

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #1) who had established advanced directives, the facility failed to ensure a resident with the status of do not perform any life sustaining cardiopulmonary resuscitation (DNR) was honored and cardiopulmonary resuscitation (CPR) was not initiated on [DATE] in accordance with the care plan. The findings include: Resident #1's diagnoses included Alzheimer's disease, dysphagia (difficulty swallowing), asthma, depression, anxiety, anemia, muscle weakness, dementia with behavioral disturbance and hallucinations. A physician's active order as of [DATE] directed Do Not Resuscitate (DNR), Do Not Intubate (DNI) and Registered Nurse may Pronounce (RNP). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily living. The Resident Care Plan dated [DATE] identified Resident #1 and the authorized representative had elected to have a code status of DNR, DNI, RNP. Interventions directed code status options will be presented and explained to the resident and/or family recognized representative, in the event of a cardiopulmonary arrest or emergency, resident will not be intubated, and CPR and/or defibrillation via automated external defibrillator (AED) will not be administered in the event of a cardiopulmonary arrest or emergency. The nurse's note dated [DATE] at 7:17 PM identified the Nursing Supervisor, Registered Nurse (RN) #1, was called by a nurse aide, who reported Resident #1 was foaming at the mouth and RN #1 observed Resident #1 foaming at the mouth and holding excessive secretions in his/her mouth and throat. The note indicated Resident #1 was suctioned several times of a good amount of secretions. The nurse's note dated [DATE] at 7:42 PM identified the family and Advanced Practice Registered Nurse (APRN) were notified. The nurse's note dated [DATE] at 11:33 PM identified 911 was called and Resident #1 was transferred to the hospital. Interview with Resident #1's Responsible Party, Person #1, on [DATE] at 9:38 AM identified on [DATE] he/she received a call from the 3-11PM Nursing Supervisor, RN #1, stating Resident #1 had passed away then after hanging up, two (2) to three (3) hours later he/she received a second call from RN #1 stating Resident #1 had a pulse. Person #1 identified Resident #1 had an order for a DNR code status, and he/she believed on [DATE] the facility performed CPR. Interview with RN #1 on [DATE] at 1:03 PM identified on [DATE] she observed Resident #1 was not moving and receiving CPR by facility staff. RN #1 explained she went to verify Resident #1's code status and discovered Resident #1 had a DNR order and when she went back into Resident #1's room, Resident #1 had a pulse. RN #1 indicated CPR should not have been administered when Resident #1 was unresponsive as he/she had an advanced directive that directed DNR. Interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on [DATE] at 2:26 PM identified on [DATE], Resident #1 was found to be in respiratory distress that initially required suctioning of secretions from the airway. The ADON and DON identified Resident #1 had a physician's order that directed the code status as DNR. The ADON and DON identified all staff are responsible for ensuring each resident's code status was honored and Resident #1 should not have had CPR performed on him/her on [DATE]. Review of the facility policy titled Advanced Directives, dated [DATE], directed, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075246
		If continuation sheet Page 1 of 2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in part, the facility will ensure that a resident's choice regarding advanced directives (code status) will be honored in accordance with state law and facility policy. Additionally, the policy directed, in part, the facility encourages the right of residents to prepare an advanced directive declaration or statement that clearly expresses their wishes regarding the use of life-prolonging measures and the declaration may designate another person to make treatment decisions in the event that the resident becomes incapable of communicating his/her choices or wishes. Although attempted, an interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1 was unsuccessful.		