2016

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



## LICENSING INSPECTION REPORT

*D/B/A Name and Address of Entity*

Fernwood Rest Home
Torrington Rd
Litchfield CT 06759

*Signature of Survey Staff*

A Thompson

Licensure Category: RCH

Licensed Bed/Bassinet Capacity: 68

Census: 56

**Date(s) of onsite inspection:** 7/14/16, 7/18/16, 7/20/16

**Date(s) additional information obtained:** _____

**Personnel contacted:** Karen Cosgrove - Person-in-charge

**REVIEW/FINDINGS/PROCESS** (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other*: (e.g. Strike)_____

[ ] Visit **OR** Revisit for the purpose of _____

[✓] See Complaint Investigation # 20263, 20127, 20258, 20012

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies **were** identified at the time of this inspection. See attached violation letter dated 8/3/16

[ ] Desk Audit _____ [ ] Amended Letter date: _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referred to: _____.

**REPORT SUBMITTED BY:** A Thompson **DATE OF REPORT:** 7/20/16

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

August 3, 2016

Karyn Adkins-Cosgrove, Person-in-Charge
Fernwood Rest Home Inc
Torrington Road, Po Box 548
Litchfield, CT 06759

Dear Ms Cosgrove:

Unannounced visits were made to Fernwood Rest Home Inc on July 14, 18 and 20, 2016 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

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.

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 August 17, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

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. 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. 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,

Karen Gworek RN SNC

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

CT#20012, #20127, #20258, #20263
cc:Nancy Shaffer

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATES OF VISIT: July 14, 18 and 20, 2016

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(D)(iv).

1. Based on clinical record reviews, review of facility documentation and interviews for one of nine sampled residents (Resident #1) who had behavioral symptoms and received antipsychotic medications, the facility failed to ensure a medication was refilled to prevent omissions of the medication and a subsequent admission to hospital secondary to an escalation of behavioral health symptoms. The findings include:
   a. Resident #1's diagnoses included schizoaffective disorder bipolar type and Parkinson's disease. Review of the Medication Administration Record (MAR) from 4/20/16 through 5/19/16 identified Clozapine 100mg two tablets to be administered 9:00 AM and 8:00 PM. Upon further review, the MAR failed to reflect documentation that Resident #1 had received the Clozapine from 4/21/16 through 4/25/16. Facility communication documentation dated 4/19/16 through 4/25/16 identified Resident #1 had exhibited symptoms of wanting to harm him/herself. Resident #1 was transferred to the hospital for an evaluation on 4/26/16. The hospital discharge summary dated 5/2/16 identified Resident #1 was diagnosed with depression, auditory hallucination and poor hygiene and had required a medication restart. In an investigation conducted by the home care agency the Clozapine was last filled on 3/20/16 and was to be refilled on 4/20/16. In an interview on 7/18/16 at 3:20 PM, LPN #1 identified during the period of 4/21/16 to 4/25/16 there was no Clozapine available for Resident #1 because the facility was acquiring the medication administration for the residents that had been the responsibility of the home care agency.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (F)(iv).

2. Based on record reviews, facility documentation and interviews for one of nine sampled residents (Residents #4) reviewed for medication administration, the facility failed to ensure a medication was destroyed at the time and date when the medication was accidentally poured. The findings include:
   a. Resident#4's diagnoses included bipolar disorder and arthritis. The June 2016 Medication Administration Record identified Resident #4 received Lorazepam 1.5 milligrams (mg) at 7:00 AM and Lorazepam 1mg at 11:30 AM and 5:00 PM. The Reportable Event Form dated 6/6/16 identified the Staff Attendant, Certified Medication Technician #2, had removed Lorazepam 1.5mg to be administered at 7:00 AM and also the Lorazepam 1mg which was not due until 11:00 AM. The facility investigation concluded Resident #4 received the scheduled dose of Lorazepam 1.5mg and did not receive the additional Lorazepam 1mg in error was identified and the extra Lorazepam was destroyed. Review of the Controlled Substance Disposition record for the Lorazepam 1mg identified two signatures next to the notation destroyed on 6/18/16, twelve days after the one tablet was removed from the packet to be administered. In an interview on 7/18/16 at 11:10 AM, Certified Medication Technician #2 identified Resident #4 had two different Lorazepam

packets, one with one and a half tablets to equal the 1.5mg and the other packet with one tablet, 1mg. Certified Medication Technician #2 identified on 6/6/16 at 7:00 AM she removed the extra tablet of Lorazepam 1mg in error and placed the tablet in the locked narcotic box to be destroyed by the Person-in-Charge. In an interview and review of the Controlled Substance Disposition record for the Lorazepam 1mg on 7/18/16 at 12:30 PM, the Person-in-Charge identified the Lorazepam 1mg was destroyed on 6/18/16 because the Registered Nurse was not available to witness the destruction and co-sign until that date.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (C) Administration (4) and/or Connecticut General Statues 19a-550 (b)(8).

