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	01/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 an allegation of abuse and/or neglect, the facility failed to ensure an allegation of neglect was reported to the State Agency when identified. The findings include:Resident #1's diagnoses included epilepsy (a chronic disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), multiple sclerosis (disorder where the body's immune system attacks the protective covering of the nerve cells, disrupting the flow of information within the brain and between the brain and the body and causing muscle weakness, vision changes, numbness and memory issues), repeated falls and adjustment disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident #1 rarely or never made decision regarding tasks of daily living. The Situation Background Assessment Recommendation (SBAR) note dated 11/10/25 at 8:33 AM identified Resident #1 had a seizure, the provider was notified and new orders were obtained to administer Ativan (fast-acting benzodiazepine used as a rescue medication to stop acute, prolonged or cluster seizures) one (1) milligram (mg) intramuscularly and transfer Resident #1 to the Emergency Department (ED) for further evaluation. The nurse's note dated 11/19/25 at 11:00 AM written by the former Director of Nursing (DON) identified per Resident #1's hospital record, Resident #1's family reported to the hospital staff concerns of the facility withholding Resident #1's anti-seizure medications. Review of the facility's Grievance Book failed to identify a grievance or documentation related to the allegation the facility withheld seizure medications from Resident #1 as documented in the 11/19/25 nurse's note. Although requested, a facility Accident and Investigation (A & I) related to the allegation of neglect was not available. Review of the State Agency Reportable Events website failed to reflect documentation the State Agency was notified of the allegation of neglect on or around 11/19/25. Interview with the former DON on 1/15/26 at 1:25 PM identified although she wrote the 11/19/25 at 11:00 AM nurse's note identifying she was aware of Resident #1's family alleging Resident #1 did not receive the anti-seizure medications prior to the 11/10/25 seizure incident, she did not report the allegation to the State Agency or fully investigate it aside from reviewing the Medication Administration Records, stating looking back she should have. Interview with the Administrator on 1/21/26 at 1:49 PM identified the former DON had casually reported to her around 11/19/25 there was a medication issue related to Resident #1 but never mentioned the incident again or reported to her it was an allegation of neglect. The Administrator identified she was unaware of the 11/19/25 nurse's note written by the former DON and stated had she seen the note or if the former DON had reported to her the extent of the medication issue she would have ensured the allegation was reported to the State Agency within two (2) hours and the allegation fully investigated by the facility. Review of the Abuse Prohibition policy dated 10/24/22 directed, in part, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that immediately upon receiving information concerning report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following: Enter allegations into the PCC Risk Management Portal, reporting allegations to the appropriate state and local authorities involving neglect, exploitation or mistreatment not later than two (2) hours after the allegation is made if the event results in serious bodily injury and within 24 hours if it does not result in serious bodily injury, notify local law enforcement, Licensing Boards and Registries and other agencies as required, initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent, causative factors and interventions to prevent further injury. The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included. Failure to report in the required time frames may result in disciplinary action, up to and including termination.

