| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075228 | A. Building<br>B. Wing | 10/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arden Care Center | 850 MIX Ave<br>Hamden, CT 06514 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of abuse, the facility failed to ensure Resident #1 was free from physical and verbal abuse by a staff member. The findings include:<br><br>Resident #1's diagnoses included a Stage III pressure ulcer on the upper back, type 2 diabetes, and chronic pain syndrome.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #1's cognition was intact, required moderate assistance with dressing, bathing, hygiene, bed mobility, and had one (1) Stage III pressure ulcer.<br><br>A physician's order dated 9/14/24 directed to apply gauze soaked with Vashe to the thoracic spine wound bed for ten (10) minutes, pat dry, apply skin prep to the peri wound, apply Aquacel Ag to the wound bed tucking into the undermined areas at three (3) to six (6) o'clock, slightly overlap to peri wound, followed by a bordered foam dressing, and change three (3) times per week and as needed.<br><br>The Resident Care Plan dated 9/16/24 identified Resident #1 had skin breakdown. Interventions directed to off load the heels, follow physician orders for treatments, turn and reposition every two (2) hours, utilize a trapeze bar for positioning, and complete a weekly wound assessment.<br><br>The nurse's note dated 9/25/24 at 3:49 PM identified Resident #1 reported staff to resident abuse without injury.<br><br>The Facility Reported Incident form dated 9/25/24 at 2:45 PM identified Resident #1 reported on 9/24/24 the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #2, entered Resident #1's room at 9:45 PM to change the dressing on the thoracic spine and LPN #2 told Resident #1 he/she did not have to tell her, the nurse, how to do her job. The report indicated Resident #1 reported the nurse was aggressive with the dressing change and considered it to be an assault and felt violated. The conclusion of the investigation identified although abuse could not be substantiated as there were no witnesses, based on LPN #2's employee file, past job performances, and customer service trends LPN #2 was terminated.<br><br>(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 |
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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The social service note dated 9/26/24 at 3:49 PM identified the social worker met with Resident #1 and Resident #1 identified he/she liked things done a certain way and the staff member did not listen to him/her. The note indicated Resident #1 reported the 3-11PM charge nurse, LPN #2, was aggressive when changing the dressing.<br><br>Interview with the 7AM-3PM unit coordinator, Licensed Practical Nurse (LPN) #1, on 10/7/24 at 11:37 AM identified Resident #1 reported to her on 9/24/24 when LPN #2 was changing the dressing LPN #2 told him/her she was a nurse and Resident #1 did not have to tell her how to do her job. LPN #1 identified Resident #1 stated LPN #2 was aggressive when cleaning the wound which made him/her feel uncomfortable.<br><br>Interview with Resident #1 on 10/7/24 at 12:40 PM identified on the 3-11PM shift on 9/24/24 the bandage fell off his/her back and he/she requested the nurse apply a new dressing. Resident #1 indicated when LPN #2 entered the room, he/she began to give LPN #2 direction on how he/she wanted the dressing changed and LPN #2 stated she was the nurse and had to do the job right. Resident #1 stated LPN #2 proceeded to clean the wound in an aggressive manor, she did not apply the soaked gauze to the wound per the physician's order. Resident #1 referred to the notes he/she had written at the time of the encounter, which identified the nurse was angry and forcefully dabbed at the wound.<br><br>Interview with the Director of Nursing (DON) on 10/7/24 at 1:15 PM identified she initiated an investigation immediately upon being informed of Resident #1's allegation. The DON stated Resident #1 told her he/she felt LPN #2 was rough with the dressing change and LPN #2 told Resident #1 not to tell her how to do the dressing change. The DON indicated she reviewed the video footage of LPN #2 entering and exiting Resident #1's room to provide wound care and LPN #2 was in the room a little over a minute therefore LPN #2 was not in the room long enough to provide wound care as it was ordered.<br><br>Interview with LPN #2 on 10/7/24 at 2:00 PM identified she began cleaning Resident #1's wound and Resident #1 stopped her and directed her to just put a new dressing over the wound and to not do the soak and Resident #1 informed her he/she would have the daytime staff do that part.<br><br>The facility policy Abuse and Neglect identified it is the facility policy to prevent any form of abuse or neglect towards a resident.<br><br>The facility policy Resident Rights identified it is the resident's right to be treated with respect and dignity. |