STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075294	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHISPERING PINES REHABILITATION AND NURSING CENTER	38 TALMADGE AVENUE EAST HAVEN, CT 06512

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of facility policy, and interviews, the facility failed to ensure a resident representative was notified promptly of a discharge to the hospital during the COVID-19 pandemic. The findings include: Resident #2's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and required limited assistance with bed mobility, transfers, and dressing. The Resident Care Plan (RCP) dated 4/8/2020 identified Resident #2 was suspected positive for the COVID-19 virus. Interventions directed to monitor for symptoms and maintain droplet precautions. A physician's orders [REDACTED]. An Advanced Practice Registered Nurse (APRN) note dated 4/9/2020 identified oxygen desaturation and cough. Several patients within the building have tested positive or are presumed positive for COVID-19. The assessment identified [MEDICAL CONDITION], cough, and notify family. The impression directed a COVID-19 check, blood work, monitor respiratory status and vital signs, provide supportive care and report change in status, keep isolated. An APRN note dated 4/10/2020 identified increased cough and [MEDICAL CONDITION] over the last 2 days, on 4 liters of oxygen, oxygen saturation only at 85 to 88 percent, mild increase in shortness of breath, increase in cough, and increase in fatigue. The patient has significant underlying lung and heart conditions and a COVID-19 swab was pending. Discussion with the patient and his/her family today regarding code status and advanced directives. an order for [REDACTED]. The nurse's note dated 4/11/202 at 12:10 AM identified that Resident #2 was unresponsive to verbal command. The APRN was updated and an order was obtained to transfer to an acute care center. A voice mail was left for the resident representative to call the facility. Interview with Person #1 on 7/13/20 at 12:05 PM identified that he/she was not aware that Resident #2 was hospitalized until he/she received a call from the hospital the following day. Person #1 identified that he/she was told by the facilty that they had left a message on his/her answering machine. Person #1 identified that he/she had provided the facility with a cell phone number on numerous occasions because he/she did not stay home three nights per week and wanted to be sure that the facility could reach him/her in the event of a change or an emergency. Person #1 identified that no one from the facility ever called to notify him/her that Resident #2 was positive for COVID-19 and that he/she found out from the hospital. Interview with Social Service #1 (SS#1) on 7/13/20 at 12:42 PM identified that the facility protocol was to put any new phone numbers provided by resident representatives in to the electronic medical record. SS #1 identified that the unit staff could update the telephone number or that sometimes the staff left the information in his/her door. SS #1 denied every seeing the communications. Interview with Admissions Person #1 on 7/13/20 at 12:43 PM identified that the facility protocol was to put any new phone numbers provided by resident representatives in to the electronic medical record. Interview with the Director of Nurses (DNS) on 7/13/20 at 1:00 PM identified that he/she was unable to find any evidence that the facility had made more than one attempt to call the responsible party on 4/10/2020 when Resident #2 was discharged to the hospital. The DNS identified that the facility staff should follow the facility policy and make more than one attempt to reach a resident representative. The DNS identified that the cell phone number may not have been recorded because the resident representative was only giving the cell phone number for vacation purposes, but could not explain why a second resident representative number was not added to the clinical record. The DNS identified that Resident #2's COVID-19 test result was not available to the facility until 4/13/2020. The DNS could not find any evidence that the facility attempted to contact Person #1 beyond leaving a message on the voice mail. Interview with the DNS and Assistant Director of Nurses (ADNS) on 7/13/2020 at 2:10 PM identified that the ADNS was working on the day following Resident #2's discharge to the hospital. The ADNS identified that Person #1 came to the building and was upset that he/she had not received a call from the facility that Resident #2 was hospitalized . The ADNS identified that he/she had told Person #1 early the next day that the supervisor from the facility had left a message on his/her answering machine the evening before. Review of the facility Change in Resident Condition policy identified, in part, that the Nursing Supervisor/Administration shall follow through with attempts to contact responsible parties and to document the changes accordingly.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, and interviews, the facility failed to appropriately screen an authorized entrant to the facility during the COVID-19 pandemic. The findings include: Resident #1's [DIAGNOSES REDACTED]. Observation on 7/13/20 at 9:08 in the front lobby identified Emergency Medical Services (EMS) #1 and EMS #2 enter the facility with a stretcher. EMS #1 and EMS #2 were greeted by Receptionist #1. Receptionist #1 directed EMS #1 and EMS #2 into the facility and stated, you know where you're going. Observation in the lobby on 7/13/2020 at 9:18 AM identified EMS #1 and EMS #2 exiting the building with Resident #1. Interview and review of facility policy with the Administrator and Director of Nurses (DNS) on 7/13/20 at 9:18 AM identified that according to the facility policy, all authorized person's entering the facility should be screened for COVID-19. The Administartor and DNS identified that Resident #1 was leaving the facility for a routine medical procedure that occured three times weekly on a continum. The Administrator directed Receptionist #1 to go and screen EMS #1 and EMS #2 as they were leaving. The Administrator identified that both EMS #1 and EMS #2 had a negative COVID-19 result. Interview with Receptionist on 7/13/20 at 9:21 AM identified that he/she had been distracted and forgot to screen EMS #1 and EMS #2. Receptionist #1 identified that he/she knew all all authorized persons entering the facility needed to be screened. Interview with EMS #1 and EMS #2 on 7/13/20 at 9:22 AM identified that they had not been screened on entry and that they were accustomed to being screened in other facilities that they entered. The facility COVID-19 screen policy dated 4/28/2020, identified, in part, that all authorized entrants into the facility will have wellness screenings near the entry, away from residents including an assessment for temperature, sore throat, new onset of shortness of breath and/or difficulty breathing, chills, muscle pain, headache, and new loss of taste or smell. Re-interview with the Administrator and DNS on 7/13/20 at 10:15 AM identified that although the facility screening form directed screening for temperature and sore throat and cough, the screening failed to include the symptoms listed on the facility policy dated 4/28/20 for new onset of shortness of breath, difficulty breathing, chills, muscle pain, headach, and new loss of taste of smell. The Administrator and DNS identified that they are in the process of revising the facility policy. Re-interview with the DNS on 7/13/20 at 1:00 PM identified that as the screening requirements changed, the screening form was changed but that the policy and screening form was never changed together and that is why the screening policy and screening being completed did not correlate. The DNS identified that they were going to update both the screening form and the policy.

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

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.