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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	Respond appropriately to all alleged violations. **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 allegations of abuse and/or neglect, the facility failed to provide documentation the allegations of abuse and/or neglect were thoroughly investigated. The findings include: Resident #1‘s diagnoses included epilepsy (a chronic disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), multiple sclerosis (disorder where the body's immune system attacks the protective covering of the nerve cells, disrupting the flow of information within the brain and between the brain and the body and causing muscle weakness, vision changes, numbness and memory issues), repeated falls and adjustment disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident #1 rarely or never made decision regarding tasks of daily living. The Situation Background Assessment Recommendation (SBAR) note dated 11/10/25 at 8:33 AM identified Resident #1 had a seizure, the provider was notified and new orders were obtained to administer Ativan (fast-acting benzodiazepine used as a rescue medication to stop acute, prolonged or cluster seizures) one (1) milligram (mg) intramuscularly and transfer Resident #1 to the Emergency Department (ED) for further evaluation. The nurse's note dated 11/19/25 at 11:00 AM written by the former Director of Nursing (DON) identified per Resident #1's hospital record, Resident #1's family reported to the hospital staff concerns of the facility withholding Resident #1's anti-seizure medications. The note indicated the October and November 2025 Medication Administration Records (MAR) were reviewed. Review of the facility's Grievance Book failed to identify a grievance or documentation related to the allegation the facility withheld seizure medications from Resident #1 as documented in the 11/19/25 nurse's note. Although requested, a facility Accident and Investigation (A & I) related to the allegation of neglect was not available. Review of the State Agency Reportable Events website failed to reflect documentation the State Agency was notified of the allegation of neglect on or around 11/19/25. Interview with the former DON on 1/15/26 at 1:25 PM identified although she wrote the 11/19/25 at 11:00 AM nurse's note identifying she was aware of Resident #1's family alleging Resident #1 did not receive the anti-seizure medications prior to the 11/10/25 seizure incident, she did not report the allegation to the State Agency or fully investigate it aside from reviewing the Medication Administration Records because the family did not report the allegation to the facility itself, only the hospital staff, and looking back she should have. Interview with the Administrator on 1/21/26 at 1:49 PM identified the former DON had casually reported to her around 11/19/25 there was a medication issue related to Resident #1 but never mentioned the incident again or reported to her it was an allegation of neglect. The Administrator identified she was unaware of the 11/19/25 nurse's note written by the former DON and stated had she seen the note or if the former DON had reported to her the extent of the medication issue she would have ensured the allegation was reported to the State Agency within two (2) hours and the allegation fully investigated by the facility. Review of the Abuse Prohibition policy dated 10/24/22 directed, in part, that immediately upon receiving information concerning report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following: Enter allegations into the PCC Risk Management Portal, reporting allegations to the appropriate state and local authorities involving neglect, exploitation or mistreatment not later than two (2) hours after the allegation is made if the event results in serious bodily injury and within 24 hours if it does not result in serious bodily injury, notify local law enforcement, Licensing Boards and Registries and other agencies as required, initiate an investigation within 24 hours of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent, causative factors and interventions to prevent further injury. The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included. Failure to report in the required time frames may result in disciplinary action, up to and including termination.

