| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075246 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Whitney Rehabilitation Care Center | 2798 Whitney Avenue<br>Hamden, CT 06518 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102<br><br>Based on observations, interviews and policy review for 1 of 2 sampled residents (Resident #26) reviewed for dignity, the facility failed to return laundry in a timely manner to ensure Resident #26 had sufficient clothes and did not have to be dressed in a hospital gown.<br><br>Resident #26's diagnoses included Type 2 Diabetes Mellitus, chronic venous hypertension with ulcer of bilateral lower extremity and cellulitis of right and left limbs.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was cognitively intact, required partial to moderate assistance for transfers and upper body dressing and was dependent for lower body dressing and toileting.<br><br>The Resident Care Plan dated 6/19/24 identified Resident #26 had an adjustment disorder. Interventions included encouragement to participate in activities of choice and providing the opportunity to communicate feelings regarding attending activities.<br><br>Interview and observation of Resident #26 on 8/29/24 at 1:15 PM during the Resident Council meeting identified Resident #26 was wearing a hospital gown and stated it was because he/she had not received clothing back from laundry in 5 days.<br><br>Interview with Resident #26 in his/her room on 8/30/24 at 11:20 AM identified he/she told everyone about the missing laundry and still not received it back.<br><br>Interview with the Nurse Aide (NA) #7 on 8/30/24 at 11:20 AM identified and agreed that Resident #26 told everyone about the missing laundry items and she notified laundry on 8/27/24, adding there is a huge pile of clothing down there and I'm not looking through that.<br><br>Interview and observation of Resident #26 on 8/30/24 at 11:42 AM identified he/she was<br><br>seated in his/her wheelchair in a common hallway with the Physical Therapist, wearing a hospital gown with both lower extremities exposed and wrapped in ace bandages. Resident #26 identified it was 5 or 6 days that he/she had to wear a hospital gown, it bothered him/her not to have their own clothing, and that was the reason he/she was not doing therapy in the gym.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 8/30/24 at 12:00 PM with the Director of Environmental Services identified the turnaround time for laundry was usually 2 to 3 days and today was the first time she heard of Resident #26 missing items. Additionally, the department was extremely short staffed, and the regular full-time employee whom it was most likely reported to worked her last day on 8/27/24. However, she was currently implementing easy to read labels and personalized bags to cut down on lost and missing resident clothing since that had been an issue.<br><br>Interview with Social Worker #2 on 8/30/24 at 12:35 PM identified that she was not made aware of Resident #26's missing clothing until 8/30/24 (despite NA #7 being aware of Resident #26's missing clothing on 8/27/24).<br><br>Interview with the Physical Therapist (PT) #1 on 8/30/24 at 12:40 PM identified that therapy was not done in the gym due to Resident #26 preference because it bothered him/her to be wearing a hospital gown when in the gym, but it did not impact the physical therapy progress.<br><br>Observation of Resident #26 on 8/30/24 at 1:54 PM identified him/her wearing a hospital gown while sitting in the dining room waiting for lunch.<br><br>Facility policy on Personal Items identified it was the responsibility of all staff members to report any missing items to the supervisor who will report it to the Social Worker and/administration. |

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| F 0568<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19953<br><br>Based on staff and resident interview and facility documentation for 1 of 2 sampled resident (Resident #28) reviewed for personal funds, the facility failed to provide quarterly statements for residents who had a Resident Trust Account with the facility. The findings include:<br><br>Resident #28's diagnoses included renal disease, Diabetes Mellitus and depression.<br><br>A quarterly Minimum Data Set assessment dated [DATE] identified Resident #28 had intact cognition.<br><br>On 8/27/24 at 12:09 PM, interview with Resident #28 identified that he/she had previously received quarterly banking statements, but over the past year, since the previous book keeper left, had not received any.<br><br>On 8/30/24 at 12:58 PM, interview with the Business Office Manager (BOM) identified that she had been the BOM since 4/29/24. Additionally, she identified that Resident #28 deposits money in the Resident Trust Account and currently has a balance of 209.25 dollars. Additionally, she identified that she has not provided any quarterly statements to either the residents or their responsible parties because Corporate sends statements directly to the resident/responsible party.<br><br>Additional interview with the BOM on 8/30/24 at 2:30 PM identified upon her inquiry to Corporate as to the date the last quarterly statements were sent by them, she was notified that she was responsible for sending the statements and not Corporate. She further identified not being aware that she was responsible to provide statements and that was the reason statements were not provided. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177<br><br>Based on interviews, review of the clinical record, and facility policy for the only sampled resident (Resident #36) reviewed for non-pressure skin conditions, the facility failed to notify the responsible party of the development of an open area requiring a treatment and for 1 of 4 residents (Resident #69) reviewed for pressure ulcers, the facility failed to notify the physician per the physician's order for a greater than 3 pound (lbs) weight loss in one day for a resident with congestive heart failure (CHF) and for 1 of 1 residents (Resident #476) reviewed for a lumbar brace, the facility failed to notify the physician/APRN of Resident #476's refusals to wear the lumbar brace. The findings include:<br><br>1. Resident #36's diagnoses included stroke, right-side hemiplegia, osteoporosis.<br><br>The Annual Minimum Data Set assessment dated [DATE] identified Resident #36 was severely cognitively impaired and dependent for toileting hygiene, for putting on and taking off footwear, and required partial/moderate assistance to roll to the left and right.<br><br>The Resident Care Plan in effect from 8/1/24 to 8/30/24 identified Resident #36 was at risk for an alteration in skin integrity related to decreased mobility. Interventions included use of a bed cradle, offloading both heels while in the bed or chair, and reporting of any areas of concerns identified during performance of skin checks with care.<br><br>A weekly skin assessment dated [DATE] at 8:51 AM identified Resident #36's right toes were pink with a rash.<br><br>A non-pressure wound weekly tracking assessment dated [DATE] at 3:15 PM identified Resident #36 had a superficial open area to the right great toe with measurements of 0.4 centimeters (cm) by 0.3 cm by 0.0 cm. The wound bed had 76% to 100% granulation, with a scant amount of bloody drainage. It was further identified that the treatment was to cleanse the right great toe with wound cleanser, pat dry, then apply Xeroform (yellow petroleum gauze) to the open area, and cover with a non-adherent pad followed by gauze wrap every day and as needed.<br><br>A physician's order dated 8/5/24 directed to cleanse the right great toe open area with wound cleanser, pat dry, then apply Xeroform to the open area, and cover with a non-adherent pad followed by gauze wrap every day and as needed.<br><br>A non-pressure wound weekly tracking assessment dated [DATE] at 1:37 PM identified that the superficial open area to the right great toe was resolved with a scab noted. It was further identified that the previous treatment was discontinued, and a new treatment initiated for skin-prep (protective barrier) to the right great toe.<br><br>A physician's order dated 8/6/24 directed to apply skin-prep to the scab to the right great toe every day on the day shift.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Clinical record review on 8/28/24 at 12:49 PM identified that from 8/2/24 when the open area to the right great toe was identified to 8/6/24 when the open area to the right great toe was documented as resolved, there had been no documentation that the responsible party for Resident #36 had been notified of an open area to Resident #36's right great toe which required a treatment.<br><br>Interview with the Wound Nurse, (RN #1) on 8/29/24 at 2:45 PM identified that the nursing staff updated RN #1 with new skin issues that were identified. RN #1 stated that it was the responsibility of the nurse or unit manager who identified the skin issue or open area to call the responsible party and update them on the new finding, unless the wound was substantial and required detailed explanation by RN #1. RN #1 was unable to identify the reason the responsible party had not been notified.<br><br>Interview with Person #1 on 8/30/24 at 9:40 AM identified that there had been no notification from the facility about the open area to Resident #36's right great toe documented by RN #1 on 8/2/24.<br><br>A facility policy for family notification of change/new orders/wounds was requested and the Change in Condition policy was provided. This policy was reviewed and directed, in part, that the responsible party must be notified of changes in status and this notification is documented in the nurses' notes.<br><br>2. Resident #69's diagnoses included chronic systolic chronic heart failure (CHF), acute kidney failure, and hypertension (high blood pressure).<br><br>A physician's order dated 7/7/24 directed to weigh Resident #69 one time a day for CHF and notify the physician or Advanced Practice Registered Nurse (APRN) if the weight was greater than or less than 3 pounds (lbs) per day, or greater than or less than 5 lbs per week.