2017

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Whitney Rehabilitation Care Ctr
2798 Whitney Ave
Hamden CT 06518
M:

Signature of FLIS Staff
Richard Howe RNC
PThompson
Patricia Tyrell

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 150

Census: 134

Date(s) of onsite inspection: 8/21, 22, 23 & 8/24/2017

Date(s) additional information obtained: ______

Personnel contacted: Albert Mislow ADM, Rose Green-Colon DNS

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[✓] See Complaint Investigation # CT 21254, CT 21852, ~~CT 21857~~ & CT 21950

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 9-19-17

[ ] Desk Audit ______ [ ] Amended Letter: ______ Original Ltr. ______

[X] Citation # 2017-54 was issued to this facility as a result of this inspection.

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

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

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to ______

REPORT SUBMITTED BY: Richard Howe RNC **DATE OF REPORT:** 8/24/17

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

s:flis\hsr\FACESHEETS
Revised 12/2016

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

September 19, 2017

Mr. Albert Mislow Sr, Administrator
Whitney Rehabilitation Care Center
2798 Whitney Avenue
Hamden, CT 06518

Dear Mr. Mislow Sr:

Unannounced visits were made to Whitney Rehabilitation Care Center on August 21, 22, 23 and 24, 2017 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by October 3, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

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

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

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

We do not anticipate making any practitioner referrals at this time.

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

DATES OF VISIT: August 21, 22, 23 and 24, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Respectfully,

Rosella A Crowley RN SNC

Rosella A. Crowley, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC/RH:jf

Complaints #21254, #21852 and #21950

DATES OF VISIT: August 21, 22, 23 and 24, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or Connecticut General Statutes 19a-550.

1. Based on clinical record review, review of facility documentation and interviews for one of three residents reviewed for nutrition (R #83), the facility failed to document a notification of change to the resident's responsible party when a decrease in the resident's weight was identified. The findings include:
   a. Resident #83's diagnoses included Alzheimer's disease, dehydration and diabetes. The minimum data set dated 4/24/17 documented that R#83 was severely impaired cognitively, was dependent on staff for ADL's, had a weight of 160 lbs and had no significant weight gain or losses in the previous 3 months.

      The resident's care plan dated 4/27/16 identified that R#83 needed increased nutrients related to wound healing. Interventions included Glucerna 1.5 8 oz at 9 am, PM, fortified food-super cereal at breakfast and super, pudding at lunch and dinner, continue diet as ordered, observe weights, observe PO intake and update plan of care as needed.

      Review of the clinical record indicated that on 7/18/17, R#83 was hospitalized and returned to the facility on 7/21/17. Review of the clinical record indicated R#83's readmission weight on 7/21 was 150 lbs for a significant weight loss of 10 lbs (>6% in 30 days).

      The clinical record failed to document that R#83's responsible party was informed of the significant weight loss and/or the new interventions.

      Interview with LPN#6 on 8/24/17 at 11:15 AM failed to provide documentation of notification of the responsible party regarding the weight loss.

      A review of the facility's policy and interview with the Director of Nurses on 8/24/17 at 2 PM indicated that the nurse is responsible for notifying the responsible party if a change in the resident's weight is identified.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or Connecticut General Statutes 19a-550.

2. Based on clinical record review, facility documentation and interviews for one of three residents reviewed for grievances (R #50), the facility failed to ensure that when a grievance was brought to the attention of the facility, that a prompt and satisfactory resolution was attained. The findings include:
   a. Resident #50's diagnoses included Parkinson's disease, adult failure to thrive, and neoplasm of the respiratory system. The quarterly minimum data set dated 5/8/17 documented that R#50 was cognitively intact and that R#50 needed one staff to provide extensive physical

assistance with ADLs.

R #50's care plan dated 1/10/17 identified behavior problems including accusatory behaviors, and noncompliance. Interventions included assist resident in developing appropriate methods of coping, monitor behaviors and attempt to determine underlying causes.

Interview with R#50 on 8/22/17 at 11:40 AM indicated that s/he had a gold colored ring that went missing 1 month prior. R#50 indicated that s/he informed the staff and that s/he spoke with Social Worker#1 (SW) about the missing ring. R#50 reported that s/he never heard anything about the lost ring since talking with the SW#1.

A review of the nursing notes dated 7/2/17 documented that R#50 verbalized concerns about the missing ring to LPN#5 and that a message was left for social service; however review of the social service notes failed to document the concern.

Interview with LPN#5 on 8/24/17 at 11AM indicated that s/he couldn't recall informing the social service department of the missing ring. LPN#5 indicated that even though s/he intended to inform social services, LPN#5 believes s/he may have been distracted and didn't leave the message as intended.

Interview with SW#1 on 8/23/17 at 1:45PM indicated that s/he could not recall being informed of the missing ring. SW#1 indicated that per the facility's policy, social services should have documented acknowledgement of the concern and also the resolution once it was achieved. SW#1 indicated that R#50 concern could have been missed in error.

Subsequent to the surveyor's inquiry SW#1 indicated that s/he would inquire with R#50 about the facts related to the missing ring.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or Connecticut General Statutes 19a-550.

3. Based on observations, clinical record reviews and interviews for 1 of 12 residents observed for dining (R #194), the facility failed to provide a dignified dining experience and/or for one of three residents reviewed for dignity (R#149), the facility failed to ensure that the resident was treated with dignity and respect. The findings include:
   a. Resident #194's diagnoses included Non-Alzheimer's dementia and dysphagia oropharyngeal phase (difficult swallowing). A quarterly assessment dated 7/20/17 identified that the resident was severely cognitively impaired, required extensive to total assistance with activities of daily living (ADLs) and was independent with eating.

      Resident care plan (RCP) dated 7/21/17 identified a problem with swallowing "resolved

with diet order and gradual significant weight loss since admission stabilizing." Interventions included independent with feeding after set up help, sippy cup with all meals and supervision with meals due to dysphagia.

Physician's orders dated 8/16/17 directed to provide a heart healthy-mechanical soft diet and nectar thick liquids.

