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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075290	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Center	200 Leeder Hill Dr Hamden, CT 06517

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 5 residents (Resident #20, 12, 3, 8 and 124) the facility failed to ensure the residents received treatment and care in accordance with professional standards and physicians orders. For Resident #20, reviewed for edema, the facility failed to ensure that weights, ordered to be obtained every other day were consistently obtained. For Resident #12, the facility failed to follow the physician's order to apply compression stockings daily. For 1 of 4 residents (Resident #3), reviewed for accidents, the facility failed to ensure that neurological checks and post fall assessments were completed after the resident had multiple unwitnessed falls with reported head strikes. For 1 of 5 residents (Resident #8), reviewed for unnecessary medications, the facility failed to complete an RN assessment after the resident was found to have an injury of unknown origin and pain. For 1 of 4 residents (Resident #124) reviewed for accidents, the facility failed to ensure neurological assessments and follow-up assessments were completed, per the facility policy, following 2 unwitnessed falls. The findings include: 1. The Hospital Discharge summary dated [DATE] identified Resident #20 was on Lasix (a diuretic) for chronic leg edema. Resident #20 was admitted to the facility on [DATE] with diagnoses that included femur fracture, chronic leg edema, and chronic peripheral venous insufficiency. A physician's order dated 11/16/24 directed to administer Lasix 10 mg (diuretic) once a day on Monday, Wednesday, and Friday. The admission History and Physical, done by MD #1 dated 11/18/24 identified Resident #20 had statis dermatitis of both legs. A physician's order dated 11/18/24 at 3:31 PM directed to obtain weights every other day during the 7:00 AM to 3:00 PM shift. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any documentation related to additional neurological monitoring or post fall assessments for Resident #3 following the fall with head. A request for all neurological checks and post fall assessment documentation was made to the DNS on 12/3/24 at 6:00 AM. Interview with RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified that she completed Resident #3's assessment on 11/19/24 but would need to look into the neurological checks and post fall assessment documentation. RN #4 identified that it was the policy of the facility to complete neurological checks following any fall with head strikes. Subsequent to surveyor inquiry to the DNS and RN #4 on 12/3/24, additional documentation was provided on 12/3/24 at 12:57 PM. RN #1 provided an in-service signature sheet dated 11/1/24 for a topic Fall Charting which identified that nursing staff should do neurological checks on all unwitnessed falls. Interview with RN #1 immediately following review of the in-servicing document identified that there had been issues with nursing staff completing neurological checks and assessments for residents with unwitnessed falls and the in service was to provide education that all nurses should ensure that these were done. Interview with the DNS on 12/4/24 at 8:15 AM identified she was aware there were issues with assessments and neurological checks following unwitnessed falls for residents of the facility, and that these also were to be done for any resident who had a reported or confirmed head strike. The DNS identified that the facility had changed documentation systems in the last 2 years, and this change along with a use of paper and computer charting may have been the issue, however the policy was that post fall assessments and neurological checks should be done per the facility policy for 72 hours after the event. Although requested, the facility failed to provide any policy related neurological monitoring. Although requested, the facility failed to provide a copy of the neurological assessment flowsheet. The facility policy on fall management system directed that any fall with a potential or actual head injury would include follow up neurological checks which would be documented on the neurological assessment flow sheet for 72 hours. The policy further directed for any fall, follow up assessment and documentation would be conducted at a minimum of every shift for 72 hours. 4. Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

dressing.

The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The care plan also identified Resident #8 has a terminal diagnosis related to end stage dementia. Interventions included to observe the resident for signs of pain, administer pain medication as ordered, and notify the physician of breakthrough pain.

The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order for an x-ray had been placed and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM.

Review of the clinical record failed to identify any additional documentation related to Resident #8's right wrist injury by LPN #2 on 8/12/24, including any interventions related to Resident #8's reports of severe pain. Further, the clinical record failed to identify any documentation related to an RN assessment of Resident #8's right wrist injury on 8/12/24.

A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture.

Review of the clinical record failed to identify any additional monitoring, assessments, or documentation of Resident #8's right wrist injury by any facility nursing staff after 8/13/24.

Review of the clinical record and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury, contact the physician, initiate an investigation, and contact Resident #8's resident representative. LPN #2 identified that during his assessment of Resident #8's right wrist, he observed that Resident #8 was crying out. LPN #2 identified initially he provided Resident #8 a dose of acetaminophen; however, following review of the clinical record, LPN #2 identified he was unable to recall what interventions were put into place for Resident #8 and this would have been addressed by RN #4 during her assessment.

