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	01/29/2026

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 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** Based on review of the clinical record, facility documentation, facility policies, and interviews, for one (1) of four (4) residents reviewed for abuse (Resident #2), the facility failed to ensure Resident #2 was free from physical abuse when the resident, who was dependent on staff for bed mobility and transfers, was discovered with multiple injuries of unknown origin including a lip laceration, forehead abrasion with swelling, and bruising to the back of the right hand and wrist, and later indicated a staff member struck him/her. The findings include:Resident #2's diagnoses included hemiplegia and hemiparesis after cerebral infarct affecting the left side, aphasia, depression, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had severely impaired cognitive function (Brief Interview for Mental Status (BIMS) score of 3), impaired movement of one side of the upper and lower extremity and was dependent on staff for bed mobility and transfers in and out of the bed and chair. The Resident Care Plan dated 10/20/25 identified Resident #2 had decreased functional mobility and was at risk of falls due to hemiplegia and hemiparesis of the left side. Interventions directed assistance of one (1) with daily living skills, bed mobility, and transfers in and out of bed and chair. The nurse's note dated 12/26/25 at 12:08 AM identified RN #1 was notified by LPN #1 that upon entering Resident #2's room to administer evening medications LPN #1 discovered Resident #2 was injured. RN #1 identified Resident #2 had a swollen right lip with a laceration approximately 2 cm by 1.5 cm in length, an abrasion to the forehead, a quarter sized bump to the forehead, and bruises to the back of the right wrist and thumb area. Upon interview, Resident #2 nodded his/her head no when asked if he/she fell or bumped his/her head. Resident #2's family member (Person #1), the police, the Advanced Practice Registered Nurse (APRN), and the Administrator were notified and the resident was sent to the hospital for an evaluation. The hospital discharge documents dated 12/26/25 identified a CT scan of the head and neck were performed and resulted negative. The hospital directed the facility to apply ice three (3) times per day and Tylenol or Ibuprofen if needed for pain. The physician's note dated 12/26/25 identified Resident #2 was alert and oriented at baseline and able to answer questions slowly with yes/no format due to aphasia. The facility reported an injury of unknown origin. Resident #2 identified he/she fell but was unable to provide further details. An interview with Person #1 on 1/28/26 at 10:50 AM identified on 12/25/25 he/she spent most of the day visiting Resident #2 and left the facility around 3:30 PM. Prior to leaving, Person #1 took a picture of Resident #2 holding a Merry Christmas sign to send to family. Around 9:00 PM, Person #1 received a call from the facility regarding Resident #2 being injured and immediately returned to the facility. Person #1 identified Resident #2 was able to understand what was said and with difficulty, due to aphasia, was able to answer questions. Person #1 identified Resident #2 would not tell him/her what happened to cause the injury. An interview with the Director of Social Services (DSS) on 1/28/26 at 12:10 PM identified Resident #2 had a BIMS score of 3 but understood more than (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was able to express due to aphasia. An interview with NA #2 on 1/28/26 at 12:43 PM identified she worked on 12/25/25 from 3 PM to 11 PM and that she did not see or provide care to Resident #2 until after NA #1 left for the evening. After NA #1 left, NA #2 assisted Resident #2 with incontinent care and at that time, observed injuries. She further identified Resident #2 was incontinent of stool, required assistance of two (2) staff to provide personal care, and that stool was found on the floor near the bed. Review of the written statement and interview with LPN #1 on 1/28/26 at 12:49 PM identified on 12/25/25 LPN #1 was passing medications when NA #1 approached him in an upset and erratic manor and stated she should not be working because it was her mother's birthday, NA #1 reported to the supervisor and left for the remainder of the shift. LPN #1 then went into Resident #2's room to administer medications and discovered injuries. Resident #2 was unable to identify what occurred. An interview with Resident #2 (with Person #1 present) on 1/28/26 at 1:10 PM was conducted. Due to Resident #2's aphasia, he/she had difficulty processing questions and answered some questions with a delayed response. Resident #2 was aware NA #1 no longer worked at the facility and was able to indicate satisfaction. Resident #2 verbally identified NA #1 struck him/her causing the injuries identified on 12/25/25 and demonstrated through forming a fist with his/her right hand and then touching hand to forehead. Resident #2 acknowledged through yes/no format that he/she fell but was unable to provide any details. Interview with the DON (Director of Nursing) on 1/28/26 at 2:55 PM identified Resident #2 told her he/she fell but after being asked multiple ways was never able to indicate how the fall occurred or how he/she got back up. The DON further identified Resident #2 would not have had the ability to get up independently and would have likely required the assistance of two (2) staff members. The DON identified there were no residents on the unit who wandered or had a history of aggression and that LPN #1 was in the hallway during the evening and would have seen or heard if a resident wandered into Resident #2's room. When the DON proceeded to inform Resident #2 that NA #1 would no longer work at the facility, Resident #2 became teary eyed and shook his/her head okay. The facility terminated NA #1 due to lack of cooperation with the investigation. Interview with NA #1 on 1/29/26 at 10:20 AM identified she worked from 3 PM to 11 PM on 12/25/26. NA #1 was the NA assigned to provide care for Resident #2 and had worked with Resident #2 several times since she began work at the facility approximately three (3) months prior. NA #1 identified no one else provided care for Resident #2 until she left her shift early due to feeling unwell. NA #1 denied that Resident #2 sustained a fall and identified if he/she fell, at least two (2) people and possibly a Hoyer lift would have been required to transfer Resident #2 off the floor. NA #1 denied harming Resident #2. Although attempted, a call was not returned by RN #1 or by the detective assigned to the case. Review of the facility policy for Resident's Rights directed in part that the Resident had the right to be free from verbal, sexual, physical or mental abuse. Review of the facility policy for Abuse, Neglect, and Exploitation identified residents would not be subjected to abuse by anyone. The policy further identified injuries of unknown origin would be investigated as if they could be a result of abuse if the source of injury was not observed, the source of injury can't be explained, or the injury is suspicious because of the extent of injury, the location of injury, the number of injuries, or the incidence of injuries over time.