During an observation of the second floor main dining room noon meal on 08/21/17 at 12:08 PM, R#194 was observed sitting alone at a portable card table on the side of dining room. The resident was holding a sippy type cup to his/her mouth from 12:08 until 12:34 PM, NA #8 was assisting another resident at an adjacent table with his/her back to R#194 for 26 minutes before s/he stood and approached the resident. Continued observation noted R#194 again holding the sippy cup to mouth. NA#9 was then observed approaching R#194 twice asking "are you done ?" with resident responding no. NA#9 was observed at 12:55 PM to approach the resident a third time asking "are you done?" and was noted to abruptly tip the sippy cup up with the resident coughing in response.

Interview with NA#9 on 08/21/17 at 1:07 PM indicated that R#194 wasn't getting any milk from the cup and s/he tipped it to help him/her.

Subsequent to surveyor inquiry, Nurses notes dated 8/21/17 identified that due to R#194 coughing, a swallow evaluation was conducted.

Physician's orders dated 08/21/17 directed a swallow evaluation. It further directed to provide honey thick liquids, aspiration precautions and supervise meals. A subsequent order on 8/22/17 directed to discontinue honey thick liquids and provide nectar thick liquid.

Facility documentation dated 8/23/17 identified provision of education to NA#9 that included direction not to lift a cup to hasten drinking.

Interview with OT #1 on 98/24/17 at 10:22 PM indicated approaches when assisting with dining and/or drinking included verbal cues, and gentle assistance.

b. Resident #149's diagnoses included aphasia, major depression, CVA and chronic kidney disease. The quarterly minimum data set dated 10/17/16 documented that R#149 was severely impaired cognitively and needed one to two staff to provide extensive physical assistance with ADLs.

Interview with R #149 on 8/21/17 at 11:15 AM indicated that s/he felt that the staff had been disrespectful to him/her. R #149 indicated that's/he reported the concerns to the DNS. A review of the clinical record and facility grievance log failed to document the allegation.

Interview with SW on 8/23/17 at 11:40 AM indicated that the resident never verbalized any

verbal and or physical abuse by staff to him/her.

Interview with RN #6 on 8/24/17 at 10 AM indicated that s/he was not aware of any allegation of verbal or physical abuse related to this resident.

Interview with the DNS on 8/23/17 at 2 PM indicated that last year R#149's family verbalized a concern with a CNA, the DNS indicated the incident was investigated however abuse was not substantiated.

Review of the investigation dated 12/28/16 indicated that NA #6 approached R #149's son and verbalized his/her (NA#6's) concerns relating to the resident calling NA #6 a "Bitch" and requesting that NA#6 no longer care for him/ her.

Review of the investigation indicated that the discussion was heard by the resident and that not only the resident but the son was very upset with the NA's discussion.

Interview with NA #6 on 8/24/17 at 11:55 AM indicated that s/he did approach the family about R #149's displeasure toward him/her. NA indicated s/he consulted the resident's family because s/he was so puzzled by R #149's behavior towards him/her. NA #6 indicated that s/he never verbally and or physically assaulted R#149. NA #6 indicated that even though s/he meant no harm, NA #6 now realized it was the wrong thing to do.

Interview with the Director of Nurses on 8/24/17 at 11:55 AM indicated that NA #6 no longer provides care to R #149. The DNS indicated that subsequent to the incident, R #149 is now care planned for 2 care givers at all times. Interview with the Director of Nurses on 8/24/17 indicated that NA #6 was educated on his/her actions.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

4. Based on clinical record review and interview for 1 of 4 residents in survey sample reviewed for accidents (R#7) facility failed to develop a comprehensive care plan to address the resident's identified potential and/or actual wandering. The findings include:
   a. Resident # 7 was admitted to facility on 3/1/17 with diagnoses that included adjustment disorder with mixed anxiety and depressed mood. An admission assessment dated 3/8/17 identified that the resident was severely cognitively impaired and had the behavior of wandering.

      Interview with SW #1 on 8/24/17 at 11:04 AM indicated that the resident was well known to him/her from previous admission, family report and observation. SW #1 further indicated that s/he had documented the assessment due to directly observing the resident's behavior of wandering around looking for his/her son and/or other familiar persons.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of the Resident's care plans and clinical record with RN#4 and SW#1 at that time failed to provide documentation that a plan of care was developed for R#7's wandering behavior.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

5. Based on clinical record review, facility documentation and interviews for one of four sampled residents reviewed for accidents (Resident #252), the facility failed to revise the plan of care to accurately reflect the resident's bed mobility. The findings include:
   a. Resident #252's diagnoses included osteomyelitis of the left foot, legal blindness, obstructive sleep apnea and chronic kidney disease. The Admission MDS dated 9/30/16 identified the resident had intact cognition and was totally dependent on two staff for bed mobility.

      The Physical Therapy Evaluation and Resident Plan of Care dated 11/30/16 identified the resident required partial/moderate assistance for rolling side to side in bed.

      The quarterly MDS dated 12/28/16 identified the resident had intact cognition and was totally dependent on two staff for bed mobility.

      The Resident Care Plan dated 1/4/17 identified the resident had a self-care performance deficit with interventions including to provide the assistance of 2 for bed mobility.

      The CNA Resident Assignment identified the resident required assistance of two for turning and repositioning, however interview with the DNS on 8/22/17 at 10:30 AM identified that the resident required the assistance of one for bed mobility.

      NA #3 indicated that he/she was regularly assigned to Resident #252 and the resident was an assist of one for bed mobility, indicating that the resident was able to routinely follow commands and hold onto the side rail while on his/her side.

      Interview with PT #1 on 8/22/17 at 2:04 PM identified he/she was very familiar with Resident #252 and the resident was able to turn and reposition in bed with the assistance of one person because he/she was able to use the assist bar .

      Interview with the DNS on 8/24/17 at 10:45 AM identified that s/he was sure the resident only required the assistance of one for bed mobility and had on multiple occasions witnessed the aides provide care. DNS further identified it would be the responsibility of the MDS Nurse to revise the resident's care plan, however the C.N.A's were confusing bed mobility with transfer status which lead to confusion. DNS indicated in-service education had been provided to the staff regarding accurate documentation.

DATES OF VISIT: August 21, 22, 23 and 24, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursings Staff (2).