Interview with RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified on 8/12/24 and 8/13/24 she was out of work and provided a review of her timesheet that identified such. RN #4 identified that during this time there were several RNs covering her leave, however, there was not a consistent nurse scheduled to cover during her absence. RN #4 identified that LPN #2 should have reported Resident #8's right wrist injury to the covering RN supervisor, who should have done an assessment and contacted the physician to report the injury as well as Resident #8's hospice physician. RN #4 also identified that the nursing staff should have notified Resident #8's resident representative, and an investigation should have been initiated and conducted to determine the cause of the right wrist injury and Resident #8's pain should have been addressed by LPN #2.

Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #1), reviewed for accidents, the facility failed to ensure the resident was transferred according to the physician's order (Sara lift with 2 staff) which resulted in the resident having to be lowered to the floor. The findings include: Resident #1 was admitted to the facility in June 2023 with diagnoses that included presence of left artificial knee joint, cardiac pacemaker, and atrial fibrillation. A physician's order dated 6/21/23 directed to use a Sara lift (mechanical lift used to lift and transfer) with the assistance of 2 staff for transfers to/from the wheelchair. The care plan dated 6/21/23 identified Resident #1 had limited mobility related to history of multiple surgeries to the bilateral lower extremities, was non-ambulatory and wheelchair bound at baseline. Interventions included transfers with the Sara lift and assist of 2 staff. The admission MDS dated [DATE] identified Resident #1 had intact cognition and required extensive 2-person assistance with transfers. The fall risk evaluation dated 6/29/23 identified Resident #1 was at low risk for falls. The August 2023 monthly physician's orders directed to transfer Resident #1 via a Sara lift with the assistance of 2 staff to/from the wheelchair (original date 6/21/23). The nurse's note dated 8/14/23 at 10:15 AM identified RN #4 was notified that Resident #1 was lowered to the floor during a transfer. RN #4 indicated that NA #3 transferred Resident #1 by herself after Resident #1 told NA #3 that he/she could be transferred with one staff. RN #4 indicated during the transfer Resident #1 became weak and needed to be lowered to the floor. No injuries were noted from the fall. Resident #1 was able to move all extremities at baseline. Resident #1 was assisted back to bed with assistance of 4 staff. The physician was present and updated. The reportable event form dated 8/14/23 at 10:15 AM identified Resident #1 was transferred with the assistance of 1 staff via stand pivot and was lowered to the floor during the transfer. An RN assessment was completed, there was no complaint of pain or distress, and the physician was notified. Report had been given to NA #3 prior to the start of shift regarding Resident #1's plan of care and she was provided with a printed copy. Will follow up with agency regarding NA #3 not following the plan of care. The fall risk evaluation dated 8/14/24 identified Resident #1 was at moderate risk for falls. Review of a statement written by NA #3 dated 8/14/23 identified Resident #1 told NA #3 that he/she can assist NA #3 with the transfer to the bathroom. NA #3 indicated she began transferring Resident #1 out of the bed to the wheelchair by herself, and as soon as Resident #1 stood up the resident started going down and she lowered Resident #1 to the floor and alerted the nurse. Review of a statement written by RN #4 dated 8/14/23 identified she was called to Resident #1's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER: Whitney Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 Leeder Hill Dr Hamden, CT 06517	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and observed Resident #1 was lying on the floor. RN #4 indicated NA #3 attempted to transfer Resident #1 by herself and the resident became weak, and NA #3 lowered the resident to the floor. RN #4 indicated NA #3 was from the agency. RN #4 indicated at the start of the shift she had given NA #3 a thorough report on each resident that was on her assignment and was also provided with a written care guide. RN #4 indicated she educated NA #3 that she should have followed Resident #1's plan of care and should have gone to the nurse for any questions or clarification. The physician note dated 8/15/23 identified he was asked to see Resident #1 who had been lowered to the floor after an unsuccessful attempt to transfer with assist of one when Resident #1 usually transfers with a mechanical lift with no obvious injuries. The physician note dated 8/16/23 identified he received a call that Resident #1's left ankle was slightly swollen and painful with recommendations for an x-ray of the affected ankle. Report came in this afternoon which identified a non-displaced fracture of the distal tibia and loosening of the fibula/tibial screw. Recommendation to keep Resident #1 non-weight bearing and call orthopedic in the morning for advice. The reportable event form dated 8/16/23 at 5:30 PM identified Resident #1 sustained a fall during a transfer on 8/14/23 with no pain or injuries noted at the time of the incident. On 8/16/23 Resident #1 developed pain in the left foot and an x-ray of the area identified a nondisplaced fracture of the left distal tibial with loosening of the fibula/tibial screw. The event resulted in a