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

IN RE: Fernwood Rest Home, Inc. of Litchfield, CT
d/b/a Fernwood Rest Home, Inc.
Torrington Road, P.O. Box 548
Litchfield, CT 06759

CONSENT ORDER

WHEREAS, Fernwood Rest Home, Inc. of Litchfield, CT ("Licensee"), has been issued License No. 1699-RCH to operate a Residential Care Home known as Fernwood Rest Home, Inc., located at 400 Torrington Road in Litchfield, Connecticut ("Facility") under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and,

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates commencing on March 10, 2015 and concluding on July 20, 2016; and,

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated March 16, 2015, September 23, 2015, December 30, 2015, and August 3, 2016 (Exhibit A – copy attached); and,

WHEREAS, office conferences regarding the September 23, 2015 and December 30, 2015 violation letters were held between the Department and the Licensee on August 10, 2015, September 23, 2015, October 21, 2015, and February 4, 2016, and,

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, its Section Chief, and the Licensee, acting herein and through Karyn Adkins Cosgrove, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Consultant ("IC") pre-approved in writing by the Department within two (2) weeks of the effective date of this Consent Order. The IC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the IC and any other costs associated with compliance with this Consent Order. Failure to pay the IC in a timely basis and in accordance with the contract, as determined by the Department in its sole and absolute discretion, shall constitute a violation of this Consent Order. Failure to pay the costs associated with the IC's duties may result in a fine not to exceed one thousand ($1000.00) dollars per day until such costs are paid.

2. The IC shall function in accordance with the FLIS's IC Guidelines (Exhibit B - copy attached). The IC shall be a Licensed Nursing Home Administrator ("LNHA") who holds a current and unrestricted license in Connecticut. The LNHA assuming the functions of the IC shall not be included in meeting any staffing requirements of the Regulations of Connecticut State Agencies. The IC shall provide consulting services for a minimum of sixty (60) days at the Facility unless the Department identifies through inspections or any other information that the Department deems relevant that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The IC shall be at the Facility twelve (12) hours per week for the first two weeks, then, at the discretion of the IC after consultation with the Department, a minimum of six hours per week and a maximum of twelve (12) hours per week for the following six (6) weeks. The IC shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the IC at the end of the sixty (60) day period and may, in its sole and absolute discretion, reduce or increase the hours of the IC and/or responsibilities, if the Department determines, based upon any information it deems relevant, that the reduction or increase is warranted. The terms of the contract executed with the IC shall include all pertinent provisions contained in this Consent Order. The Department shall base any decision regarding a reduction in the hours of services of the INC upon onsite inspections

conducted by the Department and based on all other information the Department deems relevant.

3. The IC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the residents and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.

4. The IC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within three (3) weeks after the execution of this Consent Order. The assessment shall include an evaluation of the duties and responsibilities of the Person-In-Charge assigned to such person and the ability and skill of the person currently functioning in that role to execute that role. During the initial assessment, if the Independent Consultant identifies any issues requiring immediate attention, s/he shall immediately notify the Department and the Licensee for an appropriate response.

5. The IC shall confer with the Person-in-Charge and other staff determined by the IC to be necessary to the assessment of services and the Licensee's compliance with state law and regulation.

6. The IC shall make recommendations to the Licensee for improvement in the delivery of resident care in the Facility. If the IC and the Licensee are unable to reach an agreement regarding the IC's recommendation(s), the Department, after meeting with the Licensee and the IC shall make a final determination, which shall be binding on the Licensee.

7. The IC shall submit written reports every other week to the Department documenting:
    a. The ability of the Person-in-Charge to execute his/her duties;
    b. The IC's assessment of the care and services provided to residents;
    c. Whether the Licensee is in compliance with applicable federal and state statutes and regulations; and,
    d. Any recommendations made by the IC and the Licensee's response and implementation of the recommendations.

8. Copies of all IC reports shall be simultaneously provided to the Person-in-Charge and the Department.

9. The IC shall have the responsibility for:

   a. Reviewing the duties and responsibilities assigned to the Person-In-Charge;

   b. Assessing the ability and skill set of the Person-In-Charge and capacity to execute the duties and responsibilities associated with the role to include, but not be limited to:

      i. Existing knowledge of the role;

      ii. Situational judgement;

      iii. Competency;

      iv. Identification of knowledge gaps; and

      v. Identification of developmental needs.

   c. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on resident rights, resident smoking, medication administration, reporting of unusual incidents and/or allegations of abuse to appropriate authorities, reporting significant issues to physicians, infection control, and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;

   d. Assessing, monitoring, and evaluating the coordination of resident care and services delivered by the Licensee;

   e. Recommending to the Department an increase in the IC's contract hours if the IC is unable to fulfill the responsibilities within the stipulated hours per week; and

   f. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letters dated March 16, 2015, September 23, 2015, December 30, 2015, and August 3, 2016 (Exhibit A).

10. The Person-in-Charge shall meet with the Department every two (2) weeks for the duration of the IC's tenure and then monthly thereafter for a period of one year. The first meeting must be in person at the Department, and subsequent meetings may be conducted by phone conference at a time agreeable to the Licensee and the Department. The meetings shall include discussions of issues related to the care and services provided by

the Licensee, the Person-In-Charge's abilities and the Licensee's compliance with applicable federal and state statutes and regulations.

11. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the IC and the Department, upon request.

12. The Department in its absolute and sole discretion, shall retain the authority to extend the period the IC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and any other information the Department deems relevant.

13. Within fourteen (14) days of receipt of the IC's initial assessment, the IC and the Peron-in-Charge shall develop and/or review and revise, as necessary, policies and procedures related to resident rights, resident smoking, medication administration, reporting of unusual incidents and/or allegations of abuse to appropriate authorities, reporting significant issues to physicians, and infection control.

14. Within twenty-one (21) days of the receipt of the IC's initial assessment, all appropriate staff shall be inserviced, to the policies and procedures identified in paragraph number thirteen (13).

15. Effective upon the execution of this Consent Order, the Licensee, shall ensure substantial compliance with the following:

    a. Sufficient personnel are available to meet the needs of the residents;
    b. Residents shall be free from abuse, neglect, intimidation, retaliation, and misappropriation of property;
    c. Resident rights;
    d. Resident treatments, therapies and medications are administered as prescribed by the physician;
    e. Staff orientation upon hire;
    f. Smoking assessments are performed in a timely manner and accurately reflect the condition of the patient;

g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline medical condition, deviation from ordered medications and/or blood sugar testing, deterioration of mental, physical, nutritional, and/or hydration status;

h. Resident's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;

i. All resident care shall be provided in accordance with recognized standards of care;

j. Medication safety;

k. Ensure appropriate staff have been credentialed to provide medication administration;

l. Maintain documentation for narcotic reconciliation in accordance with state laws and regulations;

m. Continuing annual education for all Facility staff to include but not be limited to emergency procedures, resident rights, behavioral management, and resident safety; and

n. Unusual incidents including, but not limited to medication errors, generator issues, facility fires, allegations of abuse/mistreatment are thoroughly investigated, tracked and monitored.