6. Based on clinical record review, facility documentation and interviews for one of four sampled residents reviewed for accidents (Resident #252) , the facility staff member failed to perform within their scope of practice. The findings include:
   a. Resident #252's diagnoses included osteomyelitis of the left foot, legal blindness, obstructive sleep apnea and chronic kidney disease. The Admission MDS dated 9/30/16 identified the resident had intact cognition and was totally dependent on two staff for bed mobility.

      The Resident Care Plan dated 10/10/16 identified the resident had an alteration in respiratory status related to sleep apnea with interventions including to provide CPAP/Settings per order.

      The Physician's order dated 1/22/17 directed the facility to provide CPAP with heated humidifiers 5 CM H20.

      Review of the CNA Resident Assignment identified the resident utilized the CPAP at bedtime.

      A written statement by NA #3 dated 1/23/17 identified that NA #3 removed the resident's CPAP mask on the morning of 1/23/17.

      Interview with NA #3 on 8/23/17 at 10:18 AM identified that he/she did indeed remove the resident's CPAP mask prior to providing AM care, indicating that Resident #252 asked him/her to do so. When asked if NA #3 realized removing the mask was outside of his/her scope of practice, he/she indicated that the facility provided education after the incident making him/her aware.

      Review of NA #3's employee file identified Inservice Education dated 1/26/17 was provided to NA#3 educating him/her that the Licensed Nurse was to remove the CPAP mask.

      Interview and review of the facility's CPAP policy with the Director of Nursing Services on 8/23/17 at 11:01 AM identified that NA #3 removing the CPAP mask was outside of his/her scope of practice, therefore the facility provided education. DNS identified that although the policy addressed the Licensed Nurse applying the mask, the expectation is a Licensed Nurse will also be responsible for removing the mask, not the C.N.A.

DATES OF VISIT: August 21, 22, 23 and 24, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursings Staff (2).

7. Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one of three sampled resident reviewed for grooming (Resident #29 and R #152) , the facility failed to ensure that the resident's nails were kept clean and trimmed. The findings include:
   a. Resident #29's diagnoses included dementia and rheumatoid arthritis. The annual MDS assessment dated 6/6/17 identified Resident #29 was without cognitive impairment, and required extensive assistance with dressing and personal hygiene.

      The Resident Care Plan (RCP) dated 6/8/17 identified an ADL self-performance/limited physical mobility deficit related to Alzheimer's dementia, Cerebrovascular Accident and Rheumatoid Arthritis. and Resident pulled off her right pointer finger by herself. Interventions directed to check nail length and trim and clean on bath day and as necessary and to report any changes to the nurse and document increase in anxiety.

      CNA Resident Assignment identified that R#29's shower day is Tuesday on the 11-7 shift.

      Review of Resident Care Flow sheets indicates that R#29 had not received a shower between 6/25/17 and 8/23/17.

      Observations on 8/22/17 at 10:49 AM identified that R#29's nails were long, curled over his/her finger tips, untrimmed with heavy black debris embedded underneath.

      Additional observation on 8/23/17 at 7:26 AM noted that R#29's nails remained curled over her fingertips with thick black debris embedded in his/her fingernails.

      An interview with NA #5 on 8/22/17 at 2:58 PM indicated that the NA assigned on the shift for shower day is responsible to provide nail care. Additionally, every day care includes, bed bath, brushing hair, nail care and/or shaving the resident and/or it is not just routine care like changing a resident's brief.

      In an observation, interview and record review with LPN #3 on 8/23/17 at 7:28 AM indicated that R #29's shower day was on the previous shift 11-7 and/or that R #29's nails were clearly untrimmed and/or cleaned for at least two weeks or more.
   b. Resident #152's diagnoses included dementia and Type 2 Diabetes. The quarterly MDS assessment dated 7/7/17 identified Resident #152 was without cognitive impairment, and required extensive assistance with bed mobility and personal hygiene.

      The Resident Care Plan (RCP) dated 8/10/17 identified an ADL self-care performance deficit. Interventions indicated that resident needs assist of one staff with personal hygiene.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Observations on 8/21/17 at 12:31 PM identified that R#152 nails are long, untrimmed, with sharp, chipped with jagged edges and/or dark brown debris embedded underneath.

Further observation on 8/22/17 at 3:29 PM noted that R#152 nails remained long with sharp, jagged edges with dark brown debris embedded underneath.

In an observation, interview and clinical record review with LPN#3 on 8/23/17 at 8:05 AM, indicated that R#152's nails were long and jagged with debris underneath the nails. He/she indicated that R#152's shower day was Saturday on the 3-11 shift and/or that the nail growth was excessive and/or that the dirt should have been removed. In addition, the dirt underneath the nails should be removed by the care provider whenever it is noticed on a Resident.

Review of facility Nail Care Policy identified in part, that residents are provided nail care weekly and PRN and the purpose for nail care is to keep the nails clean and to prevent injury by keeping nails short and smooth. The procedure indicates to file nails, if necessary, to assure they are smooth and/or use an orange stick to clean underneath the nail if needed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

8. Based on observation and interviews failed to maintain carpet in a safe and hazard free manner. The findings include:
   a. During tours of facility on 8/21/17 through 8/24/17 carpet was noted lifted/bubbled at areas where carpet met wood flooring and loosely adhered to floor causing potential fall hazards located in (but not limited to) the following areas:

      1. Resident bedrooms 233 and 234, carpeting at threshold loosely adhered to floor.
      2. Entrance to second floor dining room adjacent to storage room and recreation office.
      3. Area adjacent to second floor nurses station where carpet meets wood flooring lifted.
      4. The third floor hallway from bedroom 334 through hallway to dining room.
      5. Carpet lifted where meets wood flooring in front of social service office.
      6. Carpet located at outpatient entrance loose adhered and lifted.

      Interview with administration on 8/23/17 at 1:36 PM indicated that the facility was in progress of purchasing and/or repairing the carpet and provided estimates dated 7/31/17.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurese (2) and/or (o) Medical Records (2)(H).

9. Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident # 80) reviewed for unnecessary medications, the facility failed to ensure that the specific behaviors that led to the use of

antipsychotic medications, were being monitored accordingly. The findings include:

a. Resident # 80's diagnoses included Dementia and Cerebral Infarction. The annual MDS assessment dated 8/7/17 identified Resident # 80 was moderately cognitively impaired and required extensive assistance with transfer and personal hygiene.