3. Based on clinical record review, facility documentation and interviews for one of three sampled residents (Resident #6) who was reviewed for an allegation of mistreatment, the facility failed to ensure the resident was treated with respect and dignity. The findings include:
   a. Resident #6's diagnoses included schizophrenia. The Reportable Event Form dated 6/23/16 identified an incident occurred (date unknown) where Resident #5 overheard a staff attendant make vulgar comments towards Resident #6. Although the facility's investigation could not substantiate an allegation of abuse and/or mistreatment, the staff attendant received a verbal warning and an in-service on resident rights was scheduled to be conducted with all staff. In an interview on 7/14/16 at 2:00 PM, Resident #5 identified the staff attendant had cleaned the bathroom and Resident #5 overheard Resident #6 requesting to use the bathroom desperately. Resident #5 heard the staff attendant use vulgar terminology when addressing Resident #6. Resident #5 stated the incident was reported to the Person-in-Charge the next day and Resident #5 was informed later that the staff attendant denied making the comments. In an interview on 7/18/16 at 3:05 PM, the staff attendant identified she had cleaned the bathroom when another staff member informed her that Resident #6 required incontinent care. The staff attendant identified as she was preparing the bathroom for the resident she made a comment such as "I have to clean up s_ _ _t" and believed Resident #6 was nearby so the resident may have overheard her statement. In an interview on 7/18/16 at 3:45 PM, the Person-in-Charge identified the staff attendant had initially denied making any derogatory statements. The Person-in-Charge identified that the staff attendant received a verbal warning and all staff would be attending an in-service by the end of July regarding resident rights and abuse.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (h) General Conditions (3).

4. Based on review of facility documentation and interviews, for one of three sampled residents (Resident #6) who was reviewed for an allegation of mistreatment, the facility failed to report an allegation of verbal abuse to the state agencies within the timeframe after the incident occurred in accordance with the regulations. The findings include:
   a. The Reportable Event Form dated 6/23/16 identified an incident occurred, the exact date

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

was unknown, where Resident #5 overheard a staff attendant make vulgar comments towards Resident #6. In an interview on 7/14/16 at 2:00 PM, Resident #5 identified he/she witnessed an incident of verbal abuse towards Resident #6 and notified the Person-in-Charge the following day. Resident #5 indicated the Person-in-Charge told him/her not to report the incident to the State Agencies. Resident #5 could not recall the exact date of the incident but identified his/her written report was dated 6/23/16. In an interview on 7/21/16 at 9:30 AM, the Therapeutic Recreation Director identified Resident #5 informed her of an incident of verbal abuse towards Resident #6. Upon inquiry the Therapeutic Recreation Director determined that the incident occurred approximately a week prior to being notified by Resident #5. The Therapeutic Recreation Director stated subsequent to receiving the information from Resident #5 she notified the Ombudsman, State Agency and informed the Person-in-Charge of the reporting. In an interview on 7/18/16 at 3:45 PM the Person-in-Charge identified she recalled Resident #5 had told her about the incident and that he/she had written a note about the incident. The Person-in-Charge stated she informed Resident #5 that she would take care of the incident therefore Resident #5 did not need to notify anyone. Review of the Reportable Event form dated 6/23/16 identified that the Person-in-Charge faxed the report to the State Agency on 6/28/16 at 4:03 PM, four days after the incident had been reported to the Person-in-Charge by Resident #5.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(D)(iv).

