STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075294	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had exhibited an inappropriate behavioral symptom and was transferred to the hospital for an evaluation, the facility failed to re-admit the resident after the hospital psychiatric physicians identified Resident #1 was not a risk of harm to self or others. The findings include: Resident #1's diagnoses included alcohol abuse with alcohol-induced Korsakoff's psychosis, depression, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 made poor decisions regarding tasks of daily life and did not exhibit behavioral symptoms during the seven (7) day look back period. The Resident Care Plan dated 7/19/24 identified Resident #1 had a history of inappropriately touching staff back on 5/14/24. Interventions directed to anticipate and meet the resident's needs, provide opportunities for positive interactions, and encourage positive coping skills. The nurse's note dated 7/24/24 at 10:19 PM identified Resident #1 touched a staff member inappropriately. The resident apologized for the behavior and the psychiatric Advanced Practice Registered Nurse was notified. The psychiatric progress note dated 7/25/24 identified Resident #1 was started on Prozac 10 milligrams (mg) daily for depression following the7/24/24 incident. The psychiatric progress note dated 7/29/24 identified Resident #1 refused to take the Prozac after the first dose due to it making him/her too tired the Prozac was discontinued, and Paxil 20 mg daily was ordered. The nurse's note dated 7/30/24 at 8:17 PM identified at approximately 6:30 PM Resident #1 touched a 3-11PM nurse aide, Nurse Aide (NA) #1, in her private area and then Resident #1 slid his/her hand upward to NA #1's breast. The note identified Resident #1 was placed on one (1) to one (1) observation, notifications were made to all appropriate parties, and Resident #1 was transferred to the Emergency Department (ED) for a psychiatric evaluation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075294	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The note written by the Administrator dated 7/31/24 at 3:38 PM identified she spoke with Resident #1's Conservator and advised the Conservator the facility was unable to allow Resident #1 to return and the hospital was notified. The hospital record dated 7/30/24 identified Resident #1 had a decline in mental status since April/May. The record identified the facility reported Resident #1 allegedly touched a staff member inappropriately, was referred to the ED and required psych clearance to return. The note dated 7/31/24 indicated the facility was clear that Resident #1 was not allowed to return to the facility therefore Resident #1 was admitted to the medical team waiting for placement at a new Long Term Care (LTC) facility. The note dated 8/26/24 identified Resident #1 was discharged from the hospital to a new LTC facility on 8/24/24. Interview with the hospital Social Worker, Person #2, on 1/8/25 at 12:15 PM identified Resident #1 was admitted to the medical department from the ED. Person #2 indicated she was not aware the ED had attempted to send Resident #1 back to the facility on 7/31/24. Person #2 contacted the facility on 8/14/24 to inquire if they would re-admit the resident and they refused therefore, a referral was made to an alternate facility. Interview with Resident #1's Conservator, Person #1, on 1/8/25 at 12:25 PM identified a meeting was held with the Inter-Disciplinary Team (IDT) on 7/25/24 and there was no discussion at that time regarding discharging Resident #1. Interview with the Administrator on 1/8/25 at 2:45 PM identified the facility decided they were not going to take Resident #1 back following the 7/30/24 transfer to the ED because it was the third offense towards a staff member and the facility did not want to take the chance that it would occur again or that Resident #1 would do something to a resident. The Administrator identified the facility did not initiate a consultative process with the hospital. Review of the Resident's [NAME] of Rights policy identified, in part, the resident has the right to be allowed to stay in the facility and federal and state law permit an involuntary transfer or discharge when the health and safety of individuals in the facility is endangered. Although requested, the Administrator identified the facility did not have a specific policy for emergency discharges.