The Resident Care Plan (RCP) dated 7/30/17 identified behavior problems related to sexually and socially inappropriate behavior towards peers and staff and the resident has the potential to be physically aggressive (kicking) related to Dementia. Interventions directed to administer medications as ordered. Monitor/document for side effects and effectiveness and if reasonable, discuss the resident's behavior, explain and reinforce why behavior is inappropriate and/or unacceptable. Additionally, monitor and document observed behavior and attempted interventions in behavior log.

A physician's order dated 3/6/17 directed to staff to administer Seroquel 50 mg one tablet by mouth twice daily.

Review of psychological service progress notes dated 5/25/17 indicated that symptoms and/or stressors that impact functioning include: irritability, inappropriate interactive behaviors (i.e. kicking residents, inappropriately groping staff, and wants to go home) and that treatment modification is needed including coordination with facility staff and symptoms require more attention.

Review of Psychiatric evaluation dated 8/17/17 indicated that a Gradual Dose Reduction is contraindicated at this time secondary to risk of worsening symptoms.

Review of the Behavior/Intervention Monthly Flow Record dated April 2017, May 2017, June 2017, July 2017 and August 2017 failed to identify any of the following specific behavior's; Sexual and socially inappropriate behavior towards peers and staff and being physically aggressive (kicking).

An interview and record review with LPN #7 on 8/2/317 at 12:15 PM indicated that the behavior monitoring flow sheets monitor for sadness and/or withdrawn. LPN#7 further indicated that the flow sheets did not monitor for sexually inappropriate behaviors and/or physically aggressive behaviors. LPN#7 indicated that the resident is flirty and approaches the staff and/or will compliment peoples body parts and/or say "nice tata's" and/or reach out and try to touch you.

Interview with NA #7 on 8/23/17 at 12:21 PM described R #80 as a big flirt and will ask if he/she is married and/or wants to go on a date and/or will make comments about you that are not appropriate. NA #7 reported that this behavior occurs every day.

An interview and clinical record review with LPN #3 on 8/23/17 at 12:10 PM was unable to

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

provide documentation to reflect that physically aggressive and/or sexually inappropriate behaviors were being monitored. LPN #3 indicated that he/she did not know why they were not monitoring the striking out, physically aggressive behaviors and/or the sexually inappropriate behaviors as indicated by the psychiatric APRN.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurese (2) and/or (k) Nurse Supervisor (1).

10. Based on observations, clinical record review, and review of facility policy, the facility failed to ensure that the medical supplies were stored in a clean and sanitary manner. The findings include:
    a. Observations on 8/23/17 at 2:00 PM identified that medical supplies were being stored underneath the unlocked sink in the first floor medication room. The items found underneath the unlocked sink in the first floor medication storage room included: mulitple bags filled with Intravenous supplies such as Intravenous administration sets, Intravneous solutions, Intravenous dressing kits, and 10 cc syringes filled with normal saline.

    Observations on 8/23/17 at 2:15 PM identified that supplies were being stored underneath the sink including: 2 packages of briefs, a case of similac with immune support, heel protectors, 3 activity vests, and/or 3 coudee catheters.

    An interview with LPN #2 on 8/23/17 at 2:05 PM identified that he/she was unaware that supplies are not to be stored underneath the sink. Furthermore, he/she said that the supplies had been stored on the table until that morning.

    An interview with LPN #3 on 8/24/17 at 10:30 am indicated that maintenance had bolted the cabinet doors shut underneath the sink on the 3rd floor and/or all of the supplies had been removed and thrown away.

    An interview with the Infection Preventionist on 8/23/17 at 2:15 PM identified that the supplies should not be stored underneath the sink and/or he/she did was not aware that the cabinet underneath the sink was unlocked.

    Subsequent to surveyor inquiry, the cabinet doors underneath the sinks on the first, second and third floors were bolted shut by maintenance.

    An interview and clinical record review with the Infection Preventionist on 8/24/17 at 11:45 AM, indicated that the Infection Preventionist was unable to provide documentation/evidence that the cabinets underneath the sinks in the medication storage room were checked during the environmental rounds.

    Review of facility Medication Storage Policy identified in part, that medications are stored at appropriate place and temperature as it relates to the manufacturer's guidelines.

DATES OF VISIT: August 21, 22, 23 and 24, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurese (2) and/or (o) Medical Records (2) and/or (o)Medical Records (1).

11. Based on clinical record review, facility documentation and interviews for one of four sampled residents reviewed for accidents (Resident #252), the facility failed to document an assessment in the clinical record following a fall with injury. The findings include:
    a. Resident #252's diagnoses included osteomyelitis of the left foot, legal blindness, obstructive sleep apnea and chronic kidney disease. The Quarterly MDS dated 12/28/16 identified the resident had intact cognition, was totally dependent on two staff for bed mobility, and extensive assistance with activities of daily living.

       The Resident Care Plan dated 1/4/17 identified the resident was at risk for falls related to gait/balance problems with interventions including bed in low position at night and side rails as ordered.

       The Reportable Event Form dated 1/23/17 at 6:15 AM identified that while C.N.A. #3 was providing AM care, he/she went to fix the bed and the resident rolled off the bed to the floor, landing face down with his/her right arm under him/her.

       The Mobilex Radiology Report dated 1/23/17 identified an acute fracture involving the humeral neck with no displacement resulting in a transfer to an acute care facility.

       Interview with LPN #4 on 8/23/17 at 12:33 PM identified the RN Supervisor (RN #3) was notified of the resident's fall and did see the resident, however there is no documentation to support the assessment and/or no documentation regarding the findings of the assessment.

       Subsequent interview with LPN #4 on 8/24/17 at 12:43 PM identified he/she was able to recall filling out the Reportable Event Form, however does not recall why he/she did not document in the medical record.

       Interview and review of the clinical record with the Director of Nursing Services on 8/24/17 at 10:15 AM identified there was no nursing assessment of the resident and/or documentation regarding the fall in the clinical record. DNS indicated it was the expectation and the responsibility of the RN Supervisor to complete and document an assessment status post fall. Multiple phone calls to RN #3 for interview were not successful.