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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 #1) reviewed for medication administration, the facility failed to ensure anti-seizure medications were refilled prior to not having a supply available and not borrowing from another resident's supply. The findings include:Resident #1's diagnoses included epilepsy (a chronic disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), multiple sclerosis (disorder where the body's immune system attacks the protective covering of the nerve cells, disrupting the flow of information within the brain and between the brain and the body and causing muscle weakness, vision changes, numbness and memory issues), repeated falls and adjustment disorder. A physician's order dated 5/18/25 directed to administer levetiracetam tablet 1000 milligrams (mg), give one (1) tablet by mouth twice daily for seizures and oxcarbazepine tablet 300 mg, give one (1) tablet by mouth twice daily for seizures. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating Resident #1 rarely or never made decision regarding tasks of daily living. The Resident Care Plan dated 9/17/25 identified Resident #1 exhibited and/or was at risk for seizure activity. Interventions included medicating the resident as ordered and monitoring for effectiveness as well as side effects and report to the physician as needed, monitoring blood levels for therapeutic dose of medication as ordered and report abnormal levels to the physician and monitoring for sign and symptoms of impending seizures. The Situation Background Assessment Recommendation (SBAR) note dated 11/10/25 at 8:33 AM identified Resident #1 had a seizure, the provider was notified and new orders were obtained to administer Ativan (fast-acting benzodiazepine used as a rescue medication to stop acute, prolonged or cluster seizures) one (1) milligram (mg) intramuscularly and transfer Resident #1 to the Emergency Department (ED) for further evaluation. The nurse's note dated 11/19/25 at 11:00 AM written by the former Director of Nursing (DON) identified the October and November 2025 Medication Administration Records were reviewed and there were no missed doses of either anti-seizure medication, the levetiracetam and oxcarbazepine, noted. Review of the October and November 2025 Medication Administration Records identified both the levetiracetam and oxcarbazepine were scheduled at 9:00 AM and 9:00 PM and all doses were signed off as administered. Interview with the Pharmacist on 1/15/25 at 1:41 PM identified all deliveries of both the oxcarbazepine and levetiracetam were sent in fourteen (14) day supplies (twenty-eight (28) tablets of each medication) and the facility had not requested any STAT (immediate) deliveries of either the levetiracetam or oxcarbazepine from 5/18/25 through 11/10/25. The Pharmacist indicated the levetiracetam was stocked in the automated medication dispensing system used to store an emergency supply of medications (Pyxis) but that the oxcarbazepine was not. Review of the facility Order Audit Report for the oxcarbazepine identified:The 5/18/25 delivery was not requested for refill until 6/10/25 (9 days late).The 6/22/25 delivery was not requested for refill until 7/7/25 (1 day late).The 7/7/25 delivery was not requested for refill until 7/23/25 (2 days late).The 8/6/25 delivery was not requested for refill until 9/3/25 (14 days late).The 9/16/25 delivery was not requested for refill until 10/2/25 (2 days late). Review of the facility Order Audit Report for the levetiracetam identified:The 5/18/25 delivery was not requested for refill until 6/10/25 (9 days late).The 6/21/25 delivery was not requested for refill until 7/7/25 (2 days late).The 7/7/25 delivery was not requested for refill until 7/23/25 (2 days late).The 7/23/25 delivery was not requested for refill until 8/10/25 (4 days late).The 10/6/25 delivery was not requested for refill until 10/22/25 (2 days late).The 10/22/25 delivery was not requested for refill until (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/7/25 (2 days late). Review of the Pyxis report dated 5/18/25 through 11/10/25 failed to identify the levetiracetam had been pulled from emergency supply. Interview with the 3-11PM Registered Nurse (RN) #3 on 1/20/26 at 3:01 PM identified she worked full-time on Resident #1's unit and consistently when she returned to work after being off for a few days, would have to refill Resident #1's anti-seizure medications, as she would not be able to locate the levetiracetam or oxcarbazepine and it appeared as if other nurse's had not attempted to refill them. RN #3 indicated although she always administered both the oxcarbazepine and levetiracetam to Resident #1, if the levetiracetam or oxcarbazepine were not available she would find other residents who were on the same medications and use their supply. RN #3 identified she should not have taken the medications from other residents' supply and should have notified the nursing supervisor, pulled the medication from the Pyxis if available and called the pharmacy to request the medications STAT. Interviews with Licensed Practical Nurse (LPN) #2, LPN #11 and LPN #12 identified they could not recall ever exhausting the supply of oxcarbazepine or levetiracetam but reported they were not able to locate the medications on several occasions so instead of notifying the nursing supervisor, pulling the medication from the Pyxis and calling the pharmacy to inquire about the medications whereabouts as they should have done, they took the medications from other