<br><br>The Admission Minimum Data Set assessment dated [DATE] identified Resident #69 was moderately cognitively impaired, required partial/moderate assistance with personal hygiene, and was dependent with toileting hygiene and sit to lying position.<br><br>The Resident Care Plan dated 7/25/24 identified a potential for impaired nutrition/hydration due to chronic kidney disease, use of a diuretic, and weight loss. Interventions included diet as ordered and weights as ordered/as needed.<br><br>Review of Resident #69's weights identified that Resident 69's weight was 125.6 lbs on 7/21/24 and 120 lbs on 7/22/24 (a 5.6 lb weight loss/a greater than 3 lb weight loss in one day).<br><br>Interview with LPN #7 on 8/29/24 at 11:07 AM identified the Nurse Aides (NA) were responsible for completing the weights on the residents, and that the nurses were responsible for documenting the resident's weight in the clinical record. Additionally, if there was a weight fluctuation of greater than or less than 3 lbs in one day, then it would be the responsibility of the nurse to notify the supervisor and APRN, and document it in a nursing note.<br><br>Interview and clinical record review with APRN #1 on 8/20/24 at 9:43 AM identified that per the physician's order, she would have expected to have been notified when Resident #69 had lost more than 3 lbs in one day on 7/22/24. Additionally, APRN #1 identified that she would have assessed the change in weight further to determine the cause of the fluctuation and whether the resident needed to be evaluated.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the nurses' notes failed to identify that the physician or APRN was notified regarding the greater than 3 lb weight loss on 7/22/24.<br><br>Review of the Weights/Re-weights Policy and Procedure updated 3/4/24 directed, in part, that for residents with CHF, the physician would be consulted for orders for daily weights and/or reporting parameters, or as ordered.<br><br>3. Resident #476's diagnosis included multiple vertebral compression fractures, pneumonia, and falls.<br><br>Physician progress notes dated 8/13/24 directed Resident #476 to wear a thoracic lumbar sacral orthosis (TSLO) brace while out of bed.<br><br>An Advance Practice Registered Nurse (APRN) progress note dated 8/14/24 identified that Resident #476 was to wear the TSLO back brace when he/she was out of bed.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #476 was moderately cognitively impaired, required extensive assist of 1 for bed mobility, moderate assist for toileting, and personal hygiene, limited assist of 1 for transfers, and independent for eating.<br><br>Observation on 8/26/24 at 1:50 PM noted Resident #476 coming out of the bathroom with the walker, sat him/her self in the wheelchair without the benefit of wearing the TSLO. Additionally, observation on 8/27/24 at 9:35 AM noted Resident #476 seated in the wheelchair without the benefit of wearing the TSLO.<br><br>Further observation on 8/28/24 at 9:53 AM identified Resident #476 was seated in the wheelchair without the benefit of wearing the TSLO (the TSLO was observed to be on Resident #476's bed).<br><br>On 8/28/24 at 12:12 PM, an interview with Nurse Aide (NA) #6 identified Resident #476 refused to wear the TSLO brace and she reported that to Licensed Practical Nurse (LPN) #1.<br><br>On 8/28/24 at 12:15 PM an interview with LPN #1 identified that Resident #476 refused to wear the TSLO brace, and that she removed it all the time herself. LPN #1 also identified that she was unaware if the physician had been notified of the resident's refusal to wear the brace and if there was an order in place for refusals.<br><br>Subsequent to surveyor inquiry, nursing notes dated 8/28/24 at 2:19 PM identified that LPN#1 had notified the APRN and spoke to the spine center that follows Resident #476 regarding the resident's refusal to wear the TSLO.<br><br>On 8/30/24 at 9:42 AM, APRN #1 identified that she was unaware that Resident #476 was refusing to wear the TSLO brace and would expect to be notified of the resident's refusal to wear.<br><br>Review of the facility policy for Refusal of Treatment was to determine the resident's cognitive capacity to decide refusal of treatment, if a resident continues to refuse, determine severity of the refusal, if the refusal will negatively affect the resident notify the Physician/ APRN of refusal if noted to be of significant importance.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Subsequent to surveyor inquiry, the RCP was updated on 8/28/24 identifying Resident #476 may decline the use of the TSLO brace at times with interventions to encourage the resident to wear the TSLO brace, to reapproach as needed, and to document refusals. Furthermore, a follow-up appointment was made with the spine specialist.<br><br>51183 |

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| F 0585<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177<br><br>Based on interviews during the Resident Council meeting, staff interviews, review of the Resident Council meeting minutes, review of the facility grievance book, review of the clinical record, and facility policy for the only sampled resident (Resident #106) reviewed for grievances, the facility failed to resolve a grievance regarding a request for having a water pitcher at night. The findings include:<br><br>Resident #106's diagnoses included anemia, cervical disc disorder, and peripheral vascular disease.<br><br>A physician's order dated 1/17/24 directed to set up for feeding and set up for hygiene/grooming. Resident #106 was not identified to be on a fluid restriction.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #106 was cognitively intact and was independent with eating and oral hygiene.<br><br>The Resident Care Plan dated 4/10/24 identified Resident #106 required assistance with activities of daily living (ADLs). Interventions included to set up for feeding, set up for hygiene/grooming, and encourage resident to participate in ADLs.<br><br>Review of the Resident Council meeting minutes dated 4/30/24 identified Resident #106 had a concern regarding water pitchers not being available to him/her overnight. The Dietary department documented in the Resident Council minutes that the water pitchers were removed between 8:00 PM and 5:00 AM to be washed and were returned to the floor prior to 6:00 AM. The Administrator documented in the minutes that he would have the facility order more water pitchers. Although the Resident Council minutes identified the process for removing water pitchers and ordering more water pitchers, the Resident Council minutes did not identify that Resident #106's request for a water pitcher was provided during the overnight hours.<br><br>Review of the Resident Council meeting minutes dated 5/30/24 identified Resident #106 and another resident stated that water pitchers were still not available from 11:00 PM to 7:00 AM. The water pitchers were being removed on the 3:00 PM to 11:00 PM shift to be washed and were not being replaced to be available during the overnight hours.<br><br>Review of the Resident Council meeting minutes dated 6/27/24 identified that some residents still did not have water pitchers available overnight.<br><br>During the Resident Council meeting on 8/29/24 at 1:11 PM, Resident #106 identified that water pitchers were not available overnight and that this concern had been mentioned to the facility approximately 6 months ago.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Interview with the Assistant Director of Nursing Services (ADNS) on 8/30/24 at 10:20 AM identified that the nurses would offer residents water in cups at night, and that certain residents could have water pitchers per preference. The ADNS further indicated that the facility had ordered and had received more water pitchers (as previously stated by the Administrator). Additionally, the ADNS identified that the facility was planning to implement a water pitcher overnight, and that when a water pitcher was removed to be cleaned, another water pitcher would be provided.<br><br>Review of the Grievance policy directed, in part, that the facility administration would make every effort to promptly and satisfactorily resolve any complaint, concern, or grievance. The appropriate staff member would meet with the complainant to discuss the nature of the complaint and would attempt to resolve the matter to the resident or family's satisfaction. If the person voicing the grievance was not satisfied with the facility's response, the issue would be reviewed by administration and a care plan meeting could be held to address the concern. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177<br><br>Based on interviews and review of the clinical record for 1 of 2 residents (Resident #4) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment was accurately coded for PASRR Level II. The findings include:<br><br>Resident #4's diagnoses included schizophrenia, depressive episodes, and dementia.<br><br>The PASRR Level I assessment dated [DATE] included a diagnosis of schizophrenia and indicated that a PASRR Level II assessment must be completed. The PASRR Level II assessment dated [DATE] indicated that Resident #4 may be admitted /continue to reside in a nursing facility.<br><br>The annual MDS assessment dated [DATE] identified Resident #4 was severely cognitively impaired and required extensive assistance with a one-person physical assist for bed mobility, transfer, and personal hygiene. Additionally, the MDS identified psychiatric/mood disorders of depression and schizophrenia and that Resident #4 received antipsychotic and antidepressant medication. The MDS did not identify that Resident #4 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or related condition.<br><br>The Resident Care Plan dated 5/23/22 identified that Resident #4 used psychotropic medications related to schizophrenia. Interventions included to administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift, and psych interventions as needed.