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	05/16/2024

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

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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 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** 50250 Based on review of the clinical record, facility policy, and interviews for 1 of 6 residents (Resident #62) reviewed for nutrition, the facility failed to notify the provider when weights were not obtained per the physician's order. The findings include: Resident #62's diagnoses included heart failure, hypertension, and Chronic Obstructive Pulmonary Disease (COPD). The Nursing Admission assessment dated [DATE] identified Resident #62 was oriented to time, place, and person, was independent with eating, required one staff assist with ambulation, and the assist of two staff with bathing and grooming. The Resident Care Plan dated 8/23/23 identified Resident #62 was at risk for nutritional deficit. Interventions included monitoring weights, laboratory values, and offering a therapeutic diet with high calorie supplements as directed by the physician. A physician's order dated 8/23/23 directed to weigh Resident #62 every night shift and notify the physician of an increase of 2-3 pounds per day, or 5 pounds per week. Review of Resident #62 clinical record from 8/23/23 to 5/14/24 identified that he/she had not been weighed for 4 days, February 4, 5, 6, and 7, 2024, due to a broken scale. The clinical record failed to indicate that the physician was notified. An interview and record review with RN #6 on 15/5/24 at 10:35 AM failed to identify that the physician was notified when Resident #62 was not weighed for 4 consecutive days. Additionally, RN #6 indicated that Resident #62 could have been brought to a different scale in the facility to be weighed. Interview with Advanced Practice Registered Nurse #1 on 5/16/2024 at 11:00 AM identified that she had not been notified Resident #62 had not been weighed for 4 consecutive days but should have been as the weights were ordered to be taken daily. Review of facility policy identified, in part, that each resident will be weighed upon admission, monthly and when indicated, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident.

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

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059 Based on review of the clinical record and interview for 1 of 5 sampled residents, (Resident #11) reviewed for PASRR, the facility failed to refer the resident to the appropriate state-designated authority for a level II evaluation following a new psychiatric diagnosis. The findings include: Resident #11 was admitted in June 2020 with diagnoses that included chronic obstructive pulmonary disease, anxiety, and lung neoplasm. Review of the clinical record identified a negative PASRR level 1 dated 6/22/20 with no diagnosis of Alzheimer's dementia, or mental illness. The 5 day Minimum Data Set assessment dated [DATE] identified Resident #11 was cognitively intact and required assistance with activities of daily living. An Advanced Practice Registered Nurse progress note dated 9/29/22 identified Resident #11 with an active diagnosis of schizoaffective disorder. Further review of the clinical record failed to identify a PASRR level II was conducted following the new psychiatric diagnosis. The Resident Care Plan dated 6/23/23 identified Resident #11 was receiving psychotropic medications, had mood and behavior disorders. Interventions directed to assist Resident #11 by allowing him/her to express their feelings and to assist to de-escalate. In an interview and review of the clinical record with Social Worker #1 on 5/16/24 at 12:30 PM she identified that following Resident #11's new psychiatric diagnosis of schizoaffective disorder the state agency should have been notified to conduct a level II PASRR assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #67) reviewed for an allegation of mistreatment, the facility failed to develop a comprehensive care plan indicating refusal of care, inappropriate behaviors, and accusations towards staff. The findings include: Resident #67's diagnoses included major depressive disorder and alcohol dependence. A nurse's note dated 1/3/24 at 12:50 PM identified Resident #67 was increasingly agitated and cursing at staff and his/her roommate. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #67 was cognitively intact and required moderate assistance with personal hygiene, substantial assistance with bed mobility, and was dependent with transfers. Review of the Resident Care Plan (RCP) failed to include a care plan for behaviors. A nurse's note dated 2/21/24 at 11:26 AM indicated that Resident #67 was sexually inappropriate with staff and he/she was subsequently made an assist of 2 staff at all times. A nurse's note dated 4/25/24 at 11:25 PM identified that Resident # 67 was refusing care from certain staff members and the nursing supervisor was aware. A nurse's note dated 5/10/24 at 3:56 PM identified that Resident #67 made an allegation of staff mistreatment. Interview with Resident #67 on 5/15/24 at 9:48 AM identified that he/she has been refusing to shower for several months due to the facilities water temperature and his/her vertigo condition. Review of wound physician notes dated 5/15/24 identified that Resident #67 refused showers due to vertigo and hasn't washed his/her hair in at least a month. Interview with LPN #3 on 5/15/24 at 1:27 PM identified that a noncompliance and behavior care plan was not initiated because although she had heard staff discussing the behaviors of Resident #67, there was no documentation of the refusals and behaviors towards staff in the clinical record. In an interview and clinical record review with the DNS on 5/16/24 at 11:48 AM, it was identified that the clinical record failed to reflect an RCP regarding Resident #67's refusal of care, inappropriate behavior, and/or accusations towards staff. She indicated that she was aware of Resident #67's behaviors and that the interdisciplinary team talked about them often in morning report. Additionally, the DNS reported that the MDS nurse was responsible for the noncompliance care plan and she was unaware that a RCP for Resident #67's behaviors did not exist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan policy directed, in part, that the resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. When such refusals were made, appropriate documentation would be entered into the resident's clinical records in accordance with established policies.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #67) reviewed for Activities of Daily Living (ADL's), the facility failed to provide podiatry services to a long-term resident. The findings include: Resident #67's was admitted to the facility in August of 2023 with diagnoses that included type II diabetes mellitus, muscle weakness, difficulty in walking, and repeated falls. An admission physician's order dated 8/29/23 directed that Resident #67 may have podiatry services as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #67 was cognitively intact and required moderate staff assistance with personal hygiene, substantial staff assistance with bed mobility, and was staff dependent with transfers. The Resident Care Plan dated 2/15/24 identified Resident #67 had diabetes mellitus. Interventions included completing a body check for breaks in the skin and treat promptly as ordered by the physician. Observation on 5/10/24 at 12:12 PM, identified Resident #67 with excessively long toenails. Interview and observation with Resident #67 on 5/13/24 at 10:14 AM identified he/she had excessively long toenails. He/she indicated that they were uncomfortable and jagged, getting caught on the sheets, and reported his/her toenails had not been cut since prior to residing at the facility, almost 9 months ago. Resident #67 identified that he/she had complained to the NA's numerous times during care, but the nails still had not been cut. Interview and clinical record review with RN #1 on 5/14/24 at 2:12 PM identified that foot and nail care was completed with daily care and on shower days by the NA's; irregularities were to be reported to the licensed nursing staff. Further, RN #1 indicated that licensed nursing staff was responsible for weekly body checks and excessively long nails should have been identified during the body check. The facility policy for toenail care directed that if a resident was diabetic (as was Resident #67) or had thick nails, the resident would be required to be seen by a podiatrist. During a review of the clinical record, RN #1 indicated that she was unable to find podiatry consent for Resident #67 or that Resident #67 had previously seen a podiatrist. RN #1 stated she was unaware of Resident #67's excessively long toenails. Review of the Treatment Administration Record (TAR) and nursing notes for April and May 2024 identified that LPN #1 signed off the weekly body audit on 4/17/24, 5/1/24, and 5/7/24 but failed to note Resident #67's toenail length. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation with LPN #1 on 5/14/24 at 2:30 PM identified that on observation, Resident #67's toenails were abnormally long and needed to be cut, he/she required a podiatrist, the resident had recently transferred her unit, and the NA's had not notified her of the resident's toenail length. Although LPN #1 signed off the weekly body audit on 4/17/24, 5/1/24, and 5/7/24, she identified she had not observed the length of Resident #67's toenails prior to surveyor inquiry. Interview with Social Worker #1 on 5/14/24 at 2:47 PM identified that she was the podiatry liaison, she was unsure if podiatry services were offered to Resident #67, and she had not been notified that Resident #67 needed to be seen. Subsequent to surveyor inquiry, a signed podiatry consent was obtained on 5/15/24. Review of the Foot Care policy dated 2023 directed, in part, that the facility would provide foot care and treatment in accordance with professional standards of practice and if necessary, would assist the resident in making appointments with a qualified person.