residents who were on anti-seizure medications. LPN #2, LPN #11 and LPN #12 stated they should not have taken the medications from other residents because it then put those residents at risk for running out of their medications too early. LPN #2, LPN #11 and LPN #12 identified they were unable to identify why the medications were not refilled through either the electronic Medication Administration Record or by calling the pharmacy to refill and the medications should have been refilled at least two (2) days prior to the medication blister pack being exhausted. Interview with the Director of Nursing (DON) on 1/15/25 at 2:01 PM and on 1/21/25 at 11:17 AM identified the levetiracetam had not been pulled from emergency stock since Resident #1's admission and the oxcarbazepine was not stocked in the facility's emergency supply. The DON explained she reviewed the Order Audit Reports which identified the oxcarbazepine and levetiracetam were not being reordered timely, the charge nurses were responsible for requesting refills on medications when the supply was down two (2) to three (3) days and each shift thereafter should be calling the pharmacy to check on the status of the medication refill. The DON identified if a licensed nurse was unable to locate a medication for a resident, they should be notifying the nursing supervisor immediately, obtaining the medication from the Pyxis stock if available and calling the pharmacy to inquire about the whereabouts and requesting the medication STAT. The DON identified the nurses should not be utilizing other residents' medications at any time, as it then puts those residents at risk for running out of their medications. Review of the Reordering, Changing and Discontinued Medication Orders policy (undated) directed, in part, that the facility will communicate any medication reorders, changes or discontinuations to the pharmacy in accordance with pharmacy guidelines and state/federal regulations thus ensuring standardized process of communication. Communication may be transmitted through verbal, written or electronic orders. Review of the Medication Administration policy dated 05/01/24 directed, in part, that staff will follow written instructions provided by the provider to include the seven (7) rights of medication administration to include the: Right Individual, Right Medication, Right Dose, Right Time, Right Route, Right Documentation and the Right Response.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and interviews for three (3) sampled residents (Residents #2, #3, and #4) reviewed for medication administration, the facility failed to administer anxiolytic medications in accordance with the provider's order to prevent the administration of an incorrect, higher dose of a controlled medication and omitting doses of controlled medications. The findings include: 1. Resident #2's diagnoses included vascular dementia with mood disturbances, anxiety disorder and depressive episodes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #2 was alert and oriented and received anti-anxiety, antidepressant and anticonvulsant medications. The Resident Care Plan dated 10/18/25 identified Resident #2 exhibited or was at risk forDistressed or fluctuating mood symptoms related to sadness/depression caused by depressive episodes and/or bipolar disorder. Interventions included administering medications as ordered and referring the resident to the behavioral health specialist as needed. A physician's order dated 12/10/25 directed to administer Ativan 0.5 milligrams (mg), give 0.5 (1/2) tablet by mouth three (3) times daily for anxiety. The Facility Reported Incident form dated 12/24/25 at 9:10 AM identified an incorrect dose of Ativan 0.5 mg was administered instead of 0.25 mg to Resident #2from 12/10/25 through 12/23/25. The Situation Background Assessment, Recommendation (SBAR) dated 12/24/25 at 2:22 PM identified Resident #2 had been taking the wrong dosage of Ativan, reporting Ativan 0.5 mg instead of 0.25 mg (double the prescribed dose) was administered. The note identified there were no signs or symptoms of distress, pain or discomfort and the Advanced Practice Registered Nurse (APRN) and Resident #2's representative were notified and the Ativan order was updated and corrected. Review of the December 2025 Medication Administration Record identified Resident #2 had been administered Ativan 0.5 mg by mouth three times daily from 12/10/25 through 12/24/25. The Controlled Substance Disposition Record (a form used by facilities to track every dose of a controlled medication from the time it is received until administered to a resident or properly discarded, documents who administered the medication when given, how much was used, and how much was remaining, helping to prevent misuse and medication errors) identified on 12/1/25 the facility received a supply of thirty (30) (1/2) tablets of Ativan. Review of the order on the Controlled Substance Disposition Record read Ativan 0.5 