STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

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Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

April 25, 2023

Patricia Adkins, Person-in-Charge
Fernwood Rest Home Inc
400 Torrington Road
PO Box 548
Litchfield, CT 06759

Dear Ms Adkins:

An unannounced visit was made to Fernwood Rest Home Inc on April 18, 2023 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a multiple investigation.

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 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 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 May 9, 2023

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.

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 May 9, 2023 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 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

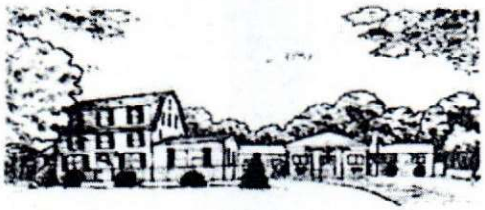
c. Mairead Painter, LTC Ombudsman Program

Complaint #33885, #34362

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4).

1. Based on facility documentation review, resident record review and staff interviews, for one sampled resident (Resident #2) who was reviewed for a change in condition, the facility failed to conduct every fifteen (15) minute checks from 7:45 PM to 11:00 PM. The findings include:

   a. Resident #2's diagnoses included alcohol and substance abuse. The Facility Reportable Event form dated 4/11/23 at 11:15PM identified Resident #2 was found unresponsive and cardiac arrest resulting in death. Review of facility documentation and interview with the Person-in-Charge identified Resident #2 was intoxicated once he/she returned to the facility on 4/11/23 between 4:00 PM and 5:00 PM, Resident #2 ate a little bit and left the facility to walk to a package store down the street. The Person-in-Charge indicated she instructed the staff to monitor Resident #2 every fifteen (15) minutes once he/she returned to the facility. The Person-in-Charge identified Resident #2 returned to the facility from the package store on 4/11/23 around 6:45 PM. The Person-in-Charge indicated Aide #1 and Medication Technician #2 witnessed Resident #2 stumbling on the street as Resident #2 was walking back to the facility, they ran to the road to help Resident #2 into the facility, they helped Resident #2 to his/her room and put Resident #2 in bed. The Person-in-Charge identified Resident #2 was intoxicated at this time. The Person-in-Charge indicated at 10:15 PM she could not reach Medication Technician #2 by the facility phone, so she came to the facility and found the volume had been turned down on the phone so that the ringer was inaudible. The Person-in-Charge identified during that time she asked Medication Technician #2 if the fifteen (15) minute checks on Resident #2 were being done, Medication Technician #2 stated the checks were being done and all was well. The Person-in-Charge indicated the 11PM-7AM shift staff found Resident #2 unresponsive in his/her room and called 911 at 11:35 PM. The Person-in-Charge identified the Emergency Medical Technicians were unsuccessful in reviving Resident #2 and pronounced Resident #2 at 12:43 AM. The Person-in-Charge indicated it was the opinion of the Emergency Medical Technicians and State Police who arrived on scene Resident #2 had passed away much earlier in the evening. The Person-in-Charge identified the staff members who were on duty during the 11PM-7AM shift were unable to find every fifteen-minute check form for Resident #2. The Person-in-Charge indicated Medication Technician #2 failed to ensure every fifteen-minute safety checks of Resident #2 were conducted. The Person-in-Charge identified Medication Technician #2 was terminated on 4/17/23.



Approved
5/9/23
KEG

Fernwood Rest Home, Inc.
Residential Care Home
400 Torrington Rd. PO Box 548
Litchfield, CT 06759
P: 860-567-9558 F: 860-567-9593

May 9th, 2023

[redacted]

In response to the Department of Public Health's violation dated April 25th 2023, Fernwood Rest Home's Person-in-Charge, Patricia Adkins took immediate steps to implement corrections to the Fifteen Minute Check policy as it applies to certain residents who are in need of further observation in regards to their health and safety.

On Thursday, April 13th 2023, Patricia Adkins performed a training with all staff who provide direct care to residents in the facility. This training consisted of reviewing the Fifteen Minute Check Log and demonstrating the correct way this form should be completed by staff. Staff were also retrained on how to check for signs of life, such as looking for chest rising, listening for breaths, how to identify off-baseline behaviors, and the appropriate questions to ask a resident to identify if their mental status is altered. Staff were reminded to look for these signs of life during every Fifteen Minute Check they perform, and to notify the Med Tech on duty of any changes in residents' status. All direct-care staff members have signed off on this training and understand the importance of performing these checks diligently and completing the logs.

To ensure that direct-care staff are complying with the Fifteen Minute Check protocol and that the logs are being filled out properly, Patricia Adkins (Person-in-Charge), Nicole Bonanni (Office Manager), or the on-duty Med Tech will be reviewing the logs daily and signing off to show that all checks have been reviewed. In the event that the Fifteen Minute Checks are not completed properly, the direct-care staff on duty will be mandated to receive additional training on Fifteen Minute Checks before they can return to their next scheduled shift. If said staff member continues to perform Fifteen Minute Checks improperly, then disciplinary action will be taken against them.

Please see our updated Fifteen Minute Check Log and Staff Sign-Off Sheet for in-service training. If you have any further questions or concerns, please do not hesitate to contact our office.

Sincerely,

Patricia Adkins

Patricia Adkins | Person-in-Charge