STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075246	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Rehabilitation Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #106) reviewed for abuse, the facility failed to ensure the resident was free from mistreatment. The findings include: Resident #106's diagnoses included osteoarthritis. The admission assessment dated [DATE] identified Resident #106 was alert and oriented and self-mobile in his/her wheelchair. The Resident Care Plan (RCP) dated 8/9/2024 Resident #106 exhibited accusatory behaviors at times and had the potential to be verbally aggressive due to ineffective copying skills. Interviention directed to guide away from sources of distress, engage calmly in conversation, if response is aggressive to staff walk away calmly and approach later. Review of the facility Reportable Event Form dated 8/16/2024 at 6:25 PM identified a staff to resident abuse without injury, Resident #106 alleged that LPN #12 swore at him/her. Review of Facility Summary Report dated 8/19/2024 at 12:00 AM identified the allegation was substantiated; LPN #11 observed the incident and intervened, the RN supervisor was immediately notified and Resident #106 had called the police. The summary indicated LPN #12's employment was terminated. Review of LPN #12's statement dated 8/16/2024 identified that he was providing care for another resident, when he looked at the door and saw his medication cart was being pushed away. LPN #12 stepped around the corner, saw Resident #106 and asked Resident #106 to not touch or move the cart, if he/she wanted it moved LPN #12 would move it. LPN #12's statement further indicated he then got into a verbal exchange with Resident #106, and he called Resident #106 an idiot and swore at him/her (called him/her a ****** ****er). Resident #106 then wheeled toward LPN #12 and LPN #12 stated go ahead and hit me as LPN #11 stepped between LPN #12 and the resident. The statement then indicated LPN #12 walked away, as Resident #106 called the police and reported that he/she had been threatened. Review of LPN #11's statement dated 8/16/2024 identified that she was passing medications when she heard arguing and observed Resident #106 and LPN #12 yelling at each another. The statement indicated both Resident #106 and LPN #12 were using profanities, she stepped between both parties in an attempt to diffuse the situation and she notified the supervisor. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with LPN #12 on 9/3/2024 at 11:49 AM identified Resident #106 was moving his medication cart and he asked Resident #106 not to touch the cart, to ask for it to be moved. LPN #12 further indicated that Resident #106 turned his/her wheelchair toward LPN #12 and they had a verbal exchange. LPN #12 stated to Resident #106 that he was not going to be the resident's ****** ****er and as LPN #11 stepped between them, the resident ran over LPN #11's foot. LPN #12 stated he walked away as more words were exchanged between him and the resident. LPN #12 stated that he did swear and he did call the resident a swear word. Interview and facility documentation review with LPN #11 on 9/3/2024 at 1:55 AM identified that Resident #106 and LPN #12 were yelling at each other and she heard a lot of cursing between them, and she stepped between them to stop the incident. Interview, clinical record review and facility documentation review with the DON and ADNS on 9/3/2024 at 1:15 PM DNS identified on 8/16/2024 at 6:30 PM, LPN #12 and Resident #106 got into a verbal exchange, and LPN #12 swore at Resident #106. The exchange was witnessed by LPN #11, and LPN #12 admitted he swore at Resident #106. LPN #12 indicated that he felt provoked by Resident #106 and the DNS stated staff should not swear at any resident; the verbal exchange should not have occurred. The DNS stated no matter what a resident says or does, staff cannot respond back. The abuse was substantiated and LPN #12's employement was terminated. Review of facility Abuse/Retaliation Prohibition Policy, directed in part to ensure each resident has the right to be free from abuse, mistreatment, neglect. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents and to their families. Facility documentation review identified staff education was initiated on 8/16/2024 for all departments regarding abuse, resident rights, customer service, and retailation, and competency testing for staff was completed. Audits were initiated, to include staff-to-resident observations, on 8/16/2024, and a QAPI meeting and Resident Council meeting was held on 8/16/2024. Based on review of facility documentation, past non-compliance was identified.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on clinical record review, facility policy review, and interviews for one of three residents (Resident #375) reviewed for advanced directives, the facility failed to ensure advance directives were addressed timely after admission to the facility. The findings include: Resident #375 was admitted on [DATE] with diagnoses that included hypothyroidism and a fracture of the left femur. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #375 had moderately impaired cognition and required assist with ADLs. The Resident Care Plan (RCP) 2/21/2024 identified Resident #375 an alteration in skin integrity, femur fracture, and potential alteration in nutrition. Interventions directed to assist with ADLs. Record review identified Resident #375 had a Power of Attorney (POA) for health care decisions. The clinical record included a living will that directed life support systems the resident did not want which included artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. Record review identified Resident #375 was a full code. Interview and record review with the DON and ADON on 9/19/2024 at 1:15 PM identified advanced directives should be addressed upon a resident admission. Interview identified Resident #375's advance directives were not addressed during Resident #375's admission. The DON and ADON stated Resident #375's advanced directives should have been addressed, and they were unable to explain why it was not done. Review of facility Policy of Advanced Directives, dated 3/31/2023, directed in part to ensure a resident's choice regarding advanced directives will be honored in accordance with state law and facility policy. The care plan and face sheet will be updated.