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] continued to identify psychiatric/mood disorders of depression and schizophrenia and that Resident #4 received antipsychotic and antidepressant medication. Additionally, the MDS assessment did not identify that Resident #4 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or related condition (despite a Level II PASRR being completed on 5/7/15 identifying a mental illness).<br><br>Interview and clinical record review with Social Worker #1 on 8/29/24 at 10:10 AM identified that Section A 1500 of the comprehensive MDS was coded by the Social Workers. Additionally, Social Worker #1 identified that the PASRR documentation in the clinical record did include a Level II having been completed on 5/7/15. Social Worker #1 further indicated that Resident #4 did not appear on her list regarding a Level II, however Resident #4 would be added to the list and section A 1500 would be coded correctly on the comprehensive MDS assessments.<br><br>Subsequent to surveyor inquiry on 8/29/24, a correction was completed and submitted for the annual MDS assessment dated [DATE] which identified Resident #4 as having a PASRR Level II status.<br><br>Although requested, a facility policy for PASRR was not provided. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102<br><br>Based on observations, interviews and record review for 1 of 2 residents (Resident #32) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure a dependent resident was provided with necessary assistance to maintain good grooming. The findings include:<br><br>Resident #32's diagnoses included unspecified macular degeneration, bilateral cataracts, cerebral infraction and dementia.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was severely cognitively impaired, and needed substantial/maximal assistance for eating, toileting and transfers.<br><br>The Resident Care Plan dated 8/28/24 identified Resident #32 had an ADL self-care performance deficit relating to confusion, Alzheimer's dementia and limited mobility. Interventions included assistance of one staff member for bathing/showering, dressing, personal hygiene, and oral care/grooming.<br><br>Nursing notes dated 8/27/24 through 8/29/24 did not identify resident refusals of care.<br><br>Observations of Resident #32 on 8/27/24 at 11:47 AM, 8/28/24 at 12:47 PM and 8/29/24 9:20 AM noted Resident 332 was unshaven with disheveled hair.<br><br>Observation of Resident #32 on 8/28/24 at 12:46 PM identified Resident #32 was still unshaven with more facial hair since 8/27/24's observation. Interview with Nurse Aide (NA) #2 on 8/28/24 at 12:47 PM identified she did not shave Resident #32 because she had a hard time using the disposable razor since it did not catch all the hair, adding that facility policy was to shave Resident #32 on shower days (residents routinely receive weekly showers) and if unable to do so, report it to the nurse.<br><br>Interview with NA #3 on 8/28/24 at 1:20 PM identified it was the facility policy to shave Resident #32 every day or every other day as needed and to let the nurse know if the resident refused.<br><br>Interview with Licensed Practical Nurse (LPN) #4 on 8/28/24 at 1:23 PM identified it was facility policy that all shifts shave residents when needed, report any refusals to the nurse, who would reapproach then document the refusal, adding there's barely any refusals here 9/10 times the residents allow it. LPN #4 identified that no refusals were reported on Resident #32 that day.<br><br>Review of the Grooming Policy directed that grooming is to be done to maintain a resident's dignity regarding hairstyle and facial hair, in addition if a resident is unable to express their personal preference socially acceptable and age-appropriate grooming should be provided. |

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| Whitney Rehabilitation Care Center | 2798 Whitney Avenue<br>Hamden, CT 06518 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177<br><br>Based on interviews, review of the clinical record, and facility policy for 1 of 2 residents (Resident #32) reviewed for positioning, the facility failed to follow physician's orders for proper positioning and documentation and for 1 of 4 residents (Resident #69) reviewed for pressure ulcers, the facility failed to follow a physician's order to obtain daily weights for a resident with Congestive Heart Failure (CHF). Additionally, for the only sampled resident (Resident #153) reviewed for anticoagulant therapy, the facility failed to address the continuation of an anticoagulant for a resident with a diagnosis of deep vein thrombosis (DVT) and for 1 of 3 residents (Resident #173) reviewed for closed records, the facility failed to perform blood glucose monitoring as directed by a provider and failed to initiate an intervention to prevent hypoglycemia for a resident experiencing hypoglycemic episodes. The findings include:<br><br>1. Resident #32's diagnoses included unspecified macular degeneration, bilateral cataracts, cerebral infraction and dementia.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was severely cognitively impaired, and required substantial/maximal assistance for eating, toileting and transfers.<br><br>The Resident Care Plan dated 8/28/24 identified Resident #32 had an Activities of Daily Living (ADL) self-care performance deficit relating to confusion, Alzheimer's dementia and limited mobility. Interventions included transfer with assistance of 2 staff members and out of bed to a customized wheelchair per a 24-hour positioning plan.<br><br>A physician's order dated 10/13/22 and currently in effect, directed Resident #32 to be out of bed per 24-hour positioning plan.<br><br>A physician's order dated 4/15/23 directed to document on Resident #32's custom wheelchair comfort, positioning and pain in the nurses progress notes every 15th of the month.<br><br>The 24-Hour Positioning Plan directed Resident #32 to be out of bed after morning (AM) care, out of chair or back to bed as needed for peri-care on the 7:00 AM to 3:00 PM shift, and out of bed as tolerated on the 3:00 PM to 11:00 PM shift.<br><br>Clinical record review of Nursing progress notes dated 3/1/24 through 8/29/24 failed to reflect monthly custom wheelchair documentation on Resident #32's comfort, positioning or pain.<br><br>Observations on 8/26/24 at 12:41 PM, 8/27/24 at 11:47 AM and 8/29/24 at 11:05 AM identified Resident #32 in bed after AM care (and not out of bed per the 24 hour positioning plan).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with the Occupational Therapist (OT) #1 on 8/29/24 at 10:42 AM identified the 24-hour positioning plan was individualized for each resident, and nursing staff was responsible for ensuring it was followed, as well as reporting issues to therapy. Furthermore, monthly notes were written by the nursing department, and quarterly notes for customized wheelchairs were written by the therapy department. OT #1 identified effects of not following the positioning plan for Resident #32 included increased weakness, pneumonia and everything that goes along with not getting out of bed.<br><br>Interview and record review with Nurse Aide (NA) #5 on 8/29/24 at 11:21 AM identified that Resident #32's care card (NA Resident Assignment) sheet directed for Resident #32 to be out of bed to a custom wheelchair with a 24-hour positioning plan, offer for back to bed after lunch/dinner and offer to be out of bed if awake on the 3:00 PM to 11:00 PM shift. NA #5 identified that she usually gets Resident #32 up and out of bed 2 times a week, and since Resident #32 was up and out of bed yesterday, she was going to keep him/her in bed today. When questioned if Resident #32 wanted to stay in bed, NA #5 confirmed no that was my preference, since he/she was up all day yesterday.<br><br>Interview and clinical record review with Licensed Practical Nurse (LPN) #6 on 8/29/24 at 11:30 AM identified the NA was responsible for getting the residents up and out of bed, and Resident #32 should have been out of bed. The clinical record failed to reflect documentation on Resident #32's customized wheelchair positing per physician's order.<br><br>Interview and clinical record review with OT #1 on 8/30/24 at 10:49 AM identified the therapy department wrote quarterly customized wheelchair notes, however notes could not be provided because Resident #32 was technically in an adaptive wheelchair, and the two terms adaptive and customized should not be used interchangeably. Review of the Occupational Therapy Encounter note dated 11/15/23 signed by OT #1 identified Resident #32 would benefit from skilled OT to maximize functional endurance for self-feed and out of bed activities in custom wheelchair.<br><br>Review of the Customized Wheelchairs policy directed to identify resident who will benefit from improved wheelchair positioning, additionally upon delivery of custom wheelchair the following will be done: complete therapy evaluation, establish a 24 hour positioning plan, complete nursing documentation monthly in PCC (the electronic health record program) using the template, complete therapy documentation quarterly in the therapy department, and request any necessary modification based on clinical review or as identified during daily care.<br><br>2. Resident #69 was admitted to the facility on [DATE] with diagnoses that included chronic systolic CHF, acute kidney failure, and hypertension (high blood pressure).<br><br>A physician's order dated 7/7/24 directed to weigh Resident #69 one time a day for CHF and notify the physician or Advanced Practice Registered Nurse (APRN) if the weight was greater than or less than 3 pounds (lbs) per day, or greater than or less than 5 lbs per week.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #69 was moderately cognitively impaired, required partial/moderate assistance with personal hygiene, and was dependent with toileting hygiene and to the sit to lying position.<br><br>The Resident Care Plan dated 7/25/24 identified a potential for impaired nutrition/hydration due to chronic kidney disease, use of a diuretic, and weight loss. Interventions included diet as ordered and weights as ordered/as needed.