mg tablet, 1/2 tab (0.25 mg) by mouth three (3) times daily. The sign out records identified two (2) half (1/2) tablets of Ativan 0.25 mg (equaling 0.5 mg) were administered in error seventeen (17) times. On 12/10/25 at 9:00 AM, 1:00 PM, and 8:00 PM, on 12/11/25 at 9:00 AM and 1:00 PM, on 12/13/25 at 9:00 AM and 1:00 PM, 12/18/25 at 8:00 PM, on 12/19/25 at 9:00 AM and 1:00 PM, on 12/21/25 at 9:00 AM, 1:00 PM, and 8:00 PM, 12/22/25 at 9:00 AM and 1:00 PM and on 12/23/25 at 9:00 AM and 1:00 PM. A physician's order dated 12/24/25 identified the Ativan order was increased and now directed to administer Ativan 0.5 milligrams (mg), give 0.5 mg (1 tablet) by mouth three (3) times daily for anxiety and/or agitation. Review of the December 2025 Medication Administration Record identified Resident #2 had been administered Ativan 0.5 mg by mouth three (3) times daily and all doses were signed off as administered from 12/24/25 through 12/31/25. Review of the Controlled Substance Disposition Record dated 12/1/25 identified Resident #2 was administered one (1) half (1/2) tab (0.25 mg) on 12/24/25 at 9:00 PM, 12/25/25 at 9:20 and 9:45 PM and on 12/26/25 at 9:00 PM. The record indicated there were four (4) errors of administering half the dose (0.25 mg) of what the 12/24/25 physician's order directed (0.5 mg). Interviews with the charge nurses Licensed Practical Nurse (LPN) and Registered Nurse (RN), LPN #1, RN #1, LPN #3, LPN #4 and LPN #5, on 1/14/26 identified they misread the 11/27/25 and/or 12/10/25 physician's order for (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Ativan, explaining they thought the order read to give 0.5 mg. They identified they should always be following the five (5) rights of medication administration (right drug, right patient, right dose, right route and right time) and failed to compare both the electronic Medication Administration Record order to the order on the blister pack of the Ativan resulting in administering double the ordered dose. 2. Resident #3's diagnoses included dementia with agitation, schizophrenia (mental health condition that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others), anxiety, major depressive disorder and epilepsy. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a staff assessment for mental status indicating short-term and long-term memory problems. The Resident Care Plan dated 11/18/25 identified that Resident #3 exhibited or was at risk for distressed and/or fluctuating mood symptoms related to major depressive disorder, anxiety and Schizophrenia. Interventions included administering medications as ordered and documenting the effectiveness, side effects and referring the resident to a behavioral health specialist as needed. A physician's order dated 12/8/25 directed to administer lorazepam 0.5 mg, give one (1)tablet by mouth every eight (8) hours for anxiety and agitation. Review of the January 2026 Medication Administration Record identified Resident #3 had been administered lorazepam 0.5 mg by mouth every eight (8) hours daily as ordered. The Medication Administration Record indicated the lorazepam was scheduled daily at 5:00 AM, 1:00 PM and 9:00 PM. Review of the Controlled Substance Disposition Record dated 10/1/25 failed to identify the lorazepam 0.5 mg was administered to Resident #3 on 1/3/26 at 5:00 AM although the medication had been signed off on the Medication Administration Record as administered. 3. Resident #4's diagnoses included dementia with behavioral disturbances, paranoid personality disorder, generalized anxiety disorder and major depressive disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen (15) indicating Resident #4 had short-term and long-term memory problems. The Resident Care Plan dated 12/26/25 identified that Resident #4 exhibited or was at risk fordistressed and/or fluctuating mood symptoms related to psychiatric disorders including paranoidpersonality disorder, anxiety disorder and alcohol use disorder. Interventions included observing for signs of delirium, including delusions and hallucinations; observing for signs and symptoms of worsening sadness, depression, anxiety, fear, anger and agitation; observing for worsening signs and symptoms of existing psychiatric disorders and notifying the provider of any changes as needed. A physician's order dated 12/16/25 directed to administer Xanax 0.5 mg, give 0.5 mg by mouth three (3) times a day for anxiety/agitation. Review of the January 2026 Medication Administration Record identified Resident #4 had been administered Xanax 0.5 mg by mouth three (3) times daily as ordered. The Medication Administration Record indicated the Xanax was scheduled daily at 9:00 AM, 1:00 PM and 5:00 PM. Review of the Controlled Substance Disposition Record dated 12/17/25 failed to indicate the Xanax 0.5 mg was administered to Resident #4 on 1/5/26 at 5:00 PM, 1/7/26 at 9:00 AM and 1:00 PM, 1/10/26 at 5:00 PM and 1/13/26 at 9:00 AM and 1:00 PM although all six (6) scheduled