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	12/01/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for the misappropriation of narcotic medication, the facility failed to ensure a narcotic medication was not removed from the medication cart by a staff member for personal use. The findings include: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 the misappropriation of narcotic medication, the facility failed to ensure a narcotic medication was not removed from the medication cart by a staff member for personal use. The findings include: Resident #1's diagnoses included generalized abdominal pain, interstitial pulmonary disease (a condition that causes inflammation and scarring to the lungs), chest pain on breathing, and anxiety. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating the resident was alert and oriented to person, place and time. The Resident Care Plan dated 8/15/25 identified Resident #1 exhibited or was at risk for alterations in comfort related to age. Interventions directed to complete a pain assessment per protocol utilizing the pain scale, monitor for nonverbal signs and symptoms of pain and administer medications as ordered. A physician's order dated 9/21/25 directed to administer oxycodone 5 milligrams (mg), give one (1) tablet by mouth every six (6) hours as needed for moderate to severe pain. The Facility Reportable Incident form dated 9/28/25 identified at 6:00 PM the charge nurse, Licensed Practical Nurse (LPN) #4, notified the nursing supervisor that both a blister pack of oxycodone 5 mg and the corresponding white disposition record sheet were missing from the medication cart and the narcotic count book. The report indicated the medication cart and medication room were searched for the oxycodone and the facility was unable to locate the oxycodone, statements were obtained from all staff who had access to the medication cart, and the Director of Nursing (DON), Administrator, provider, and police were notified. The report identified a new order was placed with the pharmacy to replace the missing oxycodone and the emergency stock of oxycodone was used as needed until Resident #1's supply was replenished. The report indicated an agency nurse, LPN #1, who was working the day shift on 9/28/25 was alleged to have taken the card of oxycodone 5 mg and the staffing agency was notified of the investigation. The Controlled Substance Disposition Record identified thirty (30) oxycodone 5 mg tablets were delivered by the pharmacy and received by the facility on 9/23/25. The September 2025 Medication Administration Records identified six (6) doses of oxycodone were documented as administered to Resident #1 between 9/23/25 and 9/27/25, leaving twenty-four (24) out of thirty (30) tablets. Review of the camera surveillance with the Director of Nursing (DON), Administrator, Regional Nurse, and Director of Maintenance on 12/1/25 identified LPN #1 arrived to the facility after 8:00 AM, LPN #1 was seen exiting the facility side employee entrance at 9:11 AM with no visible bags or belongings and meeting a white car in the parking lot, re-enters the main entrance in less than five (5) minutes and goes back up to Resident #1's unit. The video identified throughout the shift, LPN #1 was noted to park her medication cart out of view from the cameras. At 1:42 PM LPN #1 was seen parking the medication cart in front of the nurse's station with the camera directly behind her in view of the medication cart. LPN #1 was observed with unusual activity per the DON that included looking around numerous times, dropping cups multiple times, fanning herself, opening the medication cart and the locked narcotic drawer while flipping through pages in the narcotic log binder multiple times without removing any medications, writing in the narcotic log binder, staring at the pages in the narcotic log binder for extended periods, walking away from the medication cart multiple times with the narcotic log binder out of view of the camera and then reappearing within a few minutes and having an unusually large stack of papers and a clipboard binder she was seen shuffling around and then bringing the clipboard behind the nurses station. The video identified between 1:53 PM and 1:56 PM, LPN #1 was seen popping pills from multiple cards from the narcotic drawer into a medication cup, at 1:56 PM LPN #1 was seen putting the medication cup up to her mouth and then dispose of the cup. At 2:01 PM, LPN #1 was seen taking medications from the narcotic drawer again, putting them in a medication cup, putting the cup up to her mouth followed by a small drinking cup and then disposing of them. The video shows LPN #1 only left the medication cart twice from 1:42 PM to 2:03 PM with the narcotic logbook and no medication cups were noted in LPN #1's hands. Review of the Controlled Medication Shift Change Log identified the total number of count sheets, thirty-seven (37) noted to be either

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 #3) who required a controlled medication for pain management, the facility failed to ensure that narcotic pain medication was administered per physician's order and documented on accurately. The findings include:Resident #3's diagnoses included chronic pain and type II diabetes mellitus with diabetic polyneuropathy (nerve damage that leads to numbness, tingling, burning pain, loss of coordination). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was alert and oriented to person, place and time. The Resident Care Plan dated 8/11/25 identified that Resident #3 exhibited or was at risk for alterations in comfort related to leg pain secondary to lymphedema. Interventions directed to evaluate pain characteristics, utilizing the pain scale and to administer medications as needed per physician's order. A physician's order dated 9/14/25 directed to administer oxycodone 5 milligrams (mg), give one (1) tablet by mouth three (3) times daily for pain management. The September 2025 Medication Administration Record identified the oxycodone was scheduled to be administered at 6:00 AM, 2:00 PM and 10:00 PM, and was signed off as administered by LPN #1 on 9/28/25 at 2:00 PM. Review of the Controlled Substance Disposition Record failed to identify the oxycodone 5 mg tablet was administered to Resident #3 on 9/28/25 at 2:00 PM. The oxycodone 5 mg tablet ws signed out on the disposition record on 9/28/25 at 6:00 AM and 10:00 PM. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 12/1/25 at 4:21 PM identified although she could not recall Resident #3, if she did not sign off the oxycodone on the Controlled Substance Disposition Record, then she did not administer it and was unsure why. LPN #1 indicated she was unsure why the oxycodone was signed off on the Medication Administration Record as administered and not the Controlled Substance Disposition Record. Interview with the Director of Nursing (DON) on 12/1/25 at 1:26 PM identified the oxycodone 5 mg narcotic disposition sheet and the September 2025 Medication Administration Record were audited during the investigation of missing oxycodone within the facility, and she was not sure if Resident #3 received the 2:00 PM dose of oxycodone on 9/28/25. The DON indicated all licensed nurses are expected to follow physician's orders at all times and document accurately, stating the oxycodone should never have been signed off in the MAR by LPN #1 if the oxycodone was not administered. Review of the Medication Administration policy dated 05/01/24 directed, in part, that staff will follow written instructions provided by the provider and staff will document in the administration record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility documentation, facility policy and interviews, the facility failed to ensure Shift Count was conducted by two (2) licensed nurses when the narcotic keys were surrendered from one (1) licensed nursing staff to another and failed to ensure the documentation of narcotics was complete, accurate and unaltered on the Controlled Drug Inventory Sheets. The findings include:The Facility Reportable Incident form dated 9/28/25 identified at 6:00 PM the charge nurse, Licensed Practical Nurse (LPN) #4, notified the nursing supervisor that both a blister pack of oxycodone 5 mg and the corresponding white disposition record sheet were missing from the medication cart and the narcotic count book. The report indicated the medication cart and medication room were searched for the oxycodone and the facility was unable to locate the oxycodone, statements were obtained from all staff who had access to the medication cart, and the Director of Nursing (DON), Administrator, provider, and police were notified. The report identified a new order was placed with the pharmacy to replace the missing oxycodone and the emergency stock of oxycodone was used as needed until Resident #1's supply was replenished. The report indicated an agency nurse, LPN #1, who was working the day shift on 9/28/25 was alleged to have taken the card of oxycodone 5 mg and the staffing agency was notified of the investigation. Review of the Controlled Medication Shift Change Log identified the total number of count sheets had been altered from 35 to 36 but no disposition count sheet dated 9/22/25 was available. The total number of count sheets are noted to be either changed or crossed off with a different number under it from 9/22/25 through 9/28/25. Interview with the DON on 12/1/25 at 10:40 AM identified during the investigation, staff reported that on 9/28/25, LPN #1 called the facility to report she would be late for her 7AM-3PM shift. A 7AM-3PM charge nurse, LPN #3, who was working the opposite hallway on the unit, counted the narcotic medications with the 11PM-7AM charge nurse, LPN #2, so he could go home. The DON explained when LPN #1 arrived at the facility after 8:00 AM, LPN #1 stated she was already behind and did not want to count the narcotic medications with LPN #3, so LPN #3 handed LPN #1 the keys without counting which the DON identified was against policy, two (2) licensed nurses are to do narcotic count with each staff change. The DON identified when LPN #4 arrived for the 3:00 PM shift, LPN #4 reported to her being rushed by LPN #1 and although the blister cards of narcotics matched the disposition sheets and the count was correct, they did not count the total number of disposition sheets in the narcotic book and the number of physical blister cards of narcotics as required to ensure they matched up and matched previous shifts. The DON explained the shift count sheets appeared to have been altered and the total number of count sheets had been crossed off, and the number of pages were changed during the period of time from 9/22/25 through 9/28/25, stating she was unsure what had been changed and the documentation did not make sense. Interview with the 7AM-3PM charge nurse, LPN #3, on 12/1/25 at 11:56 AM identified on 9/28/25 the nursing supervisor communicated LPN #1 was going to be late, so she counted the narcotics with the 11PM-7AM shift charge nurse, LPN #2, so he could leave, and she remembered Resident #1's oxycodone 5 mg tablets being in the cart when they counted. LPN #3 identified LPN #1 arrived after 8:00 AM immediately requested the keys and would not count the narcotics with her, so she handed LPN #1 the keys and went back to her medication pass. LPN #3 identified she also worked the 3-11:00 PM shift on 9/28/25 and around dinner time, LPN #4 came to her with her cart and stated she knew she gave Resident #1 oxycodone the previous night and there were plenty remaining but now she could not find the oxycodone. LPN #3 stated she asked LPN #4 if she counted all the narcotic blister packs and the disposition sheets with LPN #1 and LPN #4 reported that she did not because LPN #1 rushed her. LPN #3 identified following the incident, she was written up by the DON for not counting the narcotics with LPN #1 per facility policy. LPN #3 explained the Controlled Medication Shift Change Log did not have entries or numbers crossed off when she counted with LPN #2 at the start of her shift, stating she would have noticed and reported it. Interview with LPN #4 on 12/1/25 at 1:42 PM identified on 9/28/25 when she counted the narcotics with LPN #1, she noticed all the sheet counts had been crossed off and the numbers had been changed on the Controlled Medication Shift Change Log, which was new from the previous day. LPN #4 explained although it was facility procedure to count all of the narcotic disposition sheets and narcotic cards and compare the numbers to the previous shifts, LPN #1 rushed her, so they did not count them. LPN #4 stated she was suspended pending the investigation and then was later written up by the DON for not following the controlled substance policy. Interview with LPN #1 on 12/1/25 at 4:21 PM identified when she arrived at the facility on 9/28/25, she did not count the narcotic medications with LPN #3. LPN #1 denied