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Electronic Medication Administration Record (EMAR) identified that daily weights were signed off as completed on 7/11/24, 7/13/24, 7/16/24, 7/18/24, 7/20/24, 7/25/24, 7/27/24, 7/29/24, 8/2/24, 8/3/24, 8/4/24, 8/5/24, 8/7/24, 8/8/24, 8/9/24, 8/10/24, 8/12/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/19/24, 8/21/24, 8/23/24, 8/25/24, 8/26/24, and 8/27/24, but the weight for each corresponding day was not documented in Resident #69's clinical record (despite being signed off as completed). Additionally, the clinical record failed to identify if Resident #69 refused to be weighed on any of these days.<br><br>Interview with Nurse Aide (NA) #3 on 8/29/24 at 10:56 AM identified that the NAs were responsible for completing the weights on the residents. Additionally, the NAs would tell the nurse how much the resident weighed, and the nurse would document the weight in the resident's clinical record. The NAs would also advise the nurse if the resident refused to be weighed. NA #3 further indicated that she would know if a resident had to be weighed daily by referring to the NA care card.<br><br>Interview with Licensed Practical Nurse (LPN) #7 on 8/29/24 at 11:07 AM identified that the NAs were responsible for completing the weights on the residents. The NAs would know if a resident had to be weighed daily by referring to their daily assignment sheet, the NA care card, and/or the nurse would verbally tell the NA. Additionally, the nurse was responsible for documenting the resident's weight in the clinical record as the NAs do not look at the EMAR. LPN #7 further indicated that it would be the responsibility of the nurse who transcribed the physician orders to also update the NA care card.<br><br>Interview and clinical record review with Registered Nurse (RN) #1 on 8/29/24 at 12:05 PM identified that she had transcribed the physician order of daily weights into the EMAR. but identified that she did not add daily weights to the NA care card. RN #1 further indicated that the NAs would know if a resident had to be weighed daily by being told verbally by the nurse and/or by referring to their daily assignment sheet.<br><br>Interview and clinical record review with LPN #6 on 8/29/24 at 12:15 PM identified that she had signed off on the EMAR that weights were completed for Resident #69 on 8/3/24, 8/4/24, 8/5/24, 8/9/24, 8/10/24, 8/12/24, 8/14/24, 8/15/24, 8/17/24, 8/19/24, 8/23/24, and 8/26/24 without documenting the weight. LPN #6 further indicated that the weights could either have not been completed or not documented on these days.<br><br>Review of the NA care card (revised 7/8/24) failed to identify that Resident #69 had to be weighed daily.<br><br>Review of the NA assignment sheet dated 8/29/24 failed to identify that Resident #69 had to be weighed daily. Additionally, a blank copy of the NA assignment sheet also failed to identify Resident #69 had to be weighed daily.<br><br>Interview with the Assistant Director of Nursing Services (ADNS) on 8/30/24 at 8:42 AM identified that it was the responsibility of the charge nurse or supervisor to update the NA care card. Additionally, the ADNS identified that he would not add daily weights to the NA care card. The ADNS further indicated that the NAs would know if a resident had to be weighed daily by referring to their daily assignment sheet.<br><br>Although requested, a facility policy for NA care cards was not provided.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Weights/Re-weights Policy and Procedure updated 3/4/24 directed, in part, that for residents with CHF, the physician would be consulted for orders for daily weights and/or reporting parameters, or as ordered. Additionally, weights would be inputted into the medical record by the nurse.<br><br>3. Resident #153's diagnoses included acute embolism and thrombosis (blood clot) of the right femoral vein and bilateral lower extremities, surgical aftercare following surgery on the circulatory system (thrombectomy/blood clot removal) and presence of other vascular implants and grafts.<br><br>An inter-agency patient referral form (W10) from Resident #153's initial admission to the facility on [DATE] indicated Lovenox (an anticoagulant medication) 100 milligrams/milliliter (mg/ml), inject 100 mg subcutaneously one time a day for status post deep vein thrombosis (blood clot in the legs, or DVT) with no end date.<br><br>A physician's order dated 6/27/24 indicated anticoagulation medication, Enoxaprin Sodium injection Solution/Lovenox 100 mg/ml , inject 100 mg subcutaneously one time a day for status post DVT and directed to monitor for signs of bleeding, bruising, change in mental status or vital signs every shift.<br><br>A physician's progress noted dated 6/28/24 at 4:15 PM identified Resident #153 was found to have an extensive clot burden in his/her bilateral lower extremities and was seen by hematology and neurology for anticoagulation recommendations. Additionally, the progress note indicated Resident #153 had been started on Lovenox for recurrent bilateral lower extremity DVT.<br><br>Review of the W10 and hospital discharge summary from Resident #153's re-admission to the facility from the acute care hospital on 7/11/24 directed Lovenox 100 mg/ml, inject 100 mg subcutaneously one time a day for status post DVT and no stop date was indicated. Additionally, the hospital discharge summary dated 7/11/24 identified that Resident #153 had presented from the skilled nursing facility (SNF) on 6/30/24 as a stroke alert for altered mental status (AMS), confusion and dysphagia (difficulty speaking) and that neurology suspected the symptoms were due to an amyloid spell (brief neurological episode).<br><br>A physician's progress note dated 7/12/24 at 9:12 PM identified recurrent bilateral lower extremity DVT with thrombectomy (clot removal) and to continue Lovenox.<br><br>A medication order from the Advanced Practice Registered Nurse (APRN #1) dated 7/12/24 indicated Enoxaparin Sodium (Lovenox) 100 mg/ml, inject 100 mg subcutaneously one time a day for history of DVT until 7/28/24.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #153 was moderately cognitively impaired and required substantial/maximal assistance of 2 persons for transfers, toileting and bed mobility. Additionally, the MDS identified Resident #153's diagnosis of DVT with indication for an anticoagulant.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A progress note from APRN #2 on 7/16/24 at 1:34 PM identified Resident #153 was readmitted to the facility following a hospitalization from [DATE]-[DATE] with recent bilateral lower extremity deep vein thrombosis (blood clot, or DVT) status post thrombectomy (clot removal) on 6/20/24 and a history of pulmonary embolism (blood clot in the lung, or PE) and inferior vena cava (IVC) filter. Additionally, the 7/16/24 progress note identified Resident #153 was on Lovenox with a prolonged hospitalization and to continue Lovenox.<br><br>The Resident Care Plan dated 7/23/24 identified anticoagulation medications with interventions that included to administer relevant medications and monitor labs as directed.<br><br>A progress note from APRN #2 on 7/29/24 at 1:32 PM identified recurrent bilateral lower extremity DVT, history of DVT and PE, status post IVC filter with recent bilateral lower extremity DVT and status post thrombectomy on 6/20/24. Additionally the progress note indicated that Lovenox was started with prolonged hospitalization and to continue Lovenox despite intermittent hematuria.<br><br>Interview and record review with the Advanced Practice Registered Nurse (APRN) #1 on 8/28/24 at 1:51 PM identified that Resident #153 had not received Lovenox from 7/28/24 through 8/28/24 in error. The inter-agency patient referral form (W10) and discharge summary from 7/11/24 did not identify an end date for the Lovenox. APRN #1 indicated that for Resident #153's re-admission to the facility on [DATE], all medication orders should have been taken from the W10 and that the Lovenox order should not have been discontinued. APRN #1 was unable to identify the reason the 7/12/24 order for the Lovenox, with an end date of 7/28/24, was put into the electronic health record (EHR) under her name. APRN #1 further identified that with Resident #153's history of DVT and PE he/she should have been continued on an anticoagulant and that not being on an anticoagulant could cause non-dissolution of blood clots and a recurrence of a DVT or PE.<br><br>Subsequent to surveyor inquiry on 8/28/24, APRN #1 entered a new order directing to administer Lovenox (Enoxaparin Sodium)100 mg/ml, inject 100 mg subcutaneously one time a day for history of DVT.<br><br>Interview and record review with the ADNS on 8/29/24 at 9:30 AM indicated that for re-admissions to the facility it was the facility policy to follow the W10 for medication orders and that the discharge summary may be cross referenced. The medication orders are then verified with the MD or APRN. The ADNS identified that both the W10 and discharge summary from 7/11/24 for Resident #153 did not indicate an end date for the Lovenox.<br><br>Interview with APRN #2 on 8/29/24 at 10:30 AM indicated that she was not aware that Resident #153 was no longer being administered Lovenox when she wrote her progress note on 7/29/24 noting Resident #153 continued on Lovenox. APRN #2 further identified that she did not recall an end date on the Lovenox order and that although her progress note from 7/29/24 was uploaded into the EHR, she was not sure if the nursing staff would have reviewed it, but that Resident #153 should have been continued on the Lovenox. Additionally APRN #2 indicated that, based on Resident #153's recent and recurrent history of DVT and PE, there was no reason for the Lovenox order to have an end date and that she had not discontinued it.