16. The Licensee, within three (3) days of the execution of this Consent Order, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

17. Any reports required by this Consent Order shall be directed to:

Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

18. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law. The allegations and findings contained in Exhibits A shall be deemed true in any subsequent proceeding in which the licensee's compliance with the Consent Order is at issue or the licensee's compliance with Connecticut statutes and regulations and/or with federal statutes and regulations is at issue.

19. The Licensee agrees that this Consent Order will be reported consistent with federal and state law and regulations and consistent with Department policy. In addition, the Licensee agrees that this Consent Order will be posted on the Department's website.

20. The Licensee agrees that this Consent Order does not limit any other agency or entity in any manner including but not limited to any actions taken in response to the factual basis of this Consent Order.

21. The execution of this Consent Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

22. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this Consent Order unless otherwise specified in this Consent Order.

23. The Licensee agrees that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the

Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

24. Should the Licensee not be able to maintain substantial compliance with the requirements of this Consent Order and the requirements of the statutes and regulations related to residential care homes, the Department retains the right to issue charges including charges related to the allegations identified in the March 16, 2015, September 23, 2015, December 30, 2015, and August 3, 2016 violation letters referenced in this Consent Order.

25. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

Karyn Adkins Cosgrove, President

On this 12th day of September, 2016, before me, personally appeared Karyn Adkins Cosgrove who acknowledged herself to be the President of Fernwood Rest Home, Inc. of Litchfield, CT and that she, as such President being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by herself as President.

My Commission Expires: Sept 30, 2018
(If Notary Public)

Bernadeta Eichner
Notary Public [X]
Commissioner of the Superior Court [ ]

BERNADETA EICHNER
NOTARY PUBLIC
My Commission Expires September 30, 2018

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: Barbara Cass
Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section

September 13, 2016

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

March 16, 2015

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

Dear Ms Bariffe:

An unannounced visit was made to Fernwood Rest Home Inc on March 10, 2015 by a representative 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.

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 March 30, 2015 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:mb
cc. Nancy Shaffer

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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DATE(S) OF VISIT: March 10, 2015

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 (b) Physical plant (S) and/or (c) Administration (1) (5) and/or (h) General Conditions (6).

1. Based on observations and interviews, the facility failed to maintain the environment to ensure the health, comfort, cleanliness and/or safety of the residents. The findings include:
   a. On 3/10/15, during the tour of the facility, the following observations were identified:
   On the first floor in the main kitchen there were food stains and spills inside the freezer in the white refrigerator. In the stainless steel upright freezer and in the stainless steel freezer counter top there was no thermometers inside to monitor food temperatures. In the main dining room in the white refrigerator the bottom floor was rusted and no thermometer was located inside. In the storage room located in the dining room there was no thermometer inside the deep freezer.
   In the laundry room next to the kitchen there was an accumulation of dirt and dust in the ceiling vent and there were dried water leak stains to ceiling tiles in the room.
   On the second floor in the bathroom next to Room 31, above the sink and next to the paper towel dispenser the wall paper was peeling from the sheetrock and there was a missing towel holder from the metal frame that was mounted to the wall. Interview with the Person in Charge identified the problems.

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

2. Based on observation, the facility failed to maintain equipment in good state of repair to function properly. The findings include:
   a. Observations on 03/10/15 during the dishwashing process on the low temperature dish machine, the gauge needles read for the wash cycle and the rinse 115 degrees Fahrenheit and that the gauges were not working properly. Further observations identified a chemical solution base connected to the dishwasher during the dish wash process. Interview with the kitchen staff attendant in charge identified that the dishwasher had a chemical solution combination attached to the dishwasher so it can sanitize during the rinse cycle. Interview with the Person in Charge identified that there was no booster to maintain the proper rinse cycle temperatures to appropriately sanitize the dishes.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (4)(A)(B) and/or (c) Administration (5).

3. Based on review of personnel files and interviews, the facility failed to ensure that reference checks were conducted upon the hiring process in the facility. The findings include:
   a. On 3/10/15 review of the personnel files for Staff Person #1 hired on hire 3/3/15 and Staff Person #2 date of hire 3/3/15 failed to reflect documentation that reference checks were conducted during the hiring process. Interview with the Person in Charge identified

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

that the reference checks were obtained verbally and she did not document the information to show that reference checks were conducted.

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (5) 19a-550.

4. Based on observations and interview, the facility failed to post and/or provide a system of communication that is sufficient to meet to needs of the residents and the requirements of the state health department. The findings include:
   a. During the facility tour on 3/10/15, there was no posting of the Resident Rights in the facility. Interview with the Person in Charge identified the problem.

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

5. Based on observations and interview, the facility did not ensure that the generator transferred the emergency power to the facility within ten seconds as required according to the State of Connecticut Fire Safety Code requirements. The findings include:
   a. On 3/10/15, during the testing of the generator, there were three observations that the transfer switch of the power exceeded the ten seconds time required according to Connecticut Fire Safety Code regulations. Subsequent to the surveyor's inquiry, the Maintenance person notified their outside generator company to respond to a repair call to correct the problem immediately.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

September 23, 2015

Karyn Adkins Cosgrove, Licensee
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 21, 23, and August 6 and 19, 2015 by representatives 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 October 7, 2015 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.

If there are any questions, please do not hesitate to contact this office at (860) 509-7472.

Respectfully,

Karen Gworek RN SNC

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

KEG:mb

c. Nancy Shaffer

Complaint #18246, #18429, #18436, #18713

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P.O. Box 340308 Hartford, CT 06134
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DATES OF VISIT: July 21, 23, August 6, and 19, 2015

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

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).

1. Based on clinical record reviews, review of facility documentation and interviews for one of two sampled residents (Resident #19) who had a verbal altercation with a staff member, the facility failed to ensure the resident was free from abuse. The findings include:
   a. Resident #19's diagnoses included ventral hernia and leukocytosis. The Reportable Event Form dated 5/2/15 identified that the cable box was missing from Resident #19's room. The report indicated that the Person-in-Charge had received a telephone call from a resident who reported that an employee, Staff Attendant #4, had disconnected the cable box and hid the box in the linen room. The incident resulted when Resident #19 had called the attendant names and Attendant #4 decided to that Resident #19 needed to be punished for his/her actions. The investigation dated 5/4/15 identified that Attendant #4 was terminated on 5/2/15. Interview with the Person-in-Charge on 7/21/2015 at 10:30 AM identified that Attendant #4 felt that there should be consequences to the resident's negative behavior. Attempts to contact Attendant #4 were unsuccessful. Review of facility bill of rights identified that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (C) Administration (4).

