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	08/26/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for wounds, the facility failed to notify the physician when staff did not administer wound treatments. The findings include:a. Resident #1 had diagnoses that included right ankle wound, pressure injuries to the sacral spine, right posterior calf, right medial ankle, and left buttocks, recurrent multifocal osteomyelitis of the right foot and ankle, multiple sclerosis, anemia, depression, anxiety, and chronic pain.The Resident Care Plan (RCP) dated 7/23/2025 identified Resident #1 at risk for skin breakdown related to multiple sclerosis, chronic recurrent osteomyelitis, actual skin breakdown to the right ankle lateral aspect, right heel, right calf, and sacrum. Interventions directed to observe skin condition daily with ADL care and report abnormalities, off load/float heels while in bed with a pillow, pat skin when drying, observe for signs of symptoms of skin breakdown, and provide wound treatments as ordered.The admission [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, occasionally incontinent of bowel, always incontinent of bladder, required substantial assistance with bed mobility, dependent on staff for all ADLs including transfers, was non-ambulatory and dependent on staff for mobility in the wheelchair. The MDS further identified Resident #1 had a stage one pressure injury, a stage three pressure injury, and an infection of the foot.The physician's order dated 7/30/2025 directed to cleanse back wound with normal saline, followed by calcium alginate, cover with abdominal pad, once daily at 9:00 P.M. and as needed.Review of Resident #1's Treatment Administration Record dated 8/2/2025 identified LPN #9 documented that Resident #1 refused the wound treatment. Interview with Licensed Practical Nurse (LPN) #9 on 8/26/2025 at 12:40 P.M. identified on 8/2/2025 Resident #1 refused wound treatment to h/her back wound. LPN #9 identified she did not notify the physician when Resident #1 refused wound care because LPN #9 felt since it was daily it was not a big deal. Interview with the Director of Nurses (DNS) on 8/25/2025 at 2:25 P.M. identified on 8/2/2025 when Resident #1 refused wound treatment, LPN #9 should have notified the on-call provider.Interview with MD #1(Medical Director) on 8/26/2025 at 3:33 P.M. identified on 8/2/2025 when Resident #1 refused the wound treatment, LPN #9 should have notified the on-call provider.b. Resident #1 had diagnoses that included right ankle wound, pressure injuries to the sacral spine, right posterior calf, right medial ankle, and left buttocks, recurrent multifocal osteomyelitis of the right foot and ankle, multiple sclerosis, anemia, depression, anxiety, and chronic pain.The Resident Care Plan (RCP) dated 7/23/2025 identified Resident #1 at risk for skin breakdown related to multiple sclerosis, chronic recurrent osteomyelitis, actual skin breakdown to the right ankle lateral aspect, right heel, right calf, and sacrum. Interventions directed to observe skin condition daily with ADL care and report abnormalities, off load/float heels while in bed with a pillow, pat skin when drying, observe for signs of symptoms of skin breakdown, and provide wound treatments as ordered.The admission [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was occasionally incontinent of bowel, always incontinent of bladder, required substantial assistance with bed mobility, dependent on staff for all ADLs including transfers, was non-ambulatory and dependent on staff for mobility in the wheelchair. The MDS further identified Resident #1 had a stage one pressure injury, a stage three pressure injury, and an infection of the foot.The physician's orders dated 7/30/2025 directed to cleanse the right ankle with generic wound cleanser, followed by xeroform, cover with abdominal pad, wrap with Kerlex (gauze wrap) one time per day on the day shift, and cleanse the right lateral calf wound with normal saline, pat dry, followed by calcium alginate, and wrap with Kerlex one time per day on the day shift.Review of the Resident #1's TAR dated 8/3/2025 identified the wound treatments for Resident #1's right ankle and right lateral calf wounds were not signed off indicating that the wound treatments were not administered.Interview with LPN #5 on 8/25/2025 at 2:07 P.M. identified on 8/3/2025 she was aware that she was supposed to administer Resident #1's wound treatments to the right ankle and right lateral calf. LPN #5 identified on 8/3/2025 she did not administer Resident #1's wound treatments. LPN #5 indicated she did not have time to administer Resident #1's wound treatments, so they were not done. LPN #5 did not notify the physician on 8/3/2025 that Resident #1's wound treatments were not administered.Interview with the DNS on 8/25/2025 identified on 8/3/2025 LPN #5 should have notified the RN supervisor she was unable to administer Resident #1's wound treatments and notified the on-call provider that Resident #1's wound treatments were not done.Interview with MD #1 on 8/26/2025 at

