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	02/17/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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) sampled residents (Resident #1) reviewed for behavioral concerns, the facility failed to develop and implement a comprehensive care plan with person-centered interventions to address intrusive behaviors. The findings include: Resident #1's diagnoses included severe dementia with psychotic disturbances (abnormal thinking and perceptions of reality), adjustment disorder with mixed anxiety and depressed mood.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4) and required supervision assistance for transfers and ambulation.The Resident Care Plan (RCP) dated 1/21/26 identified Resident #1 exhibited or was at risk for distressed/fluctuating mood symptoms, had impaired cognitive function related to dementia and impaired communication as evidenced by impaired hearing. Interventions included providing consistent, trusted caregivers and structured daily routines when possible, using short phrases that require yes or no answers, allowing time to express feelings and reassurance and referring to a Behavioral Health Specialist as needed. A nurse's note by LPN #1 dated 1/15/26 at 2:43 PM identified Resident #1 was observed being intrusive (unwanted or uninvited) in another resident's room (Resident #2) and was noted to be following the resident down the hallway. The note reported Resident #1 was immediately redirected away from the other resident, escorted away from the room, separation was maintained and Resident #1 was placed on every fifteen (15) minute safety checks. The note identified the provider was notified, social services was notified, the conservator was notified and Resident #1 was subsequently moved to a new unit.A nurse's note by RN #3 dated 2/1/26 at 5:52 PM identified Resident #1 was observed by staff in the common area tugging the front collar area of another resident's (Resident #4) shirt. The behavior was brief, non-aggressive and non-threatening. The note reported no injuries were reported from either resident and Resident #1 was easily redirected, was educated to not touch others and every 15-minute checks would remain in place.Interviews with LPN #1, LPN #2, LPN #5, NA #2, NA #4 and NA #7 on 2/17/26 identified Resident #1 enjoyed staying busy and thought he/she was at work at the facility. Resident #1 often tried to help other residents by obtaining plastic cups from the nurse's carts and passing out drinks, pushing residents down the hallway in their wheelchairs, and at times, following other residents.Review of the RCP failed to identify intrusive behaviors toward other residents or include person-centered interventions to address and redirect intrusive behaviors. Interview with the Director of Nursing (DON) on 2/17/26 at 3:10 PM identified she was aware Resident #1 frequently handed out cups of water to other residents and pushed residents down the hallway in their wheelchairs. The DON reported Resident #1 appeared to believe he/she was helping other residents and enjoyed staying busy. The DON identified a behavioral care plan should have been developed with interventions to address the behaviors and prevent further incidents. She identified potential interventions could have (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
	075228	A. Building B. Wing	02/17/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included asking Resident #1 to assist the recreation department with passing out materials during structured activities or assigning Resident #1 a task related to his/her past occupation to provide a sense of purpose. The DON reported the interdisciplinary team discussed the behaviors during morning report following the 1/15/26 incident and identified Resident #1 required a behavioral care plan to address the behaviors; however, did not follow up to ensure the care plan was developed. Review of the Person-Centered Care Plan policy dated 10/22/24 directed, in part, that Person-Centered Care Plans are developed to promote positive communication between resident, resident representative, and team to obtain the resident's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes. The care plan must be customized to each individual resident's preferences and needs. Care plans will be communicated to appropriate staff, resident, resident representatives and family members and 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.

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	02/17/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **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) sampled residents (Resident #1) reviewed for a room change, the facility failed to ensure ongoing social services monitoring for a resident with severe cognitive impairment and psychiatric diagnoses during the seventy-two (72) hour adjustment period after relocation. The findings include:Resident #1's diagnoses included severe dementia with psychotic disturbances (abnormal thinking and perceptions of reality), adjustment disorder with mixed anxiety and depressed mood. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4) and required supervision assistance for transfers and ambulation. The Resident Care Plan (RCP) dated 1/15/26 identified Resident #1 was adjusting to a new memory care environment. Interventions included encouraging reminiscence by discussing meaningful family relationships and providing opportunities for quiet and one-to-one visits. A nurse's note by LPN #1 dated 1/15/26 at 2:43 PM identified Resident #1 was observed being intrusive (unwanted or uninvited) in another resident's room (Resident #2) and was noted to be following the resident down the hallway. The note reported Resident #1 was immediately redirected away from the other resident, escorted away from the room, separation was maintained and Resident #1 was placed on every fifteen (15) minute safety checks. The note identified both the medical and psychiatric APRN's were notified for evaluation, social service staff were notified, the conservator was notified and Resident #1 was subsequently moved to a new unit. A social service note by Social Worker #3 dated 1/15/26 at 3:27 PM identified she met with Resident #1 to show him/her the new room prior to the room change, and that following the change to an adjacent unit, Resident #1 was noted to be confused with the change but was not agitated or behavioral. A social service note by Social Worker #2 dated 1/16/26 at 3:34 PM identified she assessed Resident #1 for the adjustment period following a new room change. Resident #1 was adjusting well with no signs of anxiety or distress over the room change. The note identified that she would follow up with Resident #1 two (2) more times per protocol. Review of the clinical record from 1/17/26 through 1/21/26 failed to identify any further social service follow ups for Resident #1. Interview with the Administrator on 2/17/26 at 3:40 PM identified following a resident room change, social service staff were required to follow up with the resident for 72 hours to ensure a smooth transition and that the resident was adjusting well. He/she identified that social services failed to follow up with Resident #1 after the initial visit on 1/16/26. The Administrator reported that Social Worker #2 was reassigned following the 1/16/26 visit and identified that the follow-up was missed in transition to the new social worker. Review of the Room Change policy dated 5/1/24 directed, in part, that the resident's physical, social, emotional and cognitive needs as well as preferences are assessed by the interdisciplinary team and considered prior to relocating the resident to a different room. Social Services will follow up with the resident to see how they are adjusting and will address and document any issues.