2. Based on clinical record reviews, review of facility documentation and interviews for one of two sampled residents (Resident #1) who had a verbal altercation with a staff member, the facility failed to ensure the resident was treated with respect. The findings include:
   a. Resident #20's diagnoses included adjustment disorder. The Reportable Event Form dated 8/12/15 at 7:45 PM identified Resident #20 and Attendant #5 were in the hallway and Attendant #5 was observed by Attendant #2 to be verbally abusive to Resident #20. Attendant #2 called the Person-in-Charge to report the incident and requested her assistance. Interview with Resident #20 on 8/19/15 at 9:30 PM identified that when he/she went down to the dining room to get the evening snack, Attendant #5 ignored him/her and yelled stating that Resident #20 was not to be served in the dining room and she would bring the snack to his/her room. Interview with Attendant #2 on 8/19/15 at 1:00 PM identified that she did not hear what occurred in the dining room but she did hear the verbal altercation in the hallway when the verbal exchange between the two got a little loud. Attendant #2 stated that Resident #20 does not like Attendant #5. Attendant #2 stated she called the Person-in-Charge to tell her that they were arguing. Interview with Attendant #5 on 8/19/15 at 12:30 PM identified that Attendant #2 asked her to pass out snacks and Resident #20 was supposed to eat in his/her room. Attendant #5 stated that she got out grapes for Resident #20 and the resident yelled at her. Attendant #5 stated that she may have gotten a little loud but at no time did she slam the doors and have an attitude after the event. Attendant #5 stated that she had previously discussed with the Person-in-Charge the relationship between

her and Resident #20 and felt that the resident was targeting her. Interview with the Director of Maintenance on 8/19/15 at 1:30 PM identified that he did not witness the altercation. Interview with the Person-in-Charge on 8/19/15 at 2:30 PM identified that Attendant #5 was suspended for one day and was inserviced as to resident abuse and resident rights. Review of resident's bill of rights directs that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

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

3. Based on clinical record reviews, review of facility documentation and interviews, the facility failed to ensure that the environment was safe from hazards regarding the smoking policy and procedure. The findings include:
   a. Review of facility documentation dated 6/21/15 identified Resident #5 was observed smoking outside at 4:00 AM and at 11:00 AM. On 6/25/15 Resident #5 was found smoking outside in the front of the building and on 6/28/15 after dinner. Interview with the Person-in-Charge on 7/21/15 at 12:45 PM identified there are five residents that require supervision while smoking and Resident #5 was one of the supervised smoker. The Person-in-Charge indicated that Resident #5 has a behavior and begs other residents for cigarettes.
   b. Resident #14's diagnoses included a terminal illness, chronic obstructive pulmonary disease, chronic pain, depression, bipolar disease and post-traumatic stress disorder. Resident #14 was admitted to the facility on 7/17/15. Review of facility documentation identified Resident #14 fell on 7/17/15 in the smoking area and refused to be transferred to acute care. Further review of the notes identified Resident #14 appeared "out of it" off balance and could barely keep his/her eyes open. Resident #14 fell again on 7/20/15, was transferred to the hospital and returned to the facility with a shoulder injury and wearing a sling. Observations of Resident #14 while outside smoking unsupervised on 7/21/15 at 3:15 PM identified the resident dozing. Interview with the Person-in-Charge on 7/21/15 at 3:30 PM identified that Resident #14 was admitted on 7/17/15 and had not been assessed for smoking until 7/20/15 at which time the assessment identified that the resident required supervision while smoking. The Person-in-Charge indicated that the resident probably smoked prior to the completion of the smoking assessment. The Person-in-Charge identified that the Registered Nurse was present in the facility Monday through Thursday and not available on the other days to complete the smoking assessment and there was no contingency plan in place to complete smoking assessments when she is not in the building.
   c. Review of resident's bill of rights identified that residents have the right to reasonable accommodation of your individual needs and preferences, except when your health or safety or the health or safety of others would be endangered. Review of facility policy identifies that smoking is not allowed indoors anywhere at the facility. The policy specifies that if a resident smokes, they must smoke outside in one of the designated

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

smoking areas. Interview with the Person-in-Charge on 7/21/15 at 12:45 PM identified that the doors to the facility are closed at 9:00 PM except the end door at the nursing station. That door remains open until 11:00 PM for the smokers. After 11:00 PM residents may sign themselves out at any time.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (C) Administration (1) and/or (d) Medical Supervision.

4. Based on clinical record reviews, review of facility documentation and interviews, the facility failed to assist and/or provide the appropriate services for residents who had substance abuse. The findings include:

   Review of facility documentation dated 6/1/15 through 7/21/15 identified numerous incidents reflecting ongoing use of alcohol by residents and exhibiting behaviors.

   a. Resident #2's diagnoses include emphysema, osteoarthritis, depression and alcohol abuse. Resident #2 was admitted to the facility on 5/30/14. Review of facility documentation identified that there were repeated incidents in which Resident #2 had consumed alcohol and then had incidents of aggressive behaviors towards staff and/or other residents. The documentation from 6/1/15 through 7/15/15 identified that on 6/6/15 Resident #2 was found drinking and on 6/9/15 Resident #2 was observed to be drunk, loud, verbally rude and threw a bag in which contained a metal cigarette rolling machine at Staff Attendant #2 and (Licensed Practical Nurse (LPN) #1. Both the police and emergency technicians were called to the facility. On 6/11/15 Resident #2 was observed to be drunk and stated that "he/she was going out to get more." Documentation did not reflect whether the resident had purchased more. Facility documentation dated 6/15/15 identified Resident #2 as drunk, loud and rude and was observed pushing his/her wheelchair into Resident #17. On 6/18/15 Resident #2 was drunk and his/her roommate requested a change in rooms. On 7/4/15 identified Resident #2 was drinking and two bottles of liquor were noted in Resident #2's room. On 7/15/15 two empty bottles of vodka were observed in the dumpster. Interview with LPN #1 on 7/21/15 at 3:30 PM identified that Resident #2 becomes very aggressive when drinking and there have been incidences in the past when the resident had demanded narcotics and she refuses to administer the medication when Resident #2 is drinking.

   b. Resident #3's diagnoses include alcohol dependency syndrome, anemia, anxiety state, depression and diabetes mellitus. Resident #3 was admitted to the facility on 3/24/15. Review of facility documentation from 6/3/15 through 7/23/15 identified that on 6/30/15 Resident #3 had a blood sugar in the 30's, was unresponsive with eyes rolled back, sweaty and was sent to the Emergency Department (ED). The facility documentation identified that Resident #3 was transferred to the ED on 7/4/15 and on 7/11/15 with low blood sugar levels. On 7/23/15 Resident #3 had a blood sugar of 31, fell to the floor and hit his/her head. Interview with the Person-in-Charge on 7/22/15 at 10:00 AM identified that Resident #3 continues to drink heavily and doesn't eat which in turn affects his/her blood sugars. The Person-in-Charge stated that her understanding was Resident #3 had

been going to Alcohol Anonymous prior to admission and was not going at the current time. Interview with Staff Attendant #1 on 7/22/15 at 11:30 AM identified that when Resident #3 drinks alcohol, he/she doesn't eat and his/her blood sugar drops. Staff Attendant #1 stated that Resident #3 hides the alcohol in his/her room.

c. Resident #6's diagnoses included hepatic encephalopathy, anemia, and alcohol abuse. Resident #6 was admitted to the facility 8/22/14. A physician's order dated 12/7/14 directed Resident #6 not be allowed to have alcoholic beverages. Review of facility documentation dated 6/6/15 identified Resident #6 was observed with a bag containing alcohol, on 6/9/15 was observed to be drunk and swearing at staff, on 6/10/15 Resident #6's room had a strong odor of alcohol and was swearing at staff utilizing foul language. On 6/18/15 Resident #6 was observed to be drinking again and on 7/10/15 Resident #6 admitted he/she had been drinking and his/her medications were held.