5. Based on record reviews, review of facility documentation and interviews for 9 of 57 sampled residents (Residents #1, #2, #3, #6, #10, #11, #12, #13 and #14) who were reviewed for medication errors, the facility failed to supervise the transition from the old pharmacy to a new pharmacy to ensure the residents received medication in accordance with the physician's orders. The findings include:
   a. Review of facility documentation identified there was a transition from the current pharmacy (Pharmacy #3) to a new pharmacy (Pharmacy #2) scheduled for the end of June 2016. Pharmacy #2 had acquired resident information, i.e. demographics, physician's orders and the medication administration records prior to the transition date. The transition of pharmacies was to occur in two (2) phases: the female residents would remain under the old pharmacy, Pharmacy #3, with a plan to transfer over to the new pharmacy, Pharmacy #2, by 7/16/16 and the male residents' medications were delivered to the facility 6/26/16 by the new pharmacy, Pharmacy #2. Review of facility documentation identified multiple errors were found, i.e. missing medication, wrong dose and no accompanying paperwork several days after the transition. The documentation identified that although facility staff communicated the errors to Pharmacy #2 and the medications were returned, re-processed and sent back to the facility, errors continued to occur. Subsequent to the multiple medication errors the facility decided to resume services with original pharmacy, Pharmacy #3, on 7/4/16. Review of the documentation identified a Home Care Agency, Agency #1,

provided medication administration services to Resident #1, #2, #3, #6, #7 and #8. Agency #1 had used a different pharmacy, Pharmacy #1, then the one the facility contracted with to fill the prescription orders for residents under their service. Agency #1 was also in the process of a transition from Pharmacy #1 to Pharmacy #3 during the same period as the facility in June 2016. Agency #1 had started to phase out the administration of medication to the residents in April 2016. The process was concluded by 6/24/16, during the phasing out period the facility became responsible for the medication administration and the agency was responsible for monitoring the residents and the medication regimen. Multiple medication administration errors that occurred during the transition of pharmacies and the transition of responsibility from the agency to the facility include the following:

i. Resident #1's diagnoses included schizoaffective disorder bipolar type and Parkinson's disease. A physician's order dated 5/31/16 directed Clozapine 100 milligrams (mg) 2 tablets twice daily. The June 2016 Medication Administration Record (MAR) identified Clozapine 100mg 2 tablets twice daily at 9:00 AM and 8:00 PM. The MAR cycle began with the date 6/10/16 and identified the Clozapine was administered as ordered up to 6/25/16. Review of facility documentation identified on 6/20/16 there was no Clozapine available and a request for a refill had been submitted to the pharmacy, Pharmacy #2. Facility documentation dated 6/29/16 identified Resident #1 had exhibited escalating behavioral health symptoms and was transferred to the hospital for an evaluation. The hospital discharge summary dated 7/8/16 identified Resident #1 was diagnosed and treated for depression with suicidal ideation, the resident was anxious with occasional auditory hallucinations. The report indicated that it was unknown whether the resident had received the Clozapine recently. In an interview on 7/18/16 at 11:30 AM, the Person-in-Charge identified there were multiple issues during the transition from Pharmacy #3 to Pharmacy #2 and communicated with Pharmacy #2 about the issues. In addition, the Person-in-Charge assumed that the resident's physicians and Agency #1 were notified of the missed medications. In an interview on 7/18/16 at 3:20 PM, LPN #1 identified there was no Clozapine available for Resident #1 because the facility was transitioning from one pharmacy to another and acquiring medication administration for the residents that the home care agency had been responsible for in the past. LPN #1 identified the new pharmacy, Pharmacy #2, requested laboratory testing prior to sending Clozapine and she could not recall if she had contacted the physician and/or Agency #1 regarding the pharmacy's request for blood work.

ii. Resident #2's diagnoses included schizoaffective disorder. A physician's order dated 5/29/16 directed Clozapine 100mg one tablet every morning and two tablets at bedtime. Review of the MAR from 5/29/16 through 6/25/16 identified the Clozapine was administered as ordered. Review of handwritten MAR for 6/26/16 through 7/23/16 failed to reflect documentation the Clozapine had been administered as ordered from 6/25/16 through 6/29/16. Review of facility documentation dated 6/29/16 identified Resident #2 was experiencing auditory hallucination and was sent to the hospital for an evaluation. The hospital discharge summary dated 7/8/16 identified Resident #2 was diagnosed and treated for an acute episode of schizoaffective disorder. In an interview and record review on

