

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2023
NAME OF PROVIDER OR SUPPLIER Whitney Rehabilitation Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2798 Whitney Avenue Hamden, CT 06518	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310</p> <p>Based on clinical record review, facility documentation and interviews for one sampled resident (Resident #1) who had wandered off the facility property unattended, the facility failed to thoroughly investigate the incident to determine how the resident was able to leave without staffs' awareness and failed report to the incident to the state agency at the time the incident occurred. The findings include:</p> <p>Resident #1's diagnoses included Alzheimer's disease and adjustment disorder with mixed anxiety and depressed mood.</p> <p>The Wandering Risk Evaluation dated 5/9/23 identified Resident #1 was a low risk for wandering.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made poor decisions regarding tasks of daily life and was independent with walking in the room, corridor and locomotion on the unit.</p> <p>The nurse's note dated 8/5/23 at 2:28 PM, written by the Nursing Supervisor, identified Resident #1 attempted to go home without notifying staff, spoke with Resident #1 and he/she verbalized he/she wanted to go home, stating I'm [AGE] years old and I do not belong here. Resident #1 was re-educated for safety purposes Resident #1 was not allowed to go out without his/her family or a staff member with him/her and will follow up with social worker about it on Monday and Resident #1 understood he/she will wait until then. The note indicated Resident #1 refused to have a wander guard despite several attempts, Resident #1 stated I'm responsible for myself and I'm not going to use that, I will wait until Monday. One to one (1:1) monitoring was initiated, Resident #1 was added to the wanderer/elopement list, and the staff, receptionist, and social worker were notified.</p> <p>Upon further review, the clinical record failed to reflect documentation that a Facility Reported Incident form and an investigation were initiated until 11/3/23.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility Reported Incident form dated 11/3/23 at 12:30 PM identified information was received today that Resident #1 had eloped from the facility property on 8/5/23 and was brought back to the facility by a family member. The report indicated Resident #1 was returned to the facility on [DATE] by Person #1 and the Director of Nursing (DON) was not aware that on 8/5/23 Resident #1 had left the facility property. The report identified the information given to the DON on 8/5/23 was Resident #1 was walking on the sidewalk near the driveway still on the property. The report indicated Resident #1 was currently safe in the facility and has been since 8/5/23. On 8/5/23 upon returning to nursing unit a wander guard was attempted to be placed on Resident #1, Resident #1 refused, one to one (1:1) supervision was immediately initiated and Resident #1 has been on 1:1 supervision since 8/5/23.</p> <p>Interview with Person #1 on 11/22/23 at 9:50 AM identified he/she received a phone call from a family member that Resident #1 was walking home. Person #1 indicated he/she called Resident #1 and Resident #1 stated I'm walking home and told Person #1 where he/she was. Person #1 identified he/she got in his/her car and drove directly to where Resident #1 was. Person #1 identified he/she could not find Resident #1, so Person #1 called Resident #1 again and then ended up finding Resident #1 on main road. Person #1 indicated he/she brought Resident #1 back to the facility, went in and stated to the receptionist he/she just found Resident #1 about three (3) miles from this location. Person #1 identified the facility staff did not even know that Resident #1 had left the facility.</p> <p>Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 11/22/23 at 11:39 AM identified Resident #1 was independent with walking and walked around the building. NA #1 indicated she did not know what happened on 8/5/23 and she did not know Resident #1 had left the facility premises.</p> <p>Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/22/23 at 12:35 PM identified she did not know what happened on 8/5/23 and the Nursing Supervisor was dealing with that. LPN #1 indicated Resident #1 ambulated independently on the unit and would converse with staff or certain residents. LPN #1 identified all the doors had a code on Resident #1's unit and she had seen Resident #1 push the code in to the elevator to go downstairs to the first floor where the main entrance was located. LPN #1 indicated Resident #1 had been putting the code in and on 8/5/23 it was not Resident #1's first time, Resident #1 went downstairs a couple of times a week.</p> <p>Interview with Receptionist #1 on 11/22/23 at 1:14 PM identified the only thing she remembered was Person #1 coming into the facility telling her Resident #1 was walking down a main road and Person #1 wanting to speak with the Nursing Supervisor. Receptionist #1 indicated she did not see Resident #1 exit the facility or in the lobby on 8/5/23, however there were other ways to exit the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 11/22/23 at 1:40 PM identified on 8/5/23 she received a phone call from the receptionist that Resident #1 went outside the building and Person #1 brought Resident #1 in. RN #1 indicated she was busy, and she did not go to Resident #1's room right away. RN #1 identified once she went to Resident #1's room Person #1 was no longer there. RN #1 indicated she interviewed Resident #1 and Resident #1 stated he/she wanted to go home, and he/she did not belong here at the facility. RN #1 identified she did not ask Resident #1 where he/she went. RN #1 indicated she updated the DON, left a message for Resident #1's emergency contact person and spoke with Person #1 on 8/5/23, and Person #1 stated Resident #1's emergency contact person was aware of what had happened. RN #1 identified later that evening she received a phone call from Resident #1's emergency contact person, and he/she stated he/she was trying to call Resident #1 and Resident #1 was not answering the room phone, so Resident #1's emergency contact person called Resident #1's cell phone and Resident #1 told Resident #1's emergency contact person where he/she was. RN #1 indicated Resident #1's emergency contact person called Person #1 to pick Resident #1 up. RN #1 identified Resident #1's emergency contact person mentioned the street name, however she did not remember, but it was outside the facility premises. RN #1 indicated when she received the information that Resident #1 was off the facility premises, she did not call and update the DON because it was late at night and there was a plan in place for Resident #1, Resident #1 was on one-to-one supervision, the receptionist and staff were updated, and Resident #1 was added to the elopement/wandering list.</p> <p>Interview and review of the exit doors with Maintenance Assistant #1 on 11/22/23 at 2:00 PM identified there were seven (7) exit doors on the first floor leading to the outside that required a code to open them except the main entrance where there was always a receptionist until 8:00 PM, then the main entrance door was locked. Maintenance Assistant #1 indicated the code to all the exit doors were the same code as was the code to the elevator. Maintenance Assistant #1 identified he did not remember the last time the code was changed.</p> <p>Interview with the Director of Nursing (DON) on 11/22/23 at 2:20 PM identified on 8/5/23 she received a phone call from RN #1 who stated she had heard Person #1 brought Resident #1 into the facility and she was asking RN #1 questions so she could picture as to where Resident #1 was. The DON identified she asked RN #1 if Resident #1 was on the sidewalk right up front and RN #1 replied I think so, but I do not know. The DON indicated she asked RN #1 if Person #1 visited Resident #1 as she was trying to picture how Person #1 ended up with Resident #1, however RN #1 did not have an answer for her. The DON identified she stated if Resident #1 was going outside then RN #1 needed to place a wander guard on Resident #1 and that was how they ended the conversation. The DON indicated she did not have the information as to how Resident #1 exited the facility and where Resident #1 was found.</p> <p>A subsequent interview with the DON on 11/22/23 at 3:07 PM identified the facility was not a locked unit, residents can go floor to floor and alert, oriented residents knew the code to the elevator, however she did not know how many residents knew the code. The DON indicated until today she did not know Resident #1 knew the code to the elevator.</p> <p>Interview with the Administrator on 11/22/23 at 3:10 PM identified there was no schedule to change the code. The Administrator indicated he could not recall the last time the code was changed and he had been at the facility for a little over a year.</p> <p>(continued on next page)</p>		

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