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	12/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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F 0552 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 #4), reviewed for medication administration, the facility failed to inform the resident of a new diagnosis, discuss available treatment options, and provide education regarding the risks of refusing treatment, thereby failing to support the resident's right to make an informed decision regarding care and treatment. The findings included:Resident #4 was admitted to the facility in March of 2023 and had diagnoses that included type 2 diabetes mellitus, chronic diastolic (congestive) heart failure, and end stage renal disease. The Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent for bathing, personal hygiene, and oral hygiene.The Resident Care Plan (RCP) dated 2/7/24 identified Resident #4 required total assistance of one with activity of living care for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, and was refusing medications. Interventions directed to provide a two staff approach with care if the resident had behaviors and to update the interdisciplinary team with deviations in the plan of care.A nursing note dated 3/14/24 at 7:01 PM identified Resident #4 was admitted to hospice services.A note by APRN #1 dated 3/15/24 at 12:00 AM identified Resident #4 reported nausea and watery diarrhea, and a stool sample was to be collected and tested for Clostridium Difficile, if watery.Lab results dated 3/18/24 at 2:54 PM identified Resident #4 tested positive for Clostridium Difficile.A note by APRN #1 dated 3/18/24 at 12:00 AM identified Resident #4 tested positive for Clostridium Difficile, was placed on contact precautions, and had his/her loperamide (antidiarrheal medication) discontinued. The note further noted that oral vancomycin was not started due to Resident #4's history of consistently refusing medication and due to his mentation. Further review of APRN #1's note failed to indicate Resident #4 was updated with the change of condition or that he/she was offered antibiotic treatment. A note by APRN #1 dated 3/20/24 at 12:00 AM identified Resident #4 refused antibiotic treatment for Clostridium Difficile and that vancomycin would be ordered stat (immediately) from the pharmacy as soon as the resident agreed to take it.A note by APRN #1 dated 3/22/24 at 12:00 AM identified Resident #4 agreed to start antibiotic treatment for Clostridium Difficile.Review of physician's orders dated 3/22/24 directed Vancocin (Vancomycin HCL, an antibiotic), 125 milligrams capsule, be administered every six (6) hours for ten (10) days for treatment of Clostridium Difficile.Interview with APRN #1 on 12/17/24 at 10:37 AM identified his/her standard of practice was to speak with a resident regarding a new diagnosis, update the nursing staff with refusals to start treatment, and order antibiotic treatment in the event the resident decided to accept treatment. APRN #1 further indicated he/she would have discussed Resident #4's change of condition with the resident representative if there were mentation concerns. APRN #1 identified if there was no documentation on 3/18/24 of offering the antibiotic treatment or educating the resident on the rationale for the antibiotic treatment, then the discussion did not occur.Interview with MD #1 on 12/18/25 at 9:59 AM identified that although Resident #4 was on hospice and had a history of refusing medications, the standard of practice would be for the attending provider to inform the resident of the new diagnosis, offer treatment, and if refused, educate the resident on the risks of refusing treatment. Review of the clinical record failed to identify that Resident #4 was informed of the Clostridium Difficile diagnosis, offered antibiotic treatment, or educated on the rationale for treatment on 3/18/24.The facility Medication Administration policy included, in part, that the staff will explain negative affects of refusing medications to residents and medication refusals will be documented in a progress note.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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 clinical records, interviews, facility documentation and facility policy, for one (1) of three (3) residents (Resident #4) reviewed for medication administration, the facility failed to document the removal/wasting of a controlled substance on the Controlled Substance Distribution Record (CSDR); and for two (2) of three (3) residents (Residents #4 and #5) reviewed for medication administration, the facility failed to record the administration of controlled medications on the Medication Administration Record (MAR). The findings included:1.Resident #4 was admitted to the facility in March of 2023 and had diagnoses that included Type 2 Diabetes Mellitus, chronic diastolic (congestive) heart failure, and End Stage Renal Disease. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent with bathing, personal, and oral hygiene.Review of the Resident Care Plan dated 2/7/24 identified Resident #4 required total assistance of one with activity of daily living care in bathing, personal hygiene, eating, bed mobility, transfer, and toileting, and was refusing medications. Interventions directed to provide a two staff approach with care if the resident had behaviors and to update the interdisciplinary team with deviations in the plan of care.Review of the CSDR (a form used in healthcare facilities to track every dose of a controlled medication from the time it is received until administered to a resident or properly discarded. It documents who received the medication, who administered it, when it was given, and how much was used, helping prevent misuse and medication errors while ensuring patient safety and legal compliance) with a receive date of 3/14/24 identified five (5) 50 microgram/hour Fentanyl patches were delivered to the facility for Resident #4 and administered as follows: -One (1) 50 microgram/hour patch was administered on 3/14/24 at 10:30 AM-One (1) 50 microgram/hour patch was administered on 3/17/24 at 9:30 AM-One (1) 50 microgram/hour patch was administered on 3/17/24 at 5:55 PM-One (1) 50 microgram/hour patch was administered on 3/18/24 at 12:00 PM-One (1) 50 microgram/hour patch was administered on 3/22/24 at 9:00 AM The CSDR failed to identify the patches administered on 3/14/24 at 10:30 AM and 3/22/24 at 9:00 AM were removed/wasted in accordance with facility policy Review of the CSDR with a receive date of 3/22/24 identified five (5) 100 microgram/hour Fentanyl patches were delivered to the facility for Resident #4 and administered as follows: -One (1) 100 microgram/hour patch was administered on 3/23/24 at 3:00 PM. The CSDR failed to identify this patch was removed/wasted in accordance with facility policy.Interview with the Interim Director of Nurses on 12/18/25 at 9:59 AM identified the Fentanyl patches should have been removed according to physician's orders. The interim Director of Nurse identified the facility's policy was to document the removal/wasting of a controlled substance on the CSDR (on the same line as the next administration) and that two (2) nurses were required to sign off on the removal/wasting.Review of the Controlled Drugs: Management policy identified, in part, that two licensed professionals are required to destroy and document destruction of controlled substances per state regulation.2a. Resident #4 was admitted to the facility in March of 2023 and had diagnoses that included Type 2 Diabetes Mellitus, chronic diastolic (congestive) heart failure, and End Stage Renal Disease. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent with bathing, personal, and oral hygiene.Review of the Resident Care Plan dated 2/7/24 identified Resident #4 required total assistance of one with activity of daily living care in bathing, personal hygiene, eating, bed mobility, transfer, and toileting, and was refusing medications. Interventions directed to provide a two staff approach with care if the resident had behaviors and to update the interdisciplinary team with deviations in the plan of care.A physician's order on 3/23/24 directed the administration of one (1) 72-hour 100 microgram/hour Fentanyl Patch transdermally every 72 hours for pain management and to remove per schedule.Review of the MAR dated 3/23/24 failed to identify Resident #4 was administered one (1) 100 microgram/hour Fentanyl patch.Review of the CSRD with a receive date of 3/22/24 identified Resident #4 was administered one (1) 100 microgram Fentanyl Patch on 3/23/24 at 3:00 PM. b. Resident #5 was admitted to the facility in July of 2021 and had diagnoses that included Type 2 Diabetes Mellitus, Chronic Systolic and Diastolic Congestive Heart Failure, and Chronic Pain Syndrome. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 12) and required set-up assistance with eating, dressing, oral and personal hygiene and was independent with transfers and ambulation Review

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 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 #4) reviewed for medication administration, the facility failed to administer medications in accordance with provider orders by administering an incorrect dose of a controlled medication and by administering a controlled medication prior to receiving a provider's order. The findings included:Resident #4 was admitted to the facility in March of 2023 and had diagnoses that included type 2 diabetes mellitus, chronic diastolic (congestive) heart failure, and end stage renal disease. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent for bathing, personal hygiene, and oral hygiene.Review of the Resident Care Plan (RCP) dated 2/7/24 identified Resident #4 required total assistance of one with activity of living care for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, and was refusing medications. Interventions directed to provide a two staff member approach with care if the resident had behaviors and to update the interdisciplinary team with deviations in the plan of care.1. A physician's order dated 3/18/24 directed application of two (2) 72-hour 50 microgram/hour Fentanyl Patches transdermally in the morning every three (3) days for chronic pain and to remove per schedule.Review of the Medication Administration Record (MAR) identified two (2) 50 microgram Fentanyl Patches were administered at 8:00 AM on 3/18/24.Review of the Controlled Substance Distribution Record (CSRD) (a form used in healthcare facilities to track every dose of a controlled medication from the time it is received until administered to a resident or properly discarded. It documents who received the medication, who administered it, when it was given, and how much was used, helping prevent misuse and medication errors while ensuring patient safety and legal compliance) with a received date of 3/14/24 failed to identify two (2) 50 microgram Fentanyl Patches were administered at 8:00 AM on 3/18/24. The CSRD identified that one (1) 50 microgram/hour Fentanyl Patch was administered at 12:00 PM on 3/18/25.Interview with LPN #8 on 12/18/25 at 1:40 PM identified she was the nurse assigned to provide care for Resident #4 on 3/18/24 and the correct dose of Fentanyl to be administered to Resident #4 on 3/18/24 was 100 micrograms/hour per the provider's order. LPN #8 could not identify if he/she administered two (2) 50 microgram Fentanyl Patches at 8:00 AM on 3/18/24 and then later administered one (1) 50 microgram/hour Fentanyl Patch at 12:00 PM or if he/she only administered one (1) 50 microgram/hour Fentanyl Patch at 12:00 PM.Interview with the Director of Nurses (DON) on 12/18/25 at 2:12 PM identified the Fentanyl Patches should have been administered as directed by the physician and that the five (5) medication rights, which included the right dose and the right time of administration, should have been exercised.2. A Physician's order dated 3/23/24 at 7:45 PM directed the administration of one (1) 72-hour 100 microgram/hour Fentanyl Patch transdermally every 72 hours for pain management and remove per schedule. Review of the MAR dated 3/23/24 failed to identify one (1) 100 microgram/hour patch was administered on 3/23/24.Review of the CSRD identified the administration of one (1) 100 microgram Fentanyl Patch on 3/23/24 at 3:00 PM (four (4) hours and forty-five (45) minutes before receiving the order). Although contact with LPN #3 was attempted, a returned call was not received. Interview with the Director of Nurses (DON) on 12/18/25 at 2:12 PM identified the provider's order for the 100 microgram/hour Fentanyl Patch was called in at 7:45 PM on 3/23/24 and that the Fentanyl Patch was administered prior to receiving the provider's order. The DON further indicated that the Fentanyl Patch should have been administered as directed by the provider and that the five (5) medication rights, which included the right time of administration, should have been exercised.Review of the Medication Administration policy directed staff would follow the written instructions provided by the physician/advanced practice registered nurse, and that nurses were responsible for documenting whenever a medication was given at the time the medication was administered, and not any time before or after that. The Medication Administration policy further directed staff to check the dose on the patient's chart with the dose being dispensed.