STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

May 3, 2021

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

Dear Ms. Jariffe:

Unannounced visits were made to Fernwood Rest Home Inc on March 12, 2021 and April 9, 2021 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. The state violations cannot be edited by the provider in any way.

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

The plan of correction is to be submitted to the Department by May 17, 2021.

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

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

Connecticut Department of Public Health

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

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 17, 2021 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

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

Respectfully,

Karen Gworek, RN
Karen Gworek, RN, BSN
Supervising Nurse Consultant

KEG:mb

c. Mairead Painter, LTC Ombudsman

Complaint #29691, #29865

The following are a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4) and/or Connecticut General Statutes 19a-550 (b)(8).

1. Based on, review of facility documentation and interviews for one of four residents (Resident #1) who were reviewed for an allegation of abuse, the facility failed to ensure that the resident was free from verbal abuse. The findings include:
   a. Review of the facility incident report dated 4/5/21 indicated that on 3/26/21 at around 7:00 PM Resident #1 was playing music loud and a staff member started yelling and swearing at the resident to turn the music down. The report stated the staff member was suspended pending an investigation. In an interview on 4/9/21 at 10:08 AM, the Dietary Supervisor indicated that he was in the dietary office with the door closed when he heard yelling at the med station, which is located about fifty (50) feet away from dietary office. The Dietary Supervisor stated that Med Tech #1 was yelling at Resident #1 because she thought the resident's music was too loud, he asked Med Tech #1 to stop yelling at Resident #1, Med Tech #1 stopped for a few seconds then began yelling at the resident again. The Dietary Supervisor indicated that Med Tech #1 was again asked to stop yelling, she became quite for a few seconds then started yelling at Resident #1 at which time Med Tech #1 told Resident #1 to "shut the f _ _ _ up, you're a grown person stop acting like a child." The Dietary Supervisor stated that Med Tech #1 did not handle the situation properly and should not yell or swear at a resident. The Dietary Supervisor identified that the incident was reported to the Med Tech Manager the next morning. In an interview on 4/9/21 at 10:26 AM, Staff Attendant #1 stated Resident #1 was playing music in the common area and the music was at an appropriate level, however Med Tech #1 thought the music was too loud and began yelling at Resident #1. Staff Attendant #1 identified the Dietary Supervisor asked Resident #1 and Med Tech #1 to stop yelling at each other and the resident stopped however Med Tech #1 would not stop yelling. Staff Attendant #1 indicated although the Dietary Supervisor was able to calm Resident #1, Med Tech #1 would not listen and kept yelling at the resident. Staff Attendant #1 stated that Med Tech #1 told the resident to "act your age" and asked, "what grade are you in?" In an interview on 4/9/21 at 11:35 AM, Resident #1 indicated that while listening to music in the day room a staff member began screaming and yelling in his/her face. Resident #1 identified that some staff and residents witnessed the incident and Resident #1 "felt hurt and prosecuted." In an interview on 4/9/21 at 11:40 AM, Med Tech #1 indicated that Resident #1 was not following the rules regarding playing music. Med Tech #1 identified that Resident #1 "was mentally not his/her age and can be violent" therefore she was yelling to gain the attention of other staff members. Med Tech #1 indicated she did not yell or swear at Resident #1 but calmly asked the resident to "please sit down and get away from the med station." The facility abuse policy indicated that verbal abuse is defined as any oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families within their hearing distance regardless of their age, ability to comprehend or disability.