d. Review of facility documentation dated 7/9/15 identified staff had noted a strong odor in the hallway that had the aroma of marijuana. Facility documentation dated 7/14/15 identified that Resident #7 was found on the ground outside by the door. Resident #7 stated that he/she found something on the ground and smoked it. Interview with the Person-in-Charge on 7/23/15 at 10:30 AM identified there are approximately three or four residents who are suspected of smoking marijuana but because of resident right issues, staff are unable to search the rooms. Interview with the Person-in-Charge on 7/21/15 at 11:45 AM identified that she recognized there was a problem with some residents and alcohol in their rooms. However, she feels constrained as to wanting to keep the stability in the facility and with their responsibility to protect the rights of residents. Interview with the Resident Council President on 7/21/15 at 1:30 PM identified that the facility currently has a combination of residents who drink a lot and many residents with significant behavioral symptoms. The Resident Council President indicated the staff are not prepared and do not know how to care for these type of residents and currently there are no ramifications for those residents who are not following the rules. Interview with Staff Attendant #2 on 7/21/15 at 2:00 PM identified that staff have wanted to search rooms when residents are drinking but have been told that it was violation of resident rights. Staff Attendant #2 stated that there are limited staff scheduled for nights and they are often apprehensive about their safety. Review of facility policy directs that residents are asked not to use language that is rude, crude or demanding of others and they are never to approach anyone in an aggressive, abusive or sexual manner. Review of facility policy on alcohol use identified that the facility does not allow alcohol consumption on premises unless the resident has a script from a physician giving them permission to consume alcohol. Alcohol can be consumed off the premises. The drinking of alcoholic beverages is however discouraged, only because many residents are taking medications that can interact badly with the alcohol. Any resident who purchases alcoholic beverages to drink in the facility may not share those beverages with another resident. If residents are found with alcohol in their possession, it will be destroyed. The continued use of alcohol leading to aggressive or destructive behaviors may lead to residents being recommended to leave the facility. Interview with

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

the Person-in-Charge on 7/21/15 at 11:45 AM identified that the alcohol policy was implemented in March 2015 and although having alcohol in the facility was prohibited, it is difficult to enforce due to the potential for violating resident rights to privacy, therefore the staff did not ensure there was no illegal contraband (marijuana) in resident rooms. Staff have attempted to initiate room searches of residents who appear to be drinking but the process had to stop because it was felt that it was a violation of the resident's rights.

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

5. Based on review of facility documentation and interviews, the facility failed to ensure the accurate documentation, administration and/or safe keeping of medications. The findings include:
   a. Facility documentation dated 7/9/15 identified that a package containing three (3) tablets of Valium for Resident #16 were missing. Interview with LPN #1 on 7/21/15 at 3:45 PM identified she called the pharmacy and was informed that the order had changed but they were unable to determine what happened to the three doses of Valium. Interview with the Person-in-Charge on 7/23/15 at 10:00 AM identified that the conclusion was the Valium had been administered and the sheet was put away, however there was no documentation of an investigation to the incident and/or the incident was reported to the state agency.
   b. Review of facility documentation dated 7/3/15 identified the Resident #10's was ransacked and his/her medications were missing. Resident #10's medications were signed out for 7/3/15 and from 7/4/15 through to 7:00 AM on 7/5/15. A note written by LPN #1 identified that Resident #10's medications were packaged and given to him/her and were place in the drawer which did not lock properly. LPN #1 informed Resident #10 that medications should not be pre-packaged and given to the resident to self-administer unless the resident was physically leaving the facility. This was discovered on 7/3/15. Resident #10 would not be receiving additional medications until Sunday 7/5/15 because there was no way to determine what had happened to the medications and if the resident had taken them himself. Interview with the Person-in-Charge on 7/23/15 at 10:00 AM identified that there was unable to determine what happened to the medications.
   c. Resident #8's diagnoses included schizophrenia, hypertension and arthritis. Review of the physician orders from 6/28/15 through 7/25/15 identified the medication Trazadone 100 milligrams (mg) at bedtime as needed for insomnia and a notation for Ativan. Interview with Staff Attendant #1 on 7/23/15 at 11:30 AM identified that although Resident #8 had an order for the Ativan, if Resident #8 were to get anxious through the nighttime the facility could not administer the Ativan because an outside agency administers medications twice a day and the staff do not have access to the medications.
   d. Resident #12's diagnoses included depression, diabetes, and arthritis. Review of the

physician orders from 5/24/15 through 6/20/15 directed Enoxaparin 40 milligrams /0.4 milliliter syringe, inject syringe subcutaneously every day, stop when the International Ratio (INR) was greater than two and Warfarin 4 mg for five days and one half tab for one day and hold one day. Review of facility documentation dated 6/10/15 identified that there was a new Coumadin order dated 6/8/2015 but the Coumadin had not been received as of 6/10/15. The Advanced Practice Registered Nurse (APRN) communication dated 6/12/15 identified Resident #12's INR was currently elevated with symptoms. Resident #12 was directed to take Vitamin K for two days and hold INR for the next two days. (There was no clarification with the APRN regarding hold INR versus hold the Coumadin). The APRN further directed staff to recheck INR on Monday and Coumadin will be titrated at that time. Review of documentation dated 6/15/15 identified that Resident #12 had an INR drawn on 6/15/15 with a subsequent order for Coumadin 4 mg Monday through Friday with 2 mg on Saturday and Sunday. A notation dated 6/15/15 identified the new dosage of Coumadin had not come in. Review of the June 2015 MAR failed to reflect that the Warfarin was held as directed and that Vitamin K was administered. Review of facility documentation failed to reflect the change in the Coumadin or the administration of Vitamin K. Interview with Staff Assistant #2 on 7/23/15 at 10:00 AM identified that there often was a problem procuring the correct dose of Coumadin after the bloodwork was completed and the physician was notified. Staff Assistant #2 stated there was often a delay in the physician sending the order to the pharmacy and the medication being delivered by the pharmacy.

e. Interview and review of the Medication Administration Records with Staff Assistant #2 on 8/24/15 at 1:30 PM identified that the Medication Administration Record (MAR) do not address each time the dose of medication was to be administered and if a medication was held and/or refused this would not be reflected on the MAR. If a medication was held staff would currently write an H (Hold) on the back of the blister pack and if there was a one-time order for a medication the administration of the medication should be documented in the facility notes. Interview with Pharmacy Technician #1 on 8/24/15 at 2:00 PM identified that when the pharmacy was first involved, the facility was given the opportunity to choose the system of documentation on the MAR and the current system does not reflect what time a medication was administered and/or when a medication not given and/or if there was a one-time administration of a medication.

f. Review of facility documentation dated 6/20/15 identified that Resident #17 was found sleeping outside the facility so the staff decided to check his/her room without the resident's knowledge. When pills, no specific medication was indictaed, were found in Resident #17's room the Staff Attendant held the pain medications that night. The documentation failed to reflect that the physician was notified and/or that the resident had requested pain medication through the night hours.

g. Review of facility documentation dated 7/13/15 identified Resident #16 did not receive a prescribed antibiotic on 7/11/15, 7/12/15, and 7/13/15. However the documentation indicated that Resident #16 had refused all medications xcept the narcotics. The documetnation failed to reflect that the physician had been notified.

