STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075294	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Rehabilitation and Nursing Center	38 Talmadge Avenue East Haven, CT 06512

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on clinical record review, interviews and facility documentation for one (1) of three (3) residents (Resident #1) reviewed for a change in condition, the facility failed to report a change of condition to the physician timely. The findings included: Resident #1 had diagnoses of Alzheimer's Disease, anxiety disorder, and age-related osteoporosis. Review of the Resident Care Plan dated 10/8/24 identified Resident #1 had osteoporosis with interventions directed to monitor, document, report to the physician, as needed, signs and symptoms of complications related to osteoporosis such as acute fracture, compression fractures, loss of height, kyphosis, and pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of two (2) indicative of severe cognitive impairment, and required maximal assistance with toileting, dressing, and personal hygiene. Review of the Department of Public Health Facility Licensing and Investigations Section Reportable Event Form dated 11/3/24 at 7:15 AM identified Resident #1 had an injury to his/her right pinky finger (bruise) and the right hand. A nurses note dated 11/3/24 at 11:34 AM identified that at 7:15 AM the Nurse Aide (NA) identified a bruise on the right fifth digit, the Advanced Practice Registered Nurse (APRN) was notified and an X-ray was ordered. An X-ray report dated 11/3/24 identified a a displaced transverse fracture at the base of the fifth digit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 (11:00 PM to 7:00 AM, Nursing Supervisor) on 11/21/24 at 11:00 AM identified he/she was informed by NA #1 on 11/3/24 at approximately 1:00 AM that something was wrong with Resident #1's right pinky finger. RN #1 indicated he/she checked Resident #1's right hand and saw that the pinky finger had a blue discoloration on it, however, did not appear as a new injury, and that Resident #1's right ring finger, middle finger, and hand were red but not swollen. RN #1 further identified he/she performed passive range of motion to Resident #1's right pinky finger without Resident #1 responding in pain or grimacing. RN #1 indicated he/she wanted to check nursing notes to ensure it was a new condition prior to contacting the physician, however, became distracted with a re-admission to the facility at 2:00 AM that morning and his/her other routine duties. RN #1 identified he/she didn't realize he/she had forgotten about Resident #1's injury until he/she overheard NA #2 reporting it to RN #2 during morning report. RN #1 indicated he/she then updated RN #2 with his/her previous assessment. Interview with NA #2 on 11/21/24 at 12:02 PM identified he/she was informed of the bruise on Resident #1's right hand by NA #1 during morning report on 11/3/24. Upon checking the residents hand around 7:00 AM that morning she identified Resident #1's right hand was swollen and that the right pinky was in an unusual position. NA #2 indicated he/she immediately notified RN #2 of the situation. Interview with RN #2 on 11/18/24 at 12:30 PM identified he/she assessed Resident #1's right hand following notification of the injury on 11/3/24 from NA#2 and that the pinky finger appeared to be dislocated. RN #2 further identified contacting the Advanced Practice Registered Nurse (APRN), was directed to order an x-ray which was positive for a fracture and the resident was sent to the emergency department. Interview with the Director of Nursing Services on 11/18/24 at 2:45 PM identified that the facility conducted an investigation and determined that the resident had osteoporosis and on 11/2/24 it was noted that the resident had h/her glasses in/her hand after having difficulty removing them from h/her face and questioned if this could have been the cause of the injury. The DNS identified that staff was to initiate an investigation of the injury and to notify the physician of the injury/change of condition. The DNS further indicated RN #1 should have ensured that the change in condition was reported upon assessment to the provider (the injury was identified on 11/3/24 at 1:00 AM and was not reported to the provider until 7:00 AM). Interview with the Medical Director on 11/25/24 at 4:26 PM indicated, at minimum, staff should contact the APRN when a resident's change in condition has been identified. Review of the facility's Change of Condition policy directed the Charge Nurse/Supervisor was responsible for notifying the attending physician/ APRN and the resident's responsible family members or legal representatives when a change occurs in the resident's condition, which included significant changes in physical, mental, or psychosocial status as well as any accident that results in injury and/or hospitalization .

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NAME OF PROVIDER OR SUPPLIER Whispering Pines Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 38 Talmadge Avenue East Haven, CT 06512	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on clinical record review, facility documentation, and interviews for one (1) of three (3) residents reviewed for an injury of unknown origin (Resident #5), the facility failed to ensure that the resident remained free from injury during a Hoyer lift transfer. The findings included: Resident #5 had a diagnoses of Alzheimer's disease. A care plan dated 6/12/24 identified that the resident had a self care deficit related to impaired mobility and cognition with interventions that included to assist the resident out of bed with a Hoyer lift. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that a Brief Interview for Mental Status (BIMS) of three (3) indicative of severe cognitive impairment and was dependent on staff for Activities of Daily Living (ADLs) including transfers. A nurse's note dated 11/15/24 at 12:03 PM identified that the resident had a bruise to the left chest measuring 6.5 in length 10.5 centimeters (cm) in width. An assessment was completed, no facial grimacing was noted and an X-ray of the left ribs was ordered. An X-ray report dated 11/15/24 of the left ribs were negative. Review of a reportable event dated 11/15/24 identified that a bruise of unknown origin was observed to the left upper chest during am care. The summary identified that the facility concluded that the bruise was caused by the Hoyer bar, (holds the Hoyer pad) that had aligned with the bruise. Interviews with staff who cared for the resident 24 hours prior to the identification of the bruise on 11/15/24 on 11/21/24 at various times failed to identify any incidents or issues with care that could have caused the bruising. Interview with the Director of Nurses (DNS) on 11/21/24 at 3:00 PM identified that the facility had performed a Hoyer transfer with the resident to identify potential causes of the bruise. It was identified that the Hoyer bar that attaches the Hoyer pad had aligned with the bruise, the facility believed that while the Hoyer was being pulled away from the resident, the bar was noted to swing and could have possibly hit the resident in the chest causing the bruise. The DNS identified that Resident #5 is now a nurse supervised Hoyer lift transfer. Subsequent to the incident the facility conducted competencies and education on Hoyer lift transfers with Nurse Aides. Review of the safe resident handling and transfers policy identified that residents are handled and transferred safely to prevent or minimize risk for injury.