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #53 and Resident #67) reviewed for bowel and bladder, for Resident #53, the facility failed to assess bowel and bladder continence status and failed to implement a plan to restore continence and for Resident #67 the facility failed to ensure the resident maintained bowel and bladder function. The findings include: 1. Resident #53 was admitted to the facility with diagnoses that included fall, aspiration pneumonia, and acute kidney injury. The Nursing Admission assessment dated [DATE] identified Resident #53 was cognitively intact and required a rolling walker with the assistance of 2 staff members to ambulate. The Nursing Admission Assessment failed to address bowel and bladder continence. The Resident Care Plan dated 4/13/24 identified Resident #53 was at risk for a decline in his/her ability to perform activities of daily living (ADLs) and interventions included assisting Resident #53 with toileting, dressing, and ambulating. A physician's order dated 4/14/24 directed to administer 2mg of bumetanide (a diuretic) every other day. Review of the bladder and bowel documentation from 4/13/24 until 4/30/24 indicated Resident #53 was incontinent of bladder 45 out of 49 opportunities and was incontinent of bowel 25 out of 29 opportunities. Interview with Resident #53 on 5/10/24 at 11:25 AM identified he/she used the toilet regularly at home. Resident #53 indicated that he/she would prefer to use a toilet but had only been offered a bedpan, not using the bathroom, since he/she was admitted to the facility. Resident #53 reported experiencing incontinence on several occasions due to extended wait times after requesting a bedpan. Further, Resident #53 noted that he/she suggested to the NA that they bring him/her the bedpan at scheduled intervals on the days the diuretic was administered, but this has not happened. An interview and clinical record review with the DNS on 5/15/24 at 12:25 PM, the clinical record contained a bowel and bladder assessment from Resident #53's previous admission to the facility dated 9/27/23. The evaluation identified Resident #53 as a candidate for a toileting schedule. The clinical record failed to reflect a bowel and bladder evaluation for Resident #53's current admission to the facility. The DNS indicated it was the admitting nurse's responsibility to complete the bowel and bladder assessment on admission, but she was unable to identify why an assessment had not been completed for Resident #53. Additionally, the DNS identified the lack of an assessment should have been identified during the facility's weekly Standards of Care meeting but was unable to explain how this was overlooked. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Bowel and Bladder Assessment policy dated 3/2000 directed, in part, to complete a bowel and bladder assessment within 14 days of admission to assist in determining the most effective and appropriate treatment and management of bowel and bladder function. 2. Resident #67's diagnoses included calculus of ureter and bile duct (formation of stones), presence of urogenital implants, and a history of urinary tract infections. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #67 was cognitively intact and required moderate assistance with personal hygiene, substantial assistance with bed mobility, and was dependent with transfers. The Resident Care Plan dated 3/22/24 identified that Resident #67 was incontinent of both bowel and bladder due to impaired mobility. Interventions included following incontinence protocol, monitor for signs and symptoms of a urinary tract infection, and monitor input and output per facility policy. Review of the MDS data completed since Resident #67's admission indicated: The admission MDS assessment dated [DATE] identified that Resident #67 was frequently incontinent of urine and frequently incontinent of bowel, with no toileting programs in place. The 5-day MDS dated [DATE] identified that Resident #67 was occasionally incontinent of urine and always incontinent of bowel, with no toileting programs in place. The quarterly MDS dated [DATE] identified that Resident #67 was frequently incontinent of urine and frequently incontinent of bowel, with no toileting programs in place. The quarterly MDS dated [DATE] identified that Resident #67 was always incontinent of urine and always incontinent of bowel, with no toileting programs in place. Review of the Bowel and Bladder Evaluations for Resident #67 identified that on 8/8/23, the assessment determined that the resident was a good candidate for individualized retraining. On 1/3/24, the assessment determined that the resident was a candidate for a toileting schedule (timed voiding). On 5/12/24, the assessment determined that the resident was a candidate for a toileting schedule (timed voiding). Review of the clinical record failed to identify that any individualized retraining or any toileting schedules had been completed. Interview with Resident #67 on 5/13/24 at 10:14 AM identified that although he/she was capable of using a urinal, he/she indicated that due to difficulty with bed mobility and not being able to sit on the edge of the bed without staff assistance, the urine would spill out of the urinal consistently into the bed. Additionally, Resident #67 identified that when he/she felt the need to go to the bathroom, he/she would ring the call bell, but would not get the assistance he/she required in time which subsequently led to soiling the bed. Further, Resident #67 reports he/she is no longer aware of the urge to go to the bathroom. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 (MDS Coordinator) on 5/14/24 at 11:49 AM identified that she gets the data for section H (bladder and bowel) of the MDS from the Nursing Admission Assessment, documented nurse's notes, NA documentation, and completed Bowel and Bladder Evaluations. She indicated that MDS staff is responsible for completing the Bowel and Bladder Evaluations, but reported she answers no to both the urinary and bowel toileting program questions of the MDS (H0200 and H0500), even if the assessments state the resident is a candidate for individualized retraining or toilet scheduling because it was her understanding that the facility does not have these programs. LPN #3 stated nursing would then be responsible for initiating a 3-day diary of the resident's current bladder and bowel functioning, but reported there was no current process on how to communicate that to the floor nurses. Additionally, she indicated that they have a weekly meeting on Wednesdays to discuss the at risk residents, but she was unsure if Resident #67 had been discussed for his/her declining bowel and bladder functioning. Interview with RN #1 on 5/14/24 at 2:12 PM identified that she was not aware of any resident's past or present on toileting programs and she was also not aware of how to initiate a 3 day toileting diary. Interview with RN #2 (Nursing Supervisor/MDS) on 5/15/24 at 12:01 PM identified that after he completes a bladder and bowel assessment that indicates that a resident is a good candidate for any type of retraining or toileting schedule, he verbally tells the staff on the unit to observe that resident's tendencies. RN #2 reported that he has not seen any bowel and bladder diaries completed on any residents, indicating he would think that the staff would start them on a retraining program if the resident was able to participate, but reported he was not aware of a policy or process. RN #2 identified that he is not able to follow up with the staff on the residents toileting tendencies, as he works weekends only, and reported that in the future he would start requesting the information needed in writing, not verbally. Interview with the DNS on 05/15/24 at 12:25 PM identified that Resident #67 gradually lost bladder and bowel functioning over time from admission to his current status. She indicated the facility did an initial 3-day diary at the beginning of his admission, but she was unable to identify who initiated the diary, was unable to locate the paper copy or any follow up, and was unaware if the physician was notified of the change in functioning. The DNS identified that Resident #67 had a few cancelled urology appointments, but indicated the facility should have followed up and developed a bladder and bowel schedule and added it to the NA's assignment. Further, the DNS identified that MDS staff is responsible for gathering information on the resident's bowel and bladder functioning and should have initiated a 3-day diary and then the interdisciplinary team would have discussed the results in morning report and at their weekly at-risk meeting. Review of the Bowel and Bladder Retraining policy dated 3/2001 directed, in part, that bowel and bladder retraining is the responsibility of all nursing personnel and directs to toilet the resident at the same time daily, every 2 to 3 hours, encourage adequate intake of fruits, vegetables, and roughage, and encourage exercises as tolerated. All outcomes should be documented in the clinical record and inform the physician as needed. 50095

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of the clinical record, interviews, and review of facility policy for two of six residents (Resident #14 and Resident #62) reviewed for nutrition, for Resident #14, the facility failed to ensure a significant weight change was identified in a timely manner, and for Resident #62, the facility failed to obtain weights per the physician's orders. The findings include: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses that included dementia, congestive heart failure, and diabetes. The Quarterly Minimum Data Set assessment dated [DATE] identified Resident #14 was severely cognitively impaired, required set up assist for eating, moderate assistance with personal hygiene, transferring, and bathing. The Physician orders dated 11/24/23 through 3/12/24 directed for Resident #14 to be weighed daily. Review of Resident #14's weight record identified a weight of 222.2 pounds (lbs.) on 12/20/23 and a weight of 199.0 lbs. on 2/17/24 for a total significant weight loss of 23.2 pounds (10.44 percent) over 2 months. No further weights were