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for neglect, the facility failed to protect the resident's right to be free from neglect when wound treatments were not administered as ordered. The findings includeResident #1 had diagnoses that included a right ankle wound, pressure injuries to the sacral spine, right posterior calf, right medial ankle, and left buttocks, recurrent multifocal osteomyelitis of the right foot and ankle, multiple sclerosis, anemia, depression, anxiety, and chronic pain.The Resident Care Plan (RCP) dated 7/23/2025 identified Resident #1 at risk for skin breakdown related to multiple sclerosis, chronic recurrent osteomyelitis, actual skin breakdown to the right ankle lateral aspect, right heel, right calf, and sacrum. Interventions directed to observe skin condition daily with ADL care and report abnormalities, off load/float heels while in bed with a pillow, pat skin when drying, observe for signs of symptoms of skin breakdown, and provide wound treatments as ordered.The physician's order dated 7/30/2025 directed to cleanse back wound with normal saline, followed by calcium alginate, cover with abdominal pad, once daily at 9:00 P.M. and as needed, cleanse the right ankle with generic wound cleanser, followed by xeroform, cover with abdominal pad, wrap with Kerlex (gauze wrap) one time per day on the day shift, and cleanse the right lateral calf wound with normal saline, pat dry, followed by calcium alginate, and wrap with Kerlex one time per day on the day shift.The admission [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was occasionally incontinent of bowel, always incontinent of bladder, required substantial assistance with bed mobility, dependent on staff for all ADLs including transfers, was non-ambulatory and dependent on staff for mobility in the wheelchair. The MDS further identified Resident #1 had a stage one pressure injury, a stage three pressure injury, and an infection of the foot.Review of the Treatment Administration Record (TAR) on 8/2/2025 at 9:00 P.M. identified Licensed Practical Nurse (LPN) #9 documented Resident #1 refused the following treatment: cleanse back wound with normal saline, followed by calcium alginate, cover with abdominal pad and it was not done. Review of the Treatment Administration Record (TAR) on 8/3/2025 during the 7:00 A.M. to 3:00 P.M. shift identified the following treatments were not signed off indicating they were not completed: cleanse the right ankle with generic wound cleanser, followed by xeroform, cover with abdominal pad, wrap with Kerlex (gauze wrap) one time per day on the day shift, and cleanse the right lateral calf wound with normal saline, pat dry, followed by calcium alginate, and wrap with Kerlex one time per day on the day shift.Interview with Person #1 on 8/25/2025 at 10:11 A.M. identified on 8/4/2025 h/she checked Resident #1's dressings on the right ankle, right calf, and buttocks. Person #1 indicated the dressings were soiled and dated 8/1/2025. Person #1 indicated Resident #1's wound care was supposed to be done daily. Person #1 indicated on 8/4/2025 when APRN #1 came into see Resident #1 h/she let APRN #1 know that the dressings had not been changed since 8/1/2025.Interview with APRN #1 on 8/25/2025 at 12:56 P.M. identified on 8/4/2025 Resident #1's visitors reported that Resident #1's dressings were soiled and had not been changed since 8/1/2025. APRN #1 identified on 8/4/2025 she observed the dressings on Resident #1's right ankle, right calf, and buttock. APRN #1 identified the dressings were wet, soiled, and dated as 8/1/2025. Interview with Registered Nurse (RN) #2 on 8/25/2025 at 1:15 P.M. identified on 8/4/2025 NA #4 notified him that Resident #1's family members had concerns about Resident #1's dressings. RN #2 identified he and LPN #6 went into to check Resident #1's dressings. RN #2 identified Resident #1's right calf, right ankle, and lower back/buttock dressings were dated as 8/1/2025 with LPN #3's initials. RN #2 identified Resident #1's wound treatments were supposed to be done daily and were not done on 8/2/2025 and 8/3/2025.Interview with LPN #6 on 8/25/2025 at 1:35 P.M. identified on 8/4/2025 RN #2 reported Resident #1's family members had concerns about Resident #1's dressings on h/her wounds. LPN #6 identified she and RN #2 went in to assess Resident #1. LPN #6 identified Resident #1's right calf, right ankle, and lower back/buttock dressings were soiled and dated as 8/1/2025 with LPN #3's initials. LPN #6 identified Resident #1's wound treatments were daily and were not done on 8/2/2025 and on 8/3/2025.Interview with LPN #5 on 8/25/2025 at 2:07 P.M. identified on 8/3/2025 she was aware that she was supposed to administer Resident #1's wound treatments to the right ankle and right lateral calf. LPN #5 identified on 8/3/2025 she did not administer Resident #1's wound treatments. LPN #5 indicated she did not have time to administer Resident #1's wound treatments so they were not done. Interview with the Director of Nurses (DNS) on 8/25/2025 at 2:25 P.M. identified

