STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075228	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Care Center	850 MIX Ave 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for six of six residents (Resident #3, #5, #6, #7, #8, #9) reviewed for comprehensive care plans, the facility failed to ensure the care plan was reviewed and revised timely to include placement on a secured unit. The findings include: 1. Resident #3's diagnoses included Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severely impaired cognition and had dementia. The Resident Care Plan (RCP) dated 12/17/2024 identified Resident #3 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and adjust care delivery appropriately. Clinical record review identified Resident #3 was admitted to the secured unit on 11/27/2024. Record review failed to identify the RCP included placement on a secured unit. 2. Resident #5's diagnoses included Alzheimer's disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #5 had a BIMS score of fifteen out of fifteen (15/15), which indicated Resident #5 was alert and oriented. The RCP dated 9/18/2024 identified Resident #5 had impaired cognitive function or impaired thought processes related to dementia. Interventions directed psychiatry/behavioral health and evaluate cause for behaviors. Clinical record review identified Resident #5 was admitted to the secured unit on 6/3/2024. Record review failed to identify the RCP included placement on a secured unit. 3. Resident #6's diagnoses included dementia without behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS score of nine out of fifteen (9/15), indicative of moderately impaired cognition. The RCP dated 11/4/2024 identified Resident #6 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and adjust care delivery appropriately. Clinical record review identified Resident #6 was admitted to the secured unit on 7/29/2024. Record review failed to identify the RCP included placement on a secured unit. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #7's diagnoses included Alzheimer's disease and dementia with behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #7 had a BIMS score of fifteen out of fifteen (15/15), indicative of being cognitively intact. The RCP dated 11/18/2024 identified Resident #7 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed to provide support as needed, provide a calm, quiet environment and divert attention. Clinical record review identified Resident #7 was admitted to the secured unit on 11/1/2023. Record review failed to identify the RCP included placement on a secured unit. 5. Resident #8's diagnoses included Alzheimer's disease and dementia without behavioral disturbance. The annual MDS assessment dated [DATE] identified Resident #8 had severely impaired cognition. The RCP dated 11/13/2024 identified Resident #8 had Alzheimer's disease and dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and notify physician as needed. Clinical record review identified Resident #8 was admitted to the secured/locked unit on 3/8/2017. Record review failed to identify the RCP included placement on a secured unit. 6. Resident #9's diagnoses included dementia without behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #9 had a BIMS score of three out of fifteen (3/15), indicative of being severely cognitively impaired. The RCP dated 9/20/2024 identified Resident #9 had dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical changes and notify the physician as needed. Clinical record review identified Resident #9 was admitted to the secured unit on 9/1/2023. Record review failed to identify the RCP included placement on a secured unit. Observations during survey identified Residents #3, #5, #6, #7, #8, and #9 all resided on the secured unit. Additional observations identified the entrance and exit doors to the unit required a code to be entered on a key pad to access or exit the unit and only staff had the code to unlock the egress doors. Interview with DON on 1/16/2025 at 1 PM identified all residents have individualized care plans, including details such as medical diagnosis, characteristics, functional needs, and behaviors. Interview identified although Residents #3, 5, 6, 7, 8 and 9 all resided on the secured unit, the DON stated residing on a secured unit did not need to be included in the resident's care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Care Plan Policy dated 10/20/22 directed in part, the facility will develop a comprehensive person-centered care plan for each resident and must describe the following: 1. Services that are to be furnished. 2. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment. 3. Any specialized services or specialized rehabilitative services the facility will provide as a result of PASRR recommendations. 4. In consultation with the resident and resident's representative(s), discussion of goals for admission and desired outcomes, preference and potential for future discharge, and discharge planning as appropriate. 5. The care plan must be customized to each resident's preferences and needs. If there is not a care plan available to meet a resident's needs, staff may develop one using the custom care plan. 6. Care plans will be: communicated to appropriate staff, resident, representative, and family. Further, the policy directed care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for six of six residents (Resident #3, #5, #6, #7, #8, #9) reviewed for quality of care, the facility failed to ensure the residents were assessed for clinical criteria that required placement on a secured unit and failed to ensure consent was obtained for the placement. The findings include: 1. Resident #3's diagnoses included Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severely impaired cognition and had dementia. The Resident Care Plan (RCP) dated 12/17/2024 identified Resident #3 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and adjust care delivery appropriately. Clinical record review identified Resident #3 was admitted to the secured unit on 11/27/2024. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #3's placement on the secured unit. 2. Resident #5's diagnoses included Alzheimer's disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #5 had a BIMS score of fifteen out of fifteen (15/15), which indicated Resident #5 was alert and oriented. The RCP dated 9/18/2024 identified Resident #5 had impaired cognitive function or impaired thought processes related to dementia. Interventions directed psychiatry/behavioral health and evaluate cause for behaviors. Clinical record review identified Resident #5 was admitted to the secured unit on 6/3/2024. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #5's placement on the secured unit. 3. Resident #6's diagnoses included dementia without behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS score of nine out of fifteen (9/15), indicative of moderately impaired cognition. The RCP dated 11/4/2024 identified Resident #6 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and adjust care delivery appropriately. Clinical record review identified Resident #6 was admitted to the secured unit on 7/29/2024. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #6's placement on the secured unit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #7's diagnoses included Alzheimer's disease and dementia with behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #7 had a BIMS score of fifteen out of fifteen (15/15), indicative of being cognitively intact. The RCP dated 11/18/2024 identified Resident #7 exhibited physical behaviors related to cognitive loss/dementia. Interventions directed to provide support as needed, provide a calm, quiet environment and divert attention. Clinical record review identified Resident #7 was admitted to the secured unit on 11/1/2023. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #7's placement on the secured unit. 5. Resident #8's diagnoses included Alzheimer's disease and dementia without behavioral disturbance. The annual MDS assessment dated [DATE] identified Resident #8 had severely impaired cognition. The RCP dated 11/13/2024 identified Resident #8 had Alzheimer's disease and dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical behaviors, and notify physician as needed. Clinical record review identified Resident #8 was admitted to the secured/locked unit on 3/8/2017. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #8's placement on the secured unit. 6. Resident #9's diagnoses included dementia without behavioral disturbance. The quarterly MDS assessment dated [DATE] identified Resident #9 had a BIMS score of three out of fifteen (3/15), indicative of being severely cognitively impaired. The RCP dated 9/20/2024 identified Resident #9 had dementia. Interventions directed psychiatry/behavioral health, evaluate triggers of physical changes and notify the physician as needed. Clinical record review identified Resident #9 was admitted to the secured unit on 9/1/2023. Record review failed to identify an assessment was completed and consent was obtained prior to Resident #9's placement on the secured unit. Observations during survey identified Residents #3, #5, #6, #7, #8, and #9 all resided on the secured unit. Additional observations identified the entrance and exit doors to the unit required a code to be entered on a keypad to access or exit the unit and only staff had the code to unlock the egress doors. Additional record reviews for the six (6) residents failed to identify documentation of the clinical criteria that required placement on the secured unit by the resident's physician and the facility interdisciplinary team prior to 12/26/2024. Further review failed to identify documentation that the residents/representatives were involved in the decision making for placement in the secured unit prior to 12/26/2024. Although requested, the facility failed to provide documentation of the clinical criteria used for a resident's placement on the secured unit prior to 12/26/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record reviews with Regional RN #1 on 1/16/2025 at 12:40 PM identified that although the facility had criteria for admitting residents to the secured unit prior to 12/26/2024, the facility was owned by a different corporation at that time and the current company did not have the information that was previously used to determine how a resident was assessed for placement on the secured unit. RN #1 further identified the facility was unable to provide documentation that all the residents and representatives gave consent for placement on the secured unit prior to 12/26/2024. Review of the facility undated Criteria for Admission to the Secured Dementia Unit Policy directed in part, admission to the Memory Care unit is typically for residents that have a diagnosis of dementia or Alzheimer's disease, exhibiting significant memory loss impacting daily activities, difficulty with basic tasks like dressing or bathing, potential behavioral changes, and a medical assessment confirming the need for specialized care in a secure environment designed for people with cognitive impairments. The policy further directed the following: 1. Key criteria for admission to a memory care unit: medical diagnosis, functional decline, behavioral changes, communication challenges, safety concerns, and caregiver assessment. 2. Important points to consider identified the following: Severity of cognitive impairment, individualized care plan, staff training, and secure environment. Review of facility documentation identified education was initiated on 12/31/2024 and included admission assessments and criteria for admission to the secured unit. Audits were initiated on 12/27/2024, and a QAPI meeting was held on 12/23/2024. Review identified a finding of past non-compliance of 12/31/2024.