identified in the clinical record from 12/21/23 through 2/16/24. Interview and review of the clinical record on 5/16/24 at 10:31AM with the Dietician identified Resident #14's significant weight change of 23.2 lbs. between 12/20/23 and 2/17/24 (approximately 2 months). The Dietician indicated that she was responsible to identify changes in resident weights but had been unavailable for part of the time between 2/17/24 and 3/12/24 and that no staff had been covering in her absence. Additionally, the Dietician was noted to have worked in the building on 2/21/24 and 3/7/24 but had not been notified by facility staff and had not recognized that Resident #14 had a weight loss until her third visit to the facility on [DATE] (24 days after Resident #14's weight loss). Subsequent to determining the resident had sustained a significant weight loss, she recommended Resident #14 be given double portions and requested liquid protein 30 milliliters twice a day. The Dietician was unable to indicate why Resident #14's weight loss was not addressed sooner. 2. Resident #62's diagnoses included heart failure, hypertension, and Chronic Obstructive Pulmonary Disease (COPD). The Quarterly MDS assessment dated [DATE] identified that Resident #62 was moderately cognitively impaired, was independent for transfers, supervised for ambulation, and he/she had a significant weight loss. The Resident Care Plan in effect from February 1, 2024 through February 29, 2024 identified Resident #62 was at risk for nutritional deficit with interventions that included monitoring weights, labs and offering a therapeutic diet with high calorie supplements as directed by the physician. The physician's order in effect from February 1, 2024 through February 29, 2024 directed to weigh Resident #62 every night shift and notify the physician of any increase in weight of 2-3 pounds per day or 5 pounds per week. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62 clinical record from 8/24/23 to 5/14/24 identified that he/she was not weighed for 4 days, on February 4, 5, 6, and 7, 2024. An interview and record review with RN # 6 on 5/15/24 at 10:35 AM identified that Resident #62 had not been weighed on February 4, 5, 6, and 7, 2024 due to a broken scale according to the nursing progress notes. RN #6 was unable to explain why the Resident #62 had not been weighed, but indicated that the resident could have been brought to another unit to obtain his/her weights. Review of the facilty weight policy identified that any weight gain or loss of 5 pounds or more will trigger a re-weight to be obtained with 24 hours to verify the results. Significant weight loss parameters (Per OBRA) are as follows: 5% in 30 days and 10 % in 6 months. Weights will be documented in the electronic medical record. Each resident will be weighed upon admission, monthly, and when indicated, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. 50250

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, review of the clinical record, facility policy, and interview for 1 of 2 residents (Resident #13) reviewed for oxygen, the facility failed to follow the physician's oxygen order. The findings include: Resident #13's diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD), anxiety disorder, and dementia. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was severely cognitively impaired and was dependent on staff for bed mobility, transfers, and personal hygiene and required substantial assistance with eating. Observation on 5/10/24 at 12:20 PM, identified Resident #13 in bed with the nasal cannula on, with the oxygen concentrator set to 3.0 LPM. Review of the Resident Care Plan dated 5/13/24 identified that Resident #13 had emphysema and COPD. Interventions included monitoring for difficulty breathing, monitoring for signs and symptoms of acute respiratory insufficiency and signs of respiratory infection, and to administer oxygen via nasal cannula to keep oxygen greater than 90%. Review of the physician's orders in effect from 5/1/24 through 5/13/24 directed to administer oxygen at 2.0 liters per minute (LPM) via nasal cannula continuously and as needed for shortness of breath. Observation on 5/13/24 at 10:30 AM, identified Resident #13 in bed with the nasal cannula on, with the oxygen concentrator set to 3.0 LPM. Review of the clinical record, observation, and interview with LPN #2 on 5/13/24 at 10:32 AM identified that although Resident #13 had a physician's order to administer 2.0 LPM of oxygen via a nasal cannula, he/she was noted to be receiving oxygen via the concentrator set to 3.0 LPM. LPN #2 indicated that she doesn't normally work on Resident #13's unit, she was unsure why the oxygen concentrator settings didn't match the physician's order, and that normally she would check the oxygen setting on entering Resident #13's room, but she had not seen the resident yet, during her shift. Review of the Oxygen Therapy policy directed, in part, that oxygen administration requires a physician's order, and flow meter is to be turned to the prescribed rate and the rate of flow is to be checked by the licensed staff.