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

h. Review of facility documentation dated 7/9/15 regarding Resident #10, #13 and #18 identified that the date of the MAR reflecting medication administration did not correspond to the current date on the medication card. This means that although the medications are signed out on the MAR the pharmacy card reflects that the residents did not receive the medications for one day.

i. Review of facility documentation dated 7/1/15 identified Resident #13 received a double dose of Lorazepam. The morning blister pack and evening pack both had Lorazepam in them. The morning blister pack was stored in the drawer with the daily medications and the other package was stored in the locked cabinet with the narcotics and staff prepared the Lorazepam from both packages since 6/27/15. The Reportable Event Form dated 7/1/15 identified that R#13 was administered a double dose of Lorazepam from 6/27/15 through 7/1/15.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (C) Administration (5) and/or (h) General Conditions (3).

6. Based on review of facility documentation and interviews, the facility failed to notify and/or investigate accidents, disaster and/or other unusual occurrence within seventy two hours to the department of health. The findings include:
   a. Review of facility documentation dated 6/27/15 identified at approximately 3:30 PM the fire department was called because the dryer was burning. Interview with the Person-in-Charge on 7/21/15 at 2:30 PM identified that the dryer needed to be cleaned and was not utilized for a short time. The Person-in-Charge indicated that the incident was not reported to the Department of Public Health.
   b. Review of facility documentation identified that the facility failed to report and investigate the following resident to resident and resident to staff altercations incidents to the Department of Public Health. On 6/1/15 Resident #4 had barricaded his/her room, threw a light at the staff and threatened to kill staff and was transferred to the hospital for an evaluation. On 6/5/15 Resident #8 was observed to have his/her hands on the breasts of Resident #1 while in the dining room and other residents were present. On 6/11/15 Resident #11 pushed Registered Nurse (RN) #1 down. On 6/20/15 Resident #17 was found sleeping outside the room was checked and pills were found so pain medications were held and not administered. The documentation failed to reflect that the physician was notified and/or that the resident had requested pain medication through the night hours. On 6/21/15 Resident #2 was observed pushing Staff Attendant #3 down.
   c. Facility documentation dated 7/9/15 identified that a package containing three (3) tablets of Valium for Resident #16 were missing. Interview with LPN #1 on 7/21/15 at 3:45 PM identified she called the pharmacy and was informed that the order had changed but they were unable to determine what happened to the three doses of Valium. Interview with the Person-in-Charge on 7/23/15 at 10:00 AM identified that the conclusion was the Valium had been administered and the sheet was put away, however there was no

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

documentation of an investigation to the incident and/or the incident was reported to the state agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (C) Administration (1)(5) and/or (h) General Conditions (6).

7. Based on observations and interviews with staff, the facility failed to obtain, replace and provide an adequate supply of washcloth and towels. The findings include:
   a. During a tour of the facility on 8/19/15 at 12:15 PM identified that washcloths and towels were in short supply and when provided the washcloths were worn and discolored. Observations of the linen closet identified twenty-five (25) towels and seven (7) washcloths, each item appeared dingy and of poor quality. In addition there were fifty-two (52) flat sheets, thirty (30) pillowcases and thirty-nine (39) fitted sheets. Review of facility documentation identified a capacity of 68 residents and a census of 65 residents. Interview with Director of Maintenance on 8/19/15 at 1:00 PM identified laundering of the linen except for washcloths are processed outside the facility on Monday, Wednesday and Fridays. The Director of Maintenance identified the linen par level had been increased about two weeks ago and he added thirty (30) more because the supplier was short of linen. Interview with the Person-in-Charge on 8/19/15 at 1:10 PM identified that the linen par levels have been increased, that residents are throwing out sheets and towels and that washcloths are always disappearing. Subsequent to surveyor inquiry the Director of Maintenance provided thirty-six (36) new washcloths and six (6) bath towels for resident use.

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 (1) (B)(D) (iv) (E) (i)(V1).

8. Based on a review of the clinical record, and staff interviews for three of three sampled diabetic residents who were administered Insulin (Resident #11, #22 and #24), the facility failed to notify the physician regarding the omission of blood glucose testing and subsequent treatment. The findings included:
   a. Review of the clinical record identified Resident #11 was admitted to the facility on 12/3/15 with diagnoses that included insulin dependent diabetes, anemia, hypertension, peripheral vascular disease and a right above knee amputation. Physician's orders dated 7/1/15 directed in part Novalog Insulin to be administered via a sliding scale prior to each meal. The orders directed to administer Novalog Insulin 13 units subcutaneous (SC) for a blood sugar of 200-249 mg/dl (milligram/deciliter), Novalog Insulin 15 units SC for a blood sugar of 250-299 mg/dl, Novalog insulin 17 units SC for a blood sugar of 300-349 mg/dl and Novalog Insulin 19 units SC for a blood sugar of 350-399 mg/dl. Review of the blood sugar flow sheet dated 7/1/15 through 7/22/15 identified on fifteen occasions Resident #11 refused to have his/her blood sugar tested and Insulin administered. Interview with Attendant #1 on 7/23/15 at 12:00 PM indicated she failed to notify the physician and/or person in charge that

the resident refused the blood sugar testing and the administration of Insulin. Interview with the Person-in-Change on 7/23/15 at 12:45 PM identified the Attendant should have notified the physician for further orders and/or the plan of care.

b. Review of the clinical record identified Resident #22 was admitted to the facility on 6/30/06 with diagnoses that included dementia and insulin dependent diabetes. Physician's orders dated 7/1/15 directed in part to test the resident's blood sugar once daily before breakfast and to administer Lantus Insulin 50 units SC at bedtime. Review of the blood sugar flow sheet identified Resident #22 refused to have his/her blood sugar tested on nine occasions. Interview with Attendant #1 on 7/23/15 at 1:00 PM indicated although the resident received his/her Insulin as ordered she failed to notify the physician and/or Person-in-Change of the resident's refusal to follow physician's orders.

c. Review of the clinical record identified Resident #23 was admitted to the facility on 3/16/15 with diagnoses that included insulin dependent diabetes, coronary artery disease, and peripheral vascular disease with an amputated second toe of the right foot. Physician's orders dated 7/1/15 directed in part Novalog Insulin to be administered via a sliding scale prior to each meal. The orders directed to administer Novalog Insulin 3 units SC for a blood sugar of 140-160 mg/dl, Novalog Insulin 5 units SC for a blood sugar of 161-180 mg/dl, Novalog insulin 7 units SC for a blood sugar of 251-300 mg/dl and Novalog Insulin 10 units SC for a blood sugar over 300. Review of the blood sugar flow sheet dated 7/1/15 through 7/22/15 identified on eighteen occasions Resident #11 refused to have his/her blood sugar tested and Insulin administered. Interview with Attendant #1 on 7/23/15 at 12:00 PM indicated she failed to notify the physician and/or Person-in-Change that the resident was non-compliant with blood sugar testing and the administration of Insulin. Interview with the Person-in-Change on 7/23/15 at 12:45 PM identified the Attendant should have notified the physician for further orders and/or the plan of care.