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

7/18/16 at 3:20 PM, the facility Licensed Practical Nurse (LPN) #1 identified the Clozapine 100 mg was not available on 6/26/16 during the transition of pharmacies. LPN #1 identified she contacted Pharmacy #2 for a delivery of Clozapine but was informed that bloodwork tests were required prior to the delivery of the medication. LPN #1 stated the MAR was available from 6/26/16 therefore she wrote an MAR referencing the previous month's orders but omitted the Clozapine order in error.

iii. Resident #3's diagnoses included schizoaffective disorder. A physicians order dated 6/1/16 directed Clonazepam 1mg every evening, Haldol 10mg every evening and Haldol 2mg every six hours as needed. Review of the Medication Administration Records identified handwritten MAR two dated June 2016 and two undated with the notation of the Haldol 10 mg and Clonazepam 1 mg with unclear documentation if the medications were administered. Review of the controlled drug disposition records for the Clonazepam 1 mg identified the administration from 6/1/16 through 6/30/16 and from 7/8/16 through 7/12/16. The MAR indicated the Clonazepam had not been administered from 7/1/16 through 7/8/16. In an interview on 7/14/16 at 1:20 PM, the Certified Medication Technician, #1, identified Resident #3 required a physician's appointment so the Clonazepam and Haldol could be refilled and was scheduled for 7/1/16 but the resident refused to go. The appointment was rescheduled for 7/8/16 and prescriptions for the Clonazepam and Haldol were refilled.

iv. Resident #6's diagnoses included schizophrenia. Review of the MAR from 6/21/16 through 7/20/16 identified Levothyroxine 25 micrograms (mcg), Benzotropine Mesylate 0.5mg, Paroxetine 40mg, Loratadine 10mg, Docusate sodium 100mg, Pantoprazole 40mg, Risperidone 1mg and Risperidone 3mg were not administered from 6/25/16 through 6/30/16.

v. Resident #10's diagnoses included schizophrenia. Review of the MAR identified hand written undated MAR with medication orders but no documentation, another undated hand written MAR identified Paroxetine 10mg and Reguloid laxative powder initialed and circled for the dates 6/29/16 and 6/30/16.

vi. Resident #11's diagnoses included depression and diabetes. Review of the MAR identified hand written undated MAR with Diclofenac 50mg circled for 6/29/16 and the Diclofenac 50mg was not available 7/1/16, 7/9/16 and 7/10/16.

vii. Resident #12's diagnoses included schizophrenia. An undated hand written MAR identified Linzess 290mcg was not administered as ordered on 6/29/16 and 6/30/16 because it was not available. Upon further review of the MAR failed to reflect documentation the Alendronate 70mg one tablet every Thursday was administered on 7/7/16 and 7/14/16.

viii. Resident #13's diagnoses included schizoaffective disorder. An undated hand written MAR identified Ranitidine 150mcg twice daily and Spiriva 18mcg inhaler once daily was documented as unavailable on 6/29/16 and 6/30/16. Upon further review of the MAR identified the Spiriva inhaler was not administered from 7/1/16 through 7/12/16, seven days.

ix. Resident #14's diagnoses included schizophrenia, diabetes and cerebrovascular accident. An undated hand written MAR identified Aspirin EC 325mg one tablet daily and Atenolol 25mg three tablets daily were not available for 6/29/16 and 6/30/16.
In an interview on 7/18/16 at 11:30 AM, the Person-in-Charge identified there were

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

multiple issues during the transition from Pharmacy #3 to Pharmacy #2 and communicated with Pharmacy #2 about the issues. The Person-in-Charge assumed the resident's physicians were notified of missed medications. Subsequent to the issues identified with the transition, the facility changed back to the original pharmacy, Pharmacy #3. In an interview and clinical record review on 7/18/16 at 3:20 PM, LPN #1 identified during the transition of pharmacies for the residents who were under the responsibility of the home care agency, there were delays in medication delivery and errors with the accompanying paper work. LPN #1 stated there was constant dialogue with Pharmacy #2 but medications were still wrong and the MAR had to be hand written using the previous orders from Pharmacy #3. LPN #1 identified that medications were omitted when transcribing the orders onto the MAR.

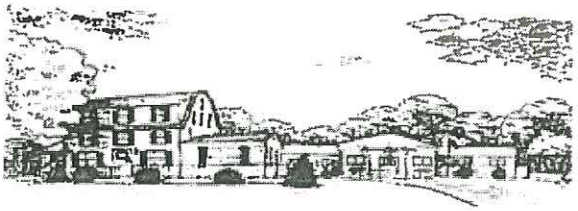
The following (is a / are) violation(s) of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(B)(iii) and/or (2)(D)(iv).

