2017

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity ***Signature of FLIS Staff***

Fernwood Rest Home — A Thompson
Torrington Rd, P.O. Box 548
Litchfield, CT 06759
M:

Licensure Category:

RCH

Licensed Bed Capacity: ____ Census: ____

Date(s) of onsite inspection: 6/9/17

Date(s) additional information obtained: ____

Personnel contacted: James Murphy (Administrator)

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: ____

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

[✓] See Complaint Investigation # 21557

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 10/17/17

[ ] Desk Audit ____ [✓] Amended Letter: 10/30/17 Original Ltr. ____

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

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

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

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to ____

REPORT SUBMITTED BY: A Thompson **DATE OF REPORT:** ____

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

October 30, 2017

James Murphy, Person-in-Charge
Fernwood Rest Home Inc
Torrington Road, PO Box 548
Litchfield, CT 06759

Dear Mr. Murphy:

This is an amended edition of the violation letter originally dated October 17, 2017.

An unannounced visit was made to Fernwood Rest Home Inc on June 9, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by October 31, 2017 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

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

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

Connecticut Department of Public Health

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

DATE(S) OF VISIT: June 6, 2017

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

Respectfully,

Karen Gworek, RN

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

cc: Nancy Shaffer

Complaint #21557

KEG:mb

DATE(S) OF VISIT: June 6, 2017

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 the Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (S) and/or (c) Administration (5).

1. Based on clinical record review, facility documentation, observations and interviews, the facility failed to ensure the locking mechanism on resident's beds were maintained and functioning to prevent a potential accident. The findings include:
   a. Observations with the Person-in-Charge on 6/9/17 of the bed that Resident#1 had on 4/14/17, inspection of the bed identified a brake at the foot of the bed moved and when gentle force was applied to the bed.
   Tour of the facility with the Person-in-Charge on 6/9/17 identified twenty-two (22) beds had inadequate locking mechanisms with a potential for the bed to move if force was applied. In an interview on 6/9/17 at 9:40 AM, the Person-in-Charge identified Resident #1 informed him the bed was not locked on the day of the incident. The Person-in-Charge stated the incident occurred on a Friday and upon notification he directed staff to move Resident #1's bed to a vacant room but he could not recall the exact date. In an interview on 6/9/17 at 10:45 AM, the Maintenance person identified there are different style of beds in the facility and the bed Resident #1 had was an old style of which other residents also currently using. The Maintenance person stated even with the locking mechanism in place these types of beds may still move because of the type of floor tile. The Maintenance person stated that the brakes on the beds are checked sporadically and in some instances the bed wheels are replaced with rubber pads to prevent the bed from moving if an issue occurs. Upon surveyor inquiry, the facility identified the beds that had inadequate locking mechanisms will be fixed, replaced and/or immobilized the beds as needed.

Approved
10-30-17
KEG

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

10/26/17

Karen Gworek,

In regards to the plan of correction for the unannounced visit made to Fernwood Rest Home on June 9th, 2017:

1. All the bed locks found to be deficient identified during the inspection conducted on June 9th were either fixed, replaced, or otherwise immobilized by June 13th so as not to present a danger to Residents. Any beds determined to be an immediate risk to Residents on June 9th were fixed, replaced, or immobilized on that day.
2. All faulty bed locks were corrected by June 13th, 2017
3. Bed locks on all beds will be inspected by maintenance upon purchase and before being put into use. Bed locks will be checked by maintenance before admitting a new Resident and before a room/bed change is made. The Administrator will inspect the bed locks periodically during weekly environmental rounds.
4. The Maintenance Supervisor is responsible for ensuring the facility's compliance with this plan of correction.

Sincerely,

James J. Murphy, Administrator, LNHA, MSHCA,
Fernwood Rest Home Inc.

James J. Murphy

Brad Adkins, Maintenance Supervisor,
Fernwood Rest Home Inc.

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October 17, 2017

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Karen Gworek, RN

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Supervising Nurse Consultant
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cc: Nancy Shaffer

Complaint #21557

KEG:mb

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1. Based on clinical record review, facility documentation, observations and interviews, the facility failed to ensure the locking mechanism on resident's beds were maintained and functioning to prevent a potential accident. The findings include:
   a. Resident #1's diagnoses included lung cancer, diabetes and hypertension. Clinical record review identified Resident #1 was placed on fifteen minute observations secondary to weakness and unsteadiness starting on 4/14/17 at 6:30 PM and was last seen at 4/14/17 at 11:30 PM. The Reportable Event Form dated 4/14/17 at 11:25 PM identified Resident #1 hit his/her head after slipping out of bed. Resident #1 was evaluated at the hospital and returned to the facility with no injury noted and no new orders. The facility's investigation and interviews identified the resident was observed by the roommate getting out of bed and then fall. Observations with the Person-in-Charge on 6/9/17 of the bed that Resident#1 had on 4/14/17, inspection of the bed identified a brake at the foot of the bed moved and when gentle force was applied to the bed.
   Tour of the facility with the Person-in-Charge on 6/9/17 identified twenty-two (22) beds had inadequate locking mechanisms with a potential for the bed to move if force was applied.
   In an interview on 6/9/17 at 9:40 AM, the Person-in-Charge identified Resident #1 informed him the bed was not locked on the day of the incident. The Person-in-Charge stated the incident occurred on a Friday and upon notification he directed staff to move Resident #1's bed to a vacant room but he could not recall the exact date. In an interview on 6/9/17 at 10:45 AM, the Maintenance person identified there are different style of beds in the facility and the bed Resident #1 had was an old style of which other residents also currently using. The Maintenance person stated even with the locking mechanism in place these types of beds may still move because of the type of floor tile. The Maintenance person stated that the brakes on the beds are checked sporadically and in some instances the bed wheels are replaced with rubber pads to prevent the bed from moving if an issue occurs. Upon surveyor inquiry, the facility identified the beds that had inadequate locking mechanisms will be fixed, replaced and/or immobilized the beds as needed.