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

2. Based on review of facility documentation and interviews for one of four residents (Resident #1) who were reviewed for an allegation of verbal abuse, the facility failed to ensure that an allegation of abuse was reported to the Person-in-Charge immediately according to facility policy and to the State Agency within seventy-two (72) hours. The findings include:
   a. Review of the facility incident report dated 4/5/21 indicated that on 3/26/21 at around 7:00 PM Resident #1 was playing music loud and a staff member started yelling and swearing at the resident to turn the music down. The report stated the staff member was suspended pending an investigation. In an interview on 4/9/21 at 9:40 AM, the Person-in-Charge indicated that she heard about the allegation of abuse a few days after incident occurred, and at that time the employee was suspended pending investigation. The Person-in-Charge further indicated the staff should have reported the incident to her immediately. In an interview on 4/9/21 at 10:08 AM, the Dietary Supervisor indicated that he was in the dietary office with the door closed when he heard yelling at the med station, which is located about fifty (50) feet away from dietary office. The Dietary Supervisor stated that Med Tech #1 was yelling at Resident #1 because she thought the resident's music was too loud, he asked Med Tech #1 to stop yelling at Resident #1, Med Tech #1 stopped for a few seconds then began yelling at the resident. The Dietary Supervisor indicated that Med Tech #1 was again asked to stop yelling, she became quite for a few seconds then started yelling at Resident #1 at which time Med Tech #1 told Resident #1 to "shut the f _ _ _ up, you're a grown person stop acting like a child." The Dietary Supervisor stated that Med Tech #1 did not handle the situation properly and should not yell or swear at a resident. The Dietary Supervisor identified that the incident was reported to the Med Tech Manager the next morning. In an interview on 4/9/21 at 11:35 AM, Resident #1 indicated that while listening to music in the day room a staff member began screaming and yelling in his/her face. Resident #1 identified that some staff and residents witnessed the incident and Resident #1 "felt hurt and prosecuted." In an interview on 4/9/21 at 12:40 PM, the Med Tech Manager indicated that the Dietary Supervisor informed her the morning after incident occurred that a staff member was yelling and swearing at a resident. The Med Tech Manager identified that she instructed the Dietary Supervisor to take care of reporting the incident because he had witnessed the interaction. The facility abuse policy indicated that any employee who witnesses or have knowledge of an abuse incident will report incident immediately to his/her supervisor. If abuse results in any physical damages seek medical attention for the resident and report incident to the police immediately. All incidents must be reported to the administrator immediately.

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

3. Based on facility documentation, observation of video surveillance, facility policy, and interviews in response to an allegation of misappropriation of property, the facility failed to ensure that a staff member who was not medication administration certified did not remove

residents' medication for their own personal use. The findings include:

a. Facility documentation indicated that the former Person-in-Charge was taking resident medications from the medication room and the storage room that contained discharged or discontinued medications. Interview with the Med Tech Manager on 3/12/21 at 9:00 AM indicated on 2/9/21 a full card of sixty (60) tablets of Xanax 1 milligram was missing after having been delivered from the pharmacy, the missing medications were reported to the former Person-in-Charge who instructed her not to report the missing medications but rather request order a new card and the facility will pay for it. The Med Tech Manager indicated that on 3/9/21 the former Person-in-Charge arrived at the facility early in the morning and relieved the night shift med tech of their duties from 3-7AM. The Med Tech Manager identified a review of the Xanax 1 mg bubble pack after 7:00 AM identified multiple missing medications throughout one (1) card. The Med Tech Manager indicated after staff suspected the misappropriation of the medications, staff would lock the current medications in another location and suspected the former Person-in-Charge started removing medications from the discharged medications that were stored in the back room. The Med Tech Manager identified when the missing medications was reported to the former Person-in-Charge she indicated the night staff must be stealing the medications, threatened the staff to not say anything, and made staff feel they could lose their job if the missing medications were reported. The Med Tech Manager identified on 3/9/21, the facility started to review the surveillance tapes of both the nursing station containing the current medications and the back room containing the discharge medications. Observations of the the video surveillance on 3/12/21 at 11:30 AM with the Med Tech Manager identified the former Person-in-Charge watching the hallways for staff before opening up the cabinet or waiting for staff to leave the nursing station before opening the cabinet, taking a handful of bubble packs from the cabinet over to a desk, removing medications from the bubble pack and placing the tablets into her pocket, and going into the back room and removing medication from the discharge medication bubble packs. On 3/9/21 the Med Tech Manager reported the findings to the owner, and on 3/10/21 local authorities removed the former Person-in-Charge from the premises. Facility investigation also identified the former Person-in-Charge had keys to the current and discharge medication cabinets although former Person-in-Charge was a non-credentialed employee, the former Person-in-Charge indicated the Department of Public Health wanted her to have a set of keys.