6. Based on record review, observations and interviews for two of nine sampled residents (Residents #9 and #15) who received medications via injections and/or required blood sugar level testing, the facility failed to ensure the staff, who are not certified, did not administer the medications and/or test the blood sugar levels. The findings include:
   a. Resident #9's diagnoses included insulin dependent diabetes mellitus, right above knee amputation and depression. Review of the medical record identified Resident #9 was readmitted to the facility on 7/5/16. The hospital discharge summary dated 7/5/16 directed Insulin Aspart inject 25 units every morning, 15 units at 12:00 PM, 10 units every evening and Insulin Glargine inject 70 units twice daily, discard vials after 28 days of opening. Observations on 7/20/16 identified two vials of insulin with Resident #9's name and no date of open was documented on vials. In an interview on 7/20/16 at 11:45 AM, Resident #9 identified he/she was able to complete the blood sugar testing three times a day as required and would inform the staff of the results. Resident #9 stated the staff provide him/her a syringe with the insulin and he/she administers the insulin, this happens three times daily. Resident #9 identified he/she was legally blind in the left eye. In an interview on 7/20/16 at 2:00 PM, LPN #1 identified the insulins comes in vials and the staff draw up the scheduled type and amount of insulin to be administered. LPN #1 stated she was not aware that the insulin vials were to be dated when opened to discard date the vials after 28 days. Subsequent to surveyor inquiry, the Person-in-Charge identified that a nursing agency has been scheduled to administer Resident #9's insulin starting 7/21/16.
   b. Resident #15's diagnoses included major depression and diabetes mellitus. Review of the medical record identified Resident #15 was admitted to the facility on 6/27/16. The long term care facility discharge summary dated 6/27/16 identified the following medications for treatment of the diabetes mellitus: Humalog Insulin 100 units per millimeter (ml) per the sliding scale before meals and at bedtime and Lantus 40 units subcutaneously at bedtime. The summary identified Resident #15 had been educated on how to check the blood glucose utilizing the glucometer and how to inject insulin. The social service discharge note

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

identified Resident #15 would be followed by a home care agency, appointments had been scheduled by the social worker with the psychiatric and medical doctors, the inter-agency referral report, prescriptions discharge assessment and medications were provided to the resident and conservator and the medication review was discussed with the accepting facility staff. Review of the Medication Administration Records from admission to 7/20/16 identified documentation that Resident #15 had refused the Insulin and glucose testing, therefore Resident #15 did not receive management of the diabetes for greater than twenty (20) days. In an interview and record review on 7/20/16 at 12:30 PM, LPN #1 identified Resident #15 had refused self-blood sugar tests and insulin administration since admission. LPN #1 stated Resident #15 was not established with a primary care physician due to his/her insurance not being accepted in the community. In an interview on 7/20/16 at 2:30 PM, Resident #15 identified he/she had not conducted the blood sugar testing and/or administered the insulin since arriving at the facility and the nurses at the previous facility he/she resided at had completed these treatments. In an interview on 7/21/16 at 3:00 PM, the Person-in-Charge identified Resident #15 returned to the facility on 7/20/16 and communication has been ongoing with the resident's conservator to locate a primary physician.

Approved
8/22/16
KEG



*Fernwood Rest Home, Inc.*
*400 Torrington Road*
*Litchfield, CT. 06759*
*(860) 567-9558 Fax: (860) 567-9593*

August 17, 2016

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigation Section
Department of Public Health
410 Capital Avenue MS # 12HSR
Hartford, CT, 06134

Dear Ms. Gworek:

This letter is in response to the violations which resulted from unannounced visits conducted on July 14, 18, and 20, 2016.