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with LPN #10 on 8/29/24 at 11:32 AM indicated that she was familiar with Resident #153 but was unable to recall all of the medication orders or the reason the 7/12/24 Lovenox order was given an end date of 7/28/24. LPN #10 further identified that APRN #1 wrote the Lovenox order on 7/12/24 with the 7/28/24 end date. LPN #10 indicated that she confirmed and transcribed the Lovenox order, but did not initiate or change the Lovenox order on 7/12/24.<br><br>Review of the facility Admissions Policy, undated, directed to review the W10 and hospital discharge summary and to transcribe all orders onto the physician's order sheet.<br><br>Review of the facility policy, Verification of New Admission Medication Orders, dated 9/2022, directed that medication orders were to be transcribed from the hospital W10/Discharge summary upon admission and put into the residents EHR.<br><br>Review of the facility policy, Anticoagulation Therapy, undated, directed the purpose of anticoagulation therapy was to treat someone who has a blood clot, such as a clot in the veins of the leg (a deep vein thrombosis, or DVT) or the arteries of the lung (a pulmonary embolus, or PE), and to prevent a blood clot in someone who is at high risk of getting one.<br><br>4. Resident #173 diagnoses included type II diabetes mellitus (DM), chronic kidney disease, and congestive heart failure.<br><br>An admission physician order dated 6/5/24 directed blood glucose monitoring four times a day (before meals and at hours of sleep) with sliding scale Insulin coverage.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #173 had intact cognition and required extensive assistance for bed mobility and transfers.<br><br>An Advanced Practice Registered Nurse (APRN) progress note dated 6/17/24 at 1:19 PM identified Resident #173 was seen for DM after experiencing hypoglycemia (low blood sugar), at times, in the morning. The Assessment and Plan section of the APRN progress note identified Humalog Insulin would be discontinued and directed to monitor blood sugars (Resident #173 was also to continue Glipizide 5 mg every day).<br><br>An APRN progress note dated 6/20/24 at 1:22 PM identified Resident #173 was seen for DM after continued hypoglycemia in the morning/fasting blood sugar in the morning was 60-80 at times. The Assessment and Plan section of the APRN progress note directed to monitor blood sugars, decrease Glipizide to 2.5 mg by mouth every day and provide a nighttime snack as needed.<br><br>Review of the June 2024 Order Summary Report identified Resident #173's Humalog Insulin was discontinued on 6/17/24 by APRN #2, attached to the Humalog Insulin order, in the electronic medical record (EMR), was the blood glucose monitoring action. The Humalog Insulin and the blood glucose monitoring were discontinued simultaneously. Additionally, there was no order in June of 2024 for providing a nighttime snack.<br><br>Review of the Weights and Vitals Summary identified blood glucose monitoring 4 times per day from admission through 6/16/24 was completed. The last blood glucose documented was on 6/17/24 at 7:26 AM with no further blood glucose monitoring completed until a transfer to the hospital was initiated on 6/29/24, and a blood glucose level of 49 was identified.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the clinical record identified Resident #173 experienced a change in condition on 6/29/24. The facility document titled SBAR Communication Form and Progress Note dated 6/29/24 at 4:59 PM identified Resident #173 complained of chest pain, was diaphoretic, had an elevated blood pressure (170/80) and a blood glucose level of 49 requiring the administration of Glucagon (an emergency injection used to treat severely low blood sugar in people with DM). Resident #173 was transferred to the hospital.<br><br>Review of the hospital discharge summary dated 7/9/24 at 3:59 PM identified Resident #173 was hypothermic upon arrival to the hospital and the hypothermia was felt to be related to the hypoglycemia.<br><br>Interview and review of the clinical record with the ADNS on 8/28/24 at 2:48 PM identified there was no provider order to provide a nighttime snack as needed. The ADNS further identified there should have been an order if the APRN directed the intervention. The ADNS was unable to provide any form of documentation that Resident #173 received nighttime snacks.<br><br>Interview with APRN #2 on 8/29/24 at 10:36 AM indicated blood glucose monitoring should be performed for a resident experiencing hypoglycemic episodes as well as for a resident requiring changes to medications used to treat DM. APRN #2 identified she was aware the blood glucose monitoring action, in the EMR, was at times attached to insulin orders and indicated it was not her intention to discontinue the blood glucose monitoring. APRN #2 further identified if she did not add an order for a nighttime snack but directed to provide a nighttime snack in her Assessment and Plan, she would have given a verbal order, to a nurse, who should have added the order in the EMR and did not know where she obtained the information that Resident #173 had hypoglycemia in the morning from her 6/20/24 progress note since there was no blood glucose monitoring results available.<br><br>Interview with the Director of Nursing (DNS) on 8/29/24 at 11:34 AM indicated orders entered by a provider were presumed to be correct by the nursing staff. The DNS stated there was an order verification process but could not describe the process and further indicated nursing would not question the accuracy of a provider entered order.<br><br>The inadvertently discontinued blood glucose monitoring omitted 50 instances of blood glucose monitoring over 13 days.<br><br>Although requested, the facility was unable to provide a policy on order verification.<br><br>50249<br><br>50890<br><br>51102 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249<br><br>Based on interviews, observations, review of the clinical record, facility documentation, and facility policy for 1 of 4 residents (Resident #74) reviewed for pressure ulcers, the facility failed to correctly set and monitor an air mattress for a resident that resulted in the worsening of a pressure ulcer. The findings include:<br><br>Resident #74's diagnoses included type 2 diabetes mellitus, anemia, and hyponatremia (low sodium in the blood).<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #74 had intact cognition and required extensive assistance of two persons for transfers, toileting and bed mobility. Additionally, the MDS identified Resident #74 had an unhealed pressure ulcer and required a pressure reducing device for his/her bed.<br><br>The Resident Care Plan (RCP) dated 8/7/24 identified an actual alteration in skin integrity due to a Stage 3 pressure ulcer to Resident # 4's left buttocks. Interventions included an air mattress to the bed but failed to include specific air mattress settings. Additionally, the RCP indicated to encourage assistance with turning and positioning every 2 hours and as needed (but there was no documentation that a turning and positioning schedule was implemented).<br><br>The Nurse Aide Care Card identified Resident #74 was an assist of 1 for bed mobility but did not indicate any turning and positioning directives.<br><br>The Wound Physician's (MD #1) progress note dated 8/7/24 at 1:02 PM identified a left buttock Stage 3 pressure ulcer with measurements of 3.0 centimeters (cm) by 4.0 cm by 0.1 cm. Wound status was indicated as improved.<br><br>The Wound Physician's (MD #1) progress note dated 8/14/24 at 1:33 PM identified a left buttock Stage 3 pressure ulcer with measurements of 3.0 cm by 3.8 cm by 0.1 cm. Wound status was indicated as improved.<br><br>The Wound Physician's (MD #1) progress note dated 8/21/24 at 6:54 PM identified a left buttock Stage 3 pressure ulcer with measurements of 3.0 cm by 3.8 cm by 0.1 cm. Wound status was indicated as improved, despite measurements.<br><br>Observation and interview on 8/26/24 at 11:45 AM identified Resident #74 was lying in bed with the head of the bed elevated. Resident #74 indicated he/she was uncomfortable in the bed and that he/she was in pain due to the wound on his/her buttocks. An air mattress was observed in place on the bed and the dial was set at 150 lbs. LPN #1 was made aware of Resident #74's complaints of being uncomfortable and in pain.<br><br>(continued on next page) |

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| | 075246 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Whitney Rehabilitation Care Center | 2798 Whitney Avenue<br>Hamden, CT 06518 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Observation and interview on 8/27/24 at 9:40 AM identified Resident #74 was sitting upright on the side of his/her bed with a bed pillow in place under his/her buttocks. Resident #74 indicated that the air mattress was very uncomfortable and that it felt like he/she was sitting on rocks. Resident #74 further indicated he/she was in pain due to the wound on his/her buttocks and the air mattress being like rocks. An air mattress was observed in place on the bed with the dial set at 150 lbs.<br><br>Observation, interview and record review on 8/27/24 at 9:45 AM with the Wound Nurse (RN #1) identified that the air mattress was in place to help relieve pressure and promote healing for Resident #74's left buttock Stage 3 pressure ulcer. RN #1 indicated that the nursing staff were responsible for monitoring and setting the air mattress for Resident #74 every shift. RN #1 further identified that although Resident #74's current weight was 104 pounds (lbs), the air mattress dial was incorrectly set for a resident at 150 lbs. RN #1 then re-set the air mattress dial to the correct weight for Resident #74 and told the resident she would check on him/her later to see that the mattress was more comfortable after her adjustment. Review of the clinical record with RN #1 identified that a physician's order for setting and monitoring the air mattress was not in place for Resident #74. RN #1 indicated that the order should have been obtained from the physician when the air mattress was first initiated and that she would obtain a new order.<br><br>On 8/27/24 at 1:00 PM observation of Resident #74 identified he/she was in his/her room, seated on a roho cushion in the wheelchair.