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

9. Based on a review of the clinical record, staff interviews and a review of the facility documentation for one sampled resident (Resident #21), the facility failed to secure medications to ensure the safety of the resident. The finding included:

   a. Resident #21 was admitted to the facility on 7/21/15 from an acute care hospital with diagnoses that included metastatic ovarian cancer, depression, polysubstance abuse, chronic pain and a seizure disorder. The resident had been admitted to the hospital for generalized abdominal pain and had suicidal ideation. Resident #21 was treated medically and consultation with psychiatry was conducted. Resident #21 was discharged on 7/21/15 to the residential care home on Trazadone 200 milligrams (mg) daily, Klonopin 2 mg four times a day, Zoloft 150 mg daily and MS-Contin and OxyContin at different strengths/doses throughout the day and evening. Further review of the clinical record indicated Resident #21 was homeless due to social issues. Review of the facility documentation identified on

DATES OF VISIT: July 21, 23, August 6, and 19, 2015

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

8/4/15 at 10:00 AM Resident #21 informed Attendant #2 that he/she wanted to look at his/her Klonopin prescription bottle and when the resident was given the medication he/she opened it and ingested five of the Klonopin tablets. Interview with Attendant #2 on 8/6/15 at 11:30 AM identified he/she handed the resident the bottle of medications and should not have. The emergency medical system (EMS) was called and the resident was transferred to the hospital for an evaluation. Interview with the Person-in-Change on 8/6/15 at 11:45 AM indicated Attendant #2 should not have allowed the resident to handle his/her own prescription bottle. Further interview with the Person-in-Change identified she re-educated the attendants regarding proper medication administration.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

December 30, 2015

Karyn Adkins Cosgrove, Licensee
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 October 22, November 13, and December 8, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and monitoring of care.

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 January 13, 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.

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

KEG

c. Nancy Shaffer

Complaint #18246, #18429, #18436, #18713

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: October 22, November 13 and December 8, 2015

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

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

1. Based on review of facility documentation, observations, and interviews, the facility failed to ensure staff had conducted control medication count between shifts and/or documented verification that the correct number of tablets remained. The findings include:
   a. Review of facility documentation dated 10/4/15 identified that a certified medication technician had reported forty-two (42) tablets of Oxycodone 5-325 milligrams were missing. Review of the Licensed Practical Nurse (LPN) #1 written statement dated 10/4/15 identified that she had administered Oxycodone to the resident at 7:00 PM. LPN #1 indicated that at 10:00-10:15 PM she was done with the medication pass so she counted off the narcotic medications in the drawer and all were accounted for. LPN #1 wrote the count was accurate so she proceeded to lock both drawers, the outside cabinet and did not administer a narcotic medication during the remainder of the shift. The statement identified that after 11:00 PM LPN #1 handed the keys over to the 11-7AM certified medication technician to administer a narcotic medication. In a written statement the 11:00 PM-7:00 AM certified medication technician identified that she had administered narcotic medications throughout the night and that she had not conducted a count on and off the shift. Observations of the control medication sheet dated October 2015 identified a second person signature missing for the medication count at change of shift for 10/1/15, 10/2/15, 10/3/15, 10/4/15, 10/5/15, 10/12/15, 10/14/15, 10/15/15, 10/16/15, 10/17/15 and 10/18/15. In an interview on 10/22/15 at 10:00 AM, certified medication technician #1 identified that the narcotic count occurs at change of shift, she always signs for the count and receives the key from the off going staff. In an interview on 10/22/15 at 10:30 AM, the Person-in-Charge identified that two staff members must do the narcotic count at change off shift and sign the count sheet.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5) and/or (d) Medical Supervision.

2. Based on review of facility documentation, clinical record review and interviews for two of three sampled residents (Resident #12 and #13), the facility failed to assist and/or ensure follow up outpatient appointments were scheduled. The findings include:
   a. Resident #12's diagnoses included anxiety, poly substance abuse, depression, chronic pain and post-traumatic stress disorder. In an interview and clinical record review with Medical Technician #1 on 10/22/15 at 10:00 AM identified that Resident #12 returned from the hospital on 10/6/15 after an unresponsive episode that occurred on 10/2/15 and was not aware if a follow up appointment had been scheduled. In an interview on 10/22/15 at 10:30 AM the Person-in-Charge identified that residents make their own appointments, will notify facility staff when the appointment was scheduled for and generally the facility does not follow up on the resident's appointment. Subsequent to inquiry the Person-in-Charge spoke with Resident #12. Resident #12 was under the impression the counselor was supposed to

contact him/her. After the conversation the behavioral health clinic was contacted and weekly meetings would be set up. In an interview on 10/22/15 at 11:30 AM, Resident #12 identified he/she called the substance abuse counselor this morning to locate a behavior health consult nearer the facility since the current behavior health was too far. Resident #12 indicated that he/she will schedule an appointment once he/she gets the information from the counselor.

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

3. Based on medical record review, review of facility documentation and interviews for one resident (Resident #10) who was reviewed for smoking, the facility failed to ensure that a smoking assessment was conducted after the resident caused a small fire while smoking independently. The findings include:
   a. Resident #10's diagnoses include hepatic encephalopathy and alcohol abuse. The safe smoking assessment form dated 3/30/15 identified Resident #10 as an independent smoker. The Reportable Event Form dated 10/9/15 at 10:30 PM identified Resident #10 ignited gasoline that had leaked from a vehicle as the vehicle drove out the driveway. In an interview and clinical record review on 10/22/15 at 10:00 AM, Medical Technician #1 identified that Resident #10 had a smoking incident 10/9/15, the last safe smoking assessment was conducted on 3/30/15 and that a Registered Nurse conducts the assessment. In an interview on 10/22/15 at 10:30 AM, the Person-in-Charge identified that Resident #10 was found to be smoking outside on 10/9/15 at approximately 10:00 PM after the staff were alerted to a small fire near a parked car. It was determined that the resident had lit a match, discarded the match believing that a wet area by the car was water. The Person-in-Charge identified the last smoking assessment for Resident #10 was dated 3/30/15 and that no smoking assessment was conducted after the incident on 10/9/15. The Person-in-Charge identified that a smoking assessment was done on admission by a nurse and expects the staff to monitor a resident if there has been a smoking incident until the resident has been assessed. The Safe Smoking assessment form dated 10/23/15, fourteen days (14) days after the 10/9/15 incident, identified that Resident #10 had lit with own lighter gasoline that was leaking from the gas tank as a visitor drove out of the parking lot. Resident #10 also had a cigarette after being told he/she was to be supervised. Subsequent to the incident the facility's smoking policy was reviewed and revised. Assessments will be conducted on admission, quarterly, if staff observes changes in the resident's mental status and/or an incident involving smoking materials.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5) and/or (h) General Conditions (3)(5).

