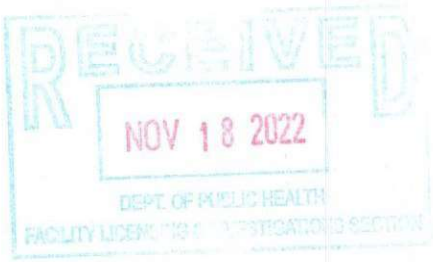
records provided indicated that one (1) fire drill was completed during the night while residents are sleeping in the last twelve (12) months. A minimum of two (2) drills in this time frame a required.

ii. The surveyors observed that in resident Room #1 the bed was placed too close to the door. The door was not able to open completely and the path of egress from the room did not meet the requirements of NFPA 101 Chapter 7.

Fernwood Manor, Inc.
LICENSED RESIDENTIAL CARE HOME

Approved 11/21/22 KEG

November 17, 2022




Karen Gworek
Supervising Nurse Consultant
Facility Licensing & Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Licensing Inspection October 27, 2022

Dear Ms. Gworek,

In response to your letter dated November 8, 2022, please find our plan of corrections for the violations listed below.

1a; Resident #1 Meloxicam 15 mg, and Aspirin, 325 mg, were removed from the resident's room on October 27, and locked in the medication room. Contact with the physician was made on October 28, and a physician's order was obtained for the Meloxicam. This medication is now administered by staff, and recorded on a M.A.R. The Aspirin was not prescribed by the physician, and was destroyed.

Resident #2 Aspirin 81mg, and Tylenol 650 mg, were removed from the resident's room on October 27, and locked in the medication room. Contact with the physician was made on October 28, and a physician's order was obtained for the Aspirin 85mg. This medication is now administered by staff, and recorded on a M.A.R. The Tylenol was not prescribed by the physician, and was destroyed.

Staff members have been instructed to remain vigilant in looking for any medications prescribed, or over the counter, that residents may have brought home and not reported. The administrative assistant will be responsible for ensuring ongoing compliance.

2a; Residents #1, & #2, have all prescribed medications now administered by staff, and therefore do not require a physician's order to self –administer.

3a; The VNA's for both residents #3 & #4 were contacted on October 27. On October 28, MAR's were left out of the locked box, and accessible. During an audit on November 15, the MAR's were once again locked in a box, and we contacted the VNA agency. We received a return call from the agency on November 17, and they stated that they will now provide current lists of medications, and a copy of the current MAR's, and notify us of any changes in medications ongoing, in lieu of leaving the original MAR which will remain locked in a box. The

administrative assistant will be responsible for monitoring the compliance by the VNA agencies for this documentation.

4a;

i. The bathroom in room #1 had grab bars installed. This was completed on November 16.
ii. The cracked tile in room #2 bathroom, will be repaired by November 28.
iii. The bathroom near room #12, will have the grab bar repaired by November 28.

The facility manager is responsible for reporting any known deficiencies, to the Administrator. The administrator will be responsible for ensuring ongoing compliance, to any facility deficiencies.

5a;

i. On October 17, our contracted service that performs our fire drills, was contacted and made aware that two drills while residents are sleeping are required within a twelve month period. The first of these two drills was performed on October 21.
ii. The bed in room #1 was moved away from the entrance door. This rearrangement was completed on October 27.

The administrator will be responsible for ongoing compliance to all physical plant requirements.

Should there be any questions regarding our submitted plan of corrections, please do not hesitate to call me directly for further clarification.

Sincerely,

Edward Weigen
Administrator