<br><br>Subsequent to surveyor inquiry, a physician's order dated 8/27/24, indicated to check setting and function of the air mattress every shift.<br><br>Observation and interview with the Wound Physician (MD #1) on 8/28/24 at 1:11 PM identified Resident #74's left buttock Stage 3 pressure ulcer had worsened since her last assessment on 8/21/24 and that the wound had more depth, with tunneling and undermining noted from 11-2 o'clock. MD #1 further identified that the area of slough she removed from the wound was right over the bone and the wound was also deeper in that area which indicated the wound had been exposed to more pressure since her last visit. MD #1 indicated that the external components of pressure, due to the air mattress being set too firm, had caused worsening of Resident # 74's wound. Additionally, MD #1 identified that she was familiar with Resident #74's wound because she had treated him/her weekly since admission. MD #1 then directed RN #1 to communicate with the nursing staff regarding regularly monitoring Resident #74's air mattress to ensure the appropriate setting.<br><br>The Wound Physician's (MD #1) progress note dated 8/28/24 at 1:44 PM identified a left buttock pressure ulcer now unstageable, with measurements of 3 cm x 3 cm x 1.5 cm with new undermining of the wound indicated from 11 o'clock to 2 o'clock which equaled 2 cm. Wound status was identified as stalled.<br><br>The on-line manufacturer's manual for the air mattress applied to Resident #74's bed directed to determine the patient's weight and set the control knob to that setting on the control unit.<br><br>Review of the facility Air Mattress policy, undated, indicated the use of an air mattress was for the prevention and treatment of wounds by providing pressure relief and/or redistribution of pressure. The policy further directed to observe the mattress each shift to make sure that the pump was functioning correctly and settings were accurate, reset as needed. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183<br><br>Based on review of the clinical record and interviews for 1 of 5 sampled residents (Resident #61) reviewed for accidents, the facility failed to ensure a physician's order for ambulation was implemented according to the resident plan of care. The findings include:<br><br>Resident #61's diagnoses included wedge compression fracture of fourth thoracic vertebra, osteoarthritis, history of breast cancer, thoracolumbar fusion of spine.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified that Resident #61 was cognitively intact, independent with personal hygiene, toilet transfers, and that ambulation was not applicable.<br><br>The Resident Care Plan dated 7/2/24 identified Resident #61 required assistance with activities of daily living (ADLs) and had decreased mobility related to chronic disease process. Interventions included Resident #61 was independent for squat pivot transfers, required one person assist for bathing and dressing, and required one person assist with ambulation for short distances using a rolling walker.<br><br>A physician's order dated 8/8/24 directed to ambulate Resident #61 with two persons assist using the rolling walker.<br><br>The Nurse Aide (NA) Resident Care Card (Individualized Resident Assignment) dated 8/8/24 identified Resident #61 required two persons assist with ambulation for short distances using a rolling walker.<br><br>The NA Resident Care Card dated 8/28/24 identified Resident #61 required two person assist with toileting, transfers, and ambulation for short distances using a rolling walker.<br><br>Interview with the Rehabilitation Director/Occupational Therapist (OT) #1 and Physical Therapist (PT) #2 on 8/29/24 at 12:15 PM identified that the facility policy was to enter their orders into the computer. This information was communicated to the Nursing Department and the nurse who entered the orders updates the Resident Care Card for the NA staff. OT #1 stated that orders were not written for a specific number of times a resident should ambulate, or where they should ambulate, and that ambulation was mostly initiated by the resident and completed to their tolerance. OT #1 indicated if there were orders in the computer for ambulation, the facility practice had been for nursing staff to ambulate Resident #61 to and from the bathroom, and in the hallway without the need to specifically direct that within the physician's order.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with NA #1 on 8/29/24 at 1:30 PM identified that she did not ambulate Resident #61 because PT does so. NA #1 indicated that if the Resident Care Card had directed her to ambulate the resident every day, she would have. NA #1 stated that she followed what is written on the Resident Care Card, but that the care card only indicated that Resident #61 requires two person assistance for ambulation and the instruction did not specify to ambulate Resident #61. NA #1 explained that this was why she had been documenting in the Point of Care electronic record that ambulation for Resident #61 was not applicable. NA #1 identified that the orders for ambulation were for PT, who was seeing the resident, not, her, and that only PT was responsible to ambulate Resident #61. NA #1 further indicated that she wheeled Resident #61 into the bathroom and would stand and pivot transfer the resident from the wheelchair to the toilet and back again. |

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| F 0803<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>19953<br><br>Based on observation and staff/resident interviews, the facility failed to follow the posted menu and provide resident's prior notification when substitutions were made. The findings include:<br><br>Observation of the lunch meal on 8/26/24 at 12:30 PM identified Resident #28 pre-selected a barbecue spare rib sandwich as his/her meal selection (which was identified on the meal ticket), and breaded fish (which was the alternative selection) was provided to him/her despite the barbecue spare rib sandwich being served from the Dietary Department.<br><br>On 8/26/24 at 10:45 AM interview with the Food Service Director (FSD) during the initial tour identified the residents formed a Food Committee to bring forth food concerns. Additionally, the FSD identified in April 2024, the Food Committee complained that the meal tickets do not match what was served and were inaccurate. The FSD identified he conducted audits in April 2024, but found no inconsistencies, the Food Committee had no specific concerns in May 2024, did not have a meeting in June 2024, and no further audits had been completed. The FSD identified that he provided one in-service to the Dietary Aide who was responsible for checking the meal ticket on the tray line, but could not provide the subject content of that in-service and no subsequent in-services had been completed with dietary staff.<br><br>On 8/28/24 at 11:45 AM interview and tray line observation with the FSD identified manicotti (no portion size identified) was on the menu for lunch, and the [NAME] was observed plating 2 stuffed shells (in place of manicotti). Additionally, sherbet was identified on the menu, and halfway through service, ice cream was substituted for sherbet. Interview with the FSD at that time identified that the cook must have removed the manicotti from the freezer by mistake, which was located near the stuffed shells, and they ran out of ice cream but could not identify the reason they didn't have sufficient ice cream. Additionally, the FSD identified he did not notify the residents of a change in the lunch menu.<br><br>On 8/28/24 at 1:11 PM, interview during the Resident Council meeting identified the meal tickets do not always reflect what they select when they choose their menu items or the meal ticket does not reflect the food that was provided/served.<br><br>50890 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>19953<br><br>Based on interviews and a sample taste tray, the facility failed to ensure food was palatable. The findings include:<br><br>Interview with Resident #45 on 8/26/24 at 11:30 AM identified he/she didn't like the taste of the food, and the food was of poor quality. Additionally, the cold food was not cold and there was not enough fresh fruit/vegetables provided.<br><br>On 8/28/24 at 12:00 PM, a taste tray was conducted which consisted of cooked broccoli stems (no florets) and 2 manicotti (substituted for stuffed shells which were on the menu). Both items (broccoli stems and manicotti) were overcooked/mushy and extremely bland.<br><br>Interview with the Food Service Director (FSD) at that time identified he was aware the broccoli was overcooked, and although there was a recipe to follow, the chef cooked the broccoli too long. He further identified although he doesn't conduct audits on the food quality, he does demonstrations with the cooks, but did not have any documentation to reflect what type of demonstrations he conducted.<br><br>On 8/29/24 at 1:11 PM, during the Resident Council meeting Resident #53 indicated the food was of poor quality, the rice was uncooked, the fish was not edible, the minestrone soup was just pasta and peas, the burger bun top was tasty but the bottom was stale, there was a lack of fresh vegetables/fruit, and the food was salty.<br><br>Additionally, Resident #106 indicated the macaroni and cheese was like a block and the ice cream was served melted and not frozen.<br><br>Also, during the Resident Council meeting on 8/29/24 at 1:11 PM, Resident #29 indicated the salad was wilted, mushy and slushy.<br><br>Facility policy for meat and vegetable cookery identified food items shall be prepared to conserve maximum nutritive value, to develop and enhance flavor and appearance. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890<br><br>Based on the tour of the Dietary Department, observations, interviews, facility policy, and facility documentation, the facility failed to ensure open food items were dated, failed to ensure the ice scoop and ice scoop tray for the ice machine and the ice machine were kept in a clean and sanitary condition, failed to maintain clean vents in the dish room and failed to cover a garbage can on the clean side of the dish room. The findings include:<br><br>Tour of the Dietary Department on [DATE] at 11:18 AM with the Dietary Manager identified the following:<br><br>a. The walk in freezer #1 contained an open package with 7 chicken patties, no open date or expiration date was identified, and the chicken patties contained freezer burn.<br><br>b. The walk in refrigerator #2 was observed with an opened package of ,d+[DATE] pound (lb) American cheese, a 1 lb open package of ham, 2 lb open package of ham and a 1 lb open package of roast beef, loosely wrapped with plastic wrap, without the benefit of an opened date and expiration dates.<br><br>c. The ice machine scoop was stored in a visibly soiled holder which was adhered to the side of the ice machine. The vents on outside of the machine had soiled removable filters and the exterior vents were covered in a thick layer of dust. Review of the Monthly Ice Machine cleaning log identified the ice machine was last cleaned [DATE].<br><br>d. 2 dish room ceiling vents were found to contain a thick layer of dust.<br><br>e. An observation on [DATE] at 9:14 AM identified an uncovered garbage can approximately ,d+[DATE] full with garbage was located on the clean side of the dish area of the dish room and not being utilized for food prep.<br><br>f. An observation on [DATE] at 12:07 PM identified the storage of a staff members beverages in the kitchen juice refrigerator near the food service tray line. The contents of the staff members beverages included: , d+[DATE] full 16 oz. plastic water bottle, ,d+[DATE] full plastic Coca-Cola bottle, and a teal colored reusable stainless steal water container. Additionally contained in the juice refrigerator were resident foods to include: 2 chef salads and 4 fruit plates. The chef salads were the lunch meal alternate.<br><br>An interview with the Dietary Manager at the time of the tour identified whoever opened food items was responsible for covering and labeling food with an open date and that the food would be considered expired 3 days after opening. The Dietary Manager further indicated the facility would not know the expiration date of the opened food if not labeled with an open date.<br><br>An interview with Dietary Aide (DA) #1 on [DATE] at 11:47 AM identified he did not notice that the ice machine was soiled, as it was last cleaned on [DATE] and was not yet cleaned for the month of August .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | An interview with the Dietary Manager on [DATE] at 9:14 AM identified the facility maintenance department was responsible for cleaning the ceiling vents and it would be the Dietary Manager's responsibility to identify the vents were dirty and notify maintenance. The interview further identified the trash on the clean side of the dish room should have been covered.<br><br>An interview with DA #1 on [DATE] at 12:07 PM identified staff beverages should not be stored in facility kitchen refrigerators and could not indicate the reason he stored his beverage in there, despite knowing he should not.<br><br>An interview with the Dietary Manager on [DATE] at 12:07 PM identified staff beverages were not to be stored in facility kitchen refrigerators and could not confirm the beverages were clean.<br><br>Review of the facility policy titled Date Marking states, in part, Foods will be date marked with the name of the product, the date of the production or opening.<br><br>Review of the facility policy titled Cleaning Ice Machine, Scoop and Tray states, in part, the ice machine and equipment (scoop and tray) will be cleaned on a regular basis to maintain a clean, sanitary condition and the ice scoop and tray will be washed and sanitized at least weekly in the dishwasher and allowed to air dry. |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094<br><br>51183<br><br>Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #61) reviewed for accidents, the facility failed to ensure consistent documentation by the Nurse Aide (NA) related to the provision of Activity of Daily Living care and for one of three residents (Resident #375) reviewed for quality of care, the facility failed to ensure a complete and accurate medical record to include the documentation of meals consumed. The findings include:<br><br>1. Resident #61's diagnoses included wedge compression fracture of fourth thoracic vertebra, osteoarthritis, history of breast cancer, thoracolumbar fusion of spine.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified that Resident #61 was cognitively intact, independent with personal hygiene, toilet transfers, and that ambulation was not applicable.<br><br>The Resident Care Plan dated 7/2/24 identified Resident #61 required assistance with activities of daily living (ADLs) and had decreased mobility related to chronic disease process. Interventions included Resident #61 was independent for squat pivot transfers, and required one person assist for bathing and dressing.<br><br>The physician's order in effect from 6/20/24 to 8/29/24 directed that Resident #61 required one person assist for bathing and dressing, was independent for toileting at wheelchair level, and that he/she may call as needed for assistance with ADLs.<br><br>Review of the facility Point Of Care (POC) documentation from 6/20/24 to 8/29/24 in the areas of bed mobility, transfers, toileting, and personal hygiene identified the following: From 6/20/24 to 6/30/24 there were 282 completed entries documented out of 1090 opportunities or 25.8 percent (%), from 7/1/24 to 7/31/24 there were 1064 completed entries documented out of 3261 opportunities or 32.6%, and from 8/1/24 to 8/29/24 there was 861 completed entries documented out of 2875 opportunities or 29.9%. This was an average POC documentation completion rate of 29.4 % from 6/20/24 to 8/29/24.<br><br>Interview with the Assistant Director of Nursing (ADNS) on 8/29/24 at 3:10 PM identified that charge nurses and unit managers should be monitoring the POC documentation and following up with Nurse Aid (NA) staff who do not complete their documentation.<br><br>Interview with Licensed Practical Nurse (LPN) #8 on 8/30/24 at 1:30 PM identified that the NA staff complete their documentation in the electronic record in POC. LPN #8 stated NA's know what they need to document in the computer, she does not check their documentation, and she was unaware that this was required of her. LPN #8 stated that she was unsure how to see the NA documentation in the computer, and that she would need to ask management how to do this.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Although requested, a facility policy for NA documentation, ADL documentation and POC documentation was not provided. Per the ADNS the facility does not have these policies. A copy of the POC kiosk training and POC kiosk management education course was provided in lieu of a policy.<br><br>2. Resident #375 was admitted to the facility on [DATE] with diagnoses that included hypothyroidism and a fracture of the left femur. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #375 had moderately impaired cognition and required assist with ADLs. The Resident Care Plan (RCP) 2/21/2024 identified Resident #375 an alteration in skin integrity, femur fracture, and potential alteration in nutrition. Interventions directed to assist with ADLs.<br><br>Record review of Resident #375 failed to identify meals consumed on 2/22 and 2/23/2024 for the meal intake for breakfast and lunch.<br><br>Interview and record review with the DNS on 9/19/2024 identified the facility failed to document the consumption of breakfast and lunch on 2/22 and 2/23/2024. The DNS indicated it should had been documented and was unable to explain why it was not done.<br><br>Review of facility undated Documentation Policy identified that NAs are responsible to complete the residents flow sheet. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on observations, reviews of the clinical record, facility documentation, facility policy, and interviews for 3 of 7 residents (Resident #32, Resident #36, Resident #74) reviewed for Enhanced Barrier Precautions (EBP) the facility failed to ensure appropriate personal protective equipment (PPE) was donned (placed on) prior to personal care, for the only sampled resident (Resident #76) reviewed for Transmission Based Precautions (TBP), the facility failed to ensure the required signage had been placed to alert all persons of the need for PPE, and during a tour of the laundry room, the facility failed to ensure fans with debris were not blowing on clean laundry. The findings include:<br><br>1. Resident #32's diagnoses included unspecified macular degeneration, bilateral cataracts, cerebral infraction and artificial opening of the urinary tract.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was severely cognitively impaired, and required substantial/maximal assistance for eating, toileting and transfers.<br><br>The Resident Care Plan dated 8/28/24 identified Resident #32 was on Enhanced Barrier Precautions relating to an illeal conduit (a surgical procedure that creates a new tube for urine to drain). Interventions included donning of a gown and gloves while bathing, showering, providing hygiene, dressing, transferring, and incontinent care (changing brief, assisting with toileting, changing linens, colostomy care, wound treatment, central line, urinary catheter, feeding tube).<br><br>A physician's order dated 4/10/24 and currently in effect directed that every shift follow Enhanced Barrier Precautions for Clostridium Difficile (C-Diff), Methicillin Resistant Staphylococcus (MRSA) and an illeal conduit.<br><br>The care card (NA Resident Assignment) identified Enhanced Barrier Precaution were in place.<br><br>Observation on 8/28/24 at 9:23 AM identified Enhanced Barrier Precaution signage on Resident #32's room door directing to wear gloves and a gown for high contact resident care (dressing, bathing, changing linen, device care and wound care) and a precaution cart stocked with gloves and gowns.<br><br>Observation on 8/28/24 at 9:24 AM identified Nurse Aide (NA) #2 in Resident #32's room emptying the illeal conduit urinary bag wearing gloves, without the benefit of a gown.<br><br>Interview with NA #2 on 8/28/24 at 9:26 AM identified she received education on Enhanced Barrier Precautions, and signage posted on the door meant the resident had a bag or wound, and she should wear gloves and a gown when emptying the bag to protect all residents, however she forgot to put the gown on.<br><br>Interview with Licensed Practical Nurse (LPN) #4 on 8/28/24 at 9:30 AM identified Enhanced Barrier Precautions signage on the door meant staff should wear personal protective equipment (gowns and gloves) with high contact activities such as providing personal care and transfers.<br><br>(continued on next page) |