doses were signed off on the Medication Administration Record as administered. Interview with the psychiatric Advanced Practice Registered Nurse (APRN) on 1/14/26 at 5:04 PM identified licensed nurses are to fully read orders, follow the five (5) rights of medication administration to include the right dose, to administer the medications per the provider's order and clarify the orders with a provider if they are unsure. The APRN indicated no one had called him to clarify or question either the 11/26/25 or the 12/10/25 Ativan orders for Resident #2 until 12/24/25 and reported he was never made aware Residents #2, #3 or #4 had omitted doses of anxiolytic medications between December 2025 and January 2026. The APRN identified although Residents #2, #3 or #4 had no documented negative effects (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 - Some	from the medication errors, they were all diagnosed with dementia and were at risk for increased anxiety, agitation and impaired comfort when scheduled anxiolytic medications were omitted. Interview with the Director of Nursing (DON) on 1/14/26 at 12:52 PM identified licensed nurses are expected to fully read the physician's order and compare the order to the label on the blister pack of medication before each medication was administered and if there were any questions they are to clarify the order with the provider, which they did not do and Resident #2 subsequently received double the dose of Ativan intended per physician's order. The DON indicated if the licensed nurses had followed the physician's orders and ensured the five (5) rights of medication administration were followed to include the right dose, the errors could have been prevented with Resident #2. The DON identified medications are expected to be signed off as administered in the Medication Administration Record at the time they are given, the Medication Administration Records for Residents #2, #3 and #4 should have matched with the corresponding Controlled Substance Disposition Record. Review of the Medication Administration policy dated 5/1/24 directed, in part, that 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. Review of the Medication Errors policy dated 6/1/21 directed, in part, that a medication error is defined as a discrepancy between what the physician/advanced practice provider ordered and what the resident received. Types of errors include medication omissions, wrong resident dose, route, rate or time, incorrect preparation and/or incorrect administration technique.

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	01/21/2026

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **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 sampled residents (Resident #2) who received medications that required laboratory monitoring, the facility failed to ensure bloodwork was obtained per the physician's order. The findings include:Resident #2's diagnoses included vascular dementia with mood disturbances, anxiety disorder and depressive episodes. A physician's order dated 8/21/25 directed to administer Depakote sprinkles delayed release oral capsule 125 milligrams (mg), give six (6) capsules by mouth at bedtime for bipolar disorder (chronic mental health disorder causing extreme mood swings ranging from extreme highs to sever lows). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #2 was alert and oriented and received anti-anxiety, antidepressant and anticonvulsant medications. The Resident Care Plan dated 10/18/25 identified that Resident #2 was at risk for complications related to the use of psychotropic medications. Interventions included monitoring for side effects and consulting the physician and/or pharmacist as needed and monitoring for the continued need of the medication. A physician's order dated 12/24/25 directed to obtain a Complete Blood Count (CBC), Complete Metabolic Panel (CMP) and a Depakote level on the next laboratory draw day. Review of the clinical record from 12/24/25 through 1/15/25 failed to reflect documentation the lab work had been obtained as per the physician's order. Interview with the Director of Nursing (DON) on 1/15/26 at 2:47 PM identified the normal facility laboratory days are on Monday, Wednesday, Friday and as needed. The DON explained Resident #2's bloodwork should have been obtained on 12/26/25 but she was unable to find documentation the lab draw had occurred. The DON indicated when laboratory orders are entered into the electronic health record, the same shift was responsible for confirming the order, writing the order in the laboratory book and the 11PM-7AM shift was responsible to ensure the order matched what was written in the laboratory book. The DON was unable to provide documentation the 12/24/25 laboratory orders were noted in the laboratory book and explain why the labs were not obtained. Although requested, facility policies for physician orders, transcription of orders and obtaining bloodwork were not provided.