1) To decrease the likelihood of a resident going without prescribed medications we have created the position of Med. Tech. Supervisor. This was done July 1, 2016. The supervisor is to: monitor the ordering of medications in a timely manner, to make sure that any bloodwork necessary for medications to be obtained from the pharmacy is done, to assure that those results reach the pharmacy, and to contact physicians for new orders if necessary. The Person-In-Charge will meet weekly with the supervisor to monitor compliance.
2) Our policy was that control medication could only be destroyed by our RN and the Person-In-Charge. That week our RN was out sick. The control med that was poured in error was double-locked until it could be destroyed according to our policy. Starting today, August 15, 2016 and going forward, we will segregate meds to be destroyed and we will contact our pharmacy and arrange for controls to be destroyed within 3 days of discontinuance or of being poured in error. The Med. Tech. Supervisor will monitor for compliance.
3) The employee involved was disciplined, and educated about resident abuse, both individually and during an in-service on July 28, 2016. As of that date we have begun a program called, "STOP Abuse," which encourages staff to be mindful of what is going on with our residents and within themselves, and to plan and take appropriate steps to meet our residents needs while maintaining respect and dignity. A portion of every monthly in-service will be devoted to this program. All supervisors will monitor for compliance.

4) I reviewed the regulations in regard to reporting abuse and will comply with them going forward. All staff was in-serviced on Abuse; the types, signs of abuse, how to aid residents who have been abused or allege that they've been abused, and reporting requirements on July 28, 2016. Our Recreation Director will monitor for Person-In-Charge's compliance.
5) We have changed pharmacies several times prior to this without incidence. We gave the new pharmacy all the information they needed in order to make the transition; we in-serviced our staff in preparation and during the transition; we requested that the new pharmacy verify orders in the weeks prior to beginning, and they didn't let us know that they were having issues until after their first delivery. To prevent this from happening if we should change pharmacies in the future we have created the position of Med. Tech. Supervisor, July 1, 2016. The supervisor will be responsible for assuring that any new pharmacy has all the information they need in order to transition smoothly; establish a relationship with a contact person at the pharmacy to deal with any issues quickly, and work with our Med. Techs. to assure that all medications are properly reconciled as they come in. The supervisor will keep the Person-In-Charge informed of the transition's progress and any issues that arise. The Person-In-Charge will monitor for compliance.
6) Fernwood's uncertified staff no longer assists residents by drawing up insulin. If a resident is unable to self-administer their finger-sticks and/or insulin, we will secure a home healthcare agency to assist him. Fernwood's Med. Techs. were notified about this policy and the need to date insulin when it is opened, and destroyed after 28 days on July 21, 2016. These points were reiterated at a Med Tech. meeting that was held August 12, 2016. The Med. Tech. Supervisor will monitor for compliance. We will have ongoing monthly Med. Tech. meetings to assure ongoing education. The Person-In-Charge will monitor for compliance.

6b) Prior to admitting a resident, Fernwood will check with discharging facilities, residents, and/or their conservators to ascertain if there are any insurance issues that might impede the resident from getting the medical care they need in this area. The administrative staff will be responsible for getting this information. The Person-In-Charge will monitor for compliance. This policy will take effect August 17, 2016

Sincerely,

Karyn Cosgrove

Karyn A. Cosgrove


*Fernwood Rest Home, Inc.*
*400 Torrington Road*
*Litchfield, CT. 06759*
*(860) 567-9558 Fax: (860) 567-9593*


August 17, 2016

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigation Section
Department of Public Health
410 Capital Avenue MS # 12HSR
Hartford, CT, 06134

Dear Ms. Gworek:

This letter is in response to the violations which resulted from unannounced visits conducted on July 14, 18, and 20, 2016.

I respectfully request an office conference to contest several of the violations.

Sincerely,

Karyn A. Cosgrove

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



# LICENSING INSPECTION REPORT

*D/B/A Name and Address of Entity*

Fernwood Rest Home
400 Torrington Rd
Litchfield CT 06759

*Signature of Survey Staff*

P Thompson

Licensure Category: RCH

Licensed Bed/Bassinet Capacity: 67

Census: 61

**Date(s) of onsite inspection:** 4/7/16

**Date(s) additional information obtained:** _____

**Personnel contacted:** Karyn Cosgrove - Manager

**REVIEW/FINDINGS/PROCESS** (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other*: (e.g. Strike)_____

[ ] Visit **OR** Revisit for the purpose of _____

[ ✓ ] See Complaint Investigation # 197155

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies **were** identified at the time of this inspection. See attached violation letter dated _____

[ ] Desk Audit _____ [ ] Amended Letter date: _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referred to: _____.