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|---|---|---|---|
| | 075246 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Whitney Rehabilitation Care Center | 2798 Whitney Avenue<br>Hamden, CT 06518 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility Enhanced Barrier Precautions policy dated 4/19/24 identified the required use of a gown and gloves for select residents during specific high-contact resident care activities in which there is an increased risk of transmission of multi drug resistant organisms.<br><br>2. Resident #36's diagnoses included dysphagia with a feeding tube, right-side hemiplegia, and a history of extended spectrum beta lactamase (ESBL) resistance infection.<br><br>The annual Minimum Data Set assessment dated [DATE] identified that Resident #36 was severely cognitively impaired and dependent for toileting hygiene, upper body dressing, and received nutrition through a feeding tube.<br><br>The Resident Care Plan dated 6/4/24 identified Resident #36 was on EBP related to the presence of a feeding tube. Interventions included donning of gown and gloves when providing hygiene, dressing, providing incontinent care, and assisting with the feeding tube.<br><br>Review of the Resident Care Card (Individualized Resident Assignment) for Resident #36 included the need for Enhanced Barrier precautions due to presence of a feeding tube.<br><br>A physician's order dated 8/14/24 directed to use EBP every shift due to Resident #36's feeding tube and history of ESBL infection.<br><br>Observation of Resident #36's doorway indicated a sign to utilize PPE for EBP.<br><br>Observation and interview with NA #4 on 8/28/24 at 2:50 PM identified that she was standing at Resident #36's bedside adjusting the blanket wearing gloves but no gown. NA #4 carried a bag that contained a dirty brief and paper towel, but no gown (PPE). NA #4 indicated that she had just completed incontinent care for Resident #36. Although NA #4 indicated that she was aware Resident #36 was on EBP and was aware of the sign outside the resident's door, Resident #36 didn't have anything. Additionally, NA #4 stated she was aware that she needed PPE (gown and gloves) when providing hands on care but didn't realize that hands on care included incontinent care.<br><br>Interview with the Infection Preventionist, Registered Nurse (RN) #3, on 8/28/24 at 3:06 PM identified that per the EBP policy PPE (gown and gloves) needed to be worn when providing care to a resident requiring contact who was on EBP per the facility policy. RN #3 indicated that NA #4 should have worn the appropriate PPE when she provided care to Resident #36. RN #3 indicated that the staff have been educated that for residents on EBP, PPE is used to protect the residents from the staff.<br><br>3. Resident #74's diagnoses included type 2 diabetes mellitus, anemia, and hyponatremia.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #74 was cognitively intact and required extensive assistance of two persons for transfers, toileting and bed mobility. Additionally, the MDS identified Resident #74 had an unhealed pressure ulcer.<br><br>The Resident Care Plan dated 8/14/24 identified EBP related to wounds with interventions that included donning of gown and gloves when providing wound treatment.<br><br>A physician's order dated 8/14/24 directed EBP to be maintained every shift for wound.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A physician's order dated 8/21/24 directed Santyl External Ointment be applied to left buttock pressure area twice daily, cleanse the pressure area with wound cleanser, and pat dry with skin prep. Additionally, the physician order directed to apply Santyl Collagenase to the per-wound area followed by Calcium Alginate which was to be covered with a foam dressing.<br><br>Observation of Resident #74's room on 8/28/24 at 1:10 PM identified EBP signage was posted on the door frame which directed staff must wear gloves and a gown for wound care. A cart containing disposable isolation gowns and other personal protective equipment (PPE) was located outside of Resident #74's room.<br><br>Observation of Resident #74's left buttock wound care with the wound doctor (MD #1) and the wound nurse (RN #1) on 8/28/24 at 1:11 PM identified RN #1 was observed to enter Resident #74's room and completed wound care to the left buttock pressure area without the benefit of donning a gown throughout the treatment.<br><br>Interview with Registered Nurse (RN) #1 on 8/29/24 at 2:38 PM identified residents on EBP, staff should wear gloves and a gown when care and treatments are provided for a resident with a wound. RN #1 indicated that she could not recall the reason she did not don a gown when she provided wound care for Resident #74 and that she must have thought she had donned a gown before she had started the wound care and then forgot.<br><br>Review of facility education on EBP directed, in part, that a gown and gloves must be worn during high contact care activities, that these residents are not on isolation, but are being protected from any organisms staff may have on their clothes and hands, and to wear the gown and gloves when providing hygiene/incontinent care/changing briefs. It was further identified that NA #4 had received this education.<br><br>Review of the facility EBP policy directed that use of gloves and a gown was required for certain residents during specific high-contact resident care activities in which there was an increased risk for transmission of multidrug-resistant organisms. High-contact resident care activities included bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care and that all staff will receive training on EBP upon hire and annually<br><br>4. Resident #76's diagnoses included Covid-19 infection, diabetes, hypertension, and muscle weakness.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #76 was severely cognitively impaired, required moderate assistance with bed mobility and transfers, and was dependent on staff for personal hygiene and toileting.<br><br>The Resident Care Plan dated 8/20/24 identified Resident #76 with a Covid-19 diagnosis. Interventions included placing Resident #76 on droplet precautions, obtaining labs as ordered, encouraging fluids, and performing respiratory monitoring and assessments per the physician's order.<br><br>Review of the clinical record identified Resident #76 had tested positive for a Covid-19 infection on 8/20/24 and was noted to be on the facility TBP list.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Physician's orders dated 8/26/24 directed facility staff to place Resident #76 on isolation precautions and to provide meals, activities, rehab and care in his/her room from 8/20/24 until 8/31/24.<br><br>Observations on 8/26/24 at 12:30 PM and 1:50 PM, failed to identify that the required signage used to alert staff and visitors of the need for additional instruction, prior to entering the room, was not posted.<br><br>Observation and interview with Licensed Practical Nurse (LPN) #3 on 8/26/24 at 1:54 PM, identified Resident #76 had been recently diagnosed with a Covid-19 infection and was still being isolated. LPN #3 indicated that although there was no current signage on Resident #76's door, the sign had been taken down by the Infection Prevention Nurse (RN #3) that morning. LPN #3 indicated that RN #3 had stated that she would replace the sign.<br><br>Interview with RN #3 on 8/28/24 at 10:00 AM, identified that the Infection Control Nurse (herself) and RN supervisors were responsible for posting signage in appropriate locations for residents on TBP. RN #3 stated that Resident #76 tested positive for a Covid-19 infection on 8/20/24 and isolation would continue for 10 days per the facility policy. RN #3 indicated signage was required to be posted outside Resident #76's door and should have been there according to the facility policy. Further RN #3 denied removing the required signage from Resident #76's door.<br><br>Review of the Covid 19 Facility Assessment policy directed, in part that signage on the use of specific PPE (for staff) will be posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility -wide).<br><br>5. On 8/28/24 at 10:50 AM, tour of the laundry room identified a fan with a heavy accumulation of dust, was blowing on clean laundry that had been placed in front of the fan.<br><br>On 8/28/27 at 11:00 AM an interview with the Director of Housekeeping identified that the fan was dirty, was unsure of when it was last cleaned and did not report the dirty fan to Maintenance.<br><br>On 8/28/24 at 11:18 AM an interview with the Director of Maintenance identified that maintenance was responsible for cleaning the facility fan in the laundry room, that it was cleaned once a month and that maybe it should be cleaned twice a month to ensure cleanliness. Also, the Maintenance Director identified that he was not notified that the fan needed to be cleaned. Furthermore, the Director of Maintenance provided a log for the cleaning of the laundry room fan which was last done on 7/11/24.<br><br>Review of the facility policy for Monthly cleaning for laundry room fan identified that the fan was to be cleaned by Maintenance Department on a regular basis to maintain a clean, and a sanitary condition.<br><br>50249<br><br>50250<br><br>51102<br><br>51183 |