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	11/17/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #1) who was a new admission from the hospital, the facility failed to transcribe a medication order by the admitting nurse from the hospital discharge summary into the Electronic Medication Administration Record (EMAR) and a second nurse failed to review and verify the orders that were entered. The findings include: Resident #1 was a new admission with diagnoses that included status post fracture of the left femur, osteoporosis and hypertension. The Hospital Discharge Summary dated 10/27/22 identified under hip fracture instructions, regarding blood clot prevention, an order directed to administer Enoxaparin 40 milligrams (mg)/0.4 milliliters (ml) syringe, Inject 0.4. ml (40mg total) under the skin daily for a total of thirty-five (35) days post operatively. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily life. The nurse's note dated 11/1/22 at 4:30 PM identified Resident #1 reported nausea and chest pian during therapy and this was reported to the nursing staff by the physical therapist. Vital signs obtained at 1:00 PM indicated a temperature of 97.6, pulse rate 104, respirations 26 and blood pressure of 117/62. The note identified when questioned further about the chest pain Resident #1 stated the pain and pressure were under the sternum into the left shoulder and radiating down the left upper extremity into the left posterior shoulder, Resident #1 was short of breath with speaking, anxious and non-diaphoretic. The note identified Resident #1's oxygen saturation level was 89% on room air at which time oxygen at four (4) liters per minute via nasal cannula was applied and the oxygen levels ranged from 87-93%. The note indicated all parties were notified and Resident #1 was transferred to the hospital for evaluation and treatment. The Facility Incident Report dated 11/2/22 at 1:00 PM identified Resident #1 had an acute onset of chest pain and shortness of breath on 11/1/22. On 11/1/22, Resident #1 was admitted to the hospital with a diagnosis of a pulmonary embolism. The report identified the facility substantiated after review of the clinical record that the Enoxaparin 40 mg subcutaneous every day had not been transcribed, and Resident #1 missed five (5) doses between the dates of 10/28/22 to 11/1/22. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the October and November 2022 Medication Administration Records identified Enoxaparin 40 mg/0.4 ml was not administered. Review of the physician's orders for the months of October and November 2022 failed to identify an order for the Enoxaparin 40 mg/0.4 ml. Review of the Hospital Discharge Summary dated 11/7/22 identified Resident #1 presented to the hospital on 11/1/22 with complaints of chest pain. The summary indicated Resident #1 had completed a left hip hemiarthroplasty on 10/24/22 after the resident sustained a left femoral neck fracture and post-op, Resident #1's hospital stay was uneventful except for a minor episode of post-op delirium. Resident #1 was discharged to rehab on prophylactic dose of Enoxaparin per post-op hip fracture protocol, but apparently had not been receiving the Enoxaparin at the rehab facility. Resident #1 was sent to the emergency department for evaluation of chest pain and was found on Computed Tomography Angiography (CTA, a medical test that combines a CT scan with an injection of special dye to produce pictures of blood vessels and tissue in a part of the body) to have a large saddle pulmonary embolism with additional bilateral central, lobar, segmental and subsegmental pulmonary emboli. Program Evaluation Review Technique ([NAME]) was activated by the emergency department and Resident #1 was admitted to the Surgical Intensive Care Unit and was started on a Heparin drip. The discharge summary identified Resident #1 was transferred to the Step-Down Unit on 11/3/22, then to a unit on 11/5/22 and discharged back to the facility on [DATE], six (6) days later with a new medication order for Eliquis indicated to pulmonary embolism prevention and treatment. The Eliquis order directed to administer Eliquis 5 mg take two (2) tablets (ten (10) mg every twelve (12) hours for seven (7) days until 11/10/22 and then start Eliquis take one (1) tablet, five (5) mg total) every twelve (12) hours until 2/9/22. A physician's progress note dated 11/7/22 identified Resident #1 was seen for re-admission to the facility. Resident #1 was hospitalized from 11/1/22 to 11/7/22 with diagnoses of acute pulmonary embolism and cor pulmonale secondary to not being anticoagulated (medication transcription error) after recent hip surgery. Interview with the Director of Nursing (DON) on 11/17/22 at 10:00 AM identified for all new admissions, the nursing supervisor will perform a medication reconciliation and contact either the attending physician or the on-call provider with any issues or concerns noted. The DON identified she reviewed Resident #1's record with the Nursing Supervisor, Registered Nurse (RN) #1, status-post hospitalization and noted the Enoxaparin 40 mg/0.4mL had not been transcribed into the physician orders. The DON identified RN #1 simply just over-looked the order and did not transcribe the order into the electronic health record. The DON identified RN #1 failed to have another licensed nurse perform a double check as per the facility policy. The DON noted since this incident, the facility has incorporated a triple-check policy to ensure accuracy with transcribing medications to prevent any errors. Although attempted, interview with RN #1 was unsuccessful. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Reconciliation Policy dated January 2020, identified upon admission, the medication list will be reviewed by the nurse and the physician will be notified of orders on the Inter-Agency Referral Form (W-10), the nurse receiving admission will review the W-10 and then call or present the orders to the physician if the physician is in the Health Center. The nurse will then enter the orders in the eMAR (electronic medical administration records), the orders will be electronically transmitted to the pharmacy (Omnicare), and a second nurse will then review the orders that were entered.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #1) who was a new admission from the hospital, the facility failed to transcribe a medication order from the hospital discharge summary into the Electronic Medication Administration Record (EMAR) resulting in a change in condition and re-hospitalization . The findings include: Resident #1 was a new admission with diagnoses that included status post fracture of the left femur, osteoporosis and hypertension. The Hospital Discharge Summary dated 10/27/22 identified under hip fracture instructions, regarding blood clot prevention, an order directed to administer Enoxaparin 40 milligrams (mg)/0.4 milliliters (ml) syringe, Inject 0.4. ml (40mg total) under the skin daily for a total of thirty-five (35) days post operatively. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily life. The nurse's note dated 11/1/22 at 4:30 PM identified Resident #1 reported nausea and chest pian during therapy and this was reported to the nursing staff by the physical therapist. Vital signs obtained at 1:00 PM indicated a temperature of 97.6, pulse rate 104, respirations 26 and blood pressure of 117/62. The note identified when questioned further about the chest pain Resident #1 stated the pain and pressure were under the sternum into the left shoulder and radiating down the left upper extremity into the left posterior shoulder, Resident #1 was short of breath with speaking, anxious and non-diaphoretic. The note identified Resident #1's oxygen saturation level was 89% on room air at which time oxygen at four (4) liters per minute via nasal cannula was applied and the oxygen levels ranged from 87-93%. The note indicated all parties were notified and Resident #1 was transferred to the hospital for evaluation and treatment. The Facility Incident Report dated 11/2/22 at 1:00 PM identified Resident #1 had an acute onset of chest pain and shortness of breath on 11/1/22. On 11/1/22, Resident #1 was admitted to the hospital with a diagnosis of a pulmonary embolism. The report identified the facility substantiated after review of the clinical record that the Enoxaparin 40 mg subcutaneous every day had not been transcribed, and Resident #1 missed five (5) doses between the dates of 10/28/22 to 11/1/22. Review of the October and November 2022 Medication Administration Records identified Enoxaparin 40 mg/0.4 ml was not administered. Review of the physician's orders for the months of October and November 2022 failed to identify an order for the Enoxaparin 40 mg/0.4 ml. (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the Hospital Discharge Summary dated 11/7/22 identified Resident #1 presented to the hospital on 11/1/22 with complaints of chest pain. The summary indicated Resident #1 had completed a left hip hemiarthroplasty on 10/24/22 after the resident sustained a left femoral neck fracture and post-op, Resident #1's hospital stay was uneventful except for a minor episode of post-op delirium. Resident #1 was discharged to rehab on prophylactic dose of Enoxaparin per post-op hip fracture protocol, but apparently had not been receiving the Enoxaparin at the rehab facility. Resident #1 was sent to the emergency department for evaluation of chest pain and was found on Computed Tomography Angiography (CTA, a medical test that combines a CT scan with an injection of special dye to produce pictures of blood vessels and tissue in a part of the body) to have a large saddle pulmonary embolism with additional bilateral central, lobar, segmental and subsegmental pulmonary emboli. Program Evaluation Review Technique ([NAME]) was activated by the emergency department and Resident #1 was admitted to the Surgical Intensive Care Unit and was started on a Heparin drip. The discharge summary identified Resident #1 was transferred to the Step-Down Unit on 11/3/22, then to a unit on 11/5/22 and discharged back to the facility on [DATE], six (6) days later with a new medication order for Eliquis indicated to pulmonary embolism prevention and treatment. The Eliquis order directed to administer Eliquis 5 mg take two (2) tablets (ten (10) mg every twelve (12) hours for seven (7) days until 11/10/22 and then start Eliquis take one (1) tablet, five (5) mg total) every twelve (12) hours until 2/9/22. A physician's progress note dated 11/7/22 identified Resident #1 was seen for re-admission to the facility. Resident #1 was hospitalized from 11/1/22 to 11/7/22 with diagnoses of acute pulmonary embolism and cor pulmonale secondary to not being anticoagulated (medication transcription error) after recent hip surgery. Interview with the Director of Nursing (DON) on 11/17/22 at 10:00 AM identified for all new admissions, the nursing supervisor will perform a medication reconciliation and contact either the attending physician or the on-call provider with any issues or concerns noted. The DON identified she reviewed Resident #1's record with the Nursing Supervisor, Registered Nurse (RN) #1, status-post hospitalization and noted the Enoxaparin 40 mg/0.4mL had not been transcribed into the physician orders. The DON identified RN #1 simply just over-looked the order and did not transcribe the order into the electronic health record. The DON identified RN #1 failed to have another licensed nurse perform a double check as per the facility policy. The DON noted since this incident, the facility has incorporated a triple-check policy to ensure accuracy with transcribing medications to prevent any errors. Interview with the primary care physician, MD #1, on 11/17/22 at 10:30 AM identified she performs medication reconciliation on all new admissions, but MD #1 indicated she used the records from the hospital's electronic charting system due to the facility currently transitioning from paper to electronic, and MD #1 did not have access to the facility's new electronic charting system at that time. MD #1 identified Resident #1 was on Enoxaparin for deep vein thrombus and pulmonary embolism prevention. MD #1 identified with Resident #1 not receiving the Enoxaparin while at the facility, certainly could have contributed to Resident #1's most recent admission to the hospital on 11/1/22. MD #1 indicated deep vein thrombus or pulmonary embolism can be very common status-post surgical procedures, and anti-coagulation therapy is necessary for the prevention of these diagnoses. MD #1 identified Resident #1 was admitted to the hospital on 11/1/22 with a diagnosis of pulmonary embolism, was treated on a Heparin drip, oxygen treatment and was made hemodynamically stable for discharge back to the facility with new orders for Eliquis. Although attempted, interview with RN #1 was unsuccessful. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Reconciliation Policy dated January 2020, identified upon admission, the medication list will be reviewed by the nurse and the physician will be notified of orders on the Inter-Agency Referral Form (W-10), the nurse receiving admission will review the W-10 and then call or present the orders to the physician if the physician is in the Health Center. The nurse will then enter the orders in the eMAR (electronic medical administration records), the orders will be electronically transmitted to the pharmacy (Omnicare), and a second nurse will then review the orders that were entered.