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	05/16/2024

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

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy and interviews for the only sampled resident (Resident #67) reviewed for mistreatment, the facility failed to monitor and document targeted behaviors per the physician's order. The findings include: Resident #67's diagnoses included major depressive disorder and alcohol dependence. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #67 was cognitively intact and required moderate assistance with personal hygiene, substantial assistance with bed mobility, and was dependent with transfers. Additionally, the MDS indicated that the resident had not exhibited any behaviors. The Resident Care Plan dated in effect from November 2023 through May 2023 identified that Resident #67 received antidepressant medication related to depression. Interventions included to monitor, document, and report to the physician ongoing signs and symptoms of depression including sadness, irritability, anger, never being satisfied, crying, shame, worthlessness, guilt, suicidal ideation, negative mood and/or comments, slowed movement, fatigue, lethargy, agitation, attention seeking, and anxiety. A physician's order dated 11/28/23 directed to monitor for any increased anxiety, yelling, agitation or any unusual behaviors, document, and report to the psychiatric Advance Practice Registered Nurse (APRN). Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from December 2023 through May 2024 identified Resident #67 was receiving psychotropic medications but failed to identify targeted behavior monitoring for psychotropic medication use. Review of the psychiatric APRN notes dated 2/15/24 and 3/19/24 identified diagnoses including adjustment disorder, anxiety disorder, major depressive disorder, and alcohol abuse. Additionally, the notes indicated that Resident #67 had been seen for behaviors including agitation and yelling at staff on 1/5/24 and directed to continue monitoring the resident for changes in mood and behavior. Interview and clinical record review with RN #1 on 5/14/24 at 2:12 PM identified that she was unable to locate behavior monitoring in Resident #67's clinical record. She reported that if a resident had a physician's order for behavior monitoring, it should be documented on in the MAR, and nurses would be responsible to document either a Y for yes behaviors were observed, or N for no behaviors were observed every shift and document any identified behaviors in the nursing progress notes. Review of nursing notes dated 1/3/24 through 5/10/24 indicated 5 nursing progress notes documenting Resident #67's mood/behaviors but no further behavior monitoring documentation was identified. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the ADNS on 5/14/24 at 2:23 PM identified that there were physician's orders directing behavior monitoring that had been incorrectly entered by the previous APRN. The ADNS indicated that due to the incorrect entry, behavior monitoring had not been conducted as directed from November 2023 through May 2024, and that subsequent to surveyor inquiry, she would correct the order to ensure behavior monitoring would occur as directed. Although requested, a policy on physician's orders was not provided. Review of the Psychotropic Medications policy directed, in part, that behavioral monitoring will be completed by nursing to record specified target behaviors, such as biting, kicking, continuous crying, pacing, hitting, scratching, screaming, yelling, etc.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50095 Based on observation, review of facility documentation, facility policy, and interviews for 1 of 2 medication rooms reviewed for medication storage and labeling, the facility failed to ensure drugs and biologicals were kept under proper temperature controls. The findings include: Observation and interview with RN #3 (the Infection Preventionist) on 5/16/24 at 12:40 PM identified recorded out-of-range temperatures documented on the Windsor Court medication refrigerator's temperature log. In May 2024 temperatures were noted to be outside of the acceptable range (35 F to 46 F) on 13 out of 16 documented days and ranged between 49 F and 60 F. In April 2024 3 out of 30 readings fell outside the acceptable range and were documented between 47 F and 54 F. Currently observed in the medication refrigerator were the following medications: 1. carboxymethyl cellulose sodium 0.5% 0.5oz 2. 1 full vial of lispro 3. 1 full vial of Levemir 4. 1 Trulicity single dosing pen 5. Aranesp 0.42ml syringes x 2 6. lorazepam oral concentrate full vial 30ml RN #3 indicated that staff should have re-checked the refrigerator temperature, and if it read outside the acceptable range, then update the log accordingly. RN #3 was unable to explain why the refrigerator temperatures weren't rechecked on the days documented with out-of-range readings and was unable to identify how long the refrigerated medications had been exposed to the unacceptable temperatures adding that the refrigerator temperatures fluctuated. Interview with LPN #4 on 5/16/24 12:48 PM identified that the 11:00 PM to 7:00 AM nurse was responsible to check the refrigerator temperature and that if the temperature was out of range, then the issue should be brought to the attention of maintenance. Review of the Medication Storage policy identified all refrigerated medications should be kept between 35 F to 46 F, as stated by the United States Pharmacopeia and by the Centers for Disease Control.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50177 Based on interviews, observation of the laundry area, and facility policy, the facility failed to ensure a clean environment in the drying and folding areas. The findings include: Observation in the laundry room with the Infection Preventionist on 5/14/24 at 2:40 PM identified a moderate coating of white/gray debris (that the Infection Preventionist and Maintenance worker identified as lint) on the protective covering over the blades of two wall-mounted fans blowing directly onto clean, uncovered laundry located on the clean linen cart. Additionally, a moderate amount of white/gray debris was observed on the dryer tops. Interview with Maintenance and the Laundry Attendant on 5/14/24 at 2:45 PM identified that the dryer tops and fans needed to be cleaned and that laundry staff were responsible for cleaning as needed. Additionally, no cleaning schedule had been implemented for the fans. Interview with the Director of Environmental Services on 5/14/24 at 2:55 PM identified that the laundry staff were responsible for cleaning the laundry area, he was unable to locate a cleaning schedule, and there was no check list for fan or dryer top cleaning. Review of the Laundry Service policy dated 8/19/22 directed, in part, that the cleaning schedule must be posted and up to date.