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to initiate an investigation for an abuse allegation. The findings include: Resident #1 had diagnoses that included right ankle wound, pressure injuries to the sacral spine, right posterior calf, right medial ankle, and left buttocks, recurrent multifocal osteomyelitis of the right foot and ankle, multiple sclerosis, anemia, depression, anxiety, and chronic pain. The admission [NAME] Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was occasionally incontinent of bowel, always incontinent of bladder, required substantial assistance with bed mobility, dependent on staff for all ADLs including transfers, was non-ambulatory and dependent on staff for mobility in the wheelchair.The Resident Care Plan (RCP) dated 8/1/2025 identified Resident #1 requires assistance/is dependent for ADL care related to multiple sclerosis, impaired balance/dizziness, and weakness affecting the lower extremities. Interventions directed to provide extensive assistance for bed mobility, eating, grooming, dressing, toileting, and assistance of 2 for transfers with use of a total mechanical lift.Review of the clinical record and review of facility documentation on 8/25/2025 failed to identify that on 8/4/2025 an investigation was initiated for an allegation that on 8/4/2025 Resident #1's family members found Resident #1 in bed, naked, and crying. Interview with Person #1 on 8/25/2025 at 10:11 A.M. identified on 8/3/2025 while visiting Resident #1 h/she described an incident that occurred earlier that morning. Around 5:00 A.M. a nurse aide entered the room, and abruptly shook Resident #1 awake, stating she was going to change h/her. Resident #1 asked for a moment to collect h/herself, but the aide ignored h/her request and began removing the diaper. Person #1 identified on 8/4/2025 when she entered Resident #1's room, Resident #1 was crying, naked, lying in the bed in the highest position, with the side rails left down, without the call light. Person #1 indicated that Resident #1 told h/her that an aide came h/her then left the room to go get linens and never returned. Person #1 indicated on 8/4/2025 h/she notified the Administrator regarding that incident. Interview with the Administrator on 8/25/2025 at 11:55 A.M. identified on 8/4/2025 Resident #1's family member came down to her office to report that Resident #1 was abused over the weekend. The Administrator indicated she went to speak with Resident #1 who reported on 8/3/2025 at approximately 5:00 A.M. Nurse Aide (NA) #1 entered the room, woke Resident #1 up, Resident #1 asked NA #1 to give h/her some time to wake up, but NA #1 did not give Resident #1 time, NA #1 proceeded to remove the diaper in a rough manner, throwing Resident #1's legs over to the other side of the bed causing soreness to the legs. The Administrator indicated an investigation was initiated into the alleged abuse that occurred on 8/3/2025 at 5:00 A.M. The Administrator indicated on 8/4/2025 Resident #1 nor Resident #1's family alleged that on 8/4/2025 Resident #1's family members found Resident #1 naked, lying in bed when NA #2 left the room to get linens, but never returned. Interview with APRN #1 on 8/25/2025 at 12:56 P.M. identified on 8/4/2025 when she went in to see Resident #1, Resident #1's family members reported when they walked into the room Resident #1 was crying because h/she was left completely naked in bed for at least 20 minutes. APRN #1 identified on 8/4/2025 Resident #1 was lying in bed naked, with just a sheet placed over h/her. Interview with Registered Nurse (RN) #2 on 8/25/2025 at 1:15 P.M. identified on 8/4/2025 NA #2 was notified that Resident #1's family reported Resident #1 was naked in bed and Resident #1's family had concerns regarding Resident #1's wound dressing. RN #2 indicated that before he went to see Resident #1, he spoke to the Administrator, and she reported Resident #1 alleged h/she was abused over the weekend. RN #2 identified when he went up to assess Resident #1, Resident #1's family members reported on 8/4/2025 when they came in to visit Resident #1, Resident #1 was in bed, naked, and crying. RN #2 identified that he did not initiate an investigation nor communicate to the Director of Nurses (DNS) or Administrator that Resident #1's family alleged Resident #1 was left naked in bed by NA #2. RN #2 indicated when he entered Resident #1's room, Resident #1 was not naked. RN #2 identified because Resident #1 was not naked, and an investigation was initiated for the allegation that Resident #1 was abused over the weekend he did think an additional investigation should be initiated. Interview with Licensed Practical Nurse (LPN) #3 (charge nurse) on 8/25/2025 at 1:50 P.M. identified on 8/4/2025 that Resident #1's family told her that Resident #1 was crying because when NA #2 was providing care to Resident #1, she left the room to obtain supplies, and NA #2 left Resident #1 naked and exposed. LPN #3 indicated Resident #1's family members went downstairs to report concerns to the Administrator