REPORT SUBMITTED BY: _____ DATE OF REPORT: 4/15/15

[ ] Approval for issuance of license granted by: _____ DATE: _____
Supervisor/Title

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 25, 2016

Karyn Adkins Cosgrove, Person-in-Charge
Fernwood Rest Home Inc
Torrington Road, Po Box 548
Litchfield, CT 06759

Dear Ms Cosgrove:

An unannounced visit was made to Fernwood Rest Home Inc on April 7, 2016 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 visit.

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 May 9, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

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.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Karen Gworek RN SNC

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

KEG/PT:jpf
c. Nancy Shaffer

CT#19755

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATE OF VISIT: April 7, 2016

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(D)(iv) and/or (2)(F)(ii).

1. Based on review of resident records, interviews and facility documentation for three of four sampled residents (Residents #1, #2 and #3) who were reviewed for medication administration, the facility failed to administer medication in accordance with the physician's order. The findings include:
    a. Resident #1's diagnoses included diabetes, depression, chronic pain and anxiety. Review of the Medication Administration Record (MAR) dated 1/12/16 through 3/1/16, a physician's order dated 2/1/16 directed to administer Clonazepam 0.5 milligram (mg) every morning and 1.0 mg at bedtime and take 0.5 mg daily as needed for anxiety. Review of the Controlled Substance Disposition Record dated 2/20/16 identified that at 8:30 AM two (2) tablets of 0.5 mg to equal 1.0 mg were signed out as administered, therefore the resident received an extra 0.5 mg of Clonazepam. Review of the Reportable Event Form dated 2/20/16 identified Resident #1 received 1.0 mg of Clonazepam at 8:30 AM. The investigation identified a certified med technician administered the Clonazepam on 2/20/16 at 8:30 AM. The certified med technician received a one (1) day suspension and Resident #1 had no apparent ill effects from the medication error.
    b. Resident #2's diagnoses included depression, diabetes mellitus, arthritis and chronic kidney disease. A physician's order dated 2/3/16 directed to administer Endocet 10-325 mg one table every four (4) to six (6) hours. Dilaudid 2 mg one (1) to two (2) tablets every four (4) to six (6) hours as needed for severe pain and hold the Endocet. Review of the Controlled Substance Disposition Record dated 2/6/16 identified both the Endocet and Dilaudid were administered at 10:00 AM despite the order to hold the Endocet. The Reportable Event Form dated 2/6/16 identified Resident #2 received Dilaudid 2 mg and Endocet 10-325 mg on 2/6/16 at 10:00 AM. The Person-in-Charge was unable to provide documentation of the facility's investigation.
    c. Resident #3's diagnoses included bipolar disorder and substance abuse. A physician's order dated 10/29/15 directed to administer Endocet 10-325 mg one tablet every four (4) to six (6) hours as needed for chronic pain, maximum three (3) tablets daily. A physician's order dated 10/29/15 directed to administer Klonopin 1 mg every eight (8) hours, at 6:00 AM, 2:00 PM, and 10:00 PM. Review of the Controlled Substance Disposition dated 12/7/15 at 3:00 PM identified the Klonopin 1 mg was documented was administered on 12/7/15 at 8:30 AM and 5:00 PM by the same certified med technician. The Reportable Event Form dated 12/7/16 at 3:00 PM identified the Klonopin 1 mg was documented as having been administered at 5:00 PM. Facility investigation identified the certified med technician was scheduled on 12/7/15 for the 7:00 AM- 3:00 PM shift. The documentation indicated that the certified med technician signed out the Klonopin at 3:00 PM, gave the medication to Resident #3 who was going out and had requested to take the 6:00 PM dose with him/her. The certified med technician was instructed to sign out the time she removed the medication and note the Leave of Absence on the medication record. The Reportable Event Form dated

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

12/11/15 identified Resident #3 received an extra dose of Endocet 10-325 mg. The investigation identified a certified med technician administered the Endocet at 10:00 PM, Resident #3 had received the Endocet at 8:30 AM, 2:00 PM and 6:00 PM prior to the 10:00 PM dose, therefore exceeding the maximum number of doses on 12/11/15. The certified med technician received education and one day suspension. Resident #3 had no apparent ill effect from the medication error. In an interview on 4/7/16 at 9:30 AM, the Person-in-Charge identified that she has been more cognizant of the certified med technician administering and documenting medication per physician's order correctly and has requested Connecticut Pharmacy to audit the medication administration in the facility. The Person-in-Charge also identified that the certified med technician had been disciplined and received education for the numerous medication errors, four (4) of which are addressed in the above paragraphs. In an interview on 4/7/16 at 12:30 PM, the Registered Nurse, RN #1, identified the certified med technician has made many medication errors and believes this was due to her hastiness and oversight while working. As part of the disciplinary process, RN #1 provided medication administration in-service for all staff.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5).