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

4. Based on review of facility documentation and interviews, the facility failed to ensure that resident accounts managed by the facility were safeguarded from theft. The findings include:
   a. Subsequent to receiving information that the former Person-in-Charge was removing resident medications from the medication room for personal use, the facility discovered that the former Person-in-Charge had embezzled monies from the facility's financial account. In an interview with the Owner on 3/11/21 he identified that the former Person-in-Charge had given herself two (2) bonuses and wrote checks for cash. The Owner identified the former Person-in-Charge was escorted from the facility by the local authorities on 3/10/21.

PLAN OF CORRECTION
FERNWOOD REST HOME, INC.

Approved 5/24/21 KEG

To whom it may concern,

Please except the plan of corrections for the regulations of Connecticut General Statutes, Section 19a- 496 made from an unannounced visit from made to Fernwood Rest home March 12th, 2021 and April 9th, 2021.

Below is the plan of correction for the following:

1. **Section 19-13-D6 (c) Administration (1) and /or (c) Administration (4) and/or Connecticut General Statues 19a-550 (b)(8): Our Facility forbids all forms abuse and take the safety of all residents serious. Our policy states and remain as such:**
   Reporting/Response:
   a. Moving forward the owner will conduct an interview and run a back ground check and reference check, to assure Person in Charge or Administrator has great standing character. The policy will be reviewed and edited as needed to assure that Neglect and Abuse in the facility complied with DPH's regulations and Residents bill of Rights.
   b. Policy was reviewed and revised om 4/13/21 no changes were made at this time. On 4/21/21 A staff training on our Neglect and Abuse policy as well as the DPH guidelines and procedures on Neglect and Abuse.
   c. Administrator/Person in Charge will assure that the neglect and abuse trying are don't annually and upon hiring.
   d. The Administrator /Person in Charge will assure compliance.
2. **Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (h) General Conditions (3):**
   a. The job description for Administrator/Person in Charge job description will be reviewed with person being hired with the owner. This will assure the DPH compliance is met.
   b. Training was done on 4/21/21 on timely reporting Neglect and Abuse incidents. Any new hires will be trained by the Administrator/Person in Charge.
   c. To assure compliance the owner will do a yearly Performance Evaluation on the Administrator or Person in Charge. To assure incidents are reported timely also staff and owner will be trained on the timely reporting annually.
   d. The Administrator /Person in Charge will assure compliance.
3. **Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and/or (c) Administration (4) (F) (ii).**
   a. The facilities medication policy will be reviewed and revised to assure that it complies with DDS regulations.
   b. On 5/12/21 the Medication Policy was reviewed and revised, to assure safety and compliance. Currently change in the policy is "The owner is the only person that will /should have a backup narcotics key."
   c. Person in Charge / Administrator will conduct a weekly check to assure compliance. All controlled medications will be counted at the beginning and end of each shift to ensure there are no dosages missing. The count sheet is signed by two staff members; the outgoing and incoming Med. Techs. A count should also be done if there is a change of

Med. Tech. mid-shift. In an extreme emergency lock the narcotics keys in the safe, but a med count must be done first, and again before meds are administered.

d. Administrator/ Person in charge will assure compliance.

4. **Regulation of Connecticut State Agencies Section 19-13-D6 (c) Administration (1) and /or (c) Administration (4)**
   a. Resident's funds are now single locked during the day and double locked after hours, the only personals with the keys to resident's funds are the Business Office Manager and Business Office Assistant
   b. Starting 6/1/21 the protocol will be revised to assure compliance.
   c. Administrator/ Person in charge will conduct random audits the assure compliance.
   d. Administrator /Person in Charge and Business office Manager will be responsible .

Please contact me for any question's comments or concerns, you may reach me via email administrator@fernwoodrch.com or via phone 860-567-9558 Ext 1001.

Best Regards,

Janice Bariffe
Person in Charge