4. Based on review of facility documentation and interviews for one resident (Resident 10) who was reviewed for smoking, the facility failed to ensure that the appropriate officials were notified when

a resident caused a small fire while smoking. The findings include:

a. Resident #10's diagnoses include hepatic encephalopathy and alcohol abuse. The safe smoking assessment form dated 3/30/15 identified Resident #10 as an independent smoker. The Reportable Event Form dated 10/9/15 at 10:30 PM identified Resident #10 ignited gasoline that had leaked from a vehicle as the vehicle drove out the driveway. The Reportable Event Form and investigation failed to reflect documentation that the fire department had been notified. The investigation indicated that the facility staff had extinguished the fire and had called the police department. In an interview and clinical record review on 10/22/15 at 10:00 AM, Medical Technician #1 identified that Resident #10 had a smoking incident 10/9/15, the last safe smoking assessment was conducted on 3/30/15 and that a Registered Nurse conducts the assessment. In an interview on 10/22/15 at 10:30 AM, the Person-in-Charge identified that Resident #10 was found to be smoking outside on 10/9/15 at approximately 10:00 PM after the staff were alerted to a small fire near a parked car. It was determined that the resident had lit a match, discarded the match believing that a wet area by the car was water.

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)

5. Based on observations, review of facility documentation and interviews for three of six sampled residents (Residents #7, #8 and #9) reviewed for medication administration; the facility failed to administer medication in accordance with the physician's order and/or failed to secure narcotic medications. The findings include:
   a. Review of Resident #7's October and November 2015 Medication Administration Record (MAR) directed Fentanyl Patch 75 mcg/hour to apply one patch topically every 72 hours. The MAR indicated signatures that the Fentanyl patch was administered on 10/13/15, 10/14/15, 10/16/15, 10/19/15, 10/22/15, 10/25/15, 10/27/15 and 10/30/15. The controlled Substance Disposition Record for the Fentanyl patch dated 10/15/15 identified the Fentanyl patch was administered on 10/19/15, 10/20/15, 10/24/15, 10/27/15 and 10/30/15. The record identified the patch was administered on 10/24/15 at 8:00 AM, the date 10/25/15 was written in and then crossed out with no initial and/or reason and 10/27/15 at 9:00 AM documentation as administered. The Reportable Event Form dated 10/27/15 identified that a medication error occurred on 10/25/15. The nurse had reported to the Person-in-Charge the second shift certified medication technician had made medication errors and Resident #7 received the Fentanyl patch on 10/24/15, a day early. It was determined that certified medication technician #3 had made the errors and subsequently would no longer be administering medications until further investigation. Resident #7 had no apparent ill effects from the medication error.
   b. Review of Resident #8's medical record a physician's order dated 10/18/15 directed to administer Phenobarbital 15 mg one tablet by mouth in the morning and evening. The November 2015 MAR identified Phenobarbital 15 mg tablet at 7:00 AM and 5:00 PM. Review of the Phenobarbital 15 mg Controlled Substance Administration Record identified

that the Phenobarbital was administered on 11/2/15 at 8:00 AM and at 12:00 PM. The Reportable Event Form dated 11/3/15 identified that a medication error occurred on 11/2/15. Resident #8 was given Phenobarbital at 12:00 PM instead of 4:00 PM, the resident received the next dose at 7:00 AM the following day and certified medication technician #2 received a written warning. The Reportable Event failed to reflect documentation that the physician was notified of the medication error and/or the staff had received direction from the attending physician. In an interview on 11/13/15 at 11:45 AM the Person-in-Charge identified that the medication error was investigated and certified medication technician #2 received a written warning. In an interview on 12/8/15 at 10:00AM, certified medication technician #2 identified that Resident #8 received Lorazepam 0.5 mg as needed and was due on 11/2/15 at 12:00PM. Certified medication technician #2 identified that in error she removed the Phenobarbital 15 mg tablet that was scheduled for 5:00 PM and gave it to the resident, documenting for the medication on the Lorazepam count sheet. During the change of shift the count on 11/2/15 at 3:00 PM, certified medication technician #2 realized the medication error, documented the Phenobarbital was given at 12:00 PM and informed the oncoming staff (certified medication technician #4) not to administer the 5:00 PM dose that evening. Review of the MAR identified Phenobarbital 15 mg tablet was not given until the next day 11/3/15 as ordered.

c. Review of Resident #9's clinical record a physician's order dated 9/30/15 directed to administer Hydromorphone 32 mg daily at 8:00 AM and 7:00 PM. Review of the October 2015 MAR identified Hydromorphone 32mg was administered on 10/25/15 at 8:00 AM but however the MAR failed to reflect documentation that the medication was administered at 7:00 PM. The controlled substance disposition record for the Hydromorphone 32 mg identified that the medication was administered on 10/25/15 at 5:00 PM and 11:00 PM by certified medication technician #3. The Reportable Event Form dated 10/27/15 identified that a medication error occurred on 10/25/15 and Resident #9 received a twice daily medication three times on 10/25/15. In an interview on 11/13/15 at 11:45 AM, the Person-in-Charge identified that the medication error was investigated and the certified medication technician would not be administering medications. Resident #9 had no apparent ill effect from the medication error.

d. Review of Resident #9's medical record, a physician's order directed Nuvigil 250 mg every morning. The Reportable Event Form dated 11/6/15 identified that the facility ran out of Nuvigil 250 mg tablets before time to be able to refill. The investigation indicated that the facility did not know the time frame since the Controlled Substance Administration Record for Nuvigil could not be located. The report identified that the pharmacy delivered seven (7) Nuvigil tablets on 10/14/15 and twenty-three (23) on 10/15/15. The facility initiated an investigation and notified the Drug Enforcement Agency (DEA). During a tour of the facility on 11/13/15 a representative from the DEA was also present investigating the incident. In an interview on 11/13/15 at 11:45 AM, the Person-in-Charge identified that the controlled substance administration record and the medication delivery sheet for the Nuvigil were still missing as of 11/13/15. The Person-in-Charge identified that LPN #1 had accepted delivery on 10/14/15 and 10/15/15 for the Nuvigil. The Person-in-Charge

indicated that she had administered the medication on 11/1/15. LPN #1 was unavailable for interview.

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

6. Based on observations and interviews for one of six sampled residents (Resident #17) who was effected by the scabies outbreak, the facility failed to ensure that the residents' clothing was laundered according to manufacturer's direction during the process of eliminating scabies. The findings include:
   a. In an interview on 12/8/15 at 1:00 PM the Person-in-Charge identified a scabies outbreak in the facility started sometime early in November 2015, the treatment protocol began on 11/18/15 which included laundering residents clothing and bed coverings by a laundering service. The Person-in-Charge indicated on 11/13/15 staff was educated on 11/13/15 about the process that would be initiated. The residents' clothing and all bed coverings were to be bagged and labeled and any clothing that could not be washed i.e. dry clean only were to be bagged and left until the scabies treatment was completed. The Person-in-Charge identified that she was aware that Resident #18 had complained of damaged clothing but not aware of other residents having the same issue. Upon surveyor inquiry, the Person-in-Charge indicated she will investigate to determine the residents who had their clothing damaged and reimburse them accordingly. In an interview on 12/8/15 at 2:00 PM, Resident #17 identified a pair of wool pants were laundered instead of dry cleaning therefore the pants shrunk.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(C).