       The facility's policy and procedure regarding guidelines for falls identified that the Licensed Staff must assess the resident, including vital signs/neuro signs per policy, complete a fracture assessment and document the fall, assessment of resident, notification of M.D. and personal legal representative (if applicable) in the medical record.

Whitney Rehab :- FID - 8/24/17

State POC

for accepted 10/18/17

August 2017 Tags: Paragraph Form

1.

Facility continues to inform the residents' physician, responsible party, and/or resident of any change in condition in physical, mental, or psychosocial condition. Facility will also promptly notify responsible party and/or resident of any need to alter treatment as well as any decision to transfer or discharge the resident from the facility as indicated by MD orders.

Resident #83 continues to resident in facility and weights remain stable. Responsible Party was also notified of weight lost while in hospital. All residents that reside in facility have the potential to be affected. Therefore, facility has re-educated licensed staff an updating MD and responsible party on any change in condition.

Facility will also do random audits on re-admissions weights, monthly weights, and weekly weights to identify any potential weight loss or gain. This will be done biweekly x4 weeks then weekly x4 weeks or until substantial compliance is met. All findings will be presented monthly to QA QI committee for review. This will be overseen by the Dietitian and/or DNS.

Completion Date: 10/5/17

2.

Facility continues to make prompt efforts to resolve grievances that residents may have. Resident #50 continues to resident in the facility and grievance has since been resolved. All residents that resident in the facility have the potential to be affected. Therefore, licensed staff has been re-educated on the grievance process i.e. reporting and documenting appropriately. Facility will do random audits weekly in the grievance log to ensure compliance. This will be done for 3 months or until substantial compliance is met. All findings will be presented monthly to QA QI committee for review. This process will be overseen by the Administrator and/or DNS.

Completion Date: 10/5/17

3.

Facility continues to treat and care for each resident in a manner and in an environment that promotes maintenance of enhancement of his or her quality of life while recognizing each resident's individuality. Facility puts all effort to protect and promote the right of the resident. Resident #194 continues to resident in the facility and remains safe as facility promotes a dignified dining experience for all residents. Direct care givers are in the process of being re-educated on dignified dining and/or feeding.

Residents #194 was evaluated by speech therapy after coughing and cleared to remain on the same diet. Resident #149 continues to reside in facility and remains safe. Staff continues to make every effort to be respectful of residents. NA#6 has never been disrespectful to resident #149 but had spoken to family of #149 related to how resident treats NA #6. Facility has since re-educated NA #6 about her speaking to the family and that it was inappropriate. NA #6 voiced understanding. Facility has also reassigned NA# 6 from assignment and unit that resident #149 resides on to prevent potential misunderstanding. All residents that reside in facility has the potential to the affected. Therefore, a house wide re-education on resident rights/dignity is in process.

To prevent potential re-occurrence random audits will be done during meal times to identify problems. This will be done weekly x4 weeks then weekly x2 months to ensure compliance. All findings will be presented monthly to QA QI committee for review. This process will be overseen by the Administrator and/or DNS.

Completion Date: 10/5/17

4.

Facility continues to make every effort to promote patient centered care. Facility continues to develop and implement a comprehensive care plan for each resident, consistent with resident rights. Goals are measureable and time frames set to meet each residents' medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

Resident #7 no longer resides in facility. All residents that residents that reside in the facility have the potential to be affected. Therefore, S.W. involved has been re-educated on assessment and proper care plans to match findings of assessment; re-education also involves proper communication with other department to prevent re-occurrence. Weekly audits will be done on admission assessments by S.W. to identify any potential wandering behavior without care plans. This will be done x3 months or until substantial compliance is met. This will be over seen by the Social Services Director and/or MDS. All findings will be presented monthly to QA QI committee for review.

Completion Date: 10/5/17

5.

All residents have the right to participate in the development and implementation of their plan of care. Resident #252 has since expired. All residents that reside in the facility have the potential to be affected. Therefore, the facility is in the process of auditing resident care plans and assessments as they are due to ensure that all documentation and care plans are in sync.

Audits will be done randomly on quarterly MDSs as they are due to ensure care plans are updated to match assessments. This will be done weekly x3 months or until substantial

compliance is met. All findings will be presented monthly to QA QI committee for review. This will be over seen by ADNS and/or MDS.

Completion Date: 10/5/17

6.

Facility continues to provide qualified persons to provide services in accordance with each residents' written plan of care. Resident #252 has since expired. Staff member involved has since been re-educated on performing duties within the scope of practice.

To prevent the potential re-occurrence facility is in the process of re-educating direct care givers about performing duties within their scope. Residents that require the use of bipap has the potential to be affected.

Random audits will be done on residents with bipap to ensure that appropriate staff are removing machine. This will done bi-weekly x4 weeks then x2 months or until substantial compliance is met. All findings will be presented monthly to QA QI committee for review. This will be over seen by DNS or designee.

Completion Date:10/5/17

7.

Facility continues to carry out activities of daily living for residents who are unable to do so for themselves, to maintain good nutrition, grooming, personal, and oral hygiene. Resident #29 and #152 continue to resident in the facility. Nails have since been trimmed and cleaned.

All residents that reside in the facility have the potential to be affected. Therefore, house wide re-education on grooming/nail care and showers are in the process of being done for all direct care givers. Audits on showers and nail care will be done randomly biweekly x4 weeks than weekly x2 months or until substantial compliance is met. All findings will be presented monthly to QA QI committee for review. This will be over seen by DNS or designee.

Completion Date: 10/5/17

8.

Facility has obtained quote to replace all carpet in the facility. Areas that were identified as more problematic are in the progress of being replaced. All findings will be presented monthly to QA QI committee for review. This will be over seen by the Administrator and/or Director of Maintenance.

Completion Date: 12/6/17

9.

Facility continues to make every effort to keep residents free from unnecessary drugs. Residents #80 still resides in the facility and appropriate behaviors are being monitored accordingly. Residents that resident in facility that use antipsychotic drugs has the potential to be affected. Therefore, nurse wide audit is in the process of being done to ensure that all residents on antipsychotic medication has the appropriate targeted behavior.

Random audits will be done to ensure staff are maintaining appropriate behavior this will be done biweekly x4 weeks, then weekly x2 months or until substantial compliance is met. This will be monitored by the DNS/designee. All findings will be presented monthly to QA QI committee for review.