serious injury or significant change in condition. The summary report dated 8/17/23 identified Resident #1 required a stand lift with assist of 2 for transfers out of bed to wheelchair. On 8/14/23 the agency nurse aide that was assigned to Resident #1 was provided with a verbal report and a copy of the resident care guide which included the residents transfer status. Resident #1 informed NA #3 that he/she could be transferred with the assist of one. NA #3 failed to follow the plan of care. On 8/16/23 Resident #1 developed left ankle pain and edema, an x-ray was ordered, and the result was a nondisplaced left distal tibial fracture with loosening of the fibula/tibial screw. New orders included to transfer the resident via Hoyer lift with assist of 2 and follow up with orthopedic for further interventions. On 8/17/23 the agency was updated that the nurse aide was no longer able to work at the facility. The nurse's note dated 8/17/23 at 11:14 AM identified the orthopedic physician indicated he was unable to give any advice/recommendation since he hasn't seen Resident #1 in several years. The nurse's note dated 8/17/23 at 11:45 AM identified the physician was notified with a new order to send Resident #1 to the hospital for evaluation. The nurse's note dated 8/17/23 at 8:34 PM identified Resident #1 returned to the facility at 7:00 PM, no surgical intervention was needed at this time per the orthopedic team. A splint was placed to left lower extremity with non-weight bearing to left lower extremity, continue with Xarelto (anticoagulant medication) for deep vein thrombosis prevention and follow up with orthopedic in 1 - 2 weeks. The nurse's note dated 8/31/23 at 1:26 PM identified Resident #1 returned from orthopedic appointment. Resident #1 is to continue non-weight bearing to left lower extremity. A short leg cast was applied to the lower left extremity. Interview and review of the clinical record with the DNS on 12/4/24 at 11:00 AM identified while (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whitney Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Leeder Hill Dr Hamden, CT 06517	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducting the investigation NA #1 stated she transferred Resident #1 by herself. The DNS indicated NA #1 should have followed Resident #1's plan of care, the physician order, and had the assistance of 2 staff with the transfer from the bed to the wheelchair. The DNS indicated NA #3 was educated by RN #4 regarding following the plan of care, and the care guide prior to providing care that day to Resident #1. The DNS indicated NA #3 stated that Resident #1 told her that the transfer could be done with one person. Interview with RN #4 on 12/4/24 at 11:30 AM identified on 8/14/23 at the beginning of the shift she had given NA #3 a verbal report on every resident that was assigned to her, and the care guide to the residents. RN #4 indicated that NA #3 should have followed Resident #1's plan of care and if she had any questions she should have asked the charge nurse on the unit. Interview with MD #1 on 12/4/24 at 11:53 AM identified she was on the unit at the time resident was observed on the floor on 8/14/23. MD #1 indicated the nurse aide should have followed the physician's order to use the Sara lift with assistance of two when transferring the resident. Interview with NA #3 on 12/4/24 at 2:08 PM identified she is from the agency. NA #3 indicated the charge nurse and RN #4 did not give her report on her assignment or provide her with an assignment sheet on Resident #1 prior to the incident. NA #3 indicated on 8/14/23 around 10:15 AM she heard Resident #1 yelling for help. NA #3 indicated she went to Resident #1's room and the resident asked to go to the bathroom. NA #3 indicated Resident #1 was alert, oriented and Resident #1 stated to her that she can transfer him/her by herself. NA #1 indicated she helped Resident #1 out of bed to a standing position by herself and that is when Resident #1 started going down and she helped the resident to the floor and notified the nurse immediately. NA #3 indicated she did not ask the staff how the resident transferred prior to moving the resident. NA #1 indicated after the incident one of the facility staff gave her an assignment sheet and explained that Resident #1 required a Sara lift with assistance of 2 staff for transfers. Review of the facility safe resident transfer policy identified upon admission and as necessary, residents will be screened by therapy to determine the best and safest means of transfer and ambulation for both the residents' and staff members' safety. Review of the facility falls management system policy identified the facility will provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all residents fall in the facility are analyzed and trended through the Quality Improvement Interdisciplinary process to maintain a safe environment. At the time of admission, each resident is assessed using the falls risk assessment to determine his/her risk for sustaining a fall. A falls risk assessment that represents a high risk for falls and requires the development of a care plan with interventions implemented designed to prevent falls. When a resident sustains a fall, assessment will include investigation using the fall investigation worksheet to determine probable cause factors. When a resident sustains a fall, a Registered Nurse completes an assessment for injury. The attending physician and family/responsible party are notified of the fall and the resident status. Follow-up assessment and documentation will be conducted for a minimum of every shift for 72 hours.