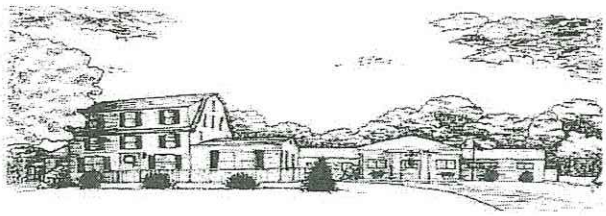
2. Based on record review, observations and interviews for one of three sampled residents (Resident #7) who are current smokers, the facility failed to ensure the resident did not have smoking material in his/her possession. The findings include:
   a. Observations of the smoking area on 4/7/16 at 10:25 AM identified Residents #5 and #6 smoking independently in the designated smoking area, both residents had been assessed as independent smokers on 3/17/16. Observations of the smoking area on 4/7/16 from 11:30 AM to 11:45 AM, the scheduled smoking time, identified ten (10) residents; five (5) residents were assessed as independent smokers and five (5) as supervised. Review of the list of residents who currently smoke identified eight (8) residents who required supervision. A staff attendant was present during the smoking cession and assisted each supervised smoker with lighting their cigarette when issued from a locked container. Multiple ashtrays were available in the area and a fire extinguisher within close proximity the staff attendant remained with the supervised residents until their cigarette was extinguished. In an interview on 4/7/16 at 11:45 AM, the staff attendant explained that smoking material for the supervised smokers are kept in a locked box within a locked box attached to the shelf in the linen room and the keys are kept at the nurse's station. The staff attendant identified if an independent smoker provided a supervised smoker with smoking material, the independent smoker would lose their smoking privileges which was something they would not want. Observations on 4/7/16 at 1:50 PM identified a resident, Resident #7, was noted to be outside in with an unlit cigarette by a non-smoking area. Resident #7 refused to tell staff how he/she obtained the cigarette. The cigarette was obtained from the resident, the resident and the resident's room were searched and no smoking material was found. Resident #7 had been assessed as a supervised smoker on 3/17/16. In an interview on 4/7/16 at 2:00 PM, the

DATE OF VISIT: April 7, 2016

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Person-in-Charge identified Resident #7 will go around asking for a cigarette from other residents and she was looking into the behavioral group to provide assistance with the resident. The Person-in-Charge stated after 10:30 PM there was no supervised smoking and independent smokers are allowed to go out at any time to smoke. The only door unlocked after 10:30 PM leads to the smoking area which is close to the nurse's station where the night shift staff are able to visualize who is going out. The Person-in-Charge identified she was not aware of any supervised smokers going outside after 10:30 PM.

Approved 5/10/16 KEG



*Fernwood Rest Home, Inc.*
***400 Torrington Road***
***Litchfield, CT. 06759***
***(860) 567-9558 Fax: (860) 567-9593***

May 9, 2016

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigation Section
Department of Public Health
410 Capital Avenue MS # 12HSR
Hartford, CT, 06134

Dear Ms. Gworek:

This letter is in response to the violations which resulted from an unannounced visit conducted on April 7, 2016.

1a-c) The Med. Tech. in question has been duly disciplined/educated as will all Med. Techs/Nurses who make medication errors. We will continue to have regular Med. Tech/Nurse's in-services. We will continue to have our pharmacy do unannounced audits of our medication administration procedures, a minimum of bi-monthly. A new policy which states that any Med. Tech/Nurse who makes six medication errors that do not result in significant injury within a three month period will be required to re-take the Med. Administration course. Med. Techs/Nurses will be in-serviced regarding this policy by May 15, 2016. Our RN will monitor for compliance.

2) Resident #7 has been, and will remain on q15 min. checks as long as she exhibits non-compliance with the smoking rules. Her psychiatric medication has been changed; nicotine nasal spray may also be added to her treatment. She attends smoking cessation classes. A behavioral modification program is being established for her. Completion date for the program and staff instruction is May 30, 2016. Our RN will monitor for compliance.

Sincerely,
Karyn A. Cosgrove