Completion Date: 10/5/17

10.

Facility continues to make every effort to label all drugs and biologicals as well as store. Drugs and biologicals In accordance with state and federal laws. All storage areas underneath sinks in medication rooms has since been screwed shut and all items were removed and discarded accordingly. Licensed staff were also re-educated on proper storage of medication and biologicals. Random audits will be done on environmental rounds to ensure compliance. This will be done weekly x3 months or until substantial compliance is met. This will be over seen by the Administrator/designee. All findings will be presented monthly to QA QI committee for review.

Completion Date: 10/5/17

11.

Facility continues to strive to maintain medical records in accordance with acceptable professional standards and practice for each resident. Resident #252 has since expired. All residents have the potential to be affected. Therefore, licensed staff are in the process of being re-educated on documenting assessments in clinical recording following a fall.

Random audits will be done after falls to ensure that there was an assessment done and documented. Notification of MD and responsible party was updated. This will be done biweekly x4 weeks then weekly x2 months or until substantial compliance is met. This will be overseen by the DNS and/or designee. All findings will be presented monthly to QA QI committee for review.

Completion Date: 10/5/17

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Whitney Center
200 Leeder Hill Dr.
Hamden, CT 06517
M:

Signature of FLIS Staff

Kelly Madden

Licensure Category: CCNH

Licensed Bed Bassinet Capacity: 58

Census: 42

Date(s) of onsite inspection: 8/18/17 - Desk Audit

Date(s) additional information obtained:

Personnel contacted: Margaret Joyce - Adm.

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[ ] See Complaint Investigation #

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

[X] Desk Audit 8/18/17 [ ] Amended Letter: Original Ltr.

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

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

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

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to

REPORT SUBMITTED BY: Kelly Madden **DATE OF REPORT:** 8/18/17

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

LICENSING INSPECTION NARRATIVE REPORT:

A desk audit was conducted on 8/18/17 by a representative of the FLIS for the purpose of reviewing the POC for the violation letter dated June 28, 2017. Violations 1-6 were identified as corrected.
The POC for Fire Life Safety reviewed. Violations 1a + 1b were identified as corrected.

Kelly Madden, NC

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity	*Signature of FLIS Staff*
Whitney Center	Kathleen Pleskin Jan Moo[illegible]
200 Leeder Hill Drive	[illegible] Clark
Hamden CT. 06517	Rosalee Cealey RN NC
M:	Richard Howe RN NC

Licensure Category: CCNH
Licensed Bed Bassinet Capacity: 59
Census: 50

Date(s) of onsite inspection: 6/5/17, 6/6/17, 6/7/17

Date(s) additional information obtained: ~~Margaret Joyce~~

Personnel contacted: Margaret Joyce ADM, Lashawn Price DNS

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

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

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

[ ] See Complaint Investigation # ___

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 6-28-17

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

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

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

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

[ ] Narrative report/additional information attached.

[X] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: Kathleen Pleskin **DATE OF REPORT:** 6/8/17

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

s:flis\hsr\FACESHEETS
Revised 12/2016

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 28, 2017

Ms. Margaret Joyce, Administrator
Whitney Center
200 Leeder Hill Dr
Hamden, CT 06517

Dear Ms. Joyce:

Unannounced visits were made to Whitney Center concluding on June 7, 2017 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a certification survey.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by July 12, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);
2. Date corrective measure will be effected;
3. The institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
4. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

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

Respectfully,

Rosella Crowley RN SNC

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC/KP:jf

DATES OF VISIT: June 5, 6 and 7, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

1. Based on review of the clinical record and interviews, for only sampled resident reviewed for hospice service, (Resident #31), the facility failed to code the MDS accurately to reflect hospice services. The findings include:
   a. Resident #31's diagnoses included a terminal illness. Resident #31 was admitted to hospice services on 4/13/2017. The quarterly MDS dated 5/1/2017 identified the resident as having no condition or chronic disease that may result in a life expectancy of less than six months.
   Interview and record review with the MDS Coordinator on 6/07/2017 at 11:11 AM identified the resident was admitted to hospice services on 4/13/2017. He/she indicated that a resident on hospice should have prognosis coded as 1 and should have had a significant change MDS after being admitted to Hospice benefit within 14 days which was not done due to the previous MDS coordinator was not aware of the need for a significant change MDS and did not code the MDS correctly for the prognosis.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

2. Based on clinical record review and interview for one of three residents reviewed for accidents (R #68) facility failed to develop a comprehensive care plan related to the utilization of a new adaptive wheel chair. The findings included:
   a. Resident #68's diagnoses included dementia. A quarterly assessment dated 03/23/2017 identified the resident was severely cognitively impaired and totally dependent on staff for transfers.

   The care plan dated 3/2017 identified a potential for falls. Interventions included PT/OT evaluation and treat as ordered.

   Facility documentation dated 5/3/17 identified that the resident was observed on the floor. The documentation identified that a new intervention was put into place that included "ensure that the resident was placed back into adaptive wheelchair after spa appointments."

   A rehabilitation screen dated 5/4/17 identified that the resident had slid from a standard wheelchair after returning from hairdresser. It further identified that the resident was care planned to be out of bed to a modified wheelchair tilt and space.

   Interview with OT #1 on 6/6/17 at 10:14 AM indicated that the resident was evaluated and provided an adaptive wheel chair for positioning due to lack of upper body strength

on 04/26/17. S/he indicated providing staff inservice for R #68 and that staff was provided inservice related to safe use of custom wheelchairs on 4/27/2017. S/he further indicated that R#68 required the adaptive tilt space for support to his/her upper body from leaning.

Interview with Nurse aide (NA #1) on 06/07/2017 10:58 AM noted that while s/he (NA #1) was at lunch, R #68 was taken to the "spa" and upon return from his/her lunch, NA #1 indicated observing R #68 in his/her bedroom sitting in a standard wheelchair next to bed. NA #1 indicated that s/he went to clock back in and heard from other staff that R #68 had fallen from the wheelchair.