7. Based on personal record review and interviews, the facility failed to ensure that staff was certified in medication administration prior to administering medications. The findings include:
   a. In an interview with the Registered Nurse (RN) #2 who conducts the medication certification program on 11/18/15 at 10:30AM identified that the certificate of completion medication administration and supervision training for certified medication technician #4 and the Person-in-Charge could not be located. The RN #2 indicated documentation was located that verified certified medication technician #4 and the Person-in-Charge had completed the four (4) day classroom section. However, RN #2 was unable to retrieve from the system that the observation section had been completed. In an interview and facility documentation review of staff certified to administered medications on 12/8/15 at 1:00 PM, the Person-in-Charge was unable to provide documentation of completion of the medication administration program. The Person-in-Charge identified certified medication technician #4 and herself completed the Medication Administration Program on 6/29/15, they did not receive the certificate at the time and she believed that they could administer medications since they had met the criteria for the program. Review of Resident #9 and #15 clinical records identified the Person-in-Charge and certified medication technician #4 administered

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

medications during November 2015.

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

8. Based on medical record reviews, review of facility documentation and interviews, the facility failed to ensure pertinent information was documented on the medication administration records, medications were administered in accordance with the physician's order and/or the safe keeping of the medications. The findings include:
    a. Resident #1's diagnoses included schizophrenia, diabetes and hypertension. A physician's order dated from 10/20/31 through 11/12/15 directed Clonazepam 1 mg four times a day at 7:00 AM, 11:00 AM, 5:00 PM and 7:00 PM. Review of the Medication Administration Record (MAR) from 11/1/15 through 12/12/15 the medication was identified by the RX #4057212 and administered at 11:00 AM and 8:00 PM. The MAR failed to reflect documentation of what the medication was that corresponded to that prescription number. Review of the Controlled Substance Disposition Record from 10/11/15 through 11/12/15 identified that the Clonazepam was administered twice a day at 11:00 AM and the evening dose had varied times, 5:00 PM, 7:00 PM, 8:00 PM, or 10:00 PM. The record indicated that on 10/23/15 the Clonazepam was administered three (3) times that day and on 10/26/15, 11/11/15 and 11/12/15 was administered only once (1). Although the Controlled Substance Disposition Record identified the Clonazepam was administered twice a day, the MAR failed to reflect documentation that the Clonazepam was administered from 11/1/15 through 11/11/15.
    b. Resident #2's diagnoses included major depression and borderline personality. A physician's order dated 11/29/15 through 12/26/15 directed acidophilus capsule one capsule by mouth three times a day. Review of the October, November and December Medication Administration Records identified the medication based on a prescription number.
    c. Resident #3's diagnoses included chronic encephalitis. A physician's order dated 10/20/15 through 11/16/15 directed Risperidone one mg two times a day, at 7:00 AM and 12:00 PM. Review of the Medication Administration Records from 10/1/15 through 12/8/15 identified two different styles of records for signing off that medications were administered. Review of the November Medication Administration Record for 11/1/2015 through 11/30/15 reflected the administration of Prescription #6776301 at 11:00 AM, without identifying the medication. Review of the MAR from10/20/15 through 12/8/15 identified documentation that the 7:00 AM medications were administered by the facility staff, however the medications are administered by the Visiting Nurse. Interview with the Visiting Nurse on 12/17/15 at 4:00 PM identified that the facility was only responsible for the administration of Risperidone 1mg at noon. Interview with certified medication technician #1 on 12/17/15 at 11:45 AM identified that she does not know why staff would be documenting on the MAR when the visiting nurse are actually administering the 7:00 AM medications. Clarification with the Visiting Nurse on 12/17/15 at 11:45 AM identified that the Visiting Nurse was responsible for the 7:00 AM medications as well as the PM medication and the

facility was only responsible for the noon medication and staff should not be documenting that the morning medications are administered by the facility staff.

d. A physician's prescription dated 12/1/15 directed Keflex 500 mg one capsule every six hours for seven days. In an interview and clinical record review certified medication technician #2 on 12/8/15 at 10:00 AM identified that the Keflex 500 mg was scheduled at 2:00 AM, 8:00 AM, 2:00 PM and 8:00 PM. Documentation indicated the Keflex was given from 12/2/15 through 12/8/15 at 8:00 AM, 2:00 PM, 8:00 PM and circled as refused for the 2:00 AM doses. Certified medication technician #2 identified there was only one medication technician on the 11-7 shift, the resident had refused the 2:00 AM dose and she would be notifying the ordering physician of the missed doses. In an interview with certified medication technician #4 on 12/8/15 at 1:30 PM identified she was scheduled for the 11:00PM-7:00PM shift and worked on 12/2/15, 12/3/15 and 12/4/15 when Resident #15 had refused the Keflex scheduled for 2:00 AM. Certified medication technician #4 stated she circled the medication administration record as refused, believed she had informed the oncoming staff of the resident's refusal and documented this on the daily report. Review of the daily report failed to reflect documentation of the resident's refusal. In an interview on 12/8/15 at 1:00PM, the Person-in-Charge identified she was not aware of Resident #15's refusal of the Keflex at 2:00 AM and would expect the staff to notify the ordering physician to modify the administration times and staff should be documenting on the back of the MAR the reason for not administering the medication.

e. Review of the Control Count Sheet from 10/1/15 through 10/22/15 failed to reflect the completion of a narcotic count at the change of the 11-7 shift on 10/2/15. Upon further review, the narcotic count record failed to reflect documentation that the completion of count was conducted by two staff members on 10/3/15, 10/5/15, 10/12/15, 10/14/15, 10/15/15, 10/16/15, 10/17/15 and 10/18/15. The November Control Count Sheet failed to identify count completed on 11/10/15 and/or the count was not completed by two staff on thirteen (13) occasions from 11/2/15 through 11/28.

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

9. Based on review of facility documentation and interviews, the facility failed to ensure the health, comfort and safety of the environment. The findings include:

a. Review of facility and exterminator documentation from 7/30/15 through 11/17/15 identified that the facility had been treated for bed bugs. Interview with the Person-in-Charge on 11/13/15 at 9:30 AM identified that the exterminator had been requested to make monthly visits but the problem has continued and attended meetings with the Torrington Health Department. Interview with the Exterminator on 12/17/15 at 1:00 PM identified that they have been very involved and have attempted to eradicate the problem in the facility. However, they have been contracted to spot treat areas and not a full evacuation. He further stated that when the extermination staff has gone into the facility there have been incidents when the rooms are not fully prepared and have continued to have

belongings in the rooms which have hampered a successful treatment. Review of facility documentation identified that the facility indicated the presence of bed bugs back in August. Recently a Reportable Event Form date 11/12/15 identified that over the past few weeks a number of residents complained of an itchy rash, the physician indicated the rash was a dermatitis and because of an increased number a physician was requested to come to the facility and exam the residents. On 11/10/15 the physician identified unconfirmed scabies and directed to initiate treatment. Facility documentation indicated that the first treatment was completed on 11/18/15 and the second November 25, 2015.

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

Exhibit A

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

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
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Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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

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

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

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

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.

Exhibit B

FLIS' Independent Consultant Guidelines

Relationship between Independent Consultant (IC) and DPH includes:

- An IC is utilized as a component of DPH's regulatory remedy process. An IC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The IC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IC and the Institution:

- The IC maintains a professional and objective relationship with the institutional staff. The IC is a consultant, not an employee of the institution. The IC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IC but must cooperate with and respond to requests of the IC related to her fulfilling her/his duties.
- The IC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Reports in accordance with the Consent Agreement/Order to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.