Interview and review of the clinical record with RN #2 on 06/07/2017 at 01:35 PM failed to provide documentation that the plan of care reflected the resident's need for the tilt in space adaptive wheelchair to maintain upper body positioning. Further review failed to note any revisions to the plan of care related to the fall out of the wheelchair on 05/03/17 to prevent further falls.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2).

3. Based on clinical record review and interview for one of three residents reviewed for accidents (R #68) facility failed to ensure the resident was positioned in the appropriate chair to prevent an accident. The findings included:
   a. Resident #68's diagnoses included dementia. A quarterly assessment dated 03/23/2017 identified the resident was severely cognitively impaired and totally dependent on staff for transfers.

      The care plan dated 3/2017 identified a potential for falls. Interventions included PT/OT evaluation and treat as ordered.

      Facility documentation dated 5/3/17 identified that the resident was observed on the floor. The documentation identified that a new intervention was put into place that included "ensure that the resident was placed back into adaptive wheelchair after spa appointments."

      A rehabilitation screen dated 5/4/17 identified that the resident had slid from a standard wheelchair after returning from hairdresser. It further identified that the resident was care planned to be out of bed to a modified wheelchair tilt and space.

      Interview with OT #1 on 6/6/17 at 10:14 AM indicated that the resident was evaluated and provided an adaptive wheel chair for positioning due to lack of upper body strength on 04/26/17. S/he indicated providing staff inservice for R #68 and that staff was

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

provided inservice related to safe use of custom wheelchairs on 4/27/2017. She/he further indicated that R#68 required the adaptive tilt space for support to his/her upper body from leaning.

Interview with Nurse aide (NA #1) on 06/07/2017 10:58 AM noted that while s/he (NA #1) was at lunch, R #68 was taken to the "spa" and upon return from his/her lunch, NA #1 indicated observing R #68 in his/her bedroom sitting in a standard wheelchair next to bed. NA #1 indicated that s/he went to clock back in and heard from other staff that R #68 had fallen from the wheelchair.

Interview and review of the clinical record with RN #2 on 06/07/2017 at 01:35 PM failed to provide documentation that the plan of care reflected the resident's need for the tilt in space adaptive wheelchair to maintain upper body positioning. Further review failed to note any revisions to the plan of care related to the fall out of the wheelchair on 05/03/17 to prevent further falls.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2).

4. Based on clinical record review, staff interview, and observations for one of three residents reviewed for weight loss (Resident #38), the facility failed to ensure a physician prescribed dietary supplement was documented and/or monitored. The findings include:
   a. Resident #38's diagnoses included dementia with delusions, and weight loss. The annual MDS assessment dated 4/21/17 identified the resident with impaired cognition, required supervision with eating, and received a mechanically altered diet.

      Physician orders dated 4/23/17 direct to discontinue house supplement (resident dislikes), start milkshake from the kitchen 4 oz daily with lunch and supper, and resource juice at breakfast instead of regular juice.

      The RCP dated 5/3/17 identified a risk for weight loss. Interventions included to provide a 4 oz milkshake and resource juice instead of regular juice with the lunch and dinner meal.

      Observations of the lunch meal on 6/6/17 at 12:45 PM noted a half filled 4 oz cup of a strawberry milkshake and an empty 4 oz cup of juice. Interview with R #38 at that time indicated h/she was done with the meal.

      Review of the MAR dated 4/23/17 through 6/7/17 failed to reflect the 4 oz of milkshake and/or resource juice had been documented as provided.

      Interview with the ADNS 06/07/2017 at 10:13 AM identified when a resident has a

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

physician order for an oral supplement, a dietary communication form is completed and sent to the dietary department. Nursing should add the order to the MAR with the type of supplement provided and the amount consumed. The clinical record failed to reflect the physician prescribed 4 oz milkshake and/or resource juice was being documented and/or monitored.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2).

5. Based on observation and interviews for the only medication storage room, the facility failed to ensure medication room was locked and/or secured. The findings include:
   a. Observations on 6/5/2017 at 9:20 AM identified one of two doors leading into the facility's only medication room did not lock, the door opened and closed without the use of a key. There was a resident present and walking in the hallway with a walker. During the time of the observation, no licensed staff were in the area or able to observe the door.
   An interview and observation 6/5/2017 at 9:25 AM with RN #1 identified that the door did not lock, RN #1 notified the ADON who observed and confirmed the door did not lock and that tape had been placed over the door locking plate, preventing the door from locking. RN #1 removed the tape. The ADON identified that the medication room should be locked, s/he does not know who applied the tape or when, and she/he will investigate and address.
   Review of facility policy for storage of medications identified, in part, that the facility should ensure that all medications are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2).

6. Based on observation and interview facility failed to handle dishware in a sanitary manner. The findings include.
   a. During a tour of the kitchen on 06/05/2017 with FSD present 9:15:25 AM through 9:39 AM noted observation of DA #1 working at the dishwasher machine alone. DA #1 was observed to handle soiled items and wipe the floor with gloved hands and then proceed to the clean side of the machine and without the benefit of removing dirty gloves and/or washing hands, handled the sanitized items including dish covers, and trays; delivering the cleaned items to their storage place throughout the kitchen.

   Interview with the FSD on 06/05/2017 at 9:50:19 AM she/he indicated that crossing from soiled to clean items could cause an infection control concern.
   Facility dishwashing policy procedure identified in part that employees must wash their hands and change gloves between touching dirty and clean dishes.

DATES OF VISIT: June 5, 6 and 7, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

WHITNEY CENTER
A Heritage of Exceptional Senior Living

200 Leeder Hill Drive, Hamden, CT 06517 • Tel (203) 281-6745 • Fax (203) 848-1609

State PA

accepted 8/3/17

July 12, 2017

RECEIVED
JUL 17 2017
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Crowley:

In response to your letter of June 28, 2017 the following plan of correction is submitted:

The submission of this plan of correction does not constitute an admission by any party as to the truth of the facts alleged or of the validity of the conclusions set forth in the alleged deficiencies. This Plan of Correction is being filed as evidence of the facility's commitment to compliance with all applicable statutes and regulations.

1. Re: Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H):

   1. Resident #31 had a revision to the last MDS to reflect the residents current hospice status.

   2. All residents placed on hospice have the potential to be affected by this alleged deficient practice.

   3. MDS staff have been educated on accurate documentation of hospice services.

   4. Random audits for residents placed on hospice on the MDS will be conducted to ensure compliance. Audits will be reviewed by members of the Quality Assurance Committee.

   Date of Completion: July 5, 2017

   Staff Monitor: The Director of Nursing Services or designee

2. Re: Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I):

   1. Resident #68 was placed in the correct adaptive wheelchair after spa appointment.

   2. All residents have the potential to be affected by this alleged deficient practice.

   3. Nursing staff and Spa staff will be re-educated on the facility's policy on adaptive wheelchair.

4. Random audits for appropriate wheelchairs will be conducted to ensure compliance. Audits will be reviewed by the Quality Assurance Committee.

Date of Completion: July 5, 2017

Staff Monitor: The Director of Nursing Services or designee

3. Re: Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and /or (m) Nursing Staff (2):

1. The care plan was updated to reflect that resident #68 has an adaptive wheelchair.

2. All residents have the potential to be affected by this alleged deficient practice.

3. Nursing staff will be re-educated on the facility's policy for care planning for adaptive chairs as appropriate and updating changes as necessary.

4. Random audits will be conducted to ensure compliance. Audits will be reviewed by the Quality Assurance Committee.

Date of Completion: July 5, 2017

Staff Monitor: The Director of Nursing Services or designee

4. Re: Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and /or (m) Nursing Staff (2):

1. Resident #38 has the percentage of the milkshake consumed documented on the Medication Kardex.

2. All residents who have a MD order for the milkshake have the potential to be affected by this alleged deficient practice.

3. Nursing staff will be re-inserviced on the required documentation for milkshakes ordered from the MD.

4. Random audits will be conducted for the residents with MD ordered milkshakes to ensure compliance. Audits will be reviewed by members of the Quality Assurance Committee.

Date of Completion: July 5, 2017

Staff Monitor: The Director of Nursing Services or designee

5. Re: Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and /or (m) Nursing Staff (2):

1. Door was inspected by facility's Maintenance Department for proper operation.

2. All medication doors will be secured at all times to prevent potential harm to any resident.

3. Nursing staff will be re-educated on the facility's policy of medication storage and securing the doors to the medication room. The nurse responsible to ensure door was securely locked is no longer employed at Whitney Center.

4. Random audits for the two doors leading to medication room will be conducted to ensure compliance. Audits will be reviewed by the Quality Assurance Committee.

Date of Completion: July 5, 2017

Staff Monitor: The Director of Nursing Services or designee

6. Re: Section 19-13-D8t (q) Dietary Services (2):

1. All dishware was cleaned and sanitized immediately.

2. All residents are at risk for possible exposure to transmission of infection.

3. Utility workers will be re-educated on proper handling of clean / dirty dishware as well as hand hygiene. Utility workers will also attend a Food Handlers course through Serve Safe.

4. Random audits will be conducted for proper handling of dishware and hand hygiene.

Date of Completion: July 5, 2017

Staff Monitor: The Director of Dining Services or designee

If you have any questions, please do not hesitate to call me at (203) 848-2611.

Sincerely,

Margaret C Joyce

Margaret C. Joyce, MS, RN, LNHA
Administrator of Health Services

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

June 20, 2017

Margaret Joyce, Administrator
Whitney Center
200 Leeder Hill Dr
Hamden, CT 06517

Dear Ms. Joyce:

An unannounced visit was made to the above facility on ***June 15, 2017*** by a representative of the Facility Licensing & Investigations Section, Building and Fire Safety Unit for the purpose of conducting certification and/or licensure inspection.

Attached are the violations of the regulation of Connecticut State Agencies and/or General Statutes of Connecticut, which were noted during the course of this visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by ***July 4, 2017*** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

a. **Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in service program, repairs, etc.).**

b. **Date corrective measures will be effected.**

c. **Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.**

If there are any questions, please do not hesitate to contact this office at (860) 509-7500.

Sincerely yours,

Anthony M. Bruno,
Building Construction & Fire Safety Unit Supervisor
Facility Licensing & Investigations Section

Enclosures
c: licensure file

DATE OF VISIT: June 15, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13D8t(f)(3):

1. During a tour of the facility and subsequent documentation review and staff interviews on *June 15, 2017*, the following was observed:

   a. The facility did not ensure that a fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70, 72 and NFPA 101 section 9.6. The Facilities Director did not provided documentation to indicate that all devices related the fire alarm system were functionally tested annually as required by NFPA 70, 72 and NFPA 101 section 9.6.; i.e., testing reports provided by Red Hawk dated 04/25/17 and 10/28/16 indicated that audio and visual devices were not tested;

   b. The facility did not ensure that there is an automatic sprinkler system installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The bio-hazard closet in the Health Center Storage Room lacked automatic sprinkler coverage. In addition the windowed part of the storage room also lacked automatic sprinkler coverage as required by NFPA 13.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

App 7-27-17 TB

The following are violations of the Regulations of Connecticut State Agencies Section 19-13D8t(f)(3):

1. During a tour of the facility and subsequent documentation review and staff interviews on *June 15, 2017*, the following was observed:

   a. The facility did not ensure that a fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70, 72 and NFPA 101 section 9.6. The Facilities Director did not provided documentation to indicate that all devices related the fire alarm system were functionally tested annually as required by NFPA 70, 72 and NFPA 101 section 9.6.; i.e., testing reports provided by Red Hawk dated 04/25/17 and 10/28/16 indicated that audio and visual devices were not tested;

   b. The facility did not ensure that there is an automatic sprinkler system installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The bio-hazard closet in the Health Center Storage Room lacked automatic sprinkler coverage. In addition the windowed part of the storage room also lacked automatic sprinkler coverage as required by NFPA 13.

Plan of correction :

1-a

1). The documentation provided by Red Hawk during their annual inspection will include that the company has tested the audio and visual devices.
2). Correction has commenced - completion date - July 13, 2017
3). The DIrector of Facilities will be responsible to monitor compliance.

1-b

1). The bio-hazard closet in the Health Center storage room will have two additional sprinklers installed - one in the bio-hazard closet and one in the window part of the storage room.
2). Correction has commenced - completion date - July 13, 2017.
3